Nebraska Mental Health Commitment Act Reference Manual 2015

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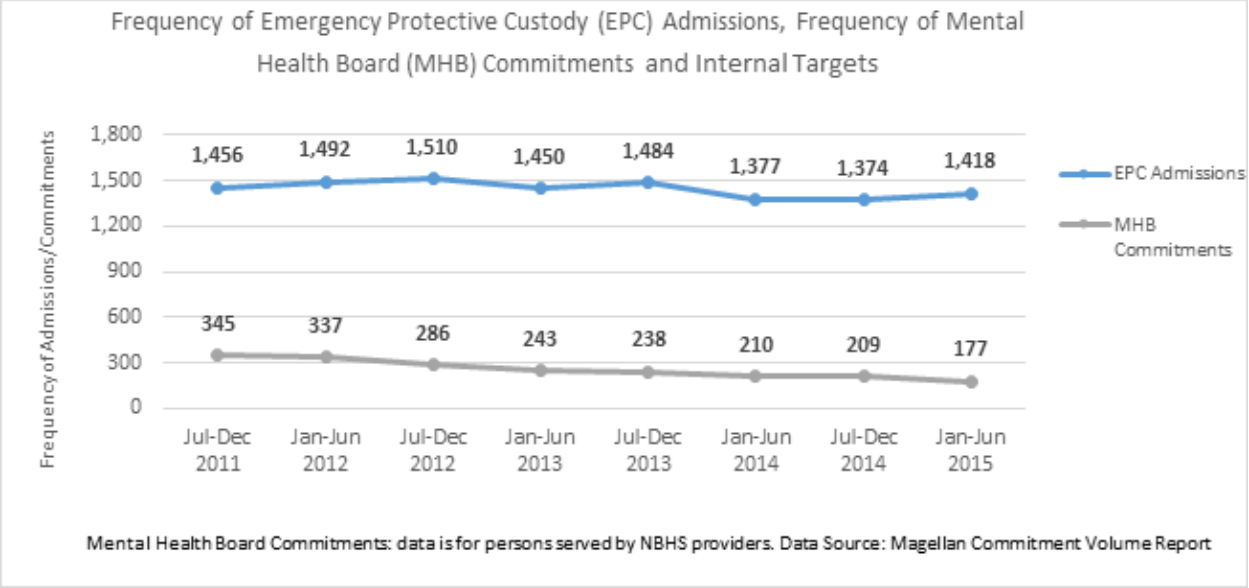
INTRODUCTION

The Nebraska Mental Health Commitment Act serves a purpose in protecting those with a mental illness who are not capable of caring for themselves in a safe manner. It is a complicated law which if misused violates individuals' civil rights. Undeniably, a mental health commitment should only be enacted in situations when all other options have been exhausted. Under the leadership of the Department of Health and Human Services Division of Behavioral Health and the Regional Behavioral Health Authorities, Nebraska continues to decrease the number of individuals committed to mental health treatment. This is due to changes in the behavioral health system that were implemented in 2004. These changes include community-based services such as crisis response services which are designed to therapeutically work with an individual experiencing a mental health crisis.

Throughout the state, crisis response services are provided to individuals who are experiencing mental health crises by licensed mental health professionals. In most cases, crisis response services are initiated by law enforcement and occur wherever the crisis is occurring. Recent data from the Division of Behavioral Health reports that when crisis response services were accessed, 84.3% of the Emergency Protective Custodies were diverted. See the chart below. It is a comparison of individuals placed in Emergency Protective Custody and those that were placed on a Mental Health Board Commitment.



This Reference Manual provides guidance for individuals, attorneys, judges, law enforcement, mental health professionals, court clerks, and advocacy organizations on how to appropriately utilize Nebraska's Mental Health Commitment Act. The manual begins with an overview of the Act, followed by clinical information regarding mental illness. In addition, guidance is given on determining dangerousness due to mental illness or substance dependency.

In Part 3, the manual describes the Mental Health Commitment Process. Relevant statutes are presented and then more description is provided to describe the role of the Mental Health Board in more detail. This process is presented in four stages: 1) Emergency Protective Custody and Mental Health Evaluation, 2) Mental Health Board Hearing, 3) Commitment to Treatment, and 4) Change in Treatment or Discharge.

In conjunction with the Dangerous Sex Offender Commitment Act, the Mental Health Commitment Act is also utilized to commit individuals lawfully deemed sex offenders to sex offender treatment. Part 4 of the manual describes that process.

Finally, precedent-setting legal cases are presented in Part 5.

The Division of Behavioral Health has created several forms for use by law enforcement, mental health professionals, and Mental Health Boards. Examples of these forms are found in the Appendix and are available on the Division's website at:
http://dhhs.ne.gov/behavioral_health/Pages/beh_commit_commit.aspx.

PREFACE

INDIVIDUAL RIGHTS

Personal Rights: Rights of a person subject to a Mental Health Board proceeding for commitment of a mentally ill and dangerous person.

A. Procedural rights

1. To written notice of the time and place of hearing.
2. To notice of the reasons alleged for believing the subject is a mentally ill and dangerous person who requires Mental Health Board Ordered treatment
3. To receive a copy of the petition.
4. To a list of his/her rights.
5. To the label of the mental disorder of the subject unless the physician or mental health professional on the board determines that it is not prudent to disclose the label of the mental disorder to the subject, then notice of this label may be disclosed to the subject's counsel rather than the subject. When the subject does not have counsel, the subject has a right to the information about his or her mental illness including its label.
6. To inquiry by the Board as to whether the subject has read and understood the petition and list of rights.
7. To a lawyer (Board appointed if the subject is indigent)
8. To access (either in person or through his/her attorney) all evidence and information including the label given to the alleged mental illness.
9. To an independent evaluation by physicians or clinical psychologists and to have their testimony and assistance in the subject's behalf. If the subject is indigent, the reasonable cost of the evaluation and related professional assistance in the subject's behalf will be paid by the Board.
10. To have continuances liberally granted.
11. To closed hearings unless the subject requests that they be open.
12. To be present at all hearings and present witnesses and information defending against the petition
13. To subpoena witnesses to testify for the subject's defense.
14. To confront and cross examine witnesses and evidence
15. To have rules of evidence applicable in civil proceedings apply to Board hearings.
16. To testify or refuse to testify.
17. To be free of such quantities of medication or other treatments prior to any Board hearing as would substantially impair his/her ability to assist in his/her defense at the hearing.
18. To written statements by the Mental Health Board about the evidence relied upon and the reasons for finding clear and convincing proof at the hearing that the subject is a mentally ill and dangerous person, that less restrictive alternatives are not available or feasible to prevent the harm and for the choice of the particular treatment ordered.
19. To have the Board's written findings made part of the person's record.
20. To have all proceedings be of record
21. To appeal the decision of the Mental Health Board to the District Court and to appeal a final order of the District Court to the Court of Appeals

B. Rights while in custody or Board ordered treatment.

1. To be considered legally competent for all purposes (i.e. Voting, contracts, use of money, marriage, divorce, etc.) unless one has been declared legally incompetent.
2. To receive prompt and adequate evaluation and treatment for mental illness and physical ailments and to participate in one's treatment planning activities (to the extent deemed appropriate by the mental health professional responsible)
3. To refuse treatment medication, except (a) in an emergency, such treatment as is essential in the judgment of the mental health professional in charge of such treatment to prevent the subject from causing injury to himself, herself or others or (b) following a hearing and order of a Mental Health Board, such treatment medication as will substantially improve his or her mental illness.
4. To communicate freely with all persons by sealed mail, personal visitation or private telephone communications.
5. To have reasonably private living conditions, including private storage space for personal belongings.
6. To engage or refuse to engage in religious worship and political activity.
7. To be compensated for labor in accordance with the fair labor standards act.
8. To have access to a grievance procedure
9. To file writs of habeas corpus to challenge the legality of his or her custody or treatment.
10. To have his/her records remain confidential except as otherwise provided by law.
11. To have access to his/her records unless ordered otherwise by the Court.

SAMHSA's Working Definition of Recovery from Mental Disorders and/or Substance Use Disorders

The Substance Abuse and Mental Health Services (SAMHSA) recognizes there are many different pathways to recovery and each individual determines his or her own way. SAMHSA engaged in a dialogue with consumers, persons in recovery, family members, advocates, policy-makers, administrators, providers, and others to develop the following definition and guiding principles for recovery. The urgency of health reform compels SAMHSA to define recovery and to promote the availability, quality, and financing of vital services and supports that facilitate recovery for individuals. In addition, the integration mandate in title II of the Americans with Disabilities Act and the Supreme Court's decision in Olmstead v. L.C., 527 U.S. 581 (1999) provide legal requirements that are consistent with SAMHSA's mission to promote a high-quality and satisfying life in the community for all Americans.

Recovery from Mental Disorders and/or Substance Use Disorders: A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

Through the Recovery Support Strategic Initiative, SAMHSA has delineated four major dimensions that support a life in recovery:

- ***Health***: overcoming or managing one's disease(s) or symptoms—for example, abstaining from use of alcohol, illicit drugs, and non-prescribed medications if one has an addiction problem—and for everyone in recovery, making informed, healthy choices that support physical and emotional wellbeing.
- ***Home:*** a stable and safe place to live;
- ***Purpose:*** meaningful daily activities, such as a job, school, volunteerism, family caretaking, or creative endeavors, and the independence, income and resources to participate in society; and
- ***Community***: relationships and social networks that provide support, friendship, love, and hope.

Guiding Principles of Recovery

Recovery emerges from hope: The belief that recovery is real provides the essential and motivating message of a better future – that people can and do overcome the internal and external challenges, barriers, and obstacles that confront them. Hope is internalized and can be fostered by peers, families, providers, allies, and others. Hope is the catalyst of the recovery process.

Recovery is person-driven: Self-determination and self-direction are the foundations for recovery as individuals define their own life goals and design their unique path(s) towards those goals. Individuals optimize their autonomy and independence to the greatest extent possible by leading, controlling, and exercising choice over the services and supports that assist their recovery and resilience. In so doing, they are empowered and provided the resources to make informed decisions, initiate recovery, build on their strengths, and gain or regain control over their lives.

Recovery occurs via many pathways: Individuals are unique with distinct needs, strengths, preferences, goals, culture, and backgrounds including trauma experiences that affect and determine their pathway(s) to recovery. Recovery is built on the multiple capacities, strengths, talents, coping abilities, resources, and inherent value of each individual. Recovery pathways are highly personalized. They may include professional clinical treatment; use of medications; support from families and in schools; faith-based approaches; peer support; and other approaches. Recovery is non-linear, characterized by continual

growth and improved functioning that may involve setbacks. Because setbacks are a natural, though not inevitable, part of the recovery process, it is essential to foster resilience for all individuals and families. Abstinence from the use of alcohol, illicit drugs, and non-prescribed medications is the goal for those with addictions. Use of tobacco and non-prescribed or illicit drugs is not safe for anyone. In some cases, recovery pathways can be enabled by creating a supportive environment. This is especially true for children, who may not have the legal or developmental capacity to set their own course.

Recovery is holistic: Recovery encompasses an individual's whole life, including mind, body, spirit, and community. This includes addressing: self-care practices, family, housing, employment, education, clinical treatment for mental disorders and substance use disorders, services and supports, primary healthcare, dental care, complementary and alternative services, faith, spirituality, creativity, social networks, transportation, and community participation. The array of services and supports available should be integrated and coordinated.

Recovery is supported by peers and allies: Mutual support and mutual aid groups, including the sharing of experiential knowledge and skills, as well as social learning, play an invaluable role in recovery. Peers encourage and engage other peers and provide each other with a vital sense of belonging, supportive relationships, valued roles, and community. Through helping others and giving back to the community, one helps one's self. Peer-operated supports and services provide important resources to assist people along their journeys of recovery and wellness. Professionals can also play an important role in the recovery process by providing clinical treatment and other services that support individuals in their chosen recovery paths. While peers and allies play an important role for many in recovery, their role for children and youth may be slightly different. Peer supports for families are very important for children with behavioral health problems and can also play a supportive role for youth in recovery.

Recovery is supported through relationship and social networks: An important factor in the recovery process is the presence and involvement of people who believe in the person's ability to recover; who offer hope, support, and encouragement; and who also suggest strategies and resources for change. Family members, peers, providers, faith groups, community members, and other allies form vital support networks. Through these relationships, people leave unhealthy and/or unfulfilling life roles behind and engage in new roles (e.g., partner, caregiver, friend, student, employee) that lead to a greater sense of belonging, personhood, empowerment, autonomy, social inclusion, and community participation.

Recovery is culturally-based and influenced: Culture and cultural background in all of its diverse representations including values, traditions, and beliefs are keys in determining a person's journey and unique pathway to recovery. Services should be culturally grounded, attuned, sensitive, congruent, and competent, as well as personalized to meet each individual's unique needs.

Recovery is supported by addressing trauma: The experience of trauma (such as physical or sexual abuse, domestic violence, war, disaster, and others) is often a precursor to or associated with alcohol and drug use, mental health problems, and related issues. Services and supports should be trauma-informed to foster safety (physical and emotional) and trust, as well as promote choice, empowerment, and collaboration.

Recovery involves individual, family, and community strengths and responsibility: Individuals, families, and communities have strengths and resources that serve as a foundation for recovery. In addition, individuals have a personal responsibility for their own self-care and journeys of recovery. Individuals should be supported in speaking for themselves. Families and significant others have responsibilities to support their loved ones, especially for children and youth in

recovery. Communities have responsibilities to provide opportunities and resources to address discrimination and to foster social inclusion and recovery. Individuals in recovery also have a social responsibility and should have the ability to join with peers to speak collectively about their strengths, needs, wants, desires, and aspirations.

***Recovery is based on respect**:* Community, systems, and societal acceptance and appreciation for people affected by mental health and substance use problems – including protecting their rights and eliminating discrimination – are crucial in achieving recovery. There is a need to acknowledge that taking steps towards recovery may require great courage. Self-acceptance, developing a positive and meaningful sense of identity, and regaining belief in one's self are particularly important.

SAMHSA has developed this working definition of recovery to help policy makers, providers, funders, peers/consumers, and others design, measure, and reimburse for integrated and holistic services and supports to more effectively meet the individualized needs of those served.

Many advances have been made to promote recovery concepts and practices. There are a variety of effective models and practices that States, communities, providers, and others can use to promote recovery. However, much work remains to ensure that recovery-oriented behavioral health services and systems are adopted and implemented in every state and community. Drawing on research, practice, and personal experience of recovering individuals, within the context of health reform, SAMHSA will lead efforts to advance the understanding of recovery and ensure that vital recovery supports and services are available and accessible to all who need and want them.[1]

[1] http://www.samhsa.gov/newsroom/press-announcements/201112220800

TRAUMA-INFORMED ENVIRONMENTS

Creating Trauma-Informed Environments: Emergency Protective Custody

Trauma-informed service provision is being recognized nationally as a critical component to recovery. Traumatic events are no longer perceived as rare events and are typically limited to a single incident of trauma. People accessing services, particularly mental health and substance use services, are more likely than not to have experienced victimization in their past. Prevalence of trauma with mental health consumers is high:

- 90% of public mental health clients have been exposed to trauma
- Most have multiple experiences of trauma (Mueser, Goodman, Trumbetta, Rosenberg , Osher, Vidaver, Auciello, & Foy, 1998; Muesar et al., 2004)[2]
- 34-53% report childhood sexual or physical abuse
- 43-81% report some type of victimization (Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995; Mental Health Association in New York State & New York State Office of Mental Health, 1994)[3]
- 97 % of homeless women with SMI have experienced severe physical and sexual abuse – 87% experience this abuse both as child and adult (Goodman, Rosenberg, Mueser, & Drake, 1997)[4]
- Current rates of PTSD in people with SMI range from 29-43%
- Epidemic among population in public mental health system, especially women (Center for Mental Health Services & Human Resource Association of the Northeast, 1995; Jennings & Ralph, 1997).[5]

Today, there exists an urgency that trauma needs to be identified and acknowledged in all aspects of behavioral health. The President's New Freedom Commission on Mental Health Report (2003) requests a comprehensive transformation of delivery of services within behavioral health. The report recognizes the impact of childhood abuse on individuals and the need to better address the consequences of traumatic events. It also notes that treatment of trauma is an important focus of mental health reform.

Using Trauma Theory to Design Service Systems, which has been developed by Harris and Fallot (2001)[6], defines trauma-informed care as knowing the history of past and current abuse in the life of the consumer who is seeking services, and, even more importantly, that those staff who are providing services understand the role that violence and victimization play in the lives of most consumers of mental health

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[2] Mueser, K.T., Goodman, L.B., Trumbetta, S.L., Rosenberg , S.D. , Osher, C., Vidaver, R., Auciello, P., & Foy, D.W. (1998). Trauma and posttraumatic stress disorder in severe mental illness. *Journal of Consulting & Clinical Psychology,* 66, 493-499.

Mueser, K.T., Salyers, M.P., Rosenberg, S.D., Goodman, L.A., Essock, S.M., Osher, F.C., Swartz, M.S., & Butterfield, M.I. (2004). Interpersonal trauma and posttraumatic stress disorder in patients with severe mental illness: Demographic, clinical, and health correlates. *Schizophrenia Bulletin*, 30(1), 45-57.

[3] Kessler, R.C., Sonnega, A., Bromet, E., Hughes, M., & Nelson, C.B. (1995). Posttraumatic stress disorder in the National Comorbidity Survey. *Archives of General Psychiatry, 52*, 1048-1060.

Mental Health Association in New York State & New York State Office of Mental Health (1994). Proceedings from the forum on sexual abuse survivors in the mental health system. Albany, NY: NYS Office of Mental Health.

[4] Goodman, L.A. , Rosenberg , S.D. , Mueser, K.T., & Drake, R.E. (1997). Physical and sexual assault history in women with serious mental illness: Prevalence, correlates, treatment, and future research directions. *Schizophrenia Bulletin, 23*, 4, 685-696.

[5] Center for Mental Health Services (CMHS) & Human Resource Association of the Northeast (HRANE). (1995, July). *Dare to vision, shaping the national agenda for abuse and mental health services*. Proceedings of a conference in Arlington, VA.

Jennings, A., & Ralph R.O. (1997). *In Their Own Words: Trauma Survivors and Professionals They Trust Tell What Hurts, What Helps, and What Is Needed for Trauma Services.* Maine Trauma Advisory Group.

[6] Harris, M., & Fallot, R. (2001). *Using trauma theory to design service systems.* Jossey-Bass: San Francisco, CA.

and substance use disorder services. In addition, programs should use that understanding to design systems that accommodate the vulnerabilities of trauma survivors and allow services to be provided in a manner that will facilitate consumer involvement in treatment. Fallot and Harris have developed an agency self-assessment for evaluation of trauma-informed services. This guide can be used by you to assess your hearing proceedings and the services that your community offers to support the person involved. The assessment uses five domains or principles of trauma-informed care: safety, trustworthiness, choice, collaboration and empowerment:

Safety—Ensuring Physical and Emotional Safety: "To what extent do the program's activities and settings ensure the physical and emotional safety of consumers and staff? How can services be modified to ensure this safety more effectively and consistently?"

Trustworthiness—Maximizing Trustworthiness through Task Clarity, Consistency, and Interpersonal Boundaries: "To what extent do the program's activities and settings maximize trustworthiness by making the tasks involved in service delivery clear, by ensuring consistency in practice, and by maintaining boundaries that are appropriate to the program? How can services be modified to ensure that tasks and boundaries are established and maintained clearly and appropriately?"

Choice—Maximizing Consumer Choice and Control: "To what extent do the program's activities and settings maximize consumer experiences of choice and control?"

Collaboration-- Maximizing Collaboration and Sharing Power: "To what extent do the program's activities and settings maximize collaboration and sharing of power between staff and consumers?"

Empowerment-Prioritizing Empowerment and Skill-Building: "To what extent do the program's activities and settings prioritize consumer empowerment and growth?"

When mental health consumers are taken into emergency protective custody (EPC), it is critical to take into account an individual's history of traumatic events. Trauma-informed environments can be created despite the circumstances and settings, and can be of great benefit to agency, staff, and consumer. The following information will offer insight for developing services that include safety, trustworthiness, choice, collaboration and empowerment.

SAFETY

The following considerations should be made in creating a physically and emotionally safe environment: A large part of establishing safety within any environment comes from acquiring as much information as possible on the history of trauma in the consumer's life. If the agency has a more comprehensive picture of the consumer's life, they will be better equipped to create a safe placement.

UNIVERSAL TRAUMA SCREENING

In trauma-informed environments, everyone who enters the program is considered a trauma survivor. Prevalence rates of trauma experiences indicate the trauma is the expectation, not the exception. With that in mind, it is imperative that an accurate history be recorded for each individual being taken into custody. The more information that staff has available to them, the less likely the circumstances will arise to initiate a crisis situation, putting both staff and consumer at risk for harm or injury.

Harris and Fallot (2001) offer the following guidelines for trauma screening:

Interviewer

1. The interviewer should be someone with skills in general assessment/interviewing and should have specific training in trauma-related concerns.
2. The interviewer, whenever possible, should be someone who has, or will have, an ongoing relationship with the consumer/survivor.
3. The interviewer should pay close attention to the overall assessment process and avoid repeating violence and trauma-related questions that have already been answered.

Timing

1. The screening questionnaire should be used as early as possible in the intake and assessment process. We recognize that there may be good reasons not to ask trauma-related questions in the initial meeting. However, we have found that many men and women are relieved to address these concerns and have rarely been invited to do so. Discussing the questionnaire's introductory information with the consumer/survivor often provides a clear indication about whether it is appropriate to continue with the screening at that time. Interviewers need to be aware of consumer/survivor needs, strengths, and vulnerabilities at the time of the interview.
2. In order to have time for following up on the consumer's responses (with appropriate time for discussion or for referrals to other services, for example), it is better to ask these questions earlier rather than later in the day.
3. It is important, especially in the event of a negative screen, to repeat the questionnaire periodically. As consumers begin to feel more safety and trust with service providers, they may be more willing to discuss their trauma history.

Suggestions for Agencies Using Screening Questionnaires

1. Agencies should provide training for staff who will use the screening instrument.
2. Agencies should identify specific staff members who will be involved in the screening.
3. Agencies should identify the timing of this screening in the overall intake and assessment process.
4. Agencies should specify time guidelines for repeating the screening.
5. Ongoing consultation for interviewers should be available.
6. If mental health and substance use screening are not part of an agency's routine initial questions, these domains should be included.
7. Agencies should develop guidelines for closing the interview; these should fit with the overall procedures and structure of the agency, including referral policies.

Maximizing Consumer/Survivor Choice and Control

1. If consumers become uncomfortable during the screening, they should be given the option of continuing when they feel more comfortable.
2. The choice of self-administering the questionnaire should be offered for consumers who feel uncomfortable with one-on-one interviews.
3. If self-directed administration is an option, providers need to be sensitive to the concerns of consumers who are unable to read.
4. During the intake and assessment process, providers should ask consumers if they have already been asked the same or similar questions to avoid a repetitive process.

Ending the Interview: Referral and Planning

If the consumer reports *no history of abuse or violence* on the screening:

a. Thank consumers for responding to the questions.

b. Let consumers know that their time has not been wasted with these questions because the information they have provided is helpful to the agency in planning for the most needed services.
c. Let consumers know they are welcome to return at any time to discuss violence, trauma, or related issues.

If the consumer answers *yes* to any of the questions:

a. Assess current danger.
b. Establish procedure for safety planning.
c. Establish procedure for providing necessary and appropriate support, including crisis intervention options (crisis phone line, other crisis services).
d. Have full range of resources available for referral.
e. Match the referral to the specific and immediate needs and preferences of the consumer/survivor.

Information from the trauma screening is critical and can be used to understand the history of the consumer, their triggers to potential crisis, and establish an opportunity to prevent the use of coercive practices as an effort to establish safety. Asking trauma screening questions offers opportunities to *plan* for crisis and establish both emotional and physical safety.

ESTABLISHING PHYSICAL SAFETY

When considering creating physically safe environments, it should include both safety for staff and consumers. The following are considerations for ensuring physical safety offered by Harris and Fallot (2001):

Availability of same-gender staff: if a female consumer has a history of being abused by males, being confronted, interviewed, or touched by a male member can be overwhelming. Many male survivors (regardless of the gender of the person who abused them) may be frightened of women (Freeman & Fallot, 1997)[7]. In addition, it may be difficult for a male survivor to disclose his history and vulnerability to a female member. It may be logistically difficult to always provide this option, but attempts should be made to offer the option of specific gender staff.

Separation of female and male consumers. If female and male consumers cannot be on separate units, there should be some sort of physical barrier between the two groups. This would include having separate sleeping areas, bathrooms and living areas. The more separation between the genders, the less likelihood of abuse between consumers.

Availability of safe and comfortable time-out space. Consumers have the right to feel safe. Comfort rooms offer a safe haven when consumers feel agitated, anxious or afraid. Comfort rooms are *not* seclusion rooms and should not resemble seclusion rooms in any way. The rooms should be small but allow room for movement, they should be comfortable and soothing—taking into consideration temperature, room color and seating. It should not be over stimulating, but offer some objects that can be used to sooth oneself. A comfort room offers a safe, private space to promote relaxation. This is a noninvasive alternative to prevent crisis.

Respect for personal space and individual boundaries. "A consumer's need for privacy is often at odds with inpatient staff members' needs for information and control for physical safety." (Harris & Fallot,

[7] Freeman, D. W. & Fallot, R. D. (1997) Trauma and trauma recovery for dually diagnosed male survivors. In *Sexual Abuse in the Lives of Women Diagnosed with Serious Mental Illness* (eds M. Harris & C. L. Landis), pp. 357–372. London: Harwood Academic.

2001). Within trauma-informed environments, boundaries should be violated as little as possible, and when they do need to occur, staff members need to explain why they are violating a boundary.

Trauma survivors have histories of having their boundaries violated, often by people who were supposed to protect them. It is important that consumers are allowed to express preferences for or concerns about interpersonal closeness, such as being touched or approached.

Respect for personal modesty. Being exposed physically can be frightening for trauma survivors, as it exposes vulnerability. Trauma-informed environments consider this when searching consumers, monitoring consumers in bathrooms and showers, or having consumers wear clothing that might not offer adequate coverage of their bodies. All policies and procedures should offer consumers as much control over their bodies as possible.

Training for staff in de-escalation techniques. During an EPC, there is a possibility that consumers may go into crisis and put themselves or others at risk of harm. In these circumstances staff should be trained in de-escalation techniques that can decrease the likelihood of using any form of restraint or seclusion. Restraint and seclusion should only be used as a last resort and is often unnecessary if other strategies are in place to intervene in a crisis. Visalli, McNasser, Johnstone, and Lazzaro (1997)[8] suggest that all staff use a five-step approach that only rarely reaches the fifth step (use of physical restraint). In the first step staff offer the consumer an option of a range of techniques to use for soothing themselves or regaining control. They may have these techniques listed in their WRAP (Wellness Recovery Action Plan) plan. Copeland (1997)[9] developed WRAP for consumers to identify their triggers for crisis and a plan to intervene at that time. Their plan will typically involve a broad array of strategies that can be used in a variety of settings. Techniques to calm oneself may include exercise, listening to music, journaling, counting out loud, wrapping themselves in a blanket, taking a walk or, talking to another person. This allows an opportunity for the consumer to regain composure while utilizing his/her choice of strategy to regain that composure. It is all conducted without coercion or force. In the second step, the consumer is offered a change in environment, such as going to his/her room, utilizing the comfort room or going to another ward, if possible. In step three, the consumer is offered medication to calm himself/herself. However, this does not mean that consumers are medicated involuntarily, but given an opportunity to use medication to decrease anxiety or agitation. In the fourth step, the consumer is placed in the seclusion room, The fifth step is the use of restraint.

It should be noted that seclusion and restraint should clearly only be used as a last resort and when all other strategies have been tried and have failed. Restraint and seclusion is widely acknowledged to be violent, humiliating and stressful. It is dangerous and puts both staff and consumers at risk for both psychological and physical harm. People have died in restraints from many causes including: asphyxia, aspiration and cardiac events. In addition to the risk of death, physical injuries to staff and consumers are common. And even if the physical consequences are somehow avoided during a restraint, the humiliation, powerlessness, shame, and re-experiencing of trauma cannot be avoided when consumers are being restrained. This is particularly true for consumers who have histories of physical and sexual abuse. The stress induced through the re-traumatizing practice of restraint and seclusion can have long-lasting effects.

[8] Visalli, H., McNasser, G., Johnstone, L., & Lazzaro, C.A. (1997). Reducing high-risk interventions for managing aggression in psychiatric settings. *Journal of Nursing Care Quality*, 11(3), 54-61.
[9] Copeland, M. E. (1997). Wellness Recovery Action Plan. Peach Press: Dummerston, VT.

ESTABLISHING EMOTIONAL SAFETY

It is also important to consider practices that ensure psychological safety during emergency protective custody. Trauma survivors often view their world as an unsafe place and they are even more hesitant when approaching programs for services. There exists little trust for good reason; often consumers have been victimized by loved ones in charge of protecting them. Therefore, it is of considerable importance that any mental health service, including those that are involuntary, make attempts to avoid all re-traumatizing practices when working with survivors. The following are considerations for ensuring emotional safety offered by Harris and Fallot (2001):

Keeping consumers fully informed. Clear expectations should be set and practices thoroughly explained. Consumers should be an active participant in their treatment or hearing. All steps of the process and consequences should be clarified. At the time of an EPC, consumers may be particularly distressed and confused and therefore lack a full appreciation of the circumstances. It is critical that consumers are fully informed during all steps of the process.

Helping consumer identify their triggers. Trauma results in neurobiological changes. For trauma survivors, environmental stimuli can be a trigger to a variety of trauma symptoms including flashbacks, hypervigilence, and dissociation. It may have been a "trigger" that initiated their crisis resulting in their EPC. Unfortunately, triggers can be just about anything in the environment: gender of staff, smells, the weather, being controlled, voice tone, slamming doors, keys jangling, etc. The list is endless. A consumer may see, smell, or hear a sound and be inundated with memories and emotions. In addition, many consumers are unaware of their triggers; therefore, it is imperative to offer consumers psycho-education on trauma, including bio physiology and symptoms of trauma. This can take place at intake and does not have to be overly complicated. When consumers receive education on trauma, they are better equipped to identify their triggers and develop a plan to prevent going into crisis.

Assist consumers in learning and utilizing coping strategies. Once consumers are able to identify their triggers, they will be able to also identify strategies to sooth themselves. A variety of coping skills should be offered and consideration should be given to where and how the skill can be utilized. For example, a skill such as deep breathing, squeezing a stress ball or quietly counting to ten can be used in more environments than exercise or listening to music. Strategies can be soothing, distracting or grounding. Utilizing these strategies will help consumers feel like they have more control over their emotions and less overwhelmed when they are confronted by fear, anxiety or anger.

Having a clear grievance procedure in place for accusations of abuse. All treatment programs, regardless of being voluntary or involuntary, should have a policy in place for responding to allegations of abuse. Accusations should always be taken seriously, an outside committee (which includes consumers/survivors) should investigate and the investigation should be conducted with immediacy. It is common for trauma survivors to be hesitant in reporting abuse; they may have been disbelieved in the past or at the very least ignored or faced indifference. Therefore it is critical that consumers are taken seriously and their safety from reprisal for making the accusation should be ensured.

In addition to establishing both physical and emotional safety, agencies should also promote trustworthiness, give consumers as much choice as possible, and encourage collaboration by partnering with consumers on their treatment decisions, and use empowerment to identify consumer skills and strengths.

PART 1. THE NEBRASKA MENTAL HEALTH COMMITMENT ACT OVERVIEW

THE NEBRASKA MENTAL HEALTH COMMITMENT ACT (SECTION 71-901 TO 71-962)
(See Appendix A)

PURPOSE OF NEBRASKA MENTAL HEALTH COMMITMENT ACT

The purpose of the Nebraska Mental Health Commitment Act is provided in Section 71-902. A point of significance is that individuals with mental illnesses should be encouraged to obtain voluntary treatment in lieu of any type of involuntary treatment.

Section 71-902 Declaration of purpose.
The purpose of the Nebraska Mental Health Commitment Act is to provide for the treatment of persons who are mentally ill and dangerous. It is the public policy of the State of Nebraska that mentally ill and dangerous persons be encouraged to obtain voluntary treatment. If voluntary treatment is not obtained, such persons shall be subject to involuntary custody and treatment only after Mental Health Board proceedings as provided by the Nebraska Mental Health Commitment Act. Such persons shall be subjected to emergency protective custody under limited conditions and for a limited period of time.

POWERS, DUTIES, COMPENSATION OF MENTAL HEALTH BOARDS

Section 71-915 provides information regarding the creation, powers, duties, and compensation of Mental Health Boards. The presiding judge in each district court judicial district (map included in Appendix B.) is required to create at least one, but not more than three Mental Health Boards in such district.

Section 71-915 Mental Health Boards; created; powers; duties; compensation.	
(1)	The presiding judge in each district court judicial district shall create at least one but not more than three Mental Health Boards in such district and shall appoint sufficient members and alternate members to such boards. Members and alternate members of a Mental Health Board shall be appointed for four-year terms. The presiding judge may remove members and alternate members of the board at his or her discretion. Vacancies shall be filled for the unexpired term in the same manner as provided for the original appointment. Members of the Mental Health Board shall have the same immunity as judges of the district court.
(2)	Each Mental Health Board shall consist of an attorney licensed to practice law in this state and any two of the following but not more than one from each category: A physician, a psychologist, a psychiatric social worker, a psychiatric nurse, a clinical social worker, or a layperson with a demonstrated interest in mental health and substance dependency issues. The attorney shall be chairperson of the board. Members and alternate members of a Mental Health Board shall take and subscribe an oath to support the United States Constitution and the Constitution of Nebraska and to faithfully discharge the duties of the office according to law.
(3)	The Mental Health Board shall have the power to issue subpoenas, to administer oaths, and to do any act necessary and proper for the board to carry out its duties. No Mental Health Board hearing shall be conducted unless three members or alternate members are present and able to vote. Any action taken at any Mental Health Board hearing shall be by majority vote.
(4)	The Mental Health Board shall prepare and file an annual inventory statement with the county board of its county of all county personal property in its custody or possession. Members of the Mental Health Board shall be compensated and shall be reimbursed for their actual and necessary expenses by the county or counties being served by such board. Compensation shall be at an hourly rate to be determined by the presiding judge of the district court, except that such compensation shall not be less than fifty

Section 71-915 Mental Health Boards; created; powers; duties; compensation.
dollars for each hearing of the board. Members shall also be reimbursed for their actual and necessary expenses, not including charges for meals. Mileage shall be determined pursuant to section 23-1112.

DEFINITIONS

Section 71-904 through Section 71-914 and Section 71-804 provide definitions on the commitment process. These and other relevant definitions are included in the Glossary of this manual (see Appendix C).

NOTE

Throughout the Nebraska Mental Health Commitment Act, the term "subject" is used. Throughout the text of this manual the term "subject" will be used when actual statute is quoted; otherwise the term "person" will be used.

MENTAL HEALTH BOARD TRAINING

Section 71-916 Mental Health Board; training; Director of Health and Human Services; duties.	
(1)	The Department of Health and Human Services shall provide appropriate training to members and alternate members of each Mental Health Board and shall consult with consumer and family advocacy groups in the development and presentation of such training. Members and alternate members shall be reimbursed for any actual and necessary expenses incurred in attending such training in a manner and amount determined by the presiding judge of the district court. No person shall remain on a Mental Health Board or be eligible for appointment or reappointment as a member or alternate member of such board unless he or she has attended and satisfactorily completed such training pursuant to rules and regulations adopted and promulgated by the department.
(2)	The Director of Health and Human Services shall provide the Mental Health Boards with blanks for warrants, certificates, and other forms and printed copies of applicable rules and regulations of the department that will enable the boards to carry out their powers and duties under the Nebraska Mental Health Commitment Act or the Sex Offender Commitment Act.

The purpose of this manual is to prepare all stakeholders to meet the roles and responsibilities set forth in the Mental Health Commitment Act. Information included in the manual is intended to provide the reader with the ability to:

- Develop a working understanding of the Emergency Protective Custody process;
- Understand the requirement of dangerous due to a mental illness;
- Understand information presented by mental health professionals related to behavioral health diagnoses;
- Appreciate the role of the Mental Health Board in preserving an individual's rights and ensuring due process at Mental Health Board hearings;
- Use the statutory requirement for least restrictive level of care to commit to outpatient/community based services when appropriate;
- Ask pertinent questions at hearings in order to gain the clear and convincing proof of dangerousness due to a mental illness needed to make a commitment decision;
- Understand the components of an individualized treatment plan;

- Decide when a change of treatment or discharge is appropriate, based on treatment progress reports;
- Understand the Dangerous Sex Offender Commitment Act and the associated definitions and conviction requirements.

Upon completion of the review of this manual, prospective Mental Health Board members shall complete the included Affidavit (see Part 6), have it notarized, and send it to the Division of Behavioral Health. This affidavit shall serve as proof of the completion of this training, and is valid for four years from the date on the Affidavit. The Division of Behavioral Health will then confirm receipt of the completed Affidavit via a written letter certifying completion of training.

MENTAL HEALTH BOARD ROLES AND RESPONSIBILITIES

Section 71-924 Hearing Mental Health Board; duties
A hearing shall be held by the Mental Health Board to determine whether there is clear and convincing evidence that the subject is mentally ill and dangerous as alleged in the petition. At the commencement of the hearing, the board shall inquire whether the subject has received a copy of the petition and list of rights accorded him or her by sections 71-943 to 71-960 and whether he or she has read and understood them. The board shall explain to the subject any part of the petition or list of rights which he or she has not read or understood. The board shall inquire of the subject whether he or she admits or denies the allegations of the petition. If the subject admits the allegations, the board shall proceed to enter a treatment order pursuant to section 71-925. If the subject denies the allegations of the petition, the board shall proceed with a hearing on the merits of the petition.

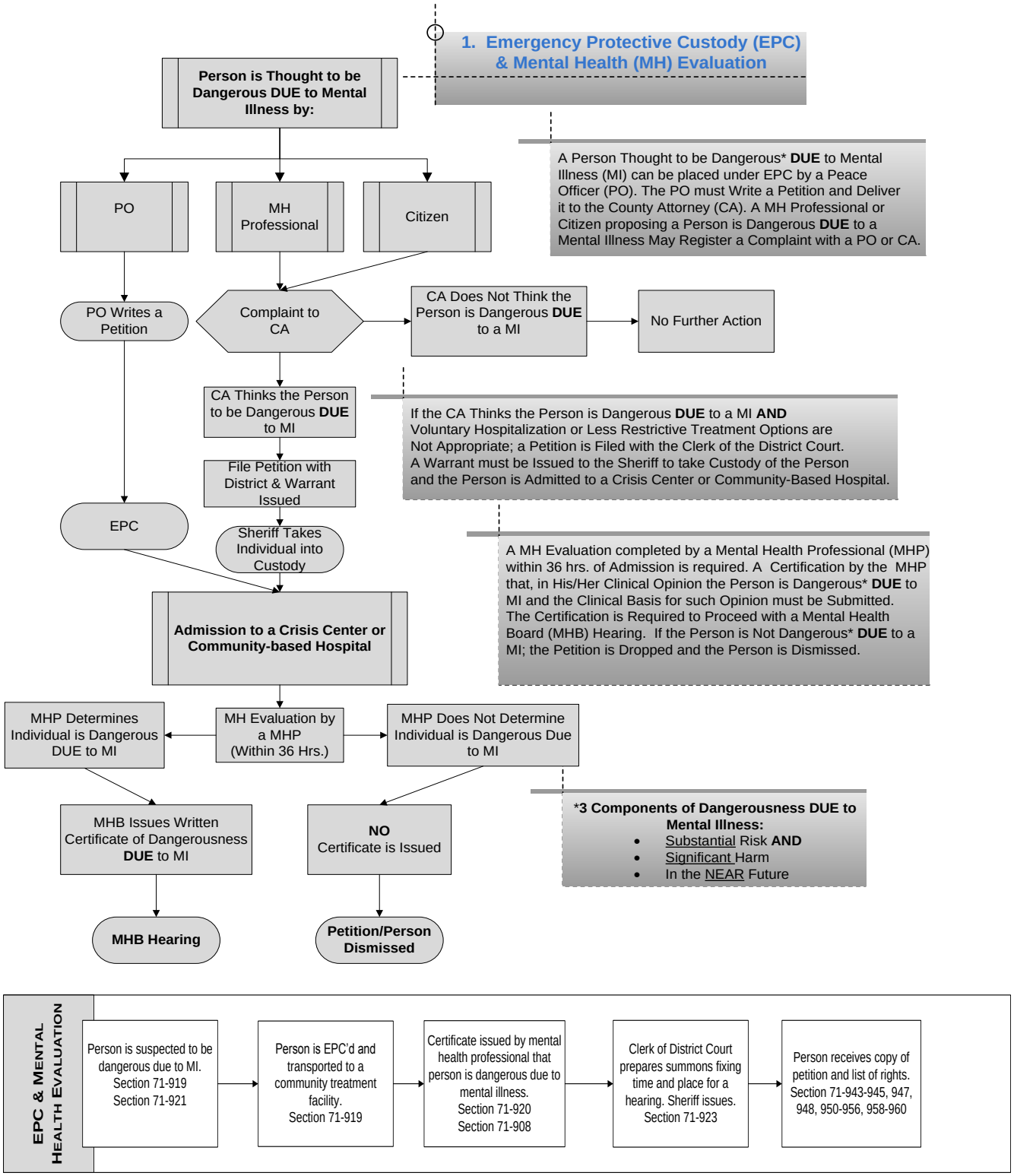
MENTAL HEALTH COMMITMENT PROCESS OVERVIEW

The mental health commitment process is specifically defined in state statutes. The statutes provide direction through every stage of the commitment process including:

1) Emergency Protective Custody and determination of need for Mental Health Board hearing;
2) Mental Health Board hearing procedures;
3) Commitment to treatment determination; and
4) Change in treatment or discharge requirements.

This manual provides a chapter on each of the above mentioned stages which includes a flowchart for each of the stages and a graph of the associated statutes. Narrative is also provided to further emphasize or to expand upon important aspects of the law. The flowcharts and graphs are collectively displayed on the next pages so the reader can become familiar with the entire process before they are broken down into separate stages.

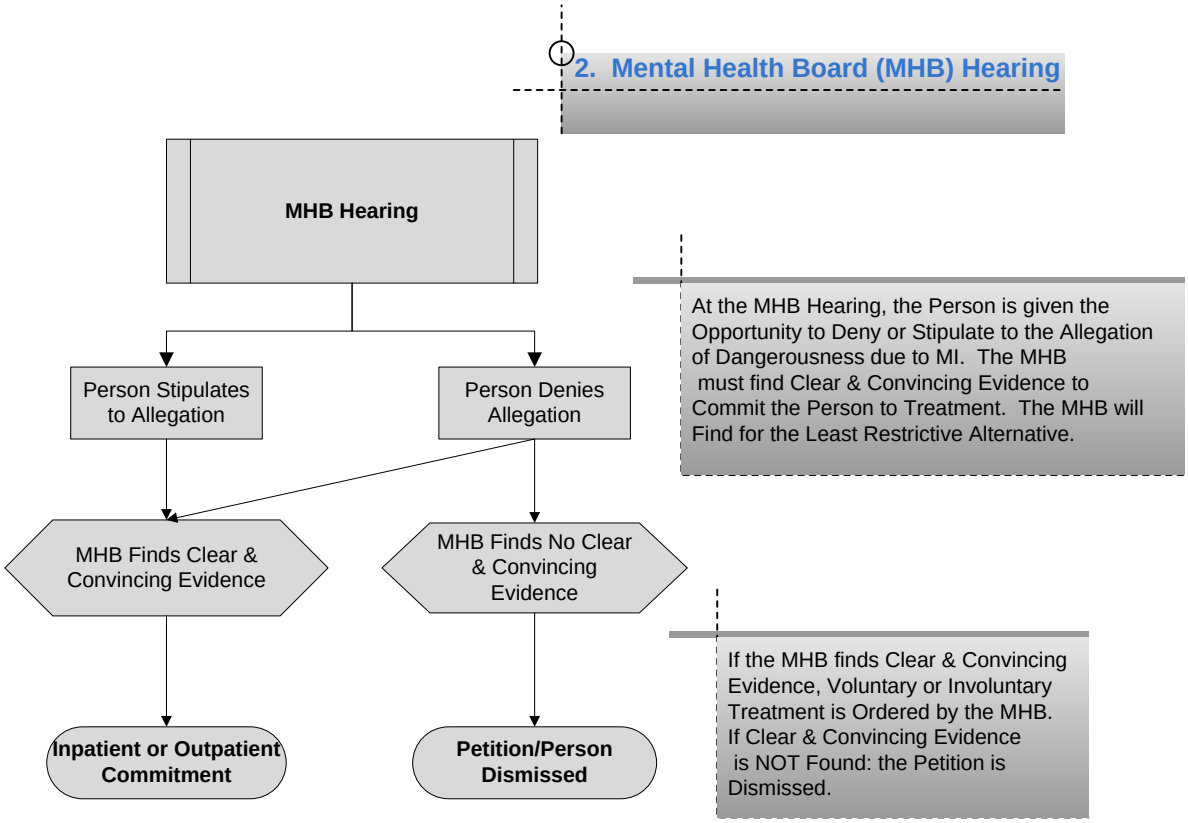
Figure 1. EPC & Mental Health Evaluation



KEY

CA = County Attorney
MHB = Mental Health Board
MHP = Mental Health Professional
EPC = Emergency Protective Custody
MI = Mental Illness
MH = Mental Health
PO = Peace Officer

Figure 2. Mental Board Hearing



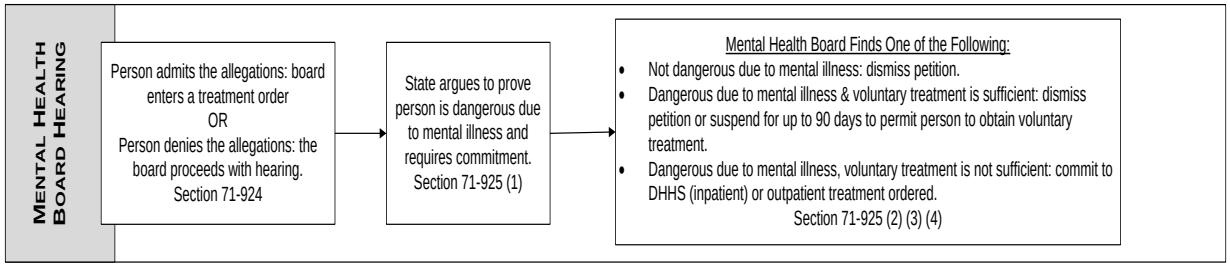


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Figure 3. Commitment to Treatment

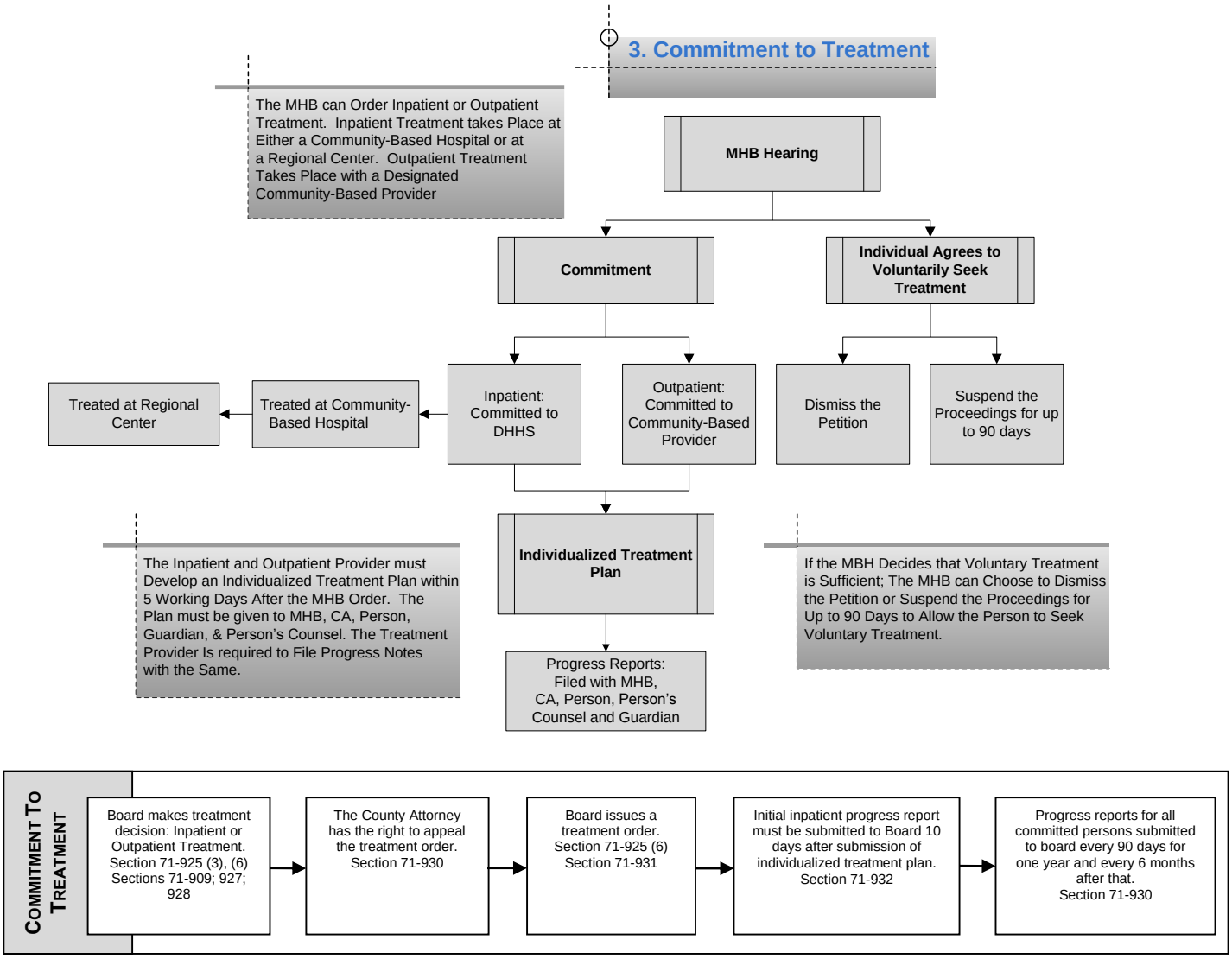

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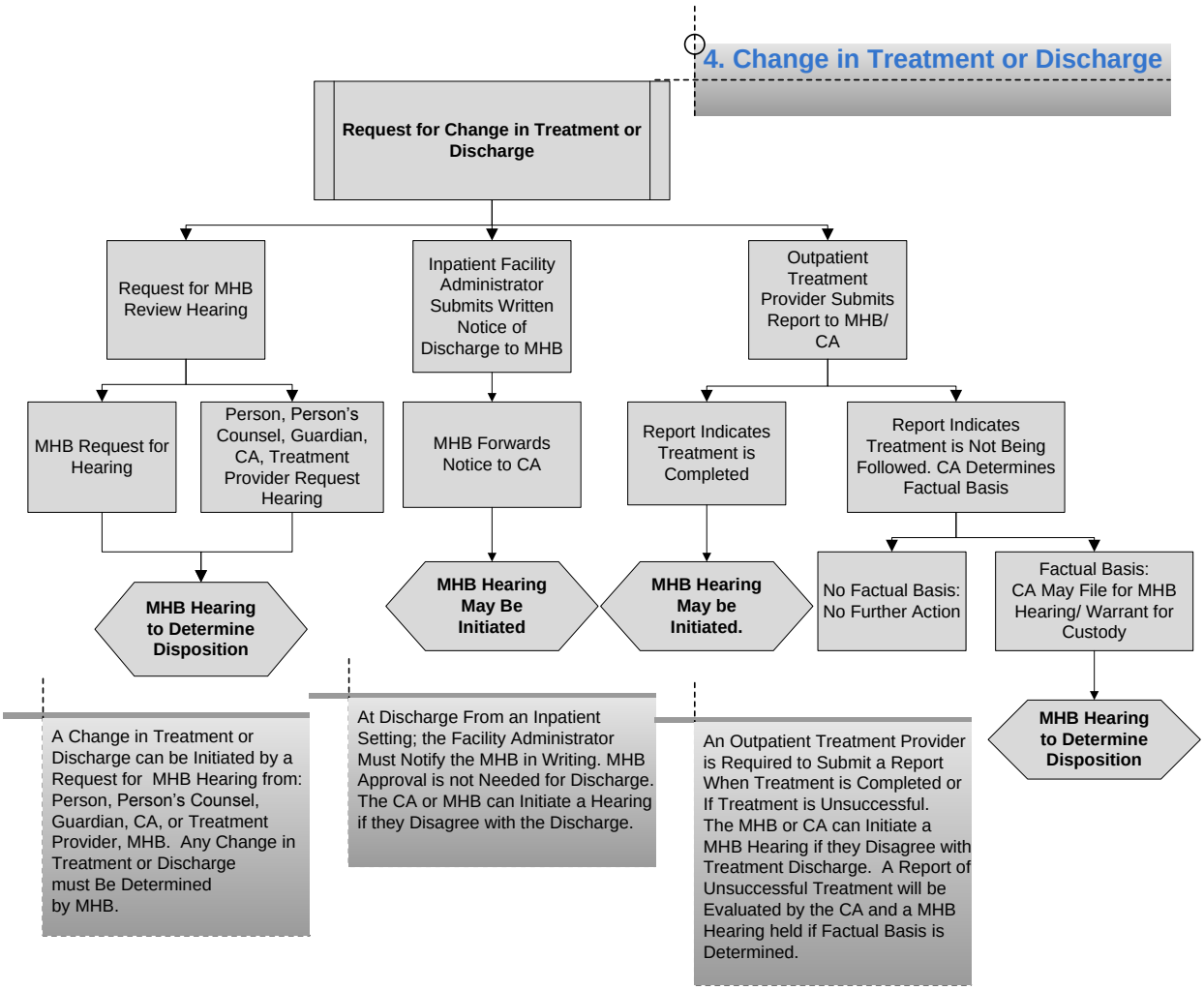
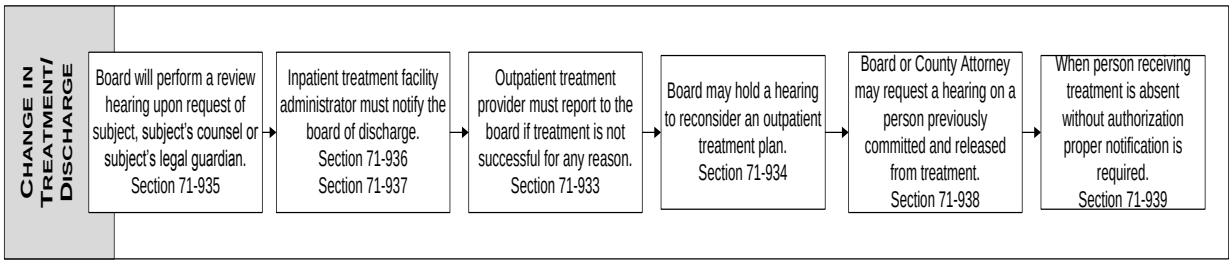
Figure 4. Change in Treatment/Discharge





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PART 2. CLINICAL OVERVIEW

A Mental Health Board is obligated by law to make commitment decisions for persons coming before them. This duty must be taken very seriously, as it potentially involves taking away a person's civil liberties. It is of utmost importance that Mental Health Board members have a working knowledge of what constitutes mental illness, substance dependence, and dangerousness. In addition, a Mental Health Board is responsible for determining commitment status for sex offenders. Thus, it is also imperative that Mental Health Board members understand mental health diagnoses related to sexual disorders. This part of the self-study guide provides background on mental illness, substance dependence, dangerousness, and diagnoses related to sexual disorders.

MENTAL ILLNESS DIAGNOSIS

Section 71-907. Mentally ill, defined.
Mentally ill means having a psychiatric disorder that involves a severe or substantial impairment of a person's thought processes, sensory input, mood balance, memory, or ability to reason which substantially interferes with such person's ability to meet the ordinary demands of living or interferes with the safety or well-being of others.

A mental illness can be viewed as a collection of symptoms, either behavioral or psychological, which cause an individual distress, increased risk of suffering, pain, disability, death, or loss of freedom. The Nebraska statute defines mental illness in Section 71-907 (see the box above). The Nebraska rules and regulations defines mental illness as follows; " Mental illness means impaired psychosocial or cognitive functioning due to disturbances in any one or more of the following processes : biological, chemical, physiological , genetic, psychological, social, or environmental. Mental illness is extremely variable in duration, severity, and prognosis, depending on the specific affliction."

The Diagnostic and statistical Manual of Mental Disorders (DSM) is the source used by clinicians to determine diagnosis. There have been successive editions of this manual over the past sixty years. The current edition, the DSM 5, was published in 2013, and supersedes the DSM 4 TR. This manual provides current diagnostic criteria and descriptions of how mental disorders are expressed. The DSM 5 definition of mental disorder is as follows:

"A mental disorder is a syndrome characterized by clinically significant disturbance in an individual's cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning. Mental disorders are usually associated with significant distress in social, occupational, or other important activities. An expectable or culturally approved response to a common stressor or loss, such as the death of a loved one, is not a mental disorder. Socially deviant behavior (e.g., political, religious, or sexual) and conflicts that are primarily between the individual and society are not mental disorders unless the deviance or conflict results from a dysfunction in the individual, as described above." (Diagnostic and Statistical Manual of Mental Disorders, 5th ed.; DSM 5; American Psychiatric Association, 2013)

The Diagnostic and statistical Manual of Mental Disorders is a comprehensive reference, covering all potential disorders and illnesses of a psychological or behavioral nature. Many of these disorders would most likely not be of the type or severity to result in a mental health board hearing or civil commitment.

Disorders that are typically deemed to be committable disorders may include but are not limited to the psychotic disorders or mood disorders. These are often called "major mental disorders" and can involve substantial impairments to an individual's cognitive functioning, including an individual's ability to regulate their own behavior. These disorders also may result in persistent and/or severe suicidal or

homicidal thoughts or behaviors and severe and persistent impairment. The following classifications were taken from the DSM 5 would be examples of these disorders.

Schizophrenia spectrum and other psychotic disorders. Individuals with these disorders experience abnormalities in perception, thought content or thought process, such as, delusions, hallucinations, disorganized thinking or disorganized behavior. Schizophrenia and schizoaffective disorder are examples of disorders in this category.

Bipolar and Related Disorders. These disorders include bipolar I disorder and are typically characterized by both elevated and depressed mood episodes.

Depressive Disorders. Are marked by periods of time where an individual might experience severe feeling of sadness, emptiness, hopelessness or irritability. Major depressive disorder is an example of a depressive disorder.

Disorders that are generally considered , not allowable, as the primary disorder for the purposes of a civil commitment are antisocial personality disorder, delirium, other illness due to a general medical condition, and developmental disorders.

MENTAL HEALTH PROFESSIONAL (MHP) CERTIFICATION

A certification by a MHP that in his/her clinical opinion, the subject is dangerous due to a mental illness and the clinical basis for such opinion must be submitted before a Mental Health Board can take place. A definition of a MHP and the mental health certification (Appendix M) which must be completed by the MHP is as follows.

Section 71-906 Mental Health Professional Defined
Mental health professional means a person licensed to practice medicine and surgery or psychology in this state under the Uniform Credentialing Act or an advanced practice registered nurse licensed under the Advanced Practice Registered Nurse Practice Act who has proof of current certification in a psychiatric or mental health specialty.

Mental Health Professional Certificate

As a mental health professional I certify that I have evaluated the subject since the subject was admitted for emergency protective custody and evaluation. It is my opinion that the above subject currently meets diagnostic criteria for the following mental disorders which are recognized utilizing criteria set out in most recent edition of the DSM.

Diagnosis:
_____

The above diagnosis is within a reasonable degree of psychiatric, psychological certainty and the Subject presents a **substantial risk of serious harm within the near future** to himself/herself, or others **as a result of the above mental illness in the following ways**:
_____
_____
_____
_____

The Mental Health Board relies heavily upon the evidence presented at the hearing to determine the mental status of the individual. Collaborative information at a minimum must include historical information and a psychiatric interview. Other information may include mental health assessments, EPC information, and nursing observations. The MHP may also perform a Mental Status Examination.[10] The purpose of the Mental Status Examination is to obtain evidence of signs and symptoms of mental disorders, including dangerousness to self and others. The Mental Status Examination is a systematic collection of data based on observation of the person's behavior while the person is in the clinician's view during, before, and after the interview. The elements contained in the Mental Health Status Examination are included in Appendix E.

[10] American Psychological Association (2010). Practice guideline for the psychiatric evaluation of adults (2nd ed.).

SUBSTANCE DEPENDENCE

In the Nebraska's Mental Health Commitment Act Section 71-908, the term mentally ill and dangerous includes individuals who are substance dependent. Section 71-913 defines substance dependent.

Section 71-913 Substance dependent, defined.
Substance dependent means having a behavioral disorder that involves a maladaptive pattern of repeated use of controlled substances, illegal drugs, or alcohol, usually resulting in increased tolerance, withdrawal, and compulsive using behavior and including a cluster of cognitive, behavioral, and physiological symptoms involving the continued use of such substances despite significant adverse effects resulting from such use.

Substance related disorders is a term that may be included in the mental health examination or used when a mental health professional is testifying. It is important that Mental Health Board members understand these terms and treatment options when deliberating about a commitment decision. Substance use disorders refers to an addiction.

However, in people who are diagnosed with substance dependence there is a pattern of repeated self-administration that can result in tolerance, withdrawal, and compulsive drug-taking behavior. A diagnosis of Substance use disorder can be applied to every class of substances except caffeine. A diagnosis of this includes meeting the criteria of increased tolerance, withdrawal symptoms, and a pattern of compulsive use. Persons who are dependent continue using substances in spite of increasingly severe consequences in personal and social lives and physical health.

Common symptoms of substance use disorders include:

1. Increasing episodes of intoxication;
2. Loss of interest in other pursuits;
3. Loss of control over usage;
4. Repeated remorse over the results of substance use;
5. Increased tolerance to the drug (including alcohol);
6. Negative reactions to withdrawal from the drug (best direct evidence of alcoholism is the appearance of withdrawal symptoms one to two days after last drinking alcohol);
7. Memory failures as a result of use;
8. Serious personal and social consequences resulting from substance use such as problems with relationships, work, or with the law.

Intoxication by itself does not indicate dependency. However, when episodes of intoxication occur with increasing frequency, involving larger amounts of a substance due to tolerance, resulting in increasingly severe personal and social consequences over an extended period of time--a diagnosis of dependency is almost certain. Indicators for alcohol use disorders are:

1. Drinking at or before breakfast;
2. Drinking non-beverage forms of alcohol (rubbing alcohol, cologne, etc.);
3. Traffic difficulties (DUI, DWI arrests);
4. Problems at work related to alcohol use;
5. Relationship problems related to usage/fighting associated with drinking;
6. Inability to stop drinking even if the person has the desire to stop;
7. Drinking binges;

8. Blackouts (a person has no memory of his behavior or events although during that time he appeared conscious and aware).

By statute, a licensed alcohol and drug abuse counselor (LADAC) can diagnose substance use disorders. If board members have questions about the reported diagnosis, symptoms, or behaviors of a person appearing before them, it is important to question the mental health professional or LADAC to receive answers.

CO-OCCURRING DISORDER (COD)

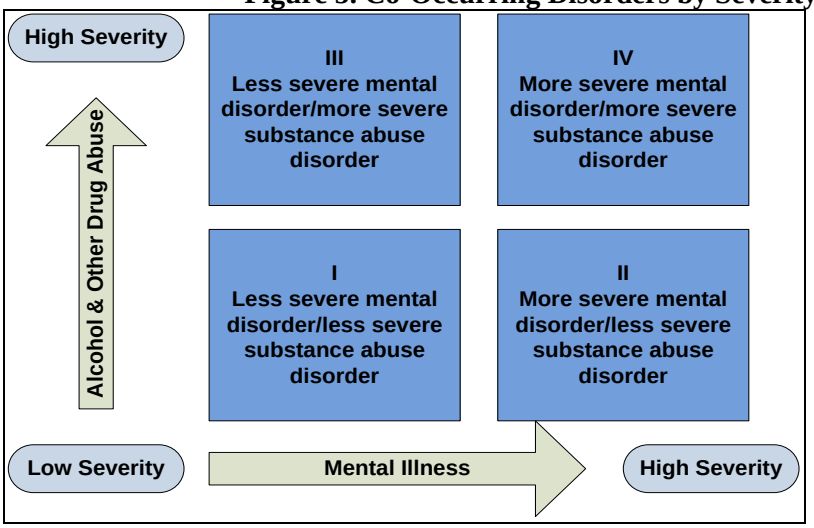
Co-occurring disorders (COD) refers to co-occurring substance-related and mental health disorders. Persons said to have COD have one or more substance-related disorders as well as one or more mental health disorders.

At the individual level, COD exist "when at least one disorder of each type can be established independent of the other and is not simply a cluster of symptoms resulting from a single disorder."

When a person with a mental illness, such as schizophrenia, acquires a substance dependency, serious consequences can result. There can be more severe impairments while using lesser quantities, less frequently. There is a higher risk of non-adherence with mental health treatment; in fact, individuals with COD are eight times more likely to be non-adherent with medications. Psychiatric symptoms can fluctuate more rapidly and are more severe. In addition, there can be increased mood swings, more psychiatric re-hospitalizations, violent acting-out behavior, suicidal ideation, and suicide attempts. If a person with substance dependency has established an entrenched pattern of chronic use, hallucinations, manic behavior, suicide ideation and delusionary behavior can occur resulting from the habitual use of substances.

A conceptual framework referred to as "Quadrants of Care" classifies COD care into four quadrants based on relative symptom severity, not diagnosis. The model provides a framework for understanding the range of co-occurring conditions and a potential need for treatment (see Figure 5).[11]

Figure 5. Co-Occurring Disorders by Severity



[11] http://media.samhsa.gov/co-occurring/

> **"The four-quadrant model provides a structure for moving beyond minimal coordination to foster consultation, collaboration, and integration among systems and providers in order to deliver appropriate care to every client with COD."**
> **SAMSHA's Co-Occurring Center for Excellence**

Persons with a mental illness report similar reasons as the general population for using substances: attempting to improve unpleasant moods such as anxiety and depression, increasing social interaction, and increasing pleasure by feeling "high." Persons with a mental illness may use substances in order to deal with symptoms. People without a mental illness can display symptoms such as anxiety, panic, mood swings, hallucinations, delusions, amnesia, personality changes, insomnia, and eating-disordered behavior due to substance use. Both dependence and psychosis feature loss of control of behavior and emotions, and in both instances symptoms respond to treatment.

Mental and substance use conditions often co-occur. In other words, individuals with substance use conditions often have a mental health condition at the same time and vice versa. Many of these individuals who come before the board will have a COD. Approximately 8.9 million adults have co-occurring disorders; that is they have both a mental and substance use disorder. Only 7.4 percent of individuals receive treatment for both conditions with 55.8 percent receiving no treatment at all.

There are many consequences of undiagnosed, untreated, or undertreated co-occurring disorders including higher likelihood of experiencing:

- Homelessness
- Incarceration
- Medical illnesses
- Suicide
- Early Mortality[12]

If a person before the board has a COD, the MHP should be able to address the course of the COD. The board should ask the MHP for their opinion regarding the course of COD as it will assist in determining commitment and/or treatment options. The following terms apply to the course of COD:

- Remission refers to the absence of distress or impairment due to a substance use or mental disorder. An individual in remission no longer meets DSM criteria for the previously diagnosed disorder but may well benefit from relapse prevention services.
- Recovery consists of gaining information, increasing self-awareness, developing skills for sober living and following a program of change. Recovery is the process in which people are able to live, work, learn and participate fully in their communities. For some individuals, recovery is the ability to live a fulfilling and productive life despite a disability. For others recovery implies the reduction or complete remission of symptoms. When people with COD are in recovery, it is implied that they are abstinent from the substance causing impairment, are able to function despite symptoms of mental illness, and participate in life activities that are meaningful and fulfilling to them.
- Relapse is the return to active substance use in a person with a diagnosed substance use disorder or the return of disabling psychiatric symptoms after a period of remission related to a non-

[12] http://media.samhsa.gov/co-occurring/

addictive mental disorder. Relapse is both an anticipated event in the course of recovery and a process in which warning signs appear prior to an individual's actual recurrence of impairment.[13]

The Mental Health Board should carefully consider treatment options for persons with COD. The person may be in need of integrated services that address the COD rather than solely mental health or substance use disorder services.

In making a determination for services, it is also important to determine if the acute symptoms are stabilized or if the person needs further stabilization before being able to benefit from a treatment program. Often a short stay at an acute inpatient program for psychiatric stabilization, and then a move to a community-based COD residential treatment program provides the most appropriate integrated services approach to address both the mental illness and the substance dependency problems simultaneously.

A person with a COD requires specific psychiatric and mental health support and monitoring in order to participate in treatment for alcohol and/or drug addiction. Due to the multiple problems, they need an individualized and flexible approach to treatment. The supportive, non-threatening approach is more therapeutic for a person with a COD, whereas a confrontational approach would be difficult to tolerate, especially if symptoms of paranoia are present.

A treatment program is defined as a formally organized array of services and interventions provided in a coherent manner at a specific level or levels of care in order to address the needs of particular target populations. A single agency may operate many different programs. Some agencies operate only mental health programs, some operate only substance abuse treatment programs, and some do both.[14] The following are three program types, which are derived from the American Society of Addiction Medicine Placement Criteria.[15]

1. Addiction- or mental-health only services refers to programs that "either by choice or lack of resources (staff or financial), cannot accommodate patients" who have co-occurring disorders that require "ongoing treatment, however stable the illness and however well-functioning the patient."
2. Dual diagnosis capable (DDC) programs are those that address co-occurring mental and substance-related disorders in their policies and procedures, assessment, treatment plan, program content and discharge planning. Even where such programs are geared primarily toward treating substance use or mental health disorders, program staff is able to address the interaction between mental and substance-related disorders and their effect on the person's readiness to change-as well as relapse and recovery environment issues-through individual and group program content.
3. Dual diagnosis enhanced (DDE) programs have a higher level of integration of substance abuse and mental health treatment services. These programs are able to provide unified substance abuse and mental health treatment to consumers who are, compared to those treatable in DDC programs, more symptomatic and/or functionally impaired as a result of their co-occurring mental disorder. Enhanced-level services place their primary focus on the integration of services for mental and substance-related disorders in their staffing, services and program content.

[13] Substance Abuse and Mental Health Services Administration (2007). Definitions and terms relating to co-occurring disorders: Co-Occurring Center for Excellence Overview Paper 1. Rockville, MD: Centers for Substance Abuse Treatment.
[14] Substance Abuse and Mental Health Services Administration (2007). Definitions and terms relating to co-occurring disorders: Co-Occurring Center for Excellence Overview Paper 1. Rockville, MD: Centers for Substance Abuse Treatment.
[15] American Society of Addition Medicine. Patient Placement Criteria (ASAM PPC-2R) (2nd ed.).

UNDERSTANDING DANGEROUSNESS DUE TO MENTAL ILLNESS OR SUBSTANCE DEPENDENCY

It is important to recognize that the majority of persons with a mental illness are not violent and dangerous, any more than the majority of the general population.

"Mental illness plays no part in the majority of violent crimes committed in our society. The assumption that any and every mental illness carries with it an almost certain potential for violence has been proven wrong in many studies. There is a relationship between violent behavior and symptoms which cause the person to feel threatened and/or involve the overriding of personal control. Examples of these criteria include specific symptoms such as command hallucinations and feeling that one's mind is being dominated by outside forces."[16]

Current research shows that people with a major mental illness are 2.5 times more likely to be the victims of violence than other members of society. This most often occurs when factors such as poverty, transient lifestyle, and substance use are present. Any of these factors make a person with mental illness more vulnerable to assault and the possibility of becoming violent in response. The pattern of violence is remarkably similar whether a person is suffering with a mental illness or not. People with a mental illness, for instance, are no more likely than anyone else to harm strangers. Violent behavior by anyone is generally aimed at family and friends, rather than strangers, and it happens in the home, not in public. Typically, spouses, other intimates, and other family members are the targets of violence committed by a person with mental illness. Most of this violence is committed by men and directed to women - as is the case in the population as a whole.

DETERMINING DANGEROUSNESS DUE TO MENTAL ILLNESS OR SUBSTANCE DEPENDENCE

Section 71-908 Mentally ill and dangerous person, defined.
Mentally ill and dangerous person means a person who is mentally ill or substance dependent and because of such mental illness or substance dependence presents: (1) A substantial risk of serious harm to another person or persons within the near future as manifested by evidence of recent violent acts or threats of violence or by placing others in reasonable fear of such harm; or (2) A substantial risk of serious harm to himself or herself within the near future as manifested by evidence of recent attempts at, or threats of, suicide or serious bodily harm or evidence of inability to provide for his or her basic human needs, including food, clothing, shelter, essential medical care, or personal safety.

A common mistake in determining dangerousness is to neglect the phrase in Section 71-908 "and because of such mental illness or substance dependence." The dangerousness **must be due** to a mental illness. For example, a concerned parent with mental illness or substance dependence may display anger and threatening behavior if she believes the school is treating her child differently than other children. If indeed, the parent has a reasonable argument for such a complaint, the anger and frustration are related to a real phenomenon and the threatening behaviors are not related to her mental illness but rather to the injustice she believes her child is experiencing. On the other hand, if the same parent is threatening to

[16] Canadian Mental Health Association. Accessed on the web on 1/2/10 at: http://www.cmha.ca

injure a school official because she believes the school is serving poisoned school lunches, the dangerousness is more likely related to the parent's false, delusionary beliefs. The determination of dangerousness must be directly due to the mental illness or substance dependence.

In addition, the risk that mental health commitment was intended to manage must be substantial and the harm must be serious. Further, this substantial risk of harm to self or others must be likely to occur within the near future.

The dangerousness standard incorporated in the Mental Health Commitment Act has timing requirements, e.g. the danger due to mental illness must be in "the near future as manifested by evidence of recent violent acts." Despite litigation, there is no bright line test for what constitutes "near" future or "recent" acts. The nature of the past acts is an important factor to be weighed in considering timing requirements and probative value. The jurisprudence of timing requirements remain subject to a Mental Health Board weighing multiple factors articulated by the Nebraska Supreme Court, as follows:

Rasmussen (1990) involved an individual whose mental illness interfered sufficiently with his "mental capacity to safely take care of his basic needs." The Court found "in determining whether a person is dangerous, <u>the focus must be on the subject's condition at the time of the hearing</u>, not the date the subject of the commitment hearing was initially taken into custody. Actions and statements of a person alleged to be mentally ill and dangerous which occur prior to the hearing are probative of the subject's present mental condition. However, <u>in order for a past act to have any evidentiary value, it must form some foundation for a prediction of future dangerousness</u> and be, therefore, probative of that issue." [Emphasis added].

Hill (1979) involved an individual who was first committed to LRC in 1959 at age 6. In 1970 he became angry with his employer over a wage dispute and set fire to a vehicle. In 1974 he was found not responsible by reason of insanity for a murder and rape in 1970. In May 1977, while incarcerated he was found sitting on his bed with a rope of torn strips of bed sheets around his neck. In October 1977, he overdosed on 7200 mg of Thorazine pills. At some point he was at the regional center and used staples and other sharp instruments to stick in his arm and pump ink from ink refills into his veins. His mental illness resulted in him "capable of taking extreme steps which admittedly could endanger his life or health" although the Court acknowledged that he "may not be suicidal in the true sense." Deputy Sheriff Clemens testified that on January 5, 1978, Hill told him that he would gladly blow up his car for $50 and if he, Clemens, tried to stop him, he would blow him up for free. Hill also told this same deputy on several occasions that it didn't bother him to hurt people. The violent acts described above occurred within periods of 9 month, 4 months, and 6 weeks, respectively, of the hearing. The question presented by this appeal is whether they were sufficiently "recent" within the meaning of the law. The Court found "each case must be decided on the basis of the surrounding facts and circumstances." That an act or threat is recent "if the time interval between it and the hearing of the mental health board is not greater than that which would indicate processing of the complaint was carried on with reasonable diligence under the circumstances existing, having due regard for the rights and welfare of the alleged mentally ill dangerous person and the protection of society in general." The Court provided the following examples. "If a person commits an act and nothing at all is done for 1 year, we would be hard pressed to define that as a 'recent act.' On the other hand, if a person kills another and is tried for murder and a year later, after having been held in custody all that time, is finally adjudged innocent by reason of insanity, it would be ridiculous to say that the killing was not a 'recent violent act.'" [Emphasis added].

Lux (1979) involved an individual with paranoid delusions who attacked his father in a violent attack at the home of Lux' parents on November 23, 1976. At that time, Lux attempted to "choke the truth" out of his father, while he was sitting in a recliner watching television. His mother attempted to stop the assault by picking up a heavy cane and hitting Lux repeatedly, but he did not stop. Finally she exclaimed, "My

God Larry, you're killing your dad." At that time he stopped and helped pick his father up off the floor. The Court concluded that although the statute refers to "recent violent acts," evidence from one violent act may be sufficient to sustain a mental health commitment. [Emphasis added].

Blythman (1981) involved an individual who was incarcerated in the Nebraska Penal and Correctional Complex after a District Court found, on April 14, 1975, that he was a sexual sociopath and that he could not be benefited by treatment. The fact situation in this case is somewhat unique in that the subject's mental illness manifests itself in sexual acts toward young girls. On May 9, 1979, the District Court sentenced the defendant to 4 years, with 4 years' credit for time served, and thereafter returned him to the Penal Complex as an untreatable sexual sociopath. On June 1, 1979, the District Court ordered that the defendant be returned to Lincoln County for further proceedings. On June 28, 1979, a petition was filed before the Board of Mental Health of Lincoln County, alleging Blythman to be a mentally ill dangerous person and requesting involuntary commitment and board-ordered treatment. The Court held that "an act occurring 5 years prior to the mental health commitment hearing is recent," where:

(a) There is evidence that the act is still probative of the subject's future dangerousness;
(b) The subject has not had an opportunity to commit a more recent act because he has been in confinement; and
(c) There is reliable medical evidence that there is a high probability of repetition of such act by the subject. [Emphasis added].

Many times, the risk of harm subsides between the time of the emergency protective custody and the Mental Health Board hearing, such that it is no longer a substantial risk. Other times, the harm dissipates and is no longer serious. If this is the case, and no threat of dangerousness is likely to occur in the near future, there is no standing for a commitment. All of these components must be attested to by a MHP which includes a physician, psychologist, or qualified advanced nurse practitioner. In summary, two important points regarding dangerousness that must be determined before an individual is committed follow.

1. The risk must be substantial and the harm must be serious and must be imminent in the time between EPC up to the hearing. All of these components must be attested to by a physician, psychologist, or specially qualified nurse, as noted in the certificate procedure.
2. Dangerousness must be due to the mental illness or substance dependency. A person with mental illness or substance dependency may exhibit dangerous behaviors which are not associated with their mental or substance use disorder.

Areas of dangerousness may include:

1. Suicide threat (verbal)
2. Suicide attempt
3. Homicide threat (verbal)
4. Homicide attempt
5. Threats to physically harm others, (verbal or nonverbal)
6. Destruction of property
7. Inability to provide the basic needs of food, clothing, shelter, safety, and medical care.

SUBSTANTIAL RISK OF SERIOUS HARM TO ANOTHER PERSON

Factors relating to dangerousness include magnitude, likelihood, imminence, frequency and situational variables, e.g. access to weapons. Situational variables may influence all preceding factors. The Mental Health Board needs to explore these factors to determine if dangerousness is present.

Factors Related to Dangerousness

Dangerousness risk is a complex interaction of five factors:

Magnitude, Likelihood, Imminence, Frequency and Situation

Considering each of these factors can help assess the potential for violence.

Magnitude of danger concerns the level of danger presented. For example, threats to harm people would be considered more dangerous than threats to harm property; threats of physical harm to others would be more serious than psychological threats. The use of a weapon escalates the risk of danger, of course, but the choice of weapon must be taken into consideration. The harm posed by a gun would be greater than that posed by a knife because a gun is five times more likely to cause death than a knife.

Likelihood of dangerousness is the probability of occurrence of violence. While **the best predictor of violence is past history of violence**, research has shown that there are many variables that correlate statistically with an increased risk of violence:

a) Psychiatric Acuity: Agitated individuals with paranoia are more violent than others.
b) Age: Violence peaks in the late teens and early 20's.
c) Gender: Males are more violent than females. However, among those with severe and persistent mental illness, the ratio of violent and aggressive acts is the same for males and females.
d) Social Class: Lower socio-economic class members experience more street violence.
e) IQ: Individuals with lower IQ's demonstrate more violence which may be related to an inability to communicate concerns or articulate needs.
f) Education: Lower levels of educational achievement are associated with more violence.
g) Employment: Risk of violence increases with job instability.
h) Residence: Risk of violence increases with frequent changes of residence.
i) Substance abuse: Use of marijuana, alcohol, and other drugs increases the risk of violent behavior three-fold; especially use of stimulants such as methamphetamine which reduce inhibitions and increase paranoia.
j) Psychotropic Medication Status: Risk of violence increases if the individual is non adherent with prescribed psychotropic medications
k) Access to Weapons: Availability of firearms increases the risk of violence.

Imminence of danger, how soon the danger might occur, is contained in the statute's description as "near future." Each Mental Health Board should have a working consensus of the definition of imminent—whether it is defined as right now, or within twenty-four hours, the most commonly used time frame. Having this time definition set before being placed under pressure to make a decision regarding a commitment is helpful. The sooner violence may occur, the greater the risk of danger due to not having a chance to mitigate circumstances or provide protection.

Frequency is a factor when considering risks of dangerousness. Future violence is best predicted by past violence. The frequency of occurrence is a clear indicator that a pattern has been set and may be reoccurring.

Situational Variables impact all previous factors to either promote or protect against risk of harm. Perhaps the most dangerous combination involves an acutely intoxicated young male with a history of paranoid ideation and violence who has access to weapons while experiencing an acute psychiatric crisis caused by stressful life events during a period of noncompliance with prescription medications.

Dangerousness risk factors can be static or dynamic. Some risks can be changed, for example, by taking away a weapon or the availability of a weapon. Another example could be when psychosis is altered by enforcing oral medication adherence or by prescribing anti-psychotic medication delivered by injection, which can last from two to four weeks. The presence of a mental illness may be static, but the risks and deficits engendered by that condition may fluctuate. However, the likelihood of violence increases if a person's illness is active and in an acute stage. This is especially true if the illness is acute and psychotic. While paranoid schizophrenia in an acute stage is more dangerous due to delusions and hallucinations, depression carries with it the risk of suicide. Those with manic mood symptoms may make more threats but cause less harm though risk of suicide is still substantial. People with personality disorders, especially those diagnosed with antisocial personality disorder who have no remorse for their behavior, and those who are impulsive, and unable to accept redirection, pose a greater risk for violence.

- *Delusions* are more dangerous than hallucinations, especially when they are well organized, specific, and persecutory, i.e. "Blue-eyed people are really aliens who are out to get me."
- *Hallucinations* present a higher risk of violence if they are command auditory hallucinations, voices which command an individual to obey. If the command voice is familiar, like that of a parent, the person is more likely to obey the command.
- **The most dangerous situation occurs when delusions are related to command hallucinations, with the delusions causing the hallucinations to make sense to the person**, i.e., "Aliens are trying to take over the earth by replacing people with robots. My wife has been replaced with a robot. My deceased mother's voice whispers to me the only way I can get my wife back is to kill the robot imposter."

SUBSTANTIAL RISK OF SERIOUS HARM TO SELF

DANGER TO SELF: SUICIDE

From 2009 to 2013, suicide was the leading cause of injury death for Nebraskans aged 25-64 years old, and the second leading cause of injury death for all age groups combined. The age-adjusted suicide rate was 10 deaths per 100,000 Nebraskans. The suicide death rate was highest among adults aged 75-84 (about 17 deaths per 100,000 persons). Overall, suicide rates were higher among males than females (17.2 per 100,000 males vs. 3.9 per 100,000 females). Approximately 54% of all suicide deaths were caused by firearm, while 26% were caused by suffocation, 14% by poisoning, and 6% by other means.

Nebraska is making progress. Nebraska's 2012 crude suicide rate per 100,000 population for youth ages 15-24 was 13.0 – Nebraska's rank was 21. In 2013 Nebraska's rate was 11.0 moving it to a ranking of 33, below the average rate of 11.1/100,000.17

[17] Data source: CDC's WISQARS website "Fatal Injury Reports," http://www.cdc.gov/wisqars/index.html; download 16 October 2014: CDC's WISQARS website "Fatal Injury Reports," http://www.cdc.gov/wisqars/index.html; download 22 January 2015

Counties with the highest overall suicide rate in Nebraska (all ages):

County	Rate
Garden	22.34
Pawnee	21.14
Kimball	21.14
Sherman	20.58
Chase	19.40
Cheyenne	19.22
Johnson	17.96
Dundy	17.72
Gage	17.68
Greeley	17.58[18]

Urban Counties
Cass – 13.20
Hall – 11.39
Lancaster – 11.18
Douglas – 10.23
Sarpy – 9.58

The content presented in this section is adapted from information presented by the American Foundation for Suicide Prevention.[19] To assist the reader in understanding the prevalence of suicide on a national level, national suicide statistics are presented in Appendix G. Frequently asked questions regarding suicide can be found in Appendix H.

Suicide risk is a broad term that includes factors explained below:

- Psychiatric Disorders: At least 90 percent of people who kill themselves have a diagnosable and treatable psychiatric illness -- such as major depression, bipolar depression, or some other depressive illness, including: schizophrenia; alcohol or drug abuse, particularly when combined with depression; posttraumatic stress disorder, or some other anxiety disorder; bulimia or anorexia nervosa; and/or personality disorders especially borderline or antisocial.
- Past History of Attempted Suicide: Between 20 and 50 percent of people who kill themselves had previously attempted suicide. Those who have made serious suicide attempts are at a much higher risk for actually taking their lives.
- Genetic Predisposition: Family history of suicide, suicide attempts, depression or other psychiatric illness indicates a higher risk for suicide.
- Neurotransmitters: A clear relationship has been demonstrated between low concentrations of the serotonin metabolite 5-hydroxyindoleactic acid (5-HIAA) in cerebrospinal fluid and an increased incidence of attempted and completed suicide in psychiatric patients.
- Impulsivity: Impulsive individuals are more apt to act on suicidal impulses.
- Demographics: Males are three to five times more likely to die by suicide than females. Elderly Caucasian males have the highest suicide rates.

A suicide crisis is a time-limited occurrence signaling immediate danger of suicide. The signs of crisis are:

- Precipitating Event: A recent event that is particularly distressing such as loss of a loved one, job, housing, or relationship or a career failure. Sometimes the individual's own behavior precipitates the event: for example, a man's abusive behavior while drinking causes his wife to leave him.

[18] 1999-2013 CDC data taken from http://www.worldlifeexpectancy.com/usa/nebraska-suicide
[19] American Foundation for Suicide Prevention (2011). Retrieved from www.afsp.org/index.cfm?fuseaction=home.viewPage&page_id=1.

- Intense Affective State in Addition to Depression: Desperation (anguish plus urgency regarding need for relief), rage, psychic pain or inner tension, anxiety, guilt, hopelessness, acute sense of abandonment.
- Changes in Behavior: Speech suggesting the individual is close to suicide. Such speech may be indirect. Be alert to such statements as, "My family would be better off without me." Sometimes those contemplating suicide talk as if they are saying goodbye or going away. Actions ranging from buying a gun to suddenly putting one's affairs in order. Deterioration in functioning at work or socially, increasing use of alcohol, other self-destructive behavior, loss of control, rage explosions.

The emotional crises that usually precede suicide are often recognizable and treatable. Although many people who are depressed are not suicidal, most people who are suicidal are depressed. Serious depression can be manifested in obvious sadness, but often it is rather expressed as a loss of pleasure or withdrawal from activities that had been enjoyable. Many individuals who are suicidal will give some warning of their intentions. The most effective way to prevent a person taking his or her life is to recognize the factors that put people at risk for suicide, take warning signs seriously, and know how to respond.

Warning signs of suicide include:

- Observable signs of serious depression: unrelenting low mood, pessimism, hopelessness, desperation, anxiety, psychic pain and inner tension, withdrawal, sleep problems
- Increased alcohol and/or other drug use
- Recent impulsiveness and taking unnecessary risks
- Threatening suicide or expressing a strong wish to die
- Making a plan: giving away prized possessions, sudden or impulsive purchase of a firearm, obtaining other means of killing oneself such as poisons or medications
- Unexpected rage or anger

DANGER TO SELF: DELIBERATE SELF-HARM

The American Self-Harm Information Clearinghouse[20] defines self-harm as the "deliberate, direct injury of one's own body that causes tissue damage or leaves marks for more than a few minutes and that is done in order to deal with an overwhelming or distressing situation." Self-harm is also known as self-injury, self-inflicted violence, or self-injurious behavior. Self-harm can include cutting (with knives, razors, glass, pins, sharp objects), burning, hitting the body with an object or the fists, picking at skin until it bleeds, biting self, pulling out hair, etc. The most commonly-seen forms of self-harm are cutting, burning, and head banging.

Self-harm will often serve a purpose or function for the person who is harming him/herself, and figuring out what function the behavior serves is important in understanding the behavior and helping the person to learn other ways to get needs met. People who self-harm provide reasons such as the following for their actions:

- "Affect modulation-distraction from emotional pain, ending feelings of numbness, lessening a desire to commit suicide, calming overwhelming/intense feelings.
- Maintaining control and distracting the self from painful thoughts or memories.
- Self-punishment-either because they believe they deserve punishment for either having good feelings or being an "evil" person or because they hope that self-punishment will avert worse punishment from some outside source.

[20] American Self-Harm Information Clearinghouse (2007). Retrieved from www.selfinjury.org/.

- Expression of things that can't be put into words-displaying anger, showing the depth of emotional pain, shocking others, seeking support and help.
- Expression of feelings for which they have no label-this phenomenon, called alexithymia (literally no words feeling), is common in people who self-harm."[21]

There are many myths associated with self-harming behavior, including:

1. Myth: *"Self-harm is usually a failed suicide attempt."*
   Truth: There is a wealth of studies showing that, although people who self-injure may be at a higher risk of suicide than others, they distinguish between acts of self-harm and attempted suicide. Many, if not most, self-injuring people who make a suicide attempt use means that are completely different to their preferred methods of self-inflicted violence.

2. Myth: *"People who self-injure are crazy and should be locked up."*
   Truth: Tracy Alderman, Ph.D., author of *The Scarred Soul*[22], addressed this: "Fear can lead to dangerous overreactions. In dealing with clients who hurt themselves, you will probably feel fear. . . . Hospitalizing clients for self-inflicted violence is one such form of overreaction. Many therapists, because they do not possess an adequate understanding of Self-Inflicted Violence (SIV), will use extreme measures to assure (they think) their clients' best interests. However, few people who self-injure need to be hospitalized or institutionalized. The vast majority of self-inflicted wounds are neither life threatening nor require medical treatment. Hospitalizing a client involuntarily for these issues can be damaging in several ways. Because SIV is closely related to feelings of lack of control and overwhelming emotional states, placing someone in a setting that by its nature evokes these feelings is very likely to make matters worse, and may lead to an incident of SIV. In addition, involuntary hospitalization often affects the therapeutic relationship in negative ways, eroding trust, communication, rapport, and honesty. Caution should be used when assessing a client's level of threat to self or others. In most cases, SIV is not life threatening… Because SIV is so misunderstood, clinicians often overreact and provide treatment that is contraindicated."

3. Myth: *"People who self-harm are just trying to get attention."*
   Truth: We all seek attention at some point in time or another; wanting attention is not bad or sick. Attention-seeking behaviors can include: wearing nice clothing, smiling at people, saying "hi," going to the check-out counter at a store, and so on. If someone is in so much distress and feels so ignored, that the only way he/she can think of to express pain is by hurting his/her body, something is probably very wrong in his/her life. This is not the time to be making moral judgments about the behavior. That said, many people who self-injure go to great lengths to hide their wounds and scars. Many consider their self-harm to be a deeply shameful secret and dread the consequences of discovery.

4. Myth: *"Self-inflicted violence is just an attempt to manipulate others."*

[21] Osuch E.A., Noll J.G., & Putnam F.W. (1999). The motivations for self-injury in psychiatric inpatients. Psychiatry, 62, pp: 334-346.
[22] Alderman, T. (1997). *The Scarred Soul.* New Haringer Publications, 5674 Stattuck Avenue, Oakland, CA 94609

Truth: Most people do not use self-inflicted injuries as an attempt to cause others to behave in certain ways. If you feel as though someone is trying to manipulate you with self-injury/self-harm, it may be more important to focus on what it is they want and how you can communicate about it while maintaining appropriate boundaries. Look for the deeper issues and work on those.

5. Myth: *"Only people with Borderline Personality Disorder (BPD) self-harm."*
   Truth: Self-harm is a criterion for diagnosing BPD, but there are eight other equally important criteria. Not everyone with BPD self-harms, and not all people who self-harm have BPD (regardless of practitioners who automatically diagnose anyone who self-injures with BPD).

6. Myth: *"If the wounds aren't 'bad enough,' self-harm isn't serious."*
   Truth: The severity of the self-inflicted wounds has very little to do with the level of emotional distress present. Different people have different methods of self-injury and different pain tolerances. The only way to figure out how much distress someone is in is to ask. Never assume; check it out with the person.

7. Myth: *"Only teenage girls self-injure."*
   Truth: The American Self-Harm Clearinghouse and the Bodies-Under-Siege Support Group have served individuals of both genders, from six continents, and ranging in age from 14 years old to over 60 years old. Self-harm is a "person-who-has-no-other-way-to-cope thing," not a teenage (or female or American or whatever) thing.[23]

DANGER TO SELF: SELF-NEGLECT

In addition to suicide and self-injury, self-neglect is a dangerous behavior often encountered by Mental Health Boards. Self-neglect could be considered dangerous when a person has an inability to provide for the basic human needs of food, clothing, shelter, safety, hygiene, and medical care. Inability to care for self may result from mental illness and/or alcohol and drug use.

Self-endangering behaviors may be evident in the life of a person with alcohol or drug-dependency; for example, drinking alcohol or drug use which compounds medical problems yet the person does not stop substance use despite deterioration in physical health. A methamphetamine user or an alcohol-dependent person on a binge may not eat for days. Frequently, persons who are dependent on alcohol become depressed and express thoughts of suicide or wanting to die while intoxicated. Persons with addictions may seriously deplete family resources to the point that money is gone---leaving them and their families without resources for procuring food, shelter, clothing or medical needs. A person with a substance dependency may endanger not only his or her own life, but also the lives of others when driving while intoxicated or under the influence of drugs.

FURTHER CONSIDERATIONS ON DETERMINING DANGEROUSNESS

If enough information about risk factors for dangerousness is not presented to the board, members have a duty to discover any elements related to dangerousness by questioning the individual before them, the MHP, and any legal representatives.

Focus on…

[23] American Self-Harm Information Clearinghouse: Website accessed on 4/8/11 http://www.selfinjury.org.

(1) Precipitating event that brought about the petition for a hearing
(2) Person's behavior
(3) Person's past history related to dangerousness

A label of "dangerous" or "violent" applied to a person should not be accepted at face value, but must rest on a report of the incident and behavior.

These facts must always be ascertained:

1	WHAT	What were the events, person's behavior, diagnosis, presence/absence of mental illness/substance abuse, etc.?
2	WHO	Who was the victim(s)? Some research has shown that if they are violent, individuals with mental illness are more likely to be violent toward family members;
3	WHEN	What were the date, time, and *frequency* of the dangerous acts?
4	WHERE	What were the location and circumstances surrounding the dangerousness?
5	WHY	What triggered the violence? Was the violence in retaliation for an imagined or real event? What was the reported motivation behind the behavior? Was it a planned, predatory, or calculated act, or did the violence arise from an emotional trigger in the moment? Planned violent acts tend to be more lethal than those that happen in the moment.
6	HOW	Is there a pattern in past behaviors? Can this pattern be predicted?

It is not always possible to predict actual violent events, however, there are elements of behaviors or actions of individuals that have been statistically found to lead to violent acts or to predict the likelihood of violence.

Mental Health Boards may use the following questions to help determine likelihood or risk of violence:

- Mental Status: Was the person psychotic or intoxicated?
- Motivation: Was this a predatory, calculated or planned act, or was the individual acting out from emotional impulse?
- Emotion: What were the person's feelings before, during, and after the event? Does the person express remorse for the act? (Fear and anger are most commonly associated with violent or aggressive acts; lack of remorse or lack of empathy for the victim can signal a higher level of dangerousness)
- Impulse: Has the person demonstrated unpredictable and impulsive behavior in the past? Has the person repressed emotions or "over-controlled" his/her behaviors? (Over-controlled behavior can also result in danger when long repressed emotions erupt suddenly, triggered by the proverbial "straw that broke the camel's back".)
- Victim(s): Was the victim familiar or known by the violent person, or was the act perpetrated against a stranger?
- Magnitude - Weapons: Were any weapons used? If so, what was the weapon and what magnitude of harm resulted or could have resulted? For example, was a plate thrown at the

wall in anger or was a gun used? Does the individual have ready access to the weapon of choice?

- Stressors: What were the biological or medical stressors affecting the person? Were there increased psychological or social stressors affecting their lives such as a lost job, broken relationship, or recently diagnosed medical condition?

RISK AND AGGRESSIVE BEHAVIOR ASSESSMENTS

There are a multitude of risk assessments available which might be completed by the MHP. The Level of Care Utilization Systems for Psychiatric and Addictions Services (LOCUS) assesses risk according to the potential for severity and occurrence. This instrument was developed by the American Association of Community Psychiatrists (see Appendix I)[24]. Mental health professionals may also categorize the risk for dangerousness as low, moderate or extreme as defined below:

Low risk correlates with consequences unlikely to result in harm, injury, property destruction, or no life-threatening incidences. Even if imminent, the magnitude of danger would be lower.
Moderate risk would present greater magnitude, not as imminent, with consequences likely to result in harm, injury, or property destruction but without life threatening consequences.
Extreme risk for dangerous behaviors is an acute level—high magnitude, imminent risk with consequences likely to include loss of life, limb, and/or major property destruction.

Aggressive behavior also falls along a spectrum--from verbal threats to severe injury. A scale for determining aggressive behavior is in Appendix J.

DANGEROUS SEX OFFENDERS

Mental Health Boards will also hear cases related to alleged dangerous sex offenders. Mental health evaluations will include diagnostic terminology important for Mental Health Board members to understand regarding diagnoses associated with sexual disorders. The following terms are taken from the Diagnostic and Statistical Manual of Mental Disorders (DSM).[25]

Personality Disorder is an enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment.

- Antisocial personality disorder represents a pervasive pattern of disregard for, and violation of, the rights of others that begins in childhood or early adolescence and continues into adulthood. Deceit and manipulation are central features. There is also a failure to conform to social norms with respect to lawful behaviors, impulsivity, irritability and aggressiveness, reckless disregard for the safety of others, consistent irresponsibility and a lack of remorse for their actions.
- Schizotypal personality disorder is a pervasive pattern of social and interpersonal deficits marked by acute discomfort with, and reduced capacity for, close relationships as well as

[24] Level of Care Utilization System for Psychiatric and Addiction Services (2010). American Association of Community Psychiatrists. Retrieved from www.communitypsychiatry.org/publications/clinical_and_administrative_tools_guidelines/locus.aspx.
[25] American Psychiatric Association (2000). Diagnostic and statistical manual of mental disorders (4th ed., Text Revision). Washington, DC: Author.

cognitive or perceptual distortions and eccentricities of behavior, beginning in early adulthood. Individuals with schizotypal personality disorder often have ideas of reference, odd beliefs, odd thinking, suspiciousness, odd behavior, lack of close friends, and excessive social anxiety.

Paraphilia's feature recurrent, intense, sexually arousing fantasies, sexual urges, or behaviors, generally involving non-human objects, suffering or humiliation of oneself or one's partner, children, or other non-consenting persons, that occurs over a period of at least 6 months. Individuals with exhibitionism, pedophilia and voyeurism make up the majority of apprehended sex offenders.

Exhibitionism involves the exposure of one's genitals to a stranger. Sometimes the individual masturbates while exposing himself. If the person acts on these urges, there is generally no attempt at further sexual activity with the stranger.

Voyeurism involves the act of observing unsuspecting individuals, usually strangers, who are naked, in the process of disrobing or engaging in sexual activity. The act of looking ("peeping") is for the purpose of achieving sexual excitement and generally no sexual activity with the observed person is sought. The behavior often is accompanied by masturbation.

Pedophilia involves sexual activity with a pre-pubescent child (generally age 13 years or younger). The individual with pedophilia must be age 16 years or older and at least 5 years older than the child. For individuals in late adolescence with pedophilia, no precise age difference is specified. People with pedophilia generally report an attraction to children of a particular age range. Some prefer males, some females, some both. Some are also attracted to adults. The course is usually chronic, especially in those attracted to males. The recidivism rate for persons with a preference for males is roughly twice that for those who prefer females. (Pedophilia is often associated with co-occurring antisocial or schizotypal personality disorder.)

Sexual sadism involves acts in which the individual derives sexual excitement from the psychological or physical suffering (including humiliation) of the non-consenting person. The activity is likely to be repeated until the person is apprehended. Usually the severity of the sadistic acts increases over time. When sexual sadism is severe, and especially when associated with antisocial personality disorder, individuals may seriously injure or kill their victims.

PART 3. MENTAL HEALTH COMMITMENT PROCESS

EMERGENCY PROTECTIVE CUSTODY (EPC) PROCESS

Section 71-919
Mentally ill and dangerous person; dangerous sex offender; emergency protective custody; evaluation by mental health professional.

(1) A law enforcement officer who has probable cause to believe that a person is mentally ill and dangerous or a dangerous sex offender and that the harm described in section 71-908 or subdivision (1) of section 83-174.01 is likely to occur before Mental Health Board proceedings under the Nebraska Mental Health Commitment Act or the Sex Offender Commitment Act may be initiated to obtain custody of the person may take such person into emergency protective custody, cause him or her to be taken into emergency protective custody, or continue his or her custody if he or she is already in custody. Such person shall be admitted to an appropriate and available medical facility, jail, or Department of Correctional Services facility as provided in subsection (2) of this section. Each county shall make arrangements with appropriate facilities inside or outside the county for such purpose and shall pay the cost of the emergency protective custody of persons from such county in such facilities. A mental health professional who has probable cause to believe that a person is mentally ill and dangerous or a dangerous sex offender may cause such person to be taken into custody and shall have a limited privilege to hold such person until a law enforcement officer or other authorized person arrives to take custody of such person.

(2) (a) A person taken into emergency protective custody under this section shall be admitted to an appropriate and available medical facility unless such person has a prior conviction for a sex offense listed in section 29-4003.
(b) A person taken into emergency protective custody under this section who has a prior conviction for a sex offense listed in section 29-4003 shall be admitted to a jail or Department of Correctional Services facility unless a medical or psychiatric emergency exists for which treatment at a medical facility is required. The person in emergency protective custody shall remain at the medical facility until the medical or psychiatric emergency has passed and it is safe to transport such person, at which time the person shall be transferred to an available jail or Department of Correctional Services facility.

(3) Upon admission to a facility of a person taken into emergency protective custody by a law enforcement officer under this section, such officer shall execute a written certificate prescribed and provided by the Director of Health and Human Services. The certificate shall allege the officer's belief that the person in custody is mentally ill and dangerous or a dangerous sex offender and shall contain a summary of the person's behavior supporting such allegations. A copy of such certificate shall be immediately forwarded to the county attorney.

(4) The administrator of the facility shall have such person evaluated by a mental health professional as soon as reasonably possible but not later than thirty-six hours after admission. The mental health professional shall not be the mental health professional who causes such person to be taken into custody under this section and shall not be a member or alternate member of the Mental Health Board that will preside over any hearing under the Nebraska Mental Health Commitment Act or the Sex Offender Commitment Act with respect to such person. A person shall be released from emergency protective custody after completion of such evaluation unless the mental health professional determines, in his or her clinical opinion, that such person is mentally ill and dangerous or a dangerous sex offender.

Section 71-920
Mentally ill and dangerous person; certificate of mental health professional; contents.

(1) A mental health professional who, upon evaluation of a person admitted for emergency protective custody under section 71-919, determines that such person is mentally ill and dangerous shall execute a written certificate as provided in subsection (2) of this section not later than twenty-four hours after the completion of such evaluation. A copy of such certificate shall be immediately forwarded to the county attorney.

(2) The certificate shall be in writing and shall include the following information:

a. The subject's name and address, if known;
b. The name and address of the subject's spouse, legal counsel, guardian or conservator, and next-of-kin, if known;
c. The name and address of anyone providing psychiatric or other care or treatment to the subject, if known;
d. The name and address of any other person who may have knowledge of the subject's mental illness or substance dependence who may be called as a witness at a Mental Health Board hearing with respect to the subject, if known;
e. The name and address of the medical facility in which the subject is being held for emergency protective custody and evaluation;
f. The name and work address of the certifying mental health professional;
g. A statement by the certifying mental health professional that he or she has evaluated the subject since the subject was admitted for emergency protective custody and evaluation; and
h. A statement by the certifying mental health professional that, in his or her clinical opinion, the subject is mentally ill and dangerous and the clinical basis for such opinion.

Information regarding the process for admissions to treatment through the EPC process can be found in Appendix K, and a suggested form, "The Emergency Admittance Pursuant to Certificate of a Peace Officer and Attachment A. Mental Health Emergency Assessment Form," is located in Appendix L. The Mental Health Professional Certificate is located in Appendix M.

MENTAL HEALTH BOARD PETITION, SUMMONS, HEARING

Once it has been determined that a Mental Health Board hearing is needed, Section 71-923 comes into play. The Mental Health Board Order form is located in Appendix N.

Section 71-923
Petition; summons; hearing; sheriff; duties; failure to appear; warrant for custody.

Upon the filing of the petition under section 71-921, the clerk of the district court shall cause a summons fixing the time and place for a hearing to be prepared and issued to the sheriff for service. The sheriff shall personally serve upon the subject and the subject's legal guardian or custodian, if any, the summons and copies of the petition, the list of rights provided by sections 71-943 to 71-960, and a list of the names, addresses, and telephone numbers of mental health professionals in that immediate vicinity by whom the subject may be evaluated prior to his or her hearing. The summons shall fix a time for the hearing within seven calendar days after the subject has been taken into emergency protective custody. The failure of a subject to appear as required under this section shall constitute grounds for the issuance by the Mental Health Board of a warrant for his or her custody.

INDIVIDUAL PROCEDURAL RIGHTS

Persons who are subject to a Mental Health Board hearing have individual rights which must be granted.

Section 71-943
Subjects' rights during proceedings against them.

In addition to the rights granted subjects by any other provisions of the Nebraska Mental Health Commitment Act, such subjects shall be entitled to the rights provided in sections 71-943 to 71-960 during proceedings concerning the subjects under the act.

Section 71-944

Subject's rights; written notice of the time and place of hearing; reasons alleged for treatment; procedure.

A subject shall, in advance of the Mental Health Board hearing conducted under section 71-924 or 71-1208, be entitled to written notice of the time and place of such hearing, the reasons alleged for believing that he or she is mentally ill and dangerous or a dangerous sex offender requiring inpatient or outpatient treatment ordered by the Mental Health Board, and all rights to which such subject is entitled under the Nebraska Mental Health Commitment Act or the Sex Offender Commitment Act. The notice requirements shall be deemed satisfied by personal service upon the subject of the summons or notice of time and place of the hearing and copies of the petition and list of rights required by sections 71-923 and 71-924 or sections 71-1207 and 71-1208. If the subject has counsel and if the physician or mental health professional on the board determines that the nature of the alleged mental disorder or personality disorder, if true, is such that it is not prudent to disclose the label of the mental disorder or personality disorder to the subject, then notice of this label may be disclosed to the subject's counsel rather than to the subject. When the subject does not have counsel, the subject has a right to the information about his or her mental illness or personality disorder, including its label. The clerk shall issue the summons by order of the Mental Health Board.

Section 71-945

Subject's rights; representation by counsel; appointment of counsel if indigent.

A subject shall have the right to be represented by counsel in all proceedings under the Nebraska Mental Health Commitment Act or the Sex Offender Commitment Act. Counsel for a subject who is in custody shall have full access to and the right to consult privately with the subject at all reasonable times. As soon as possible after a subject is taken into emergency protective custody under section 71-919, or after the filing of a petition under section 71-921 or 71-1205, whichever occurs first, and before the Mental Health Board hearing conducted under section 71-924 or 71-1208, the board shall determine whether the subject is indigent. If the subject is found to be indigent, the board shall certify that fact to the district or county court by causing to be delivered to the clerk of such court a certificate for appointment of counsel as soon as possible after a subject is taken into emergency protective custody or such petition is filed.

Section 71-947

Appointed counsel; fees; reimbursement of costs incurred; procedure.

Counsel appointed as provided in subdivision (1) of section 71-946 shall apply to the court in which his or her appointment is recorded for fees for services performed. Such counsel may also apply to the court to secure separate professional examination of the person for whom counsel was appointed and shall be reimbursed for costs incurred in securing such separate examination or examinations or in having other professional persons as witnesses before the Mental Health Board. The court, upon hearing the application, shall fix reasonable fees, including reimbursement of costs incurred. The county board of the county in which the application was filed shall allow the account, bill, or claim presented by the attorney for services performed under the Nebraska Mental Health Commitment Act or the Sex Offender Commitment Act in the amount determined by the court. No such account, bill, or claim shall be allowed by the county board until the amount thereof has been determined by the court.

Section 71-948

Subject's rights; independent evaluation and assistance in proceedings; fees and expenses.

A subject or the subject's counsel shall have the right to employ mental health professionals of his or her choice to independently evaluate the subject's mental condition and testify for and otherwise assist the subject in proceedings under the Nebraska Mental Health Commitment Act or the Sex Offender Commitment Act. If the subject is indigent, only one such person may be employed except with leave of the Mental Health Board. Any person so employed by a subject determined by the board to be indigent, except a subject represented by the

public defender, shall apply to the board for expenses reasonably necessary to such person's effective assistance of the subject and for reasonable fees for services performed by such person in assisting the subject. The board shall then fix reasonable fees and expenses, and the county board shall allow payment to such person in the full amount fixed by the board.

Section 71-950

Continuances; liberally granted.

Continuances shall be liberally granted at the request of the subject. Continuances may be granted to permit the subject to obtain voluntary treatment at a private facility.

Section 71-951

Mental Health Board hearings; closed to public; exception; where conducted.

All Mental Health Board hearings under the Nebraska Mental Health Commitment Act shall be closed to the public except at the request of the subject and shall be held in a courtroom or at any convenient and suitable place designated by the Mental Health Board. The board shall have the right to conduct the proceeding where the subject is currently residing if the subject is unable to travel.

Section 71-952

Subject's rights; appear in person and testify in own behalf; present witnesses and evidence.

A subject shall appear personally and be afforded the opportunity to testify in his or her own behalf and to present witnesses and tangible evidence in defending against the petition at the hearing.

Section 71-953

Subject's rights; compulsory process to obtain testimony of witnesses.

A subject shall be entitled to compulsory process to obtain the testimony of witnesses in his or her favor.

Section 71-954

Subject's rights; confront and cross-examine adverse witnesses and evidence.

A subject shall have the right at a hearing held under the Nebraska Mental Health Commitment Act or the Sex Offender Commitment Act to confront and cross-examine adverse witnesses and evidence equivalent to the rights of confrontation granted by Amendments VI and XIV of the United States Constitution and Article I, section 11, of the Constitution of Nebraska.

Section 71-955

Hearings; rules of evidence applicable.

The rules of evidence applicable in civil proceedings shall apply at all hearings held under the Nebraska Mental Health Commitment Act. In no event shall evidence be considered which is inadmissible in criminal proceedings.

Section 71-956

Subject's rights; written statements; contents.

A subject shall be entitled to written statements by the Mental Health Board as to the evidence relied on and reasons (1) for finding clear and convincing evidence at the subject's hearing that he or she is mentally ill and dangerous or a dangerous sex offender and that neither voluntary hospitalization nor other treatment alternatives less restrictive of the subject's liberty than inpatient or outpatient treatment ordered by the Mental Health Board are available or would suffice to prevent the harm described in section 71-908 or subdivision (1) of section 83-174.01 and (2) for choosing the particular treatment specified by its order of final disposition. The Mental Health

Board shall make similar written findings when it orders a subject held in custody rather than released on conditions pending hearings to determine whether he or she is mentally ill and dangerous or a dangerous sex offender and in need of treatment ordered by the Mental Health Board or pending the entry of an order of final disposition under section 71-925 or 71-1209.

Section 71-958

Qualified mental health professional; provide medical treatment to subject; when.

Any qualified mental health professional, upon being authorized by the administrator of the treatment facility having custody of the subject, may provide appropriate medical treatment for the subject while in custody, except that a subject shall not be subjected to such quantities of medication or other treatment within such period of time prior to any hearing held under the Nebraska Mental Health Commitment Act or the Sex Offender Commitment Act as will substantially impair his or her ability to assist in his or her defense at such hearing.

Section 71-960

Subject; waive rights; manner.

A subject may waive any of the proceedings or rights incident to proceedings granted him or her under the Nebraska Mental Health Commitment Act or the Sex Offender Commitment Act by failing to request any right expressly required to be requested but, in the case of all other such rights, only if the record reflects that such waiver was made personally, intelligently, knowingly, understandingly, and voluntarily by the subject and such subject's legal guardian or conservator, if any. Such rights may otherwise be denied only by a Mental Health Board or court order for good cause shown after notice to the subject, the subject's counsel, and such subject's guardian or conservator, if any, and an opportunity to be heard. If the Mental Health Board determines that the subject is not able to waive his or her rights under this section, it shall be up to the discretion of the subject's counsel to exercise such rights. When the subject is not represented by counsel, the rights may not be waived.

RIGHTS IN CUSTODY OR WHILE RECEIVING TREATMENT

A person has specific rights which must be honored while he/she is in custody or receiving treatment while awaiting a Mental Health Board hearing. These rights are communicated in Section 71-959. A summary of all of the person's rights are included in the Preface at the beginning of the manual. A copy of these rights should be given to persons subject to a Mental Health Board preceding.

Section 71-959

Subject in custody or receiving treatment; rights; enumerated.

A subject in custody or receiving treatment under the Nebraska Mental Health Commitment Act or the Sex Offender Commitment Act has the right:

(1) To be considered legally competent for all purposes unless he or she has been declared legally incompetent. The Mental Health Board shall not have the power to declare an individual incompetent;
(2) To receive prompt and adequate evaluation and treatment for mental illness, personality disorders, and physical ailments and to participate in his or her treatment planning activities to the extent determined to be appropriate by the mental health professional in charge of the subject's treatment;
(3) To refuse treatment medication, except (a) in an emergency, such treatment medication as is essential in the judgment of the mental health professional in charge of such treatment to prevent the subject from causing injury to himself, herself, or others or (b) following a hearing and order of a Mental Health Board, such treatment medication as will substantially improve his or her mental illness or personality disorder or reduce the risk posed to the public by a dangerous sex offender;
(4) To communicate freely with any other person by sealed mail, personal visitation, and private telephone conversations;

(5) To have reasonably private living conditions, including private storage space for personal belongings;
(6) To engage or refuse to engage in religious worship and political activity;
(7) To be compensated for his or her labor in accordance with the federal Fair Labor Standards Act, 29 U.S.C. 206, as such section existed on January 1, 2004;
(8) To have access to a patient grievance procedure; and
(9) To file, either personally or by counsel, petitions or applications for writs of habeas corpus for the purpose of challenging the legality of his or her custody or treatment.

DEVELOPMENTAL DISABILITIES COURT-ORDERED CUSTODY ACT

The Developmental Disabilities Court-Ordered Custody Act (Section 71-1101 *et seq.*) provides a procedure for court-ordered custody and treatment of a person with developmental disabilities when he or she poses a threat of harm to others. Although this Act is sometimes viewed as similar to a mental health commitment, it is a distinctly separate legal proceeding with separate standards, unrelated to Mental Health Board processes. Individuals who meet the definitions of developmental disabilities and threat of harm to others as described in Section 71-1115, should not come before a Mental Health Board, unless the threat of harm is due to mental illness or substance dependency

The Act defines Developmental Disability in a manner that is inconsistent with other Nebraska laws. Compare the following three definitions:

Section 71-1107 Developmental disability, defined
Developmental disability means an intellectual disability or a severe chronic cognitive impairment, other than mental illness, that is manifested before the age of twenty-two years and is likely to continue indefinitely.

Section 71-1110 Mental retardation, defined
Intellectual disability means a state of significantly sub average general intellectual functioning existing concurrently with deficits in adaptive behavior which originates in the developmental period.

Section 71-1113 Severe chronic cognitive impairment, defined
Severe chronic cognitive impairment means clinically significant difficulties in the ability to remember, think, perceive, apply sound judgment, and adequately use deductive reasoning not attributable to a mental illness.

Then consider these definitions in contrast that occur in the Developmental Disabilities Services Act:

Section 83-1205 Developmental disability, defined
Developmental disability shall mean: (1) Intellectual disability; or (2) A severe, chronic disability other than an intellectual disability or mental illness which: (a) Is attributable to a mental or physical impairment other than a mental or physical impairment caused solely by mental illness; (b) Is manifested before the age of twenty-two years; (c) Is likely to continue indefinitely; and

(d) Results in:

(i) In the case of a person under three years of age, at least one developmental delay; or

(ii) In the case of a person three years of age or older, a substantial limitation in three or more of the following areas of major life activity, as appropriate for the person's age:

(A) Self-care;

(B) Receptive and expressive language development and use;

(C) Learning;

(D) Mobility;

(E) Self-direction;

(F) Capacity for independent living; and

(G) Economic self-sufficiency.

References to "other than mental illness" and "impairment caused solely by mental illness" remain a source of confusion that has not been resolved in litigation. Indeed, the reliability of differential diagnosis in these matters is a source of confusion such that reasonable mental health professionals may disagree in a manner that gives rise to legal cases or controversies. Further, it is possible for an individual with a developmental disability to experience acute-onset mental illness that places him or her in substantial risk of significant harm in the near future.

Section 71-1115 defines threat of harm to others as significant likelihood of substantial harm to others as evidenced by one or more of the following:

- Having inflicted or attempted to inflict serious bodily injury on another;
- Having committed an act that would constitute a sexual assault or attempted sexual assault;
- Having committed lewd and lascivious conduct toward a child;
- Having set or attempted to set fire to another person or to any property of another without the owner's consent;
- By the use of an explosive, having damaged or destroyed property, put another person at risk of harm, or injured another person.

The Attorney General or county attorney may file a petition in the district court of the county in which a subject resides or the county in which an alleged act constituting a threat of harm to others occurs. The Mental Health Board is not involved in these procedures.

In re Interest of C.R. (2011) distinguished mental health commitment from developmental disabilities court-ordered custody, finding the Developmental Disabilities Court-Ordered Custody Act "does not require proof of future harm before a court determines that the subject is in need of court-ordered custody and treatment" under Section 71-1115. Specifically, mental health commitment carries a higher standard of proof because the diagnosis of a mental illness is more challenging, the presence of a mental illness is often more transient, and mental health commitment requires expert testimony regarding the likelihood of future harm. Although the two statutory schemes serve similar purposes, mental health commitment requires a nexus between the mental illness and future harm, while developmental disabilities custody does not require any nexus. Despite these differences, the Nebraska Supreme Court ruled that the Developmental Disabilities Court-Ordered Custody Act "provides procedures and evidentiary standards which protect an individual's constitutionally protected liberty interest. It does not violate the subject's due process rights."

TRIBAL HOLD ORDERS/TRIBAL COMMITMENT ORDERS

State of Nebraska statute does not recognize Tribal Hold Orders or Tribal Commitment Orders. If there is a need for an individual living on a reservation to be placed on an Emergency Protective Custody order, admitted to a hospital, and considered for a Mental Health Board commitment; the process must be initiated by a Nebraska county.

MENTAL HEALTH BOARD HEARING

Mental Health Board members often question their liability when making commitment decisions. Functioning as a neutral fact-finder in a legal court proceeding where civil justice is dispensed, board members have judicial immunity from potential liability. The Mental Health Board's duty (Section 71-924) is to determine whether there is clear and convincing proof that the person before them is a mentally ill and dangerous person as alleged in the petition. The petition requires a mental health certificate (Appendix M) from an appropriately qualified mental health professional. In the certificate, the mental health professional must provide a written description of how the imminent and substantial risk of harm (danger) to the person or to others results from the most current DSM diagnosed mental illness. Clinicians use the latest edition of the DSM, published by the American Psychiatric Association, as the standard for diagnostic criteria in determining mental illness. Mental health commitments cannot proceed without:

1) DSM diagnosis for the person named in the petition and,
2) Imminent risk of substantial harm to self or others due to the DSM diagnosed mental illness as determined by an appropriate mental health professional.

Section 71-924 Hearing; Mental Health Board; duties.
A hearing shall be held by the Mental Health Board to determine whether there is clear and convincing evidence that the subject is mentally ill and dangerous as alleged in the petition. At the commencement of the hearing, the board shall inquire whether the subject has received a copy of the petition and list of rights accorded him or her by sections 71-943 to 71-960 and whether he or she has read and understood them. The board shall explain to the subject any part of the petition or list of rights which he or she has not read or understood. The board shall inquire of the subject whether he or she admits or denies the allegations of the petition. If the subject admits the allegations, the board shall proceed to enter a treatment order pursuant to section 71-925. If the subject denies the allegations of the petition, the board shall proceed with a hearing on the merits of the petition.

DETERMINATION OF LEAST RESTRICTIVE TREATMENT ALTERNATIVE

Section 71-925 communicates that the board must also determine that neither voluntary hospitalization nor a less restrictive alternative level of care will keep the person from harming him/herself or others. The mental health professional determining mental illness and dangerousness will testify as such at the Mental Health Board hearing. It is important for the Mental Health Board to ask the clinician what other levels of care and services were considered by the clinician or the treatment team before arriving at the placement recommendation to the board.

In addition, the Mental Health Board may ask the mental health professional if the individual has been pre-authorized for Acute or Subacute hospital services. Treatment providers determine appropriate level of care for an individual before he/she appears before the Mental Health Board. The information provided will assist the Mental Health Board in further determining an appropriate treatment option for the individual.

If there is a finding of mental illness, the board next makes a legal decision regarding danger to self or others. If dangerousness criteria of imminent risk of substantial harm to self or others are met, then the board must determine whether that imminent risk is caused by the diagnosed mental illness. After all preceding elements have been met, the board must decide whether commitment to community-based/outpatient treatment will satisfy the needs of the person and public safety in the most integrated setting. When clear and convincing evidence shows that the imminent risk of substantial harm due to the

mental illness is so great, inpatient commitment may be ordered as a necessary last resort. (Appendix O. Warrant of Inpatient Admission Form)

The level of evidence needed to make a commitment decision is *clear and convincing evidence*, that there is highly probability or reasonable certainty that the event happened. This is less than the *beyond reasonable doubt* required for a criminal conviction, but more than the *preponderance of the evidence* needed in the usual civil case, . The burden to show clear and convincing evidence falls upon the party filing the petition, e.g., the county attorney. The board serves as final decision-maker, determining if a person's civil liberties must be taken from them **temporarily** to protect the person or society in exchange for needed treatment for mental health and/or substance dependency. By questioning the mental health professional, county attorney, defense counsel, and the person themselves, the board will obtain evidence to support a decision for: (1) release; (2) outpatient commitment to a community-based service which best meets safety and treatment needs; **or** (3) inpatient commitment to the Department of Health and Human Services, which will determine placement at an acute inpatient service either at the Lincoln Regional Center or community hospital contracted with by one of the six behavioral health regions.

Section 71-925

Burden of proof; Mental Health Board; hearing; orders authorized; conditions; rehearing.

(1) The state has the burden to prove by clear and convincing evidence that (a) the subject is mentally ill and dangerous and (b) neither voluntary hospitalization nor other treatment alternatives less restrictive of the subject's liberty than inpatient or outpatient treatment ordered by the Mental Health Board are available or would suffice to prevent the harm described in section 71-908.

(2) If the Mental Health Board finds that the subject is not mentally ill and dangerous, the board shall dismiss the petition and order the unconditional discharge of the subject.

(3) If the Mental Health Board finds that the subject is mentally ill and dangerous but that voluntary hospitalization or other treatment alternatives less restrictive of the subject's liberty than treatment ordered by the Mental Health Board are available and would suffice to prevent the harm described in section 71-908, the board shall (a) dismiss the petition and order the unconditional discharge of the subject or (b) suspend further proceedings for a period of up to ninety days to permit the subject to obtain voluntary treatment. At any time during such ninety-day period, the county attorney may apply to the board for reinstatement of proceedings with respect to the subject, and after notice to the subject, the subject's counsel, and the subject's legal guardian or conservator, if any, the board shall hear the application. If no such application is filed or pending at the conclusion of such ninety-day period, the board shall dismiss the petition and order the unconditional discharge of the subject.

(4) If the subject admits the allegations of the petition or the Mental Health Board finds that the subject is mentally ill and dangerous and that neither voluntary hospitalization nor other treatment alternatives less restrictive of the subject's liberty than inpatient or outpatient treatment ordered by the board are available or would suffice to prevent the harm described in section 71-908, the board shall, within forty-eight hours, (a) order the subject to receive outpatient treatment or (b) order the subject to receive inpatient treatment. If the subject is ordered by the board to receive inpatient treatment, the order shall commit the subject to the custody of the Department of Health and Human Services for such treatment.

(5) A subject who (a) is ordered by the Mental Health Board to receive inpatient treatment and (b) has not yet been admitted for such treatment pursuant to such order may petition for a rehearing by the Mental Health Board based on improvement in the subject's condition such that inpatient treatment ordered by the board would no longer be necessary or appropriate.

(6) A treatment order by the Mental Health Board under this section shall represent the appropriate available treatment alternative that imposes the least possible restraint upon the liberty of the subject. The board shall consider all treatment alternatives, including any treatment program or conditions suggested by the subject, the subject's counsel, or other interested person. Inpatient hospitalization or custody shall only be considered

as a treatment alternative of last resort. The county attorney and the subject may jointly offer a proposed treatment order for adoption by the board. The board may enter the proposed order without a full hearing.

(7) The Mental Health Board may request the assistance of the Department of Health and Human Services or any other person or public or private entity to advise the board prior to the entry of a treatment order pursuant to this section and may require the subject to submit to reasonable psychiatric and psychological evaluation to assist the board in preparing such order. Any mental health professional conducting such evaluation at the request of the Mental Health Board shall be compensated by the county or counties served by such board at a rate determined by the district judge and reimbursed for mileage at the rate provided in section 81-1176.

ADDRESSING PERSONS BEFORE THE BOARD HEARING OCCURS

Persons appearing before a Mental Health Board deserve to be shown the utmost respect from all parties present. These are some basic guidelines in communicating with persons coming before the board:

- Refer to the person by their name first, not their diagnosis.
- Never talk about the person as if they are not in the room listening.
- Communicate directly with the person, even if the person does not appear to be listening to you.
- Realize that medications can cause side-effects that may influence a person's ability to sit still, make a repetitive movement, or enunciate words properly.
- Offer signs of basic concern for the person's well-being, like offering a cup of water or giving them a tissue if they are upset.
- Realize that people who experience trauma may have impairments in memory.
- Do not silence the person; let them write a response if it is too lengthy for the hearing.
- Tell the person that you believe they can and will recover, even if it will take a long time.
- Encourage them to call family, friends, and loved ones for support

QUESTIONS TO BE ASKED AT A MENTAL HEALTH BOARD HEARING

Questions to Ask the Mental Health Professional:

- Is the person a danger to self or others?
- What levels of care have you considered?
- What is the least restrictive level of care that this person could be safe as well as effectively treated?
- What barriers exist to community-based treatment? (Lack of support system, inadequate transportation, etc.)
- What, if any, successful treatment history exists for this person?
- Has the person previously been in recovery?
- What behavioral health assessment tools were administered? (face-to-face interview, record review, psychological testing, medical consult, family interview)
- Was this person in a mental health or substance abuse/dependence service at the time they were placed under an EPC?
- What are the person's mental illness and/or substance use disorder diagnoses?
- Are there any medical conditions that can worsen the mental illness and/or substance use disorder diagnosis? (Note: a diagnosis of <u>dependency</u> not abuse is required to commit a person to substance dependency treatment.)
- Is this person medically and psychiatrically stable enough to participate in primary substance use disorder treatment? (administer their own medications, perform activities of daily living, free from aggression)
- Does this person have a crisis plan?

- Are all the behavioral health professionals involved in the assessment of this person in agreement regarding the current treatment recommendations?
- What arrangements have been made for the treatment recommended? (outpatient appointments, AA group locations, transportation arrangements)

Questions to ask the individual while at the Board Hearing:

- Do you understand the recommended treatment plan?
- What is your current diagnosis?
- Have you recently been in recovery? What helped you while you were in recovery?
- Do you have a crisis plan or a WRAP plan?
- What medications are you taking and why do you take them?
- What current treatment are you receiving and with whom?
- When was the last time you saw a behavioral health professional and who was it?
- What behavioral health programs have you previously attended? Did they help you?
- Do you believe you can comply with the recommended treatment plan?
- What would prevent you from succeeding in this treatment?

COMMITMENT TO TREATMENT

DETERMINATION OF COMMITMENT

During the Mental Health Board hearing, it is the state's (county attorney's) responsibility to prove that the person is mentally ill and dangerous and requires further treatment. Once all of the evidence is presented, the Mental Health Board will find one of the following three dispositions:

(1) Not mentally ill and dangerous: dismiss petition.
(2) Mentally ill and dangerous and voluntary treatment is sufficient: dismiss petition or suspend for up to 90 days to permit person to obtain voluntary treatment.
(3) Mentally ill and dangerous, voluntary treatment is not sufficient: commit to DHHS (inpatient) or outpatient community-based treatment.

It is the board's responsibility to decide where a person's interest would be best served. Clearly, according to the statute, inpatient hospitalization is the treatment modality to be considered last. When the board determines an outpatient commitment is more appropriate they can determine which type of community-based outpatient commitment would provide the necessary treatment in a less restrictive environment, while also ensuring public safety. Board members should familiarize themselves with mental health and substance use disorder services available (frequently asked questions-Appendix V) in the state of Nebraska and the agencies providing those services in their Region. In the case of substance dependency, for example, a high need for treatment can be accommodated by outpatient/community-based commitment to a short-term residential substance abuse program. If short-term residential services are not available, another alternative for community substance dependency treatment is commitment to an IOP (Intensive Outpatient) substance dependency program, and substance dependency community support.

Consideration of treatment options is dependent upon an individual's strengths and needs, and traumatic life events must be factored into the equation. An appearance before a Mental Health Board and subsequent committal can be a life-changing event, not always for the better. Along with the emotional trauma and disruption, there is always risk associated with hospitalization, including hospital-acquired infections, and physical danger from peers whose symptoms are more acute and less well-controlled. The rationale for use of least restrictive placement is based on research showing outcome is more positive in a less restrictive setting. Good treatment at the appropriate level of care is also cost effective; it prevents the need to treat a person again and again, and it prevents costly over-treatment at an unnecessary level of care.

Mental Health Board members need to consider an individual's experiences of trauma when making treatment decisions. Traumatic events should no longer be perceived as rare events. People with mental health and substance use disorders are more likely than not to have experienced victimization in their past. There is a growing body of research on trauma-informed care. One model defines trauma-informed care as knowing the history of past and current abuse in the life of the individual who is seeking services, and even more importantly, that those staff who are providing services understand the role that violence and victimization play in the lives of most individuals accessing behavioral health services. The vulnerabilities of trauma survivors must be recognized and services designed in a manner that facilitates individual involvement in treatment. Trauma-informed environments can be created despite the circumstances and settings.

In trauma-informed environments, everyone who enters the program is considered a trauma survivor. An important component to trauma-informed services is the administration of a trauma screening instrument.

Screening questionnaires are widely available and should be used as early as possible in the intake and assessment process. An accurate history should be recorded for each individual being taken into custody and the Mental Health Board should have access to relevant trauma-related information so that an appropriate treatment option can be selected. More information regarding trauma-informed environments can be found on page 3.

VOLUNTARY TREATMENT

Voluntary treatment should always be the first treatment alternative considered by the board. The board must always consider the person's liberty in making commitment decisions. Section 71-925 (3) communicates the board's options in ordering voluntary treatment.

Section 71-925 (3)
If the Mental Health Board finds that the subject is mentally ill and dangerous but that voluntary hospitalization or other treatment alternatives less restrictive of the subject's liberty than treatment ordered by the Mental Health Board are available and would suffice to prevent the harm described in section 71-908, the board shall (a) dismiss the petition and order the unconditional discharge of the subject or (b) suspend further proceedings for a period of up to ninety days to permit the subject to obtain voluntary treatment. At any time during such ninety-day period, the county attorney may apply to the board for reinstatement of proceedings with respect to the subject, and after notice to the subject, the subject's counsel, and the subject's legal guardian or conservator, if any, the board shall hear the application. If no such application is filed or pending at the conclusion of such ninety-day period, the board shall dismiss the petition and order the unconditional discharge of the subject.

OUTPATIENT TREATMENT COMMITMENT

Section 71-909 Outpatient treatment, defined.
Outpatient treatment means treatment ordered by a Mental Health Board directing a subject to comply with specified outpatient treatment requirements, including, but not limited to, (1) taking prescribed medication, (2) reporting to a mental health professional or treatment facility for treatment or for monitoring of the subject's condition, or (3) participating in individual or group therapy or educational, rehabilitation, residential, or vocational programs.

Section 71-925(6) communicates that the board should consider all treatment options inclusive of outpatient treatment alternatives before considering a commitment to inpatient treatment.

Section 71-925(6)
A treatment order by the Mental Health Board under this section shall represent the appropriate available treatment alternative that imposes the least possible restraint upon the liberty of the subject. The board shall consider all treatment alternatives, including any treatment program or conditions suggested by the subject, the subject's counsel, or other interested person. Inpatient hospitalization or custody shall only be considered as a treatment alternative of last resort. The county attorney and the subject may jointly offer a proposed treatment order for adoption by the board. The board may enter the proposed order without a full hearing.

Section 71-931 also requires every outpatient treatment order to include directions for the preparation and implementation of an individualized treatment plan. DHHS suggests using the Outpatient Commitment Order Form located in Appendix P. Unlike the statutes pertaining to the placement of inpatient

commitments (sections 71-927 to 71-71-928), the law does not specify how the board is to secure placement of the subject following an order of commitment to an outpatient treatment facility.

INPATIENT TREATMENT COMMITMENT

NRS Sec. 71-925 (4) provides in part: "If the subject is ordered by the board to receive inpatient treatment, the order shall commit the subject to the custody of the DHHS for such treatment." The foregoing was a change in the statutes enacted in July 2004 and was enacted to eliminate Inpatient Warrant Orders that committed a person to a specific Regional Center, which historically caused problems for both the person and the Regional Centers. By virtue of section 71-925 (4), if the Mental Health Board desires to commit a person to inpatient treatment, the order must recite that the person is placed in the custody of the DHHS (See Appendix N).

A warrant must be issued (Section 71-927), and a form suggested by DHHS for Warrant of Inpatient Admission is located in Appendix O.

Section 71-927 Mentally ill and dangerous subject; board; issue warrant; contents; immunity.
If the Mental Health Board finds the subject to be mentally ill and dangerous and commits the subject to the custody of the Department of Health and Human Services to receive inpatient treatment, the department shall secure placement of the subject in an appropriate inpatient treatment facility to receive such treatment. The board shall issue a warrant authorizing the administrator of such treatment facility to receive and keep the subject as a patient. The warrant shall state the findings of the board and the legal settlement of the subject, if known, or any available information relating thereto. Such warrant shall shield every official and employee of the treatment facility against all liability to prosecution of any kind on account of the reception and detention of the subject if the detention is otherwise in accordance with the Nebraska Mental Health Commitment Act, rules and regulations adopted and promulgated under the act, and policies of the treatment facility.

When a person is ordered to receive inpatient treatment, the findings of the Mental Health Board and warrant shall be delivered to the sheriff or other suitable person appointed by the board to execute the warrant. Although the statutes do not delineate the term, "findings" could reasonably be interpreted to mean, among other things, a copy of the order of commitment.

Upon receipt of the warrant from the Mental Health Board, the sheriff (or other appointed person) has the responsibility of delivering the warrant, the findings, and the person to the treatment facility as designated on the warrant. All females must be transported to an inpatient treatment facility in the company of another female or relative of the subject. Section 71-928 communicates that the sheriff (or other appointed person) may take with him/her such assistance as may be required to execute the warrant.

The administrator of the treatment facility has the responsibility to acknowledge the delivery of the warrant by signing the same. The administrator, in the acknowledgement of admission of the person, shall also record the name(s) of any individual(s) accompanying the committed person. The sheriff has the duty to return the warrant to the clerk of the district court along with his/her costs.

Section 71-928 Inpatient treatment; subject taken to facility; procedure.
When an order of a Mental Health Board requires inpatient treatment of a subject within a treatment facility, the warrant filed under section 71-927, together with the findings of the Mental Health Board, shall be delivered to the sheriff of the county who shall execute such warrant by conveying and delivering the warrant, the findings,

Section 71-928 Inpatient treatment; subject taken to facility; procedure.
and the subject to the treatment facility. The administrator, over his or her signature, shall acknowledge the delivery on the original warrant which the sheriff shall return to the clerk of the district court with his or her costs and expenses endorsed thereon. If neither the sheriff nor deputy sheriff is available to execute the warrant, the chairperson of the Mental Health Board may appoint some other suitable person to execute the warrant. Such person shall take and subscribe an oath or affirmation to faithfully discharge his or her duty and shall be entitled to the same fees as the sheriff. The sheriff, deputy sheriff, or other person appointed by the Mental Health Board may take with him or her such assistance as may be required to execute the warrant. No female subject shall be taken to a treatment facility without being accompanied by another female or relative of the subject. The administrator in his or her acknowledgment of delivery shall record whether any person accompanied the subject and the name of such person.

TREATMENT ORDER APPEAL

The person or the county attorney has the right to appeal the treatment order as described in Section 71-930.

Section 71-930 Treatment order of Mental Health Board; appeal; final order of district court; appeal
The subject of a petition or the county attorney may appeal a treatment order of the Mental Health Board under section 71-925 to the district court. Such appeals shall be de novo on the record. A final order of the district court may be appealed to the Court of Appeals in accordance with the procedure in criminal cases. The final judgment of the court shall be certified to and become a part of the records of the Mental Health Board with respect to the subject.

DEVELOPMENT OF AN INDIVIDUALIZED TREATMENT PLAN

The individualized treatment plan for a person committed to either outpatient or inpatient treatment must be filed with the Mental Health Board within five working days after the entry of the board's order. Treatment is to commence within two working days after the preparation of the plan. The person is entitled to know the contents of the individualized treatment plan and what she/he must do in order to meet the requirements of the plan. The Mental Health Board is required to notify the person of any changes to the treatment order or when discharge from treatment is ordered.

DHHS suggests that mental health professionals developing the individual treatment plan use the Board of Mental Health Individualized Treatment Plan form located in Appendix Q.

Section 71-931 Treatment order; individualized treatment plan; contents; copy; filed; treatment; when commenced.
(1) Any treatment order entered by a Mental Health Board under section 71-925 shall include directions for (a) the preparation and implementation of an individualized treatment plan for the subject and (b) documentation and reporting of the subject's progress under such plan. (2) The individualized treatment plan shall contain a statement of (a) the nature of the subject's mental illness or substance dependence, (b) the least restrictive treatment alternative consistent with the clinical diagnosis of the subject, and (c) intermediate and long-term treatment goals for the subject and a projected timetable for the attainment of such goals. (3) A copy of the individualized treatment plan shall be filed with the Mental Health Board for review and inclusion in the subject's file and served upon the county attorney, the subject, the subject's counsel, and the

Section 71-931 Treatment order; individualized treatment plan; contents; copy; filed; treatment; when commenced.
subject's legal guardian or conservator, if any, within five working days after the entry of the board's order. Treatment shall be commenced within two working days after preparation of the plan. (4) The subject shall be entitled to know the contents of the individualized treatment plan and what the subject must do in order to meet the requirements of such plan. (5) The subject shall be notified by the Mental Health Board when the Mental Health Board has changed the treatment order or has ordered the discharge of the subject from commitment.

(For discussion of forced or involuntary medication see Pages 146-147)

LINCOLN REGIONAL CENTER SERVICES

The Lincoln Regional Center, by statute (83-338), is required to follow the following priorities of admission:

Section 83-338 State hospitals for the mentally ill; order of admission when facilities are limited.
If at any time it becomes necessary, for lack of capacity or other cause, to establish priorities for the admission of patients into the state hospitals for the mentally ill, the following priorities for admission shall be recognized: (1) Patients whose care in the state hospital is necessary in order to protect the public health and safety; (2) patients committed by a Mental Health Board under the Nebraska Mental Health Commitment Act or the Sex Offender Commitment Act or by a district court; (3) patients who are most likely to be benefitted by treatment in the state hospitals, regardless of whether such patients are committed by a Mental Health Board or whether such patients seek voluntary admission to one of the state hospitals; and (4) when cases are equally meritorious, in all other respects, patients who are indigent.

Taking the statute into consideration, the following is a listing of the agreed upon standards/criteria for admissions into the Regional Center:

1. Individuals who are ordered by district courts to be admitted to the Regional Center
2. Individuals who are committed under the Sex Offender Commitment Act
3. Individual who are committed under the Nebraska Mental Health Commitment Act and who are violent or pose a safety threat to the community.
4. Individuals who are committed under the Nebraska Mental Health Commitment Act and for whom community placement is not available.

It is difficult for strictly substance abuse treatment agencies to serve a person with a co-occurring disorder (COD) just as it is difficult for strictly mental health treatment agencies to serve a person with COD. It is important to note that the Lincoln Regional Center (LRC) provides dual diagnosis capable treatment for COD only. They do not have dual diagnosis enhanced treatment programs at the writing of this document. The mission of the LRC is to provide acute inpatient mental health services for those who have been court ordered or committed. While they have a few dual licensed professionals on staff to do substance abuse assessment and a minimal amount of groups, treating substance dependency and substance abuse is not the primary treatment modality at LRC. The expertise in substance use treatment in Nebraska is in outpatient and residential community-based programs.

PROGRESS REPORTS

The Mental Health Board will receive progress reports from both inpatient and outpatient providers of a person who is committed for treatment. In the case of an inpatient commitment, the treatment provider must submit a report no later than ten days after submission of the subject's individualized treatment plan. All treatment providers (inpatient and outpatient) must submit progress reports every ninety days for a period of a year and every six months after that. It is the responsibility of the board to review reports submitted as needed.

Section 71-932 Person responsible for subject's individualized treatment plan; periodic progress reports; copies; filed and served.
The person or entity designated by the Mental Health Board under section 71-931 to prepare and oversee the subject's individualized treatment plan shall submit periodic reports to the Mental Health Board of the subject's progress under such plan and any modifications to the plan. The Mental Health Board may distribute copies of such reports to other interested parties as permitted by law. With respect to a subject ordered by the Mental Health Board to receive inpatient treatment, such initial report shall be filed with the Mental Health Board for review and inclusion in the subject's file and served upon the county attorney, the subject, the subject's counsel, and the subject's legal guardian or conservator, if any, no later than ten days after submission of the subject's individualized treatment plan. With respect to each subject committed by the Mental Health Board, such reports shall be so filed and served no less frequently than every ninety days for a period of one year following submission of the subject's individualized treatment plan and every six months thereafter.

HANDGUN REGISTRATION REQUIREMENTS

The clerks of the various district courts are required to notify the Department of Health and Human Services and the Nebraska State Patrol of all Mental Health Board commitments and discharges from commitments. The Nebraska State Patrol shall be furnished with only such information as may be necessary for the sole purpose of determining whether an individual is disqualified from purchasing or possessing a handgun. This is a recent change (2012) in the law. Previously, clerks were only required to report the information to the Department of Health and Human Services. With the enactment of the new statutory language, clerks must also notify the Nebraska State Patrol when a change in commitment status occurs.

Section 69-2409.01 Data base; created; disclosure; limitation; liability; prohibited act; violation; penalty.
(1) For purposes of sections 69-2401 to 69-2425, the Nebraska State Patrol shall be furnished with only such information as may be necessary for the sole purpose of determining whether an individual is disqualified from purchasing or possessing a handgun pursuant to state law or is subject to the disability provisions of 18 U.S.C. 922(d)(4) and (g)(4). Such information shall be furnished by the Department of Health and Human Services. The clerks of the various courts shall furnish to the Department of Health and Human Services and Nebraska State Patrol, as soon as practicable but within thirty days after an order of commitment or discharge is issued or after removal of firearm-related disabilities pursuant to section 71-963, all information necessary to set up and maintain the data base required by this section. This information shall include (a) information regarding those persons who are currently receiving mental health treatment pursuant to a commitment order of a Mental Health Board or who have been discharged, (b) information regarding those persons who have been committed to treatment pursuant to section 29-3702, and (c) information regarding those persons who have had firearm-related disabilities removed pursuant to section 71-963. The Mental Health Board shall notify the Department of Health and Human Services and

Section 69-2409.01
Data base; created; disclosure; limitation; liability; prohibited act; violation; penalty.

the Nebraska State Patrol when such disabilities have been removed. The Department of Health and Human Services shall also maintain in the data base a listing of persons committed to treatment pursuant to section 29-3702. To ensure the accuracy of the data base, any information maintained or disclosed under this subsection shall be updated, corrected, modified, or removed, as appropriate, and as soon as practicable, from any data base that the state or federal government maintains and makes available to the National Instant Criminal Background Check System. The procedures for furnishing the information shall guarantee that no information is released beyond what is necessary for purposes of this section.

(2) In order to comply with sections 69-2401 and 69-2403 to 69-2408 and this section, the Nebraska State Patrol shall provide to the chief of police or sheriff of an applicant's place of residence or a licensee in the process of a criminal history record check pursuant to section 69-2411 only the information regarding whether or not the applicant is disqualified from purchasing or possessing a handgun.

(3) Any person, agency, or Mental Health Board participating in good faith in the reporting or disclosure of records and communications under this section is immune from any liability, civil, criminal, or otherwise, that might result by reason of the action.

(4) Any person who intentionally causes the Nebraska State Patrol to request information pursuant to this section without reasonable belief that the named individual has submitted a written application under section 69-2404 or has completed a consent form under section 69-2410 shall be guilty of a Class II misdemeanor in addition to other civil or criminal liability under state or federal law.

Source: Laws 1996, LB 1055, § 1; Laws 1997, LB 307, § 112; Laws 2011, LB512, § 3.
Operative Date: January 1, 2012

Nebraska has numerous levels of behavioral health services throughout the state. Each behavioral health service funded by the state of Nebraska has a service definition. A snapshot of behavioral health service definitions is located in Appendix D. of this document. Complete descriptions of service definitions can be obtained from the Division of Behavioral Health. In addition, the Division of Behavioral Health supports a website to assist in the location of behavioral health service providers throughout the state at: http://dhhs.ne.gov/behavioral_health/Pages/networkofcare_index.aspx.

If an individual is committed to outpatient treatment, the Outpatient Treatment Order form (Appendix P) should be completed.

CHANGE IN TREATMENT OR DISCHARGE

REVIEW HEARINGS

Section 71-935(1) provides that upon the filing of the periodic report, the subject is entitled to a hearing within 14 days of his/her request to seek an order of discharge or a change in treatment. The board also has the authority to schedule a review hearing:

(a) At any time a treatment facility notifies the board of its intent to release the subject from its custody pursuant to section 71-937 or at any time the board feels it necessary to determine whether the subject is adhering to the conditions of his release
(b) Upon request of the subject, the subject's counsel, the subject's legal guardian or conservator, if any, the county attorney, or the entity designated to oversee the subject's individualized treatment plan
(c) Upon the board's own motion.

Such hearings have the same due process protections as are afforded in the commitment hearings. Section 71-935(2) provides the board the authority at a review hearing to discharge the subject or enter a new treatment order.

Section 71-935
Mental Health Board; review hearing; order discharge or change treatment disposition; when.

(1) Upon the filing of a periodic report under section 71-932, the subject, the subject's counsel, or the subject's legal guardian or conservator, if any, may request and shall be entitled to a review hearing by the Mental Health Board and to seek from the board an order of discharge from commitment or a change in treatment ordered by the board. The Mental Health Board shall schedule the review hearing no later than fourteen calendar days after receipt of such request. The Mental Health Board may schedule a review hearing (a) at any time pursuant to section 71-937 or 71-938, (b) upon the request of the subject, the subject's counsel, the subject's legal guardian or conservator, if any, the county attorney, the official, agency, or other person or entity designated by the Mental Health Board under section 71-931 to prepare and oversee the subject's individualized treatment plan, or the mental health professional directly involved in implementing such plan, or (c) upon the board's own motion.

(2) The board shall immediately discharge the subject or enter a new treatment order with respect to the subject whenever it is shown by any person or it appears upon the record of the periodic reports filed under section 71-932 to the satisfaction of the board that (a) cause no longer exists for the care or treatment of the subject or (b) a less restrictive treatment alternative exists for the subject. When discharge or a change in disposition is in issue, due process protections afforded under the Nebraska Mental Health Commitment Act shall attach to the subject.

Annotations:
The Nebraska Mental Health Commitment Act clearly and plainly contemplates that due process be afforded at hearings other than the one held upon the filing of the initial petition. In re Interest of Powers, 242 Neb. 19, 493 N.W.2d 166 (1992).
Upon review of a commitment under this section, the State must prove by clear and convincing evidence that the individual remains mentally ill and dangerous. In re Interest of Dickson, 238 Neb. 148, 469 N.W.2d 357 (1991).

DISCHARGE FROM A REGIONAL CENTER OR TREATMENT FACILITY

Section 71-936 requires an administrator of the Regional Center or treatment facility to notify the board if an individual is discharged or placed on convalescent leave. Section 71-937 provides that the treatment facility notifies the board in writing of the release of the subject. The notice must be immediately

forwarded to the county attorney. Further, "The Mental Health Board shall, upon the motion of the county attorney, or may upon its own motion, conduct a hearing to determine whether the individual is mentally ill and dangerous and consequently not a proper subject for release." It is important to note that the administrator of the Regional Center or treatment facility does not have to seek approval from the Mental Health Board **before** a person under a mental health commitment is released from the hospital setting. As stated earlier, the requirement is to notify the board that an individual has been discharged.

Section 71-936

Regional center or treatment facility; administrator; discharge of involuntary patient; notice.

When the administrator of any regional center or treatment facility for the treatment of persons who are mentally ill or substance dependent determines that any involuntary patient in such facility may be safely and properly discharged or placed on convalescent leave, the administrator of such regional center or treatment facility shall immediately notify the Mental Health Board of the judicial district from which such patient was committed.

Section 71-937

Mental Health Board; notice of release; hearing.

A Mental Health Board shall be notified in writing of the release by the treatment facility of any individual committed by the Mental Health Board. Such notice shall immediately be forwarded to the county attorney. The Mental Health Board shall, upon the motion of the county attorney, or may upon its own motion, conduct a hearing to determine whether the individual is mentally ill and dangerous and consequently not a proper subject for release. Such hearing shall be conducted in accordance with the procedures established for hearings under the Nebraska Mental Health Commitment Act. The subject of such hearing shall be accorded all rights guaranteed to the subject of a petition under the act.

INTERVENTION IN AN OUTPATIENT SETTING

Section 71-933 sets forth a process to be followed in an outpatient setting that allows the board to intervene to protect the person or others. The outpatient treatment provider has the duty to report to the board and the county attorney if:

(a) The subject is not complying with the individualized treatment plan;
(b) The subject is not following conditions set by the board;
(c) The treatment plan is not effective; or
(d) A significant change occurs in the subject's mental illness or substance dependence.

The county attorney has the duty to investigate the report. If the county attorney determines the report has no factual basis, no further action need be taken other than notifying the board. If the county attorney determines that there is a factual basis for the report and that intervention by the board is necessary to protect the person or others, the county attorney may motion the matter back before the board for further hearing. The county attorney has the option of applying for a warrant to take the subject into immediate custody pending hearing if the county attorney believes the person poses a threat of danger to self or others. The application for a warrant must be supported by an affidavit or sworn testimony of the county attorney or "any informed person" (section 71-933[2] [d]). Sworn testimony may be taken telephonically at the discretion of the board. A suggested form, "Warrant to Take Custody of Outpatient Pending R-hearing," is in Appendix S.

Section 71-933 Outpatient treatment provider; duties; investigation by county attorney; warrant for immediate custody of subject; when.
(1) Any provider of outpatient treatment to a subject ordered by a Mental Health Board to receive such treatment shall report to the board and to the county attorney if (a) the subject is not complying with his or her individualized treatment plan, (b) the subject is not following the conditions set by the Mental Health Board, (c) the treatment plan is not effective, or (d) there has been a significant change in the subject's mental illness or substance dependence. Such report may be transmitted by facsimile, but the original of the report shall be mailed to the board and the county attorney no later than twenty-four hours after the facsimile transmittal. (2) (a) Upon receipt of such report, the county attorney shall have the matter investigated to determine whether there is a factual basis for the report. (b) If the county attorney determines that there is no factual basis for the report or that no further action is warranted, he or she shall notify the board and the treatment provider and take no further action. (c) If the county attorney determines that there is a factual basis for the report and that intervention by the Mental Health Board is necessary to protect the subject or others, the county attorney may file a motion for reconsideration of the conditions set forth by the board and have the matter set for hearing. (d) The county attorney may apply for a warrant to take immediate custody of the subject pending a rehearing by the board under subdivision (e) of this subsection if the county attorney has reasonable cause to believe that the subject poses a threat of danger to himself or herself or others prior to such rehearing. The application for a warrant shall be supported by affidavit or sworn testimony by the county attorney, a mental health professional, or any other informed person. The application for a warrant and the supporting affidavit may be filed with the board by facsimile, but the original shall be filed with the board not later than three days after the facsimile transmittal, excluding holidays and weekends. Sworn testimony in support of the warrant application may be taken over the telephone at the discretion of the board.

Section 71-934 communicates that the board may, on its own motion or through a motion filed by the county attorney, hold a hearing to determine whether a person on an outpatient commitment can be adequately and safely served by the individualized treatment plan on file. Pending hearing, the board may issue a warrant directing any law enforcement officer to take custody of the person and transport the person to a treatment facility. No person is to be held for more than seven days unless the board grants a continuance. At the time of execution of the warrant, the person is to be personally served with a motion and notice of hearing, along with a list of rights guaranteed to the person under the Act. Following a hearing, the board determines if outpatient treatment will be continued, modified or ended.

Section 71-934 Outpatient treatment; hearing by board; warrant for custody of subject; subject's rights; board determination.
The Mental Health Board shall, upon motion of the county attorney, or may, upon its own motion, hold a hearing to determine whether a subject ordered by the board to receive outpatient treatment can be adequately and safely served by the individualized treatment plan for such subject on file with the board. The Mental Health Board may issue a warrant directing any law enforcement officer in the state to take custody of the subject and directing the sheriff or other suitable person to transport the subject to a treatment facility or public or private hospital with available capacity specified by the board where he or she will be held pending such hearing. No person may be held in custody under this section for more than seven days except upon a continuance granted by the board. At the time of execution of the warrant, the sheriff or other suitable person designated by the board shall personally serve upon the subject, the subject's counsel, and the subject's legal guardian or conservator, if any, a notice of the time and place fixed for the hearing, a copy of the motion for hearing, and a list of the rights provided by the Nebraska Mental Health Commitment Act. The subject shall be accorded all the rights guaranteed to a subject by the act. Following the hearing, the board shall determine whether outpatient treatment will be continued, modified, or ended.

POST RELEASE HEARINGS

Section 71-938 provides for a Mental Health Board hearing to "determine whether a person who has been ordered by the board to receive inpatient or outpatient treatment is adhering to the conditions of his or her release from such treatment, including the taking of medication." The hearing may be held on the board's own motion or upon a motion filed by the county attorney. A finding that the subject is mentally ill and dangerous by clear and convincing evidence mandates that the board enter an order of final disposition providing for the treatment of such person in accordance with section 71-925.

Section 71-938 Mental Health Board; person released from treatment; compliance with conditions of release; conduct hearing; make determination.
The Mental Health Board shall, upon the motion of the county attorney, or may upon its own motion, hold a hearing to determine whether a person who has been ordered by the board to receive inpatient or outpatient treatment is adhering to the conditions of his or her release from such treatment, including the taking of medication. The subject of such hearing shall be accorded all rights guaranteed to a subject under the Nebraska Mental Health Commitment Act, and such hearing shall apply the standards used in all other hearings held pursuant to the act. If the Mental Health Board concludes from the evidence at the hearing that there is clear and convincing evidence that the subject is mentally ill and dangerous, the board shall so find and shall within forty-eight hours enter an order of final disposition providing for the treatment of such person in accordance with section 71-925.

ESCAPE FROM TREATMENT FACILITY

Section 71-939 states that when a subject is absent without authorization from a treatment facility, the administrator shall immediately notify the Nebraska State Patrol and the court or clerk of the Mental Health Board of the judicial district from which such person was committed. The notice shall include:

a) Person's name
b) Description of the person
c) Determination by a psychiatrist, clinical director, administrator, or program director as to whether the person is believed to be currently dangerous to others.

The clerk shall issue the warrant of the board directed to the sheriff of the county for the arrest and detention of such person. A law enforcement officer may execute such warrant. Pending the issuance of the warrant, any peace officer may seize and detain such person when the peace officer has probable cause to believe that the person is reported to be absent without authorization. Such person shall be returned to the treatment facility or shall be placed in a facility for emergency protective custody as described in section 71-919 until the subject can be returned to the treatment facility. A suggested Warrant of Arrest Form is located in Appendix T.

Section 71-939 Escape from treatment facility or program; notification required; contents; warrant; execution; peace officer; powers.
When any person receiving treatment at a treatment facility or program for persons with mental illness or substance dependence pursuant to an order of a court or Mental Health Board is absent without authorization from such treatment facility or program, the administrator or program director of such treatment facility or program shall immediately notify the Nebraska State Patrol and the court or clerk of the Mental Health Board of the judicial district from which such person was committed. The notification shall include the person's name, description and a determination by a psychiatrist, clinical director, administrator, or program director as to whether the person is believed to be currently dangerous to others. The clerk shall issue the warrant of the board directed to the sheriff of the county for the arrest and detention of such person. Such warrant may be executed by the sheriff or any other peace officer. Pending the issuance of the warrant of the Mental Health Board, any peace officer may seize and detain such person when the peace officer has probable cause to believe that the person is reported to be absent without authorization as described in this section. Such person shall be returned to the treatment facility or program or shall be taken to a facility as described in section 71-919 until he or she can be returned to such treatment facility or program.

CHANGE IN TREATMENT ORDER

Mental Health Board commitments are not open ended. A mental health commitment is made to protect the public interest during a crisis in an individual's life in which the individual presents a danger to themselves or others (Sections 71-901 to 71-962). Mental health commitments are initiated to protect an individual from harming themselves or from harming others. The board is responsible for the individual during the commitment period and should receive and review periodic reports from the treating facility, if it is an inpatient commitment, or from a mental health professional, if it is an outpatient commitment. The board is encouraged to take immediate action on reports by the treating facility or a mental health professional.

If a commitment order is amended from inpatient to outpatient, a discharge from inpatient treatment is generated, and a new commitment order must be produced for outpatient treatment. Both the discharge from inpatient and the order for outpatient must be reported to DBH and the Nebraska State Patrol (NSP) per Section 69-2409.01. The *Reporting the Order of Commitment* form was developed for this purpose and is found in Appendix U of this manual and on the DBH website. In summary, the following commitment changes must be reported by the board to DBH and NSP: 1) inpatient and outpatient commitments, 2) discharges from commitment, and 3) corrections to commitments.

In addition, Section 71-931(5) provides for the notification to individuals under a Mental Health Board commitment by a Mental Health Board when a treatment order has been changed or he/she is discharged from commitment. It is the responsibility of the Mental Health Board to initiate the notification process and the clerk of the district court to issue a notice to the individual. In the past, individuals have remained committed for years even though mental health treatment has been completed. It is an injustice to these individuals to remain in a committed status and it also can present legal difficulties for the individual.

PART 4. SEX OFFENDER COMMITMENT ACT

There have been a number of laws related to sex offenders enacted over the last several years that have created requirements for Nebraska state agencies to assess, treat, supervise and register convicted sex offenders. However, there are some instances in which a person for whom civil commitment is being sought does not have a sex offense conviction but the "dangerousness" they have displayed may have been sex-related. In these instances individuals may be committed under the Mental Health Commitment Act. A minority of convicted sex offenders are civilly committed. Most offenders receive probation or incarceration and are released without additional provisions except registration with the Nebraska State Patrol Sex Offender Registry. The decision to seek civil commitment of people who fit the criteria for such consideration is and should be taken as seriously as for those persons with mental illness. Individuals under probation are frequently referred for treatment as a condition of supervision. For those incarcerated, treatment is available within the Nebraska Department of Correctional Services (NDCS) and/or Nebraska Department of Health and Human Services (NDHHS). The NDCS has varying levels of treatment based on an offender's assessed risk and history to be commensurate with his or her needs. The Convicted Sex Offender Act (CSO) allows convicted persons another option for treatment while incarcerated.

DANGEROUS SEX OFFENDER DEFINITION

Nebraska law clearly defines dangerous sex offender in Section 83-174.01.

Section 83-174.01
Dangerous sex offender; terms, defined.

For purposes of sections 83-174 to 83-174.05:

(1) Dangerous sex offender means (a) a person who suffers from a mental illness which makes the person likely to engage in repeat acts of sexual violence, who has been convicted of one or more sex offenses, and who is substantially unable to control his or her criminal behavior or (b) a person with a personality disorder which makes the person likely to engage in repeat acts of sexual violence, who has been convicted of two or more sex offenses, and who is substantially unable to control his or her criminal behavior;

(2) Likely to engage in repeat acts of sexual violence means the person's propensity to commit sex offenses resulting in serious harm to others is of such a degree as to pose a menace to the health and safety of the public;

(3) Person who suffers from a mental illness means an individual who has a mental illness as defined in section 71-907;

(4) Person with a personality disorder means an individual diagnosed with a personality disorder;

(5) Sex offense means any of the offenses listed in section 29-4003 for which registration as a sex offender is required; and

(6) Substantially unable to control his or her criminal behavior means having serious difficulty in controlling or resisting the desire or urge to commit sex offenses.

CONVICTED SEX OFFENDERS

NRS Sec. 29-2922 et seq. creates a requirement for the DHHS to evaluate those sex offenders convicted of first or second degree sexual assault, first, second or third degree sexual assault of a child, incest or attempt to commit sexual assault in the first degree and sentenced to a term of imprisonment in the Nebraska Department of Correctional Services (NDCS) adult correctional facility within 60 days of commitment to NDCS to determine appropriateness of treatment of that person in a DHHS facility. If determined to be appropriate, the person may be transferred to a DHHS facility for sex offender

treatment. The individual's progress will be monitored with annual progress reports being sent to NDCS. Once the person has been determined to meet his or her treatment team goals, the individual will either be returned to NDCS or recommended for parole back to DHHS for gradual release into the community depending on the person's remaining sentence. Individuals who are not meeting treatment goals or act out inappropriately will be returned to the NDCS to complete their sentence and may be considered for civil commitment upon completion of their sentence if they refuse or fail treatment within the correctional environment.

Throughout the criminal justice process, there are opportunities for sex offender assessment, treatment and supervision decision-making both by the governmental entities and the individual as well. It is during these stages that individuals are strongly encouraged and afforded opportunities to address issues, thus decreasing dangerousness and a need for civil commitment upon completion of one's sentence.

CIVIL COMMITMENT OF DANGEROUS SEX OFFENDERS

Section 71-1201 et seq. adopts the Sex Offender Commitment Act (see Appendix X). The purpose of this act is to provide for the court-ordered treatment of sex offenders who completed their sentences, but continue to pose a threat of harm to others. It is the public policy of this state that dangerous sex offenders be encouraged to obtain voluntary treatment. This act provides for the civil commitment of dangerous sex offenders. The procedures, such as filing of the petition, Mental Health Board hearings, treatment orders, commitments, executing a warrant and rules of evidence, mirror the current Mental Health Commitment Act. The language of the Sex Offender Commitment Act is incorporated into the current mental health commitment statutes.

Section 83-174 holds that at least 90 days prior to the release of a sex offender, the agency with jurisdiction over such individual shall notify the Attorney General, Nebraska State Patrol, prosecuting county attorney and the county attorney of the county in which an individual is incarcerated, supervised or committed. Also, the Board of Parole shall notify these same parties within 5 days after scheduling a parole hearing. Further, a county attorney shall, no later than 45 days after receiving notice of the pending release of a sex offender, notify the Attorney General whether he/she intends to initiate civil commitment proceedings against such individual upon their release.

NDCS bears the responsibility of initiating the civil commitment of dangerous sex offenders in most instances. That agency has established procedures to complete such evaluations in a way that is consistent with nationally recognized sex offender risk assessment recommendations.

NRS Sec. 83-174.02 requires the NDCS to order evaluations to determine whether or not an offender is a "dangerous sex offender." Evaluations must be ordered for offenders who have at least one conviction of first degree sexual assault or first degree sexual assault of a child. Evaluation must also be ordered for those convicted of two or more offenses for non-parental kidnapping of a minor, first, second or third degree sexual assault of a child, first or second degree sexual assault, sexual assault of a child, incest of a minor, sexual assault of a vulnerable adult, visual depiction of sexually explicit conduct of a child or any substantially equivalent offenses in another jurisdiction. For those sex offenders who assaulted a minor and either refused treatment or failed in treatment during their term of incarceration, an evaluation must be ordered, as well as for offenders who have violated the Sex Offender Registration Act. This evaluation shall be ordered at least 180 days before the release of the individual. Upon completion of this evaluation, this department shall send written notice to the Attorney General, the county attorney of the county where the offender is incarcerated and the prosecuting county attorney. An affidavit of the mental health professional shall be included in the notice describing his or her findings with respect to whether or not the individual is a dangerous sex offender.

Upon completion of the evaluation with findings that an individual is a dangerous sex offender, the civil commitment process is consistent with that of commitment under the Mental Health Commitment Act in terms of procedures and safeguards to the person.

If a person is determined to require inpatient civil commitment, the individual will be committed to the DHHS to begin sex offender specific treatment that is based on the needs of the individual. This includes but is not limited to psychological, psychosocial, psychiatric and medical assessment to provide psychiatric services, individual therapy, sex offender group therapy, psycho-educational groups, substance abuse, treatment, therapeutic recreation, occupational therapy and appropriate medical care. Individuals are assessed on an on-going basis and are gradually given more privileges as they progress through treatment. It is expected that individuals will progress to the point that they obtain community-based services with or without an outpatient commitment and eventual discharge from commitment while maintaining the safety of others.

EMERGENCY PROTECTIVE CUSTODY OF DANGEROUS SEX OFFENDERS

NRS Sec. 71-1204 provides a process for emergency protective custody of dangerous sex offenders. Such persons shall be admitted to an appropriate and available medical facility unless they have a prior sex offense conviction. If such persons have a prior sex offense conviction, they shall be admitted to a jail or NDCS unless a medical or psychiatric emergency exists. More details regarding this process are available in Appendices. In addition, a form to be used by law enforcement when delivering an individual to a facility is located in Appendices.

The Mental Health Professional Certificate-Dangerous Sex Offender (Appendix Y) must be completed by a mental health care professional and forwarded to the county attorney upon completion. The purpose of the form is to certify that the mental health professional has evaluated the individual admitted for emergency protective custody and, in his/her professional judgment, the individual is a dangerous sex offender. In addition, the mental health professional must agree that the diagnosis of the individual is within a reasonable degree of psychiatric, psychological certainty and the individual presents a substantial risk of serious harm within the near future to himself/herself or others as a result of the diagnosis.

COMMUNITY SUPERVISION

Some sex offenders will be subject to lifetime community supervision. These individuals may be under civil commitment or not. Section 83-174.03 provides for lifetime community supervision of sex offenders convicted or released from a term of incarceration on or after July 14, 2006. Upon completion of his/her term of incarceration or release from civil commitment, the following classes of sex offenders will be supervised in the community by the Office of Parole Administration (Office) for the remainder of his/her life:

- Repeat sex offenders,
- Offenders convicted of sexual assault of a child in the first degree or
- Offenders convicted of, or completing a term of incarceration for, an aggravated offense.

Section 29-4001.01(1) defines aggravated offense “any registrable offense under Section 29-4003 which involves the penetration of, direct genital touching of, oral to anal contact with, or oral to genital contact with (a) a victim age thirteen years or older without the consent of the victim, (b) a victim under the age of thirteen years, or (c) a victim who the sex offender knew or should have known was mentally or physically incapable of resisting or appraising the nature of his or her conduct.

Section 83-174.03(2) states the agency or political subdivision which has custody of such individuals shall notify the Parole Office at least 60 days prior to release. Such individuals shall undergo a risk assessment and evaluation by the Office. Conditions of community supervision imposed by the Parole Office are provided. Individuals that violate one or more of the conditions of community supervision shall undergo a review by the Office. The Parole Office may revise or impose additional conditions, request prosecution by the Attorney General or county attorney, or recommended civil commitment. Criminal penalties are provided.

Section 83-1103.01 provides duties for parole officers. Also, this law provides notification and supervision duties for the Office. Such individuals are entitled to an appeal whenever there is a determination or revision of conditions of community supervision. An appeal process is provided. In addition, notification requirements to such individuals are provided for the sentencing court.

Section 29-4019 – Prior to the release of a person serving a sentence of an offense requiring lifetime community supervision, the NDCS, DHHS, or city or county correctional or jail facility shall provide written notice that he/she shall be subject to lifetime community supervision by the Parole Office. This notice shall inform the person that he/she is subject to lifetime community supervision, the consequences of violations of conditions and the right to challenge the determination of the conditions. Also, these agencies or county/city jails must require the defendant to read and sign a form stating they understand these conditions and retain a copy of the written notification.

SEX OFFENDER REGISTRATION ACT

Individuals who are not subject to civil commitment under the Sex Offender Commitment Act or lifetime supervision, i.e., those discharged from any type of supervision or incarceration prior to July 14, 2006, are still required to register as long as they were convicted or released from supervision on or after January 1, 1997, for any of the following crimes:

- Kidnapping of a minor pursuant to section 28-313, except when the person is the parent of the minor and was not convicted of any other offense in this section;
- False imprisonment of a minor pursuant to section 28-314 or 28-315;
- Sexual assault pursuant to section 28-319 or 28-320;
- Sexual assault of a child in the second or third degree pursuant to section 28-320.01;
- Sexual assault of a child in the first degree pursuant to section 28-319.01;
- Sexual abuse of a vulnerable adult pursuant to subdivision (1)(c) of section 28-386;
- Incest of a minor pursuant to section 28-703;
- Pandering of a minor pursuant to section 28-802;
- Visual depiction of sexually explicit conduct of a child pursuant to section 28-1463.03 or 28-1463.05;
- Knowingly possessing any visual depiction of sexually explicit conduct which has a child as one of its participants or portrayed observers pursuant to section 28-813.01;
- Criminal child enticement pursuant to section 28-311;
- Child enticement by means of an electronic communication device pursuant to section 28-320.02;
- Debauching a minor pursuant to section 28-805; or
- Any attempt, solicitation, aiding or abetting, being an accessory, or conspiracy to commit an above listed offense.

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Additional changes were made to this act in 2009 through LB 285. Effective January 1, 2010, any person on or after that date who is found guilty of, plead *nolo contendere* or plead guilty to the following must register:

- Murder in the first degree pursuant to section 28-303;
- Murder in the second degree pursuant to section 28-304;
- Manslaughter pursuant to section 28-305;
- Assault in the first degree pursuant to section 28-308;
- Assault in the second degree pursuant to section 28-309;
- Assault in the third degree pursuant to section 28-310;
- Stalking pursuant to section 28-311.03;
- Unlawful intrusion on a minor pursuant to section 28-311.08;
- Kidnapping pursuant to section 28-313;
- False imprisonment pursuant to section 28-314 of 28-315;
- Sexual abuse of an inmate or parolee in the first degree pursuant to section 28-322.02;
- Sexual abuse of an inmate or parole in the second degree pursuant to section 28-322.03
- Sexual abuse of a protected individual pursuant to section 28-322.04;
- Incest pursuant to section 28-703;
- Child abuse pursuant to subdivision (1)(d) or (e) of section 28-707;
- Enticement by electronic communication device pursuant to section 28-833; or
- Any attempt, solicitation, aiding or abetting, being an accessory or conspiracy to commit any of these crimes in which a court shall have found evidence of sexual penetration or sexual contact.

Also, any person who enters the state and is required to register as a sex offender under the laws of another state, territory, commonwealth or other U.S. jurisdiction must register in this state. Section 29-4003 clarifies the reporting requirements of sex offenders under this act. Within three working days, persons under this act must register in person and complete a form with the sheriff in the county the person resides and subsequently notify the sheriff in person and complete a form of any changes in address, employment, vocation, school of attendance, temporary domicile, and name change. Persons required to register for 25 years must do so every 6 months and those who meet lifetime registration requirements must do so every 3 months.

Section 29-4007

Sentencing court; duties; Department of Correctional Services or local facility; Department of Motor Vehicles; notification requirements; Attorney General; approve form.

(1) When sentencing a person convicted of a registrable offense under section 29-4003, the court shall:

(a) Provide written notification of the duty to register under the Sex Offender Registration Act at the time of sentencing to any defendant who has pled guilty or has been found guilty of a registrable offense under section 29-4003. The written notification shall:

(i) Inform the defendant of whether or not he or she is subject to the act, the duration of time he or she will be subject to the act, and that he or she shall report to a location designated by the Nebraska State Patrol for purposes of accepting such registration within three working days after the date of the written notification to register;

(ii) Inform the defendant that if he or she moves to another address within the same county, he or she must report to the county sheriff of the county in which he or she is residing within three working days before his or her move;

(iii) Inform the defendant that if he or she no longer has a residence, temporary domicile, or habitual living location, he or she shall report such change in person to the sheriff of the county in which he or she is located within three working days after such change in residence, temporary domicile, or habitual living location;

Section 29-4007
Sentencing court; duties; Department of Correctional Services or local facility; Department of Motor Vehicles; notification requirements; Attorney General; approve form.

(iv) Inform the defendant that if he or she moves to another county in the State of Nebraska, he or she must notify, in person, the county sheriff of the county in which he or she had been last residing, had a temporary domicile, or had a habitual living location and the county sheriff of the county in which he or she is residing, has a temporary domicile, or is habitually living of his or her current address. The notice must be given within three working days before his or her move;
(v) Inform the defendant that if he or she moves to another state, he or she must report, in person, the change of address to the county sheriff of the county in which he or she has been residing, has had a temporary domicile, or has had a habitual living location and must comply with the registration requirements of the state to which he or she is moving. The notice must be given within three working days before his or her move;
(vi) Inform the defendant that he or she shall (A) inform the sheriff of the county in which he or she resides, has a temporary domicile, or is habitually living, in person, of each educational institution at which he or she is employed, carries on a vocation, or attends school, within three working days after such employment or attendance, and (B) notify the sheriff of any change in such employment or attendance status of such person at such educational institution, within three working days;
(vii) Inform the defendant that he or she shall (A) inform the sheriff of the county in which the employment site is located, in person, of the name and address of any place where he or she is or will be an employee, within three working days after such employment, and (B) inform the sheriff of the county in which the employment site is located, in person, of any change in his or her employment;
(viii) Inform the defendant that if he or she goes to another state to work or goes to another state as a student and still resides, has a temporary domicile, or has a habitual living location in this state, he or she must comply with the registration requirements of both states;
(ix) Inform the defendant that fingerprints, palm prints, a DNA sample if not previously collected, and a photograph will be obtained by any registering entity in order to comply with the registration requirements;
(x) Inform the defendant of registry and verification locations; and
(xi) Inform the defendant of the reduction request requirements, if eligible, under section 29-4005;

(b) Require the defendant to read and sign a form stating that the duty of the defendant to register under the Sex Offender Registration Act has been explained;
(c) Retain a copy of the written notification signed by the defendant; and
(d) Provide a copy of the signed, written notification, the judgment and sentence, the information or amended information, and the journal entry of the court to the county attorney, the defendant, the sex offender registration and community notification division of the Nebraska State Patrol, and the county sheriff of the county in which the defendant resides, has a temporary domicile, or has a habitual living location.

(2) When a person is convicted of a registrable offense under section 29-4003 and is not subject to immediate incarceration upon sentencing, prior to being released by the court, the sentencing court shall ensure that the defendant is registered by a Nebraska State Patrol office or other location designated by the patrol for purposes of accepting registrations.
(3)(a) The Department of Correctional Services or a city or county correctional or jail facility shall provide written notification of the duty to register pursuant to the Sex Offender Registration Act to any person committed to its custody for a registrable offense under section 29-4003 prior to the person's release from incarceration. The written notification shall:

(i) Inform the person of whether or not he or she is subject to the act, the duration of time he or she will be subject to the act, and that he or she shall report to a location designated by the Nebraska State Patrol for purposes of accepting such registration within three working days after the date of the written notification to register;
(ii) Inform the person that if he or she moves to another address within the same county, he or she must report all address changes, in person, to the county

sheriff of the county in which he or she has been residing within three working days before his or her move;

(iii) Inform the defendant that if he or she no longer has a residence, temporary domicile, or habitual living location, he or she shall report such change in person to the sheriff of the county in which he or she is located within three working days after such change in residence, temporary domicile, or habitual living location;

(iv) Inform the person that if he or she moves to another county in the State of Nebraska, he or she must notify, in person, the county sheriff of the county in which he or she had been last residing, had a temporary domicile, or had a habitual living location and the county sheriff of the county in which he or she is residing, has a temporary domicile, or is habitually living of his or her current address. The notice must be given within three working days before his or her move;

(v) Inform the person that if he or she moves to another state, he or she must report, in person, the change of address to the county sheriff of the county in which he or she has been residing, has had a temporary domicile, or has been habitually living and must comply with the registration requirements of the state to which he or she is moving. The report must be given within three working days before his or her move;

(vi) Inform the person that he or she shall (A) inform the sheriff of the county in which he or she resides, has a temporary domicile, or is habitually living, in person, of each educational institution at which he or she is employed, carries on a vocation, or attends school, within three working days after such employment or attendance, and (B) notify the sheriff of any change in such employment or attendance status of such person at such educational institution, within three working days after such change;

(vii) Inform the person that he or she shall (A) inform the sheriff of the county in which the employment site is located, in person, of the name and address of any place where he or she is or will be an employee, within three working days after such employment, and (B) inform the sheriff of the county in which the employment site is located, in person, of any change in his or her employment;

(viii) Inform the person that if he or she goes to another state to work or goes to another state as a student and still resides, has a temporary domicile, or has a habitual living location in this state, he or she must comply with the registration requirements of both states;

(ix) Inform the defendant that fingerprints, palm prints, a DNA sample if not previously collected, and a photograph will be obtained by any registering entity in order to comply with the registration requirements;

(x) Inform the defendant of registry and verification locations; and

(xi) Inform the defendant of the reduction request requirements, if eligible, under section 29-4005.

(b) The Department of Correctional Services or a city or county correctional or jail facility shall:

(i) Require the person to read and sign the notification form stating that the duty to register under the Sex Offender Registration Act has been explained;

(ii) Retain a signed copy of the written notification to register; and

(iii) Provide a copy of the signed, written notification to register to the person and to the sex offender registration and community notification division of the Nebraska State Patrol.

Section 29-4007 **Sentencing court; duties; Department of Correctional Services or local facility; Department of Motor Vehicles; notification requirements; Attorney General; approve form.**	
	(4) If a person is convicted of a registrable offense under section 29-4003 and is immediately incarcerated, he or she shall be registered as required under the act prior to discharge, parole, or work release. (5) The Department of Motor Vehicles shall cause written notification of the duty to register to be provided on the applications for a motor vehicle operator's license and for a commercial driver's license. (6) All written notification as provided in this section shall be on a form approved by the Attorney General.

Public notice provisions are expanded to include all registered sex offenders. Also, information of sex offenders working, volunteering at or attending a postsecondary educational institution must be disclosed to law enforcement or campus police.

SEXUAL PREDATOR RESIDENCY RESTRICTION ACT

Those offenders who have been convicted of an "aggravated offense" and were convicted of victimizing a person 18 years of age or younger may be subject to residency restrictions. NRS Sec. 29-4015 et. seq. allows a political subdivision to enact an ordinance, resolution, or other legal restriction prescribing where sex offenders may reside. The restrictions may not extend more than 500 feet from a school or child care facility. Exemptions for correctional institutions, treatment facilities and dates of establishing a residence are provided. Ordinances, resolutions or other legal restrictions are void if they do not meet the requirements of this act.

It is important for Mental Health Board decision-makers to be familiar with the criminal code definitions of the relevant sex offenses evaluated as part of the civil commitment process as it helps to define the nature of the offense. Familiarity with sex offender risk assessment tools and literature would also be helpful.

FISCAL RESPONSIBILITY OF COUNTIES

The state is generally responsible for costs of treatment of a committed dangerous sex offender. The county is subject to the costs of due process associated with the commitment process. The following are statutes relating to county costs.

Section 71-1207 Petition; summons; hearing; sheriff; duties; failure to appear; warrant for custody
Upon filing of a petition under the Sex Offender Commitment Act, the subject shall have the rights as provided for in the Mental Health Commitment Act, which includes a due process hearing before a county Mental Health Board as authorized in the Mental Health Commitment Act.

Section 71-915(4)
Mental Health Board members shall be compensated for their actual and necessary expenses by the county or counties being served by such board.

Section 71-919
Each county shall pay the cost of the emergency protective custody if the subject is placed in a county facility.

Section 71-925(7)
The county is responsible for costs associated with any mental health professional for evaluations conducted prior to the entry of a treatment order.

Section 71-929(4)
The county shall be responsible for costs relating to the admission or return of a subject to a treatment facility.

PART 5. PRECEDENT SETTING LEGAL CASES

Three court cases setting legal precedent for Mental Health Boards may have an impact on commitment decisions and should be noted: those of Comstock, Olmstead, Wickwire, and Albert. These cases involve (1) the authority to civilly commit sexually dangerous persons after serving out their sentence, (2) the mandate for least restrictive placement; (3) the lack of jurisdiction over a person with mental retardation; and (4) the importance of obtaining the required training set by law for Mental Health Board members.

In *United States vs. Comstock*, the U.S. Supreme Court held Congress has power under the Necessary and Proper Clause to enact a law authorizing the Federal Government to civilly commit "sexually dangerous person(s)" beyond the date it lawfully could hold them on a charge or conviction for a federal crime. Although addressing only federal detainees, the Court found that federal law does not "invade" state sovereignty in this matter, but rather requires accommodation of state interests: Among other things, it directs the Attorney General to inform the States where the federal prisoner "is domiciled or was tried" of his detention. Further, it gives either State the right, at any time, to assert its authority over the individual, which will prompt the individual's immediate transfer to State custody.

The *Olmstead v. L.C.*, 527 U.S. 581 (1999) case involved a person held in a Georgia mental institution who wanted community placement. Using the Americans with Disabilities Act as reference, the U.S. Supreme Court confronted the question whether the proscription of discrimination may require placement of persons with mental disabilities in community settings rather than in institutions. The Court answered with a "qualified yes." Such action is in order when:

1) The state's treatment professionals have determined that community placement is appropriate,
2) The transfer from institutional care to a less restrictive setting is not opposed by the affected individuals, and
3) The placement can be reasonably accommodated, taking into account the resources available to the state and the needs of others with mental disabilities.

It was argued that unjustified retention is a form of discrimination limiting exposure to the outside community that a person's rights were violated when held in an inappropriate level of care. Treatment professionals are obligated to search for services in the "most integrated setting" – a setting that enables individuals with disabilities to interact with non-disabled persons to the fullest extent possible.

Nebraska's decision *In re Wickwire* 259 Neb. 305, 609 NW2d 384 (Neb. 2000) concerned an individual with an IQ of 40, considered to be mentally retarded who did not have a diagnosis of mental illness. His developmental disability included serious behavioral issues and, due to his aggressive and violent behavior, the Lancaster County Attorney filed a Mental Health Board petition stating that Wickwire was a mentally ill and dangerous person, recommending inpatient placement at the Lincoln Regional Center. However, psychiatrists at the Lincoln Regional Center testified that treatment at a psychiatric hospital would not benefit Wickwire due to his diagnosis of mental retardation, not mental illness. The court ruled that although the Mental Health Board found him a dangerous person, they had no jurisdiction over persons with mental retardation; and that the state of Nebraska did not intend the terms "mental illness" and "mental retardation" to be used interchangeably.

In another Nebraska District Court case, *Albert*, from Platte County District Court, (August 24, 2001), a Mental Health Board decision was declared null and void because two of the three board members had not completed Mental Health Board training as required by statute within the past two years. Section 71-916 still makes mental health trainings mandatory. Albert had served time in prison for first degree sexual assault. At the time of his release, a petition was filed under the Mental Health Commitment Act and he was committed to the Norfolk Regional Center as a mentally ill and dangerous person. Albert brought a

writ of habeas corpus, alleging that he was unlawfully imprisoned because the actions of the board were void due to their not having followed the law requiring yearly training for board members. The court found for Albert and he was discharged.

NEW LAW CASES

1. The Mental Health Commitment Act, NRS Sec. 71-901 et seq., has been amended in a number of ways.

   (i.) **NRS Sec. 71-906**. The legislature twice expanded the definition of "mental health professional." First, in 2005, to include an advanced practice registered nurse who has certification in a mental health specialty, as well as a person licensed to practice medicine and surgery or psychology. Then again, in 2007, to include an advanced practice nurse who has proof of current certification in a psychiatric or mental health specialty.

   (ii.) **NRS Sec**. **71-922**. The legislature mandated that board proceedings are deemed to have commenced upon the earlier of (a) the filing of a petition or (b) notification by the county attorney to the law enforcement officer who took the subject into emergency protective custody or the administrator of the treatment center having charge of the subject of his or her intention to file such petition. The county attorney shall file such petition as soon as reasonably practicable after such notification.

2. *In re Interest of E.M.,* 13 Neb. App. 287 (2005) examined section 83-1045.02, which provides that "no person may be held in custody pending the hearing for a period exceeding seven days, except upon a continuance granted by the board." The language remains essentially the same in the new MHCA at section 71-934, which provides "no person may be held in custody under this section for more than seven days except upon a continuance granted by the board." The subject in *E.M.* was taken into custody on September 17, 2003 and the hearing was held on September 25. The subject argued that he was denied his statutory right to a hearing within 7 days of being taken into custody. **Held**: "The 'seven days' language of Section 83-1045.02 is directory, not mandatory, and that even assuming the provision was violated in this case, violation of the provision does not mandate dismissal of the proceedings." 13 Neb. App. 287 (2005) at 294.

3. *In re Interest of Verle O.,* 13 Neb. App. 256 (2005). In 1993, Verle entered a plea of "no contest" to attempted first-degree sexual assault of a child in a criminal case and was incarcerated. Nine years later, at the time that Verle was to be discharged from the Department of Correctional Services, the state filed a petition with the Mental Health Board alleging Verle was mentally ill and dangerous. Under Section 83-1009 [re-codified at 71-908], there must be a recent violent act, a threat of violence, or an act placing others in reasonable fear in order to find that a person is dangerous. The Board found Verle to be mentally ill and dangerous, but failed to specify any specific recent violent act or threat of violence that would make Verle dangerous as required by statute. Instead, the board relied on the no contest plea and statements made on the record by Verle at that plea hearing as the factual basis for finding Verle mentally ill and dangerous.
   Held: By entering a plea of no contest (as opposed to entering a guilty plea), Verle avoided making any admissions of fact; therefore, any statements made by Verle in connection with the no contest plea were not admissible as evidence in the civil commitment proceeding. The mere fact that Verle plead no contest to an attempted assault does not in and of itself establish that Verle performed recent violent acts as required by statute. Additional facts must be established to sustain a commitment.

4. *In re Interest of R.P.,* 2007 WL 1532327 (Neb. App. 2007). R.P. was convicted in 1993 for second degree sexual assault of an 8-year old female. In 2004, the Board found that R.P. continued to be mentally ill and a danger to others. However, the Board's decision was a 2-1 vote in favor of sustaining the motion for reconsideration of petition conditions and returning R.P. to LRC for

inpatient commitment. While the majority found that the State proved by clear and convincing evidence that the least restrictive treatment alternative was inpatient commitment, the dissenting Board member found that the State did not meet its burden of showing that R.P. could not be successfully maintained on outpatient commitment. R.P. appealed to the district court, alleging that there was insufficient evidence to support a finding by clear and convincing evidence R.P. is a mentally ill and dangerous person in need of Board-ordered inpatient treatment and that the Board erred in "relying on speculation and conjecture that evidence of dangerousness to others."
Held: Citing *E.M.*, the court found no merit to R.P.'s assignment of error that the district court erred in affirming the Board's order sustaining the State's motion for reconsideration of petition conditions.

5. *Winters v. O'Neill,* 2006 WL 12663 (D. Neb., 2006). Winters served a sentence for sexual assault of a child and was involuntarily committed to the Norfolk Regional Center ("NRC") for evaluation as a mentally ill and dangerous person, until he could be admitted to the Lincoln Regional Center ("LRC") or another facility for treatment. The plaintiff alleges that he was "warehoused" at the NRC for eighteen months under deplorable conditions, including grossly unsanitary facilities, lack of exercise or fresh air, no law library, no treatment or programs for sex offenders, none of the passes, home visits and other amenities afforded other patients at the NRC, and lack of appropriate medical treatment. The plaintiff also complains that the defendants failed to conduct a timely evaluation after his admission to the NRC. The plaintiff's resistance to the court-ordered mental health evaluation contributed to the delay in transferring the plaintiff out of the NRC to a facility which offered treatment programs. The defendants were not unreasonable in requiring the plaintiff's compliance with the court-ordered evaluation or in restricting the plaintiff to the building while he was confined on a custody warrant.
Held: Winters did not demonstrate the violation of a constitutional right, and he did not establish that any of the defendants' acts violated clearly established law. The defendants' motion for summary judgment will be granted, case dismissed.

6. *In re Interest of D.C.*, 2007 WL 2372613 (Neb. App., 2007). D.C.'s sex offenses against children in 1983, 2002, and 2003 were recent for purposes of assessing that he was a very strong risk and likelihood to reoffend, that D.C. posed a marked danger to others, and that the least restrictive treatment program was inpatient treatment. The Board determined that there was clear and convincing evidence that the allegations in the petition were true and that the least restrictive treatment alternative was inpatient sexual offender treatment. D.C. claimed the district court erred in affirming the Board's determination that there was sufficient evidence to support a finding by clear and convincing evidence that D.C. was mentally ill and presented a substantial risk of harm to himself or others within the near future. The State does not address such argument, because D.C. did not have a corresponding assignment of error in the appropriate section of the brief.

7. *In re Interest of C.R.* (2011) distinguished mental health commitment from developmental disabilities court-ordered custody, finding the Developmental Disabilities Court-Ordered Custody Act "does not require proof of future harm before a court determines that the subject is in need of court-ordered custody and treatment" under Section 71-1115. Specifically, mental health commitment carries a higher standard of proof because the diagnosis of mental illness is more challenging, the presence of a mental illness is often more transient, and mental health commitment requires expert testimony regarding the likelihood of future harm. Although the two statutory schemes serve similar purposes, mental health commitment requires a nexus between the mental illness and future harm, while developmental disabilities custody does not require any nexus. Despite these differences, the Nebraska Supreme Court ruled that the Developmental Disabilities Court-Ordered Custody Act

8. D.I. v. Gibson et al., 291 Neb. 554 (2015). In 2003, D.I. was convicted of sexual assault on a child. Shortly before finishing his prison sentence, the Douglas County Attorney filed a petition with the

Mental Health Board that D.I. was a dangerous sex offender under the Sex Offender Commitment Act. The Mental Health Board issued a warrant directing the Department of Correctional Services to hold D.I. until the commitment hearing. November 16, 2006, was the last day of D.I.'s sentence. On December 21, 2006, the Mental Health Board held a commitment hearing and determined that D.I. was a dangerous sex offender. In May 2013, D.I. petitioned for writ of habeas corpus. D.I. alleged the Mental Health Board's failure to hold a hearing within seven days as outline in Neb. Rev. Stat. §71-1207 violated the Sex Offender Commitment Act and his due process rights. Neb. Rev. Stat. §71-1207 states "[t]he summons shall fix a time for the hearing within seven calendar days after the subject has been taken into emergency protective custody." The court held that the seven day period was discretionary instead of mandatory. The court stated that the word "shall" is construed as "permissive if the spirit and purpose of the legislation requires such construction." The primary purpose of the Sex Offender Commitment Act "is to protect the public from sex offenders who continue to pose a threat." The fundamental purpose of the Sex Offender Commitment Act rebuts the presumption that "shall" "creates a mandatory duty."

PART 6. AFFIDAVIT OF COMPLETION OF TRAINING

Upon completion of the review of this manual, prospective Mental Health Board members shall complete the following Affidavit, have it notarized, and send it to the Division of Behavioral Health. This affidavit shall serve as proof of the completion of this training, and is valid for four years from the date on the Affidavit. The Division of Behavioral Health will confirm receipt of the completed Affidavit via a written letter.

Please fill out the following information and include with the Affidavit.

Both items can then be mailed to:

Nebraska Division of Behavioral Health
c/o: Mental Health Board Training Coordinator
PO Box 95026
Lincoln, NE 68509

PLEASE PRINT

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

Email: _____

Judicial District (s): _____

Mental Health Board Appointment(s):_____

Date of Appointment:_____

Length of Appointment: _____

Identify if this is a New Appointment or Recertification: _____

In re: Interest of Department of Health and Human Services (DHHS)	)	
Mental Health Board Training	)	***AFFIDAVIT OF _____***
Attestation of Compliance	)	

STATE OF NEBRASKA)
) ss.
COUNTY OF _____)

I, _____, being first duly sworn, hereby depose and state as follows:

1. I have read and carefully considered all material contained within the 2015 DHHS Nebraska Mental Health Commitment Act Reference Manual.
2. I understand that commitment orders for inpatient treatment must specify DHHS, not regional centers.
3. I understand that orders for medication over objection result from a separate proceeding that is distinct from a commitment proceeding.
4. I understand that with effective treatment, individuals must be released from commitment and have all rights restored.
5. I will conduct myself and all Mental Health Board proceedings consistent with the 2015 DHHS Nebraska Mental Health Commitment Act Reference Manual and the understandings stated herein.

Further Affiant sayeth not.

Dated this ___ day of _____, 20___.

_____
Affiant

Subscribed and sworn to before me this ___ day of _____, 20___.

_____
Notary Public

APPENDIX A
NEBRASKA MENTAL HEALTH COMMITMENT ACT

*Accessed from: http://nebraskalegislature.gov/laws/laws-index/chap71-full.html (April 20, 2011)

71-901. Act, how cited.

Sections 71-901 to 71-962 shall be known and may be cited as the Nebraska Mental Health Commitment Act.

Source: Laws 1976, LB 806, § 89; Laws 1988, LB 257, § 6; Laws 1994, LB 498, § 12; Laws 1996, LB 1155, § 116; R.S.1943, (1999), § 83-1078; Laws 2004, LB 1083, § 21.

71-902. Declaration of purpose.

The purpose of the Nebraska Mental Health Commitment Act is to provide for the treatment of persons who are mentally ill and dangerous. It is the public policy of the State of Nebraska that mentally ill and dangerous persons be encouraged to obtain voluntary treatment. If voluntary treatment is not obtained, such persons shall be subject to involuntary custody and treatment only after Mental Health Board proceedings as provided by the Nebraska Mental Health Commitment Act. Such persons shall be subjected to emergency protective custody under limited conditions and for a limited period of time.

Source: Laws 1976, LB 806, § 1; Laws 1996, LB 1155, § 93; R.S.1943, (1999), § 83-1001; Laws 2004, LB 1083, § 22.

Cross References

Persons supposed mentally ill, limitations on restraint of liberty, see section 83-357.

Annotations

The Nebraska Mental Health Commitment Act applies to any person who is mentally ill and dangerous. In re Interest of G.H., 279 Neb. 708, 781 N.W.2d 438 (2010).

One of the declared public policy purposes of the Nebraska Mental Health Commitment Act is that all personal records required by the act shall be confidential except as otherwise specifically provided. In re Interest of Michael M., 6 Neb. App. 560, 574 N.W.2d 774 (1998).

71-903. Definitions, where found.

For purposes of the Nebraska Mental Health Commitment Act, unless the context otherwise requires, the definitions found in sections 71-904 to 71-914 shall apply.

Source: Laws 1976, LB 806, § 2; Laws 1994, LB 498, § 4; R.S.1943, (1999), § 83-1002; Laws 2004, LB 1083, § 23.

71-904. Administrator, defined.

Administrator means the administrator or other chief administrative officer of a treatment facility or his or her designee.

Source: Laws 1976, LB 806, § 5; R.S.1943, (1999), § 83-1005; Laws 2004, LB 1083, § 24.

71-905. Mental Health Board, defined.

Mental Health Board means a board created under section 71-915.

Source: Laws 1976, LB 806, § 4; R.S.1943, (1999), § 83-1004; Laws 2004, LB 1083, § 25.

71-906. Mental health professional, defined.

Mental health professional means a person licensed to practice medicine and surgery or psychology in this state under the Uniform Credentialing Act or an advanced practice registered nurse licensed under the Advanced Practice Registered Nurse Practice Act who has proof of current certification in a psychiatric or mental health specialty.

Source: Laws 1976, LB 806, § 10; Laws 1991, LB 10, § 6; Laws 1994, LB 1210, § 159; R.S.1943, (1999), § 83-1010; Laws 2004, LB 1083, § 26; Laws 2005, LB 534, § 1; Laws 2007, LB463, § 1185.

Cross References

Advanced Practice Registered Nurse Practice Act, see section 38-201.
Uniform Credentialing Act, see section 38-101.

Annotations

The opinion of a general practitioner of medicine as to mental conditions is admissible in commitment proceedings, provided a proper foundation is laid. Lux v. Mental Health Board of Polk County, 202 Neb. 106, 274 N.W.2d 141 (1979).

71-907. Mentally ill, defined.

Mentally ill means having a psychiatric disorder that involves a severe or substantial impairment of a person's thought processes, sensory input, mood balance, memory, or ability to reason which substantially interferes with such person's ability to meet the ordinary demands of living or interferes with the safety or well-being of others.

Source: Laws 1977, LB 204, § 27; R.S.1943, (1999), § 83-1009.01; Laws 2004, LB 1083, § 27.

Annotations

Substance dependence can be considered for purposes of determining that an individual is a dangerous sex offender. In re Interest of G.H., 279 Neb. 708, 781 N.W.2d 438 (2010).

71-908. Mentally ill and dangerous person, defined.

Mentally ill and dangerous person means a person who is mentally ill or substance dependent and because of such mental illness or substance dependence presents:

(1) A substantial risk of serious harm to another person or persons within the near future as manifested by evidence of recent violent acts or threats of violence or by placing others in reasonable fear of such harm; or

(2) A substantial risk of serious harm to himself or herself within the near future as manifested by evidence of recent attempts at, or threats of, suicide or serious bodily harm or evidence of inability to provide for his or her basic human needs, including food, clothing, shelter, essential medical care, or personal safety.

Source: Laws 1976, LB 806, § 9; Laws 1977, LB 204, § 26; Laws 1985, LB 252, § 2; R.S.1943, (1999), § 83-1009; Laws 2004, LB 1083, § 28.

Annotations

1. Requirements of section

Involuntary commitment as a mentally ill dangerous person is improper when, although a person is clearly mentally ill, there is no showing of dangerousness. Petersen v. County Board of Mental Health, 203 Neb. 622, 279 N.W.2d 844 (1979).

Showing that a person is a spendthrift and improvident is insufficient to demonstrate dangerousness as required by this statute. Petersen v. County Board of Mental Health, 203 Neb. 622, 279 N.W.2d 844 (1979).

The requirements of this section, which defines a mentally ill dangerous person, are met when medical diagnoses of paranoid schizophrenia and an unprovoked assault and threatening behavior are shown by clear and convincing proof. Lux v. Mental Health Board of Polk County, 202 Neb. 106, 274 N.W.2d 141 (1979).

2. Evidentiary issues

There is no definite time-oriented period to determine whether an act is recent for the purposes of this section. Each case must be decided on the basis of the surrounding facts and circumstances. In re Interest of Kochner, 266 Neb. 114, 662 N.W.2d 195 (2003).

To meet the definition of a mentally ill dangerous person, the State must show that the person suffers from a mental illness and that the person presents a substantial risk of harm to others or to himself or herself. In re Interest of Kochner, 266 Neb. 114, 662 N.W.2d 195 (2003).

A person who is mentally retarded does not fall within the definition of "mentally ill dangerous person" unless there is a secondary diagnosis of mental illness. In re Interest of Wickwire, 259 Neb. 305, 609 N.W.2d 384 (2000).

Actions and statements of a person alleged to be mentally ill and dangerous which occur prior to the hearing are probative of the subject's present mental condition. However, in order for a past act to have any evidentiary value, it must form some foundation for a prediction of future dangerousness and be, therefore, probative of that issue. In re Interest of Rasmussen, 236 Neb. 572, 462 N.W.2d 621 (1990).

In proving the dangerousness of a mentally ill person as manifested by "evidence of inability to provide for his basic human needs," within the meaning of this section, expert testimony may be used to prove such a condition. In re Interest of Kinnebrew, 224 Neb. 885, 402 N.W.2d 264 (1987).

An act occurring five years prior to the mental health commitment hearing is recent within the meaning of this section where: (a) There is evidence that the act is still probative of the subject's future dangerousness; (b) the subject has not had an opportunity to commit a more recent act because he has been in confinement; and (c) there is reliable medical evidence that there is a high probability of repetition of such act by the subject. Under Mental Health Commitment Act, the determination of whether an act of violence is recent must be decided on the basis of all the surrounding facts and circumstances. In re Interest of Blythman, 208 Neb. 51, 302 N.W.2d 666 (1981).

That an act or threat is recent “if the time interval between it and the hearing of the mental health board is not greater than that which would indicate processing of the complaint was carried on with reasonable diligence under the circumstances existing, having due regard for the rights and welfare of the alleged mentally ill dangerous person and the protection of society in general.” Hill v. County Board of Mental Health, Douglas County, 203 Neb. 610, 279 N.W.2d 838 (1979).

Although this section refers to "recent violent acts," commitment may be based upon evidence of only one violent act or threat. Lux v. Mental Health Board of Polk County, 202 Neb. 106, 274 N.W.2d 141 (1979).

3. Standard of proof

The State must prove by clear and convincing evidence that an individual poses a substantial risk of harm to others or to himself to have that individual declared mentally ill and dangerous under the Nebraska Mental Health Commitment Act. In re Interest of Dickson, 238 Neb. 148, 469 N.W.2d 357 (1991).

Evidence must be clear and convincing to support a finding that a person is mentally ill and dangerous. In re Interest of Rasmussen, 236 Neb. 572, 462 N.W.2d 621 (1990).

4. Constitutionality

The definitions of mentally ill dangerous persons in the Nebraska Mental Health Commitment Act and the statutes governing persons acquitted of a crime on grounds of insanity are constitutional and do not violate equal protection guarantees. Tulloch v. State, 237 Neb. 138, 465 N.W.2d 448 (1991).

5. Appeal

An order adjudicating an individual as a mentally ill dangerous person pursuant to this section and ordering that person retained for an indeterminate amount of time is an order affecting a substantial right in a special proceeding from which an appeal may be taken. In re Interest of Saville, 10 Neb. App. 194, 626 N.W.2d 644 (2001).

71-909. Outpatient treatment, defined.

Outpatient treatment means treatment ordered by a Mental Health Board directing a subject to comply with specified outpatient treatment requirements, including, but not limited to, (1) taking prescribed medication, (2) reporting to a mental health professional or treatment facility for treatment or for monitoring of the subject's condition, or (3) participating in individual or group therapy or educational, rehabilitation, residential, or vocational programs.

Source: Laws 1994, LB 498, § 5; R.S.1943, (1999), § 83-1007.01; Laws 2004, LB 1083, § 29.

71-910. Peace officer or law enforcement officer, defined.

Peace officer or law enforcement officer means a sheriff, a jailer, a marshal, a police officer, or an officer of the Nebraska State Patrol.

Source: Laws 1976, LB 806, § 11; Laws 1981, LB 95, § 5; Laws 1988, LB 1030, § 52; R.S.1943, (1999), § 83-1011; Laws 2004, LB 1083, § 30.

71-911. Regional center, defined.

Regional center means a state hospital for the mentally ill as designated in section 83-305.

Source: Laws 1976, LB 806, § 7; R.S.1943, (1999), § 83-1007; Laws 2004, LB 1083, § 31.

71-912. Subject, defined.

Subject means any person concerning whom a certificate or petition has been filed under the Nebraska Mental Health Commitment Act. Subject does not include any person under eighteen years of age unless such person is an emancipated minor.

Source: Laws 1976, LB 806, § 14; Laws 1996, LB 1155, § 94; R.S.1943, (1999), § 83-1014; Laws 2004, LB 1083, § 32.

71-913. Substance dependent, defined.

Substance dependent means having a behavioral disorder that involves a maladaptive pattern of repeated use of controlled substances, illegal drugs, or alcohol, usually resulting in increased tolerance, withdrawal, and compulsive using behavior and including a cluster of cognitive, behavioral, and physiological symptoms involving the continued use of such substances despite significant adverse effects resulting from such use.

Source: Laws 1985, LB 252, § 3; R.S.1943, (1999), § 83-1009.02; Laws 2004, LB 1083, § 33.

71-914. Treatment facility, defined.

Treatment facility means a facility which is licensed to provide services for persons who are mentally ill or substance dependent or both.

Source: Laws 1976, LB 806, § 6; Laws 1985, LB 252, § 1; Laws 1995, LB 275, § 24; R.S.1943, (1999), § 83-1006; Laws 2004, LB 1083, § 34.

71-915. Mental Health Boards; created; powers; duties; compensation.

(1) The presiding judge in each district court judicial district shall create at least one but not more than three Mental Health Boards in such district and shall appoint sufficient members and alternate members to such boards. Members and alternate members of a Mental Health Board shall be appointed for four-year terms. The presiding judge may remove members and alternate members of the board at his or her discretion. Vacancies shall be filled for the unexpired term in the same manner as provided for the original appointment. Members of the Mental Health Board shall have the same immunity as judges of the district court.

(2) Each Mental Health Board shall consist of an attorney licensed to practice law in this state and any two of the following but not more than one from each category: A physician, a psychologist, a psychiatric social worker, a psychiatric nurse, a clinical social worker, or a layperson with a demonstrated interest in mental health and substance dependency issues. The attorney shall be chairperson of the board. Members and alternate members of a Mental Health Board shall take and subscribe an oath to support the United States Constitution and the Constitution of Nebraska and to faithfully discharge the duties of the office according to law.

(3) The Mental Health Board shall have the power to issue subpoenas, to administer oaths, and to do any act necessary and proper for the board to carry out its duties. No Mental Health Board hearing shall be conducted unless three members or alternate members are present and able to vote. Any action taken at any Mental Health Board hearing shall be by majority vote.

(4) The Mental Health Board shall prepare and file an annual inventory statement with the county board of its county of all county personal property in its custody or possession. Members of the Mental Health Board shall be compensated and shall be reimbursed for their actual and necessary expenses by the county or counties being served by such board. Compensation shall be at an hourly rate to be determined by the presiding judge of the district court,

except that such compensation shall not be less than fifty dollars for each hearing of the board. Members shall also be reimbursed for their actual and necessary expenses, not including charges for meals. Mileage shall be determined pursuant to section 23-1112.

Source: Laws 1976, LB 806, § 27; Laws 1981, LB 95, § 7; Laws 1990, LB 822, § 39; Laws 1994, LB 498, § 6; R.S.1943, (1999), § 83-1017; Laws 2004, LB 1083, § 35.

71-916. Mental Health Board; training; department; duties.

(1) The Department of Health and Human Services shall provide appropriate training to members and alternate members of each Mental Health Board and shall consult with consumer and family advocacy groups in the development and presentation of such training. Members and alternate members shall be reimbursed for any actual and necessary expenses incurred in attending such training in a manner and amount determined by the presiding judge of the district court. No person shall remain on a Mental Health Board or be eligible for appointment or reappointment as a member or alternate member of such board unless he or she has attended and satisfactorily completed such training pursuant to rules and regulations adopted and promulgated by the department.

(2) The department shall provide the Mental Health Boards with blanks for warrants, certificates, and other forms and printed copies of applicable rules and regulations of the department that will enable the boards to carry out their powers and duties under the Nebraska Mental Health Commitment Act or the Sex Offender Commitment Act.

Source: Laws 2004, LB 1083, § 36; Laws 2006, LB 1199, § 35; Laws 2007, LB296, § 461.

Cross References

Sex Offender Commitment Act, see section 71-1201.

71-917. Clerk of the district court; duties relating to Mental Health Board.

The clerk of the district court appointed for that purpose by a district judge of that district court judicial district shall sign and issue all notices, appointments, warrants, subpoenas, or other process required to be issued by the Mental Health Board and shall affix his or her seal as clerk of the district court. The clerk shall file and preserve in his or her office all papers connected with any proceedings of the Mental Health Board and all related notices, reports, and other communications. The clerk shall keep minutes of all proceedings of the board. All required notices, reports, and communications may be sent by mail unless otherwise provided in the Nebraska Mental Health Commitment Act or the Sex Offender Commitment Act. The fact and date that such notices, reports, and communications have been sent and received shall be noted on the proper record.

Source: Laws 1976, LB 806, § 16; Laws 1981, LB 95, § 6; Laws 2000, LB 884, § 5; R.S.Supp.,2002, § 83-1016; Laws 2004, LB 1083, § 37; Laws 2006, LB 1199, § 36.

Cross References

Sex Offender Commitment Act, see section 71-1201.

71-918. Facility or programs for treatment of mental illness, substance dependence, or personality disorders; voluntary admission; unconditional discharge; exception.

Any person may voluntarily apply for admission to any public or private hospital, other treatment facility, or program for treatment of mental illness, substance dependence, or personality disorders in accordance with the regulations of such facilities or programs governing such admissions. Any person who is voluntarily admitted for such treatment shall be unconditionally discharged from such hospital, treatment facility, or program not later than

forty-eight hours after delivery of his or her written request to any official of such hospital, treatment facility, or program, unless action is taken under the Nebraska Mental Health Commitment Act or the Sex Offender Commitment Act to continue his or her custody.

Source: Laws 1976, LB 806, § 29; Laws 1978, LB 501, § 1; Laws 1985, LB 252, § 4; Laws 2000, LB 884, § 6; R.S.Supp.,2002, § 83-1019; Laws 2004, LB 1083, § 38; Laws 2006, LB 1199, § 37.

Cross References

Sex Offender Commitment Act, see section 71-1201.

71-919. Mentally ill and dangerous person; dangerous sex offender; emergency protective custody; evaluation by mental health professional.

(1) A law enforcement officer who has probable cause to believe that a person is mentally ill and dangerous or a dangerous sex offender and that the harm described in section 71-908 or subdivision (1) of section 83-174.01 is likely to occur before Mental Health Board proceedings under the Nebraska Mental Health Commitment Act or the Sex Offender Commitment Act may be initiated to obtain custody of the person may take such person into emergency protective custody, cause him or her to be taken into emergency protective custody, or continue his or her custody if he or she is already in custody. Such person shall be admitted to an appropriate and available medical facility, jail, or Department of Correctional Services facility as provided in subsection (2) of this section. Each county shall make arrangements with appropriate facilities inside or outside the county for such purpose and shall pay the cost of the emergency protective custody of persons from such county in such facilities. A mental health professional who has probable cause to believe that a person is mentally ill and dangerous or a dangerous sex offender may cause such person to be taken into custody and shall have a limited privilege to hold such person until a law enforcement officer or other authorized person arrives to take custody of such person.

(2)(a) A person taken into emergency protective custody under this section shall be admitted to an appropriate and available medical facility unless such person has a prior conviction for a sex offense listed in section 29-4003.

(b) A person taken into emergency protective custody under this section who has a prior conviction for a sex offense listed in section 29-4003 shall be admitted to a jail or Department of Correctional Services facility unless a medical or psychiatric emergency exists for which treatment at a medical facility is required. The person in emergency protective custody shall remain at the medical facility until the medical or psychiatric emergency has passed and it is safe to transport such person, at which time the person shall be transferred to an available jail or Department of Correctional Services facility.

(3) Upon admission to a facility of a person taken into emergency protective custody by a law enforcement officer under this section, such officer shall execute a written certificate prescribed and provided by the Department of Health and Human Services. The certificate shall allege the officer's belief that the person in custody is mentally ill and dangerous or a dangerous sex offender and shall contain a summary of the person's behavior supporting such allegations. A copy of such certificate shall be immediately forwarded to the county attorney.

(4) The administrator of the facility shall have such person evaluated by a mental health professional as soon as reasonably possible but not later than thirty-six hours after admission. The mental health professional shall not be the mental health professional who causes such person to be taken into custody under this section and shall not be a member or alternate member of the Mental Health Board that will preside over any hearing under the Nebraska Mental Health Commitment Act or the Sex Offender Commitment Act with respect to such person. A person shall be released from emergency protective custody after completion of such evaluation unless the mental health professional determines, in his or her clinical opinion, that such person is mentally ill and dangerous or a dangerous sex offender.

Source: Laws 1976, LB 806, § 30; Laws 1978, LB 501, § 2; Laws 1988, LB 257, § 2; Laws 1996, LB 1044, § 964; Laws 1996, LB 1155, § 95; R.S.1943, (1999), § 83-1020; Laws 2004, LB 1083, § 39; Laws 2006, LB 1199, § 38; Laws 2007, LB296, § 462.

Cross References

Sex Offender Commitment Act, see section 71-1201.

71-920. Mentally ill and dangerous person; certificate of mental health professional; contents.

(1) A mental health professional who, upon evaluation of a person admitted for emergency protective custody under section 71-919, determines that such person is mentally ill and dangerous shall execute a written certificate as provided in subsection (2) of this section not later than twenty-four hours after the completion of such evaluation. A copy of such certificate shall be immediately forwarded to the county attorney.

(2) The certificate shall be in writing and shall include the following information:

(a) The subject's name and address, if known;

(b) The name and address of the subject's spouse, legal counsel, guardian or conservator, and next-of-kin, if known;

(c) The name and address of anyone providing psychiatric or other care or treatment to the subject, if known;

(d) The name and address of any other person who may have knowledge of the subject's mental illness or substance dependence who may be called as a witness at a Mental Health Board hearing with respect to the subject, if known;

(e) The name and address of the medical facility in which the subject is being held for emergency protective custody and evaluation;

(f) The name and work address of the certifying mental health professional;

(g) A statement by the certifying mental health professional that he or she has evaluated the subject since the subject was admitted for emergency protective custody and evaluation; and

(h) A statement by the certifying mental health professional that, in his or her clinical opinion, the subject is mentally ill and dangerous and the clinical basis for such opinion.

Source: Laws 2004, LB 1083, § 40.

71-921. Person believes another to be a mentally ill and dangerous person; notify county attorney; petition; when.

(1) Any person who believes that another person is mentally ill and dangerous may communicate such belief to the county attorney. The filing of a certificate by a law enforcement officer under section 71-919 shall be sufficient to communicate such belief. If the county attorney concurs that such person is mentally ill and dangerous and that neither voluntary hospitalization nor other treatment alternatives less restrictive of the subject's liberty than inpatient or outpatient treatment ordered by a Mental Health Board is available or would suffice to prevent the harm described in section 71-908, he or she shall file a petition as provided in this section.

(2) The petition shall be filed with the clerk of the district court in any county within: (a) The judicial district in which the subject is located; (b) the judicial district in which the alleged behavior of the subject occurred which constitutes the basis for the petition; or (c) another judicial district in the State of Nebraska if authorized, upon good cause shown, by a district judge of the judicial district in which the subject is located. In such event, all proceedings before the Mental Health Board shall be conducted by the Mental Health Board serving such other county, and all costs relating to such proceedings shall be paid by the county of residence of the subject. In the order transferring such cause to another county, the judge shall include such directions as are reasonably necessary to protect the rights of the subject.

(3) The petition shall be in writing and shall include the following information:

(a) The subject's name and address, if known;

(b) The name and address of the subject's spouse, legal counsel, guardian or conservator, and next-of-kin, if known;

(c) The name and address of anyone providing psychiatric or other care or treatment to the subject, if known;

(d) A statement that the county attorney has probable cause to believe that the subject of the petition is mentally ill and dangerous;

(e) A statement that the beliefs of the county attorney are based on specific behavior, acts, attempts, or threats which shall be specified and described in detail in the petition; and

(f) The name and address of any other person who may have knowledge of the subject's mental illness or substance dependence and who may be called as a witness at a Mental Health Board hearing with respect to the subject, if known.

Source: Laws 1976, LB 806, § 34; Laws 1981, LB 95, § 9; Laws 2000, LB 884, § 8; R.S.Supp.,2002, § 83-1024; Laws 2004, LB 1083, § 41.

71-922. Mental Health Board proceedings; commencement; custody; conditions; dismissal; when.

(1) Mental Health Board proceedings shall be deemed to have commenced upon the earlier of (a) the filing of a petition under section 71-921 or (b) notification by the county attorney to the law enforcement officer who took the subject into emergency protective custody under section 71-920 or the administrator of the treatment center or medical facility having charge of the subject of his or her intention to file such petition. The county attorney shall file such petition as soon as reasonably practicable after such notification.

(2) A petition filed by the county attorney under section 71-921 may contain a request for the emergency protective custody and evaluation of the subject prior to commencement of a Mental Health Board hearing pursuant to such petition with respect to the subject. Upon receipt of such request and upon a finding of probable cause to believe that the subject is mentally ill and dangerous as alleged in the petition, the court or chairperson of the Mental Health Board may issue a warrant directing the sheriff to take custody of the subject. If the subject is already in emergency protective custody under a certificate filed under section 71-919, a copy of such certificate shall be filed with the petition. The subject in such custody shall be held in the nearest appropriate and available medical facility and shall not be placed in a jail. Each county shall make arrangements with appropriate medical facilities inside or outside the county for such purpose and shall pay the cost of the emergency protective custody of persons from such county in such facilities.

(3) The petition and all subsequent pleadings and filings in the case shall be entitled In the Interest of ....., Alleged to be Mentally Ill and Dangerous. The county attorney may dismiss the petition at any time prior to the commencement of the hearing of the Mental Health Board under section 71-924, and upon such motion by the county attorney, the Mental Health Board shall dismiss the petition.

Source: Laws 1976, LB 806, § 36; Laws 1981, LB 95, § 10; Laws 2000, LB 884, § 9; R.S.Supp.,2002, § 83-1026; Laws 2004, LB 1083, § 42; Laws 2005, LB 551, § 9.

71-923. Petition; summons; hearing; sheriff; duties; failure to appear; warrant for custody.

Upon the filing of the petition under section 71-921, the clerk of the district court shall cause a summons fixing the time and place for a hearing to be prepared and issued to the sheriff for service. The sheriff shall personally serve upon the subject and the subject's legal guardian or custodian, if any, the summons and copies of the petition, the list of rights provided by sections 71-943 to 71-960, and a list of the names, addresses, and telephone numbers of mental health professionals in that immediate vicinity by whom the subject may be evaluated prior to his or her hearing. The summons shall fix a time for the hearing within seven calendar days after the subject has been taken into emergency protective custody. The failure of a subject to appear as required under this section shall constitute grounds for the issuance by the Mental Health Board of a warrant for his or her custody.

Source: Laws 1976, LB 806, § 37; Laws 1981, LB 95, § 11; Laws 1996, LB 1155, § 98; R.S.1943, (1999), § 83-1027; Laws 2004, LB 1083, § 43.

71-924. Hearing; Mental Health Board; duties.

A hearing shall be held by the Mental Health Board to determine whether there is clear and convincing evidence that the subject is mentally ill and dangerous as alleged in the petition. At the commencement of the hearing, the board shall inquire whether the subject has received a copy of the petition and list of rights accorded him or her by sections 71-943 to 71-960 and whether he or she has read and understood them. The board shall explain to the subject any part of the petition or list of rights which he or she has not read or understood. The board shall inquire of the subject whether he or she admits or denies the allegations of the petition. If the subject admits the allegations, the board shall proceed to enter a treatment order pursuant to section 71-925. If the subject denies the allegations of the petition, the board shall proceed with a hearing on the merits of the petition.

Source: Laws 1976, LB 806, § 45; Laws 1981, LB 95, § 14; R.S.1943, (1999), § 83-1035; Laws 2004, LB 1083, § 44.

71-925. Burden of proof; Mental Health Board; hearing; orders authorized; conditions; rehearing.

(1) The state has the burden to prove by clear and convincing evidence that (a) the subject is mentally ill and dangerous and (b) neither voluntary hospitalization nor other treatment alternatives less restrictive of the subject's liberty than inpatient or outpatient treatment ordered by the Mental Health Board are available or would suffice to prevent the harm described in section 71-908.

(2) If the Mental Health Board finds that the subject is not mentally ill and dangerous, the board shall dismiss the petition and order the unconditional discharge of the subject.

(3) If the Mental Health Board finds that the subject is mentally ill and dangerous but that voluntary hospitalization or other treatment alternatives less restrictive of the subject's liberty than treatment ordered by the Mental Health Board are available and would suffice to prevent the harm described in section 71-908, the board shall (a) dismiss the petition and order the unconditional discharge of the subject or (b) suspend further proceedings for a period of up to ninety days to permit the subject to obtain voluntary treatment. At any time during such ninety-

day period, the county attorney may apply to the board for reinstatement of proceedings with respect to the subject, and after notice to the subject, the subject's counsel, and the subject's legal guardian or conservator, if any, the board shall hear the application. If no such application is filed or pending at the conclusion of such ninety-day period, the board shall dismiss the petition and order the unconditional discharge of the subject.

(4) If the subject admits the allegations of the petition or the Mental Health Board finds that the subject is mentally ill and dangerous and that neither voluntary hospitalization nor other treatment alternatives less restrictive of the subject's liberty than inpatient or outpatient treatment ordered by the board are available or would suffice to prevent the harm described in section 71-908, the board shall, within forty-eight hours, (a) order the subject to receive outpatient treatment or (b) order the subject to receive inpatient treatment. If the subject is ordered by the board to receive inpatient treatment, the order shall commit the subject to the custody of the Department of Health and Human Services for such treatment.

(5) A subject who (a) is ordered by the Mental Health Board to receive inpatient treatment and (b) has not yet been admitted for such treatment pursuant to such order may petition for a rehearing by the Mental Health Board based on improvement in the subject's condition such that inpatient treatment ordered by the board would no longer be necessary or appropriate.

(6) A treatment order by the Mental Health Board under this section shall represent the appropriate available treatment alternative that imposes the least possible restraint upon the liberty of the subject. The board shall consider all treatment alternatives, including any treatment program or conditions suggested by the subject, the subject's counsel, or other interested person. Inpatient hospitalization or custody shall only be considered as a treatment alternative of last resort. The county attorney and the subject may jointly offer a proposed treatment order for adoption by the board. The board may enter the proposed order without a full hearing.

(7) The Mental Health Board may request the assistance of the Department of Health and Human Services or any other person or public or private entity to advise the board prior to the entry of a treatment order pursuant to this section and may require the subject to submit to reasonable psychiatric and psychological evaluation to assist the board in preparing such order. Any mental health professional conducting such evaluation at the request of the Mental Health Board shall be compensated by the county or counties served by such board at a rate determined by the district judge and reimbursed for mileage at the rate provided in section 81-1176.

Source: Laws 1976, LB 806, § 47; Laws 1978, LB 501, § 7; Laws 1981, LB 95, § 16; Laws 1996, LB 1155, § 102; R.S.1943, (1999), § 83-1037; Laws 2004, LB 1083, § 45.

Annotations

The board of mental health's conclusion that a person before it is a mentally ill dangerous person and that a less restrictive alternative is not available or would not suffice to prevent the harm described in section 83-1009 must be supported by clear and convincing evidence. In re Interest of Vance, 242 Neb. 109, 493 N.W.2d 620 (1992).

In determining whether a person is dangerous, the focus must be on the subject's condition at the time of the hearing, not the date the subject of the commitment hearing was initially taken into custody. In re Interest of Rasmussen, 236 Neb. 572, 462 N.W.2d 621 (1990).

Statute requires proof that person is dangerous before he will be subject to involuntary confinement. Richards v. Douglas County, 213 Neb. 313, 328 N.W.2d 783 (1983).

71-926. Subject; custody pending entry of treatment order.

(1) At the conclusion of a Mental Health Board hearing under section 71-924 and prior to the entry of a treatment order by the board under section 71-925, the board may (a) order that the subject be retained in custody

until the entry of such order and the subject may be admitted for treatment pursuant to such order or (b) order the subject released from custody under such conditions as the board deems necessary and appropriate to prevent the harm described in section 71-908 and to assure the subject's appearance at a later disposition hearing by the board. A subject shall be retained in custody under this section at the nearest appropriate and available medical facility and shall not be placed in a jail. Each county shall make arrangements with appropriate medical facilities inside or outside the county for such purpose and shall pay the cost of the emergency protective custody of persons from such county in such facilities.

(2) A subject who has been ordered to receive inpatient or outpatient treatment by a Mental Health Board may be provided treatment while being retained in emergency protective custody and pending admission of the subject for treatment pursuant to such order.

Source: Laws 1976, LB 806, § 49; Laws 1988, LB 257, § 4; Laws 1996, LB 1044, § 967; Laws 1996, LB 1155, § 103; R.S.1943, (1999), § 83-1039; Laws 2004, LB 1083, § 46.

71-927. Mentally ill and dangerous subject; board; issue warrant; contents; immunity.

If the Mental Health Board finds the subject to be mentally ill and dangerous and commits the subject to the custody of the Department of Health and Human Services to receive inpatient treatment, the department shall secure placement of the subject in an appropriate inpatient treatment facility to receive such treatment. The board shall issue a warrant authorizing the administrator of such treatment facility to receive and keep the subject as a patient. The warrant shall state the findings of the board and the legal settlement of the subject, if known, or any available information relating thereto. Such warrant shall shield every official and employee of the treatment facility against all liability to prosecution of any kind on account of the reception and detention of the subject if the detention is otherwise in accordance with the Nebraska Mental Health Commitment Act, rules and regulations adopted and promulgated under the act, and policies of the treatment facility.

Source: Laws 1976, LB 806, § 51; Laws 1985, LB 252, § 5; Laws 1994, LB 337, § 1; R.S.1943, (1999), § 83-1041; Laws 2004, LB 1083, § 47.

71-928. Inpatient treatment; subject taken to facility; procedure.

When an order of a Mental Health Board requires inpatient treatment of a subject within a treatment facility, the warrant filed under section 71-927, together with the findings of the Mental Health Board, shall be delivered to the sheriff of the county who shall execute such warrant by conveying and delivering the warrant, the findings, and the subject to the treatment facility. The administrator, over his or her signature, shall acknowledge the delivery on the original warrant which the sheriff shall return to the clerk of the district court with his or her costs and expenses endorsed thereon. If neither the sheriff nor deputy sheriff is available to execute the warrant, the chairperson of the Mental Health Board may appoint some other suitable person to execute the warrant. Such person shall take and subscribe an oath or affirmation to faithfully discharge his or her duty and shall be entitled to the same fees as the sheriff. The sheriff, deputy sheriff, or other person appointed by the Mental Health Board may take with him or her such assistance as may be required to execute the warrant. No female subject shall be taken to a treatment facility without being accompanied by another female or relative of the subject. The administrator in his or her acknowledgment of delivery shall record whether any person accompanied the subject and the name of such person.

Source: Laws 1976, LB 806, § 52; R.S.1943, (1999), § 83-1042; Laws 2004, LB 1083, § 48.

71-929. Mental Health Board; execution of warrants; costs; procedure.

(1) If a Mental Health Board issues a warrant for the admission or return of a subject to a treatment facility and funds to pay the expenses thereof are needed in advance, the board shall estimate the probable expense of conveying

the subject to the treatment facility, including the cost of any assistance that might be required, and shall submit such estimate to the county clerk of the county in which such person is located. The county clerk shall certify the estimate and shall issue an order on the county treasurer in favor of the sheriff or other person entrusted with the execution of the warrant.

(2) The sheriff or other person executing the warrant shall include in his or her return a statement of expenses actually incurred, including any excess or deficiency. Any excess from the amount advanced for such expenses under subsection (1) of this section shall be paid to the county treasurer, taking his or her receipt therefore, and any deficiency shall be obtained by filing a claim with the county board. If no funds are advanced, the expenses shall be certified on the warrant and paid when returned.

(3) The sheriff shall be reimbursed for mileage at the rate provided in section 33-117 for conveying a subject to a treatment facility under this section. For other services performed under the Nebraska Mental Health Commitment Act, the sheriff shall receive the same fees as for like services in other cases.

(4) All compensation and expenses provided for in this section shall be allowed and paid out of the treasury of the county by the county board.

Source: Laws 2004, LB 1083, § 49.

71-930. Treatment order of Mental Health Board; appeal; final order of district court; appeal.

The subject of a petition or the county attorney may appeal a treatment order of the Mental Health Board under section 71-925 to the district court. Such appeals shall be de novo on the record. A final order of the district court may be appealed to the Court of Appeals in accordance with the procedure in criminal cases. The final judgment of the court shall be certified to and become a part of the records of the Mental Health Board with respect to the subject.

Source: Laws 1976, LB 806, § 53; Laws 1991, LB 732, § 155; R.S.1943, (1999), § 83-1043; Laws 2004, LB 1083, § 50.

Annotations

In reviewing a district court's judgment under this act, the Supreme Court will affirm the district court's judgment unless, as a matter of law, the judgment is unsupported by evidence which is clear and convincing. In re Interest of Rasmussen, 236 Neb. 572, 462 N.W.2d 621 (1990).

This section requires the district court to review appeals from the Mental Health Board de novo on the record, and this court to hear appeals from the district court in accordance with criminal procedures. In re Interest of Aandahl, 219 Neb. 414, 363 N.W.2d 392 (1985).

A finding that the accused is incompetent to stand trial may be appealed to the Supreme Court as a final order. State v. Guatney, 207 Neb. 501, 299 N.W.2d 538 (1980).

The Supreme Court will not interfere on appeal with a final order made by the district court in mental health commitment proceedings unless it can say as a matter of law that the order is not supported by clear and convincing evidence. Hill v. County Board of Mental Health, Douglas County, 203 Neb. 610, 279 N.W.2d 838 (1979).

Commitment proceedings are judicial in nature and the District Courts must review the decisions of Mental Health Boards de novo on the record. Lux v. Mental Health Board of Polk County, 202 Neb. 106, 274 N.W.2d 141 (1979).

An order adjudicating an individual as a mentally ill dangerous person pursuant to section 71-908 and ordering that person retained for an indeterminate amount of time is an order affecting a substantial right in a special proceeding from which an appeal may be taken. In re Interest of Saville, 10 Neb. App. 194, 626 N.W.2d 644 (2001).

The subject of a mental health petition (or the county attorney) has the statutory right to appeal the Mental Health Board's decision to the district court, which reviews the case de novo on the record. In re Interest of Michael M., 6 Neb. App. 560, 574 N.W.2d 774 (1998).

71-931. Treatment order; individualized treatment plan; contents; copy; filed; treatment; when commenced.

(1) Any treatment order entered by a Mental Health Board under section 71-925 shall include directions for (a) the preparation and implementation of an individualized treatment plan for the subject and (b) documentation and reporting of the subject's progress under such plan.

(2) The individualized treatment plan shall contain a statement of (a) the nature of the subject's mental illness or substance dependence, (b) the least restrictive treatment alternative consistent with the clinical diagnosis of the subject, and (c) intermediate and long-term treatment goals for the subject and a projected timetable for the attainment of such goals.

(3) A copy of the individualized treatment plan shall be filed with the Mental Health Board for review and inclusion in the subject's file and served upon the county attorney, the subject, the subject's counsel, and the subject's legal guardian or conservator, if any, within five working days after the entry of the board's order. Treatment shall be commenced within two working days after preparation of the plan.

(4) The subject shall be entitled to know the contents of the individualized treatment plan and what the subject must do in order to meet the requirements of such plan.

(5) The subject shall be notified by the Mental Health Board when the Mental Health Board has changed the treatment order or has ordered the discharge of the subject from commitment.

Source: Laws 1976, LB 806, § 54; Laws 1978, LB 501, § 9; Laws 1981, LB 95, § 17; Laws 1996, LB 1155, § 105; R.S.1943, (1999), § 83-1044; Laws 2004, LB 1083, § 51.

71-932. Person responsible for subject's individualized treatment plan; periodic progress reports; copies; filed and served.

The person or entity designated by the Mental Health Board under section 71-931 to prepare and oversee the subject's individualized treatment plan shall submit periodic reports to the Mental Health Board of the subject's progress under such plan and any modifications to the plan. The Mental Health Board may distribute copies of such reports to other interested parties as permitted by law. With respect to a subject ordered by the Mental Health Board to receive inpatient treatment, such initial report shall be filed with the Mental Health Board for review and inclusion in the subject's file and served upon the county attorney, the subject, the subject's counsel, and the subject's legal guardian or conservator, if any, no later than ten days after submission of the subject's individualized treatment plan. With respect to each subject committed by the Mental Health Board, such reports shall be so filed and served no less frequently than every ninety days for a period of one year following submission of the subject's individualized treatment plan and every six months thereafter.

Source: Laws 1976, LB 806, § 55; Laws 1978, LB 501, § 10; Laws 1996, LB 1155, § 106; R.S.1943, (1999), § 83-1045; Laws 2004, LB 1083, § 52.

71-933. Outpatient treatment provider; duties; investigation by county attorney; warrant for immediate custody of subject; when.

(1) Any provider of outpatient treatment to a subject ordered by a Mental Health Board to receive such treatment shall report to the board and to the county attorney if (a) the subject is not complying with his or her individualized treatment plan, (b) the subject is not following the conditions set by the Mental Health Board, (c) the treatment plan is not effective, or (d) there has been a significant change in the subject's mental illness or substance dependence. Such report may be transmitted by facsimile, but the original of the report shall be mailed to the board and the county attorney no later than twenty-four hours after the facsimile transmittal.

(2)(a) Upon receipt of such report, the county attorney shall have the matter investigated to determine whether there is a factual basis for the report.

(b) If the county attorney determines that there is no factual basis for the report or that no further action is warranted, he or she shall notify the board and the treatment provider and take no further action.

(c) If the county attorney determines that there is a factual basis for the report and that intervention by the Mental Health Board is necessary to protect the subject or others, the county attorney may file a motion for reconsideration of the conditions set forth by the board and have the matter set for hearing.

(d) The county attorney may apply for a warrant to take immediate custody of the subject pending a rehearing by the board under subdivision (c) of this subsection if the county attorney has reasonable cause to believe that the subject poses a threat of danger to himself or herself or others prior to such rehearing. The application for a warrant shall be supported by affidavit or sworn testimony by the county attorney, a mental health professional, or any other informed person. The application for a warrant and the supporting affidavit may be filed with the board by facsimile, but the original shall be filed with the board no later than three days after the facsimile transmittal, excluding holidays and weekends. Sworn testimony in support of the warrant application may be taken over the telephone at the discretion of the board.

Source: Laws 1994, LB 498, § 9; R.S.1943, (1999), § 83-1045.01; Laws 2004, LB 1083, § 53.

71-934. Outpatient treatment; hearing by board; warrant for custody of subject; subject's rights; board determination.

The Mental Health Board shall, upon motion of the county attorney, or may, upon its own motion, hold a hearing to determine whether a subject ordered by the board to receive outpatient treatment can be adequately and safely served by the individualized treatment plan for such subject on file with the board. The Mental Health Board may issue a warrant directing any law enforcement officer in the state to take custody of the subject and directing the sheriff or other suitable person to transport the subject to a treatment facility or public or private hospital with available capacity specified by the board where he or she will be held pending such hearing. No person may be held in custody under this section for more than seven days except upon a continuance granted by the board. At the time of execution of the warrant, the sheriff or other suitable person designated by the board shall personally serve upon the subject, the subject's counsel, and the subject's legal guardian or conservator, if any, a notice of the time and place fixed for the hearing, a copy of the motion for hearing, and a list of the rights provided by the Nebraska Mental Health Commitment Act. The subject shall be accorded all the rights guaranteed to a subject by the act. Following the hearing, the board shall determine whether outpatient treatment will be continued, modified, or ended.

Source: Laws 1994, LB 498, § 10; Laws 1996, LB 1155, § 107; R.S.1943, (1999), § 83-1045.02; Laws 2004, LB 1083, § 54.

71-935. Mental Health Board; review hearing; order discharge or change treatment disposition; when.

(1) Upon the filing of a periodic report under section 71-932, the subject, the subject's counsel, or the subject's legal guardian or conservator, if any, may request and shall be entitled to a review hearing by the Mental Health Board and to seek from the board an order of discharge from commitment or a change in treatment ordered by the board. The Mental Health Board shall schedule the review hearing no later than fourteen calendar days after receipt of such request. The Mental Health Board may schedule a review hearing (a) at any time pursuant to section 71-937 or 71-938, (b) upon the request of the subject, the subject's counsel, the subject's legal guardian or conservator, if any, the county attorney, the official, agency, or other person or entity designated by the Mental Health Board under section 71-931 to prepare and oversee the subject's individualized treatment plan, or the mental health professional directly involved in implementing such plan, or (c) upon the board's own motion.

(2) The board shall immediately discharge the subject or enter a new treatment order with respect to the subject whenever it is shown by any person or it appears upon the record of the periodic reports filed under section 71-932 to the satisfaction of the board that (a) cause no longer exists for the care or treatment of the subject or (b) a less restrictive treatment alternative exists for the subject. When discharge or a change in disposition is in issue, due process protections afforded under the Nebraska Mental Health Commitment Act shall attach to the subject.

Source: Laws 1976, LB 806, § 56; Laws 1994, LB 498, § 11; Laws 1996, LB 1155, § 108; R.S.1943, (1999), § 83-1046; Laws 2004, LB 1083, § 55.

Annotations

The Nebraska Mental Health Commitment Act clearly and plainly contemplates that due process be afforded at hearings other than the one held upon the filing of the initial petition. In re Interest of Powers, 242 Neb. 19, 493 N.W.2d 166 (1992).

Upon review of a commitment under this section, the State must prove by clear and convincing evidence that the individual remains mentally ill and dangerous. In re Interest of Dickson, 238 Neb. 148, 469 N.W.2d 357 (1991).

71-936. Regional center or treatment facility; administrator; discharge of involuntary patient; notice.

When the administrator of any regional center or treatment facility for the treatment of persons who are mentally ill or substance dependent determines that any involuntary patient in such facility may be safely and properly discharged or placed on convalescent leave, the administrator of such regional center or treatment facility shall immediately notify the Mental Health Board of the judicial district from which such patient was committed.

Source: Laws 1967, c. 251, § 16, p. 670; Laws 1981, LB 95, § 4; R.S.1943, (1999), § 83-340.01; Laws 2004, LB 1083, § 56.

71-937. Mental Health Board; notice of release; hearing.

A Mental Health Board shall be notified in writing of the release by the treatment facility of any individual committed by the Mental Health Board. Such notice shall immediately be forwarded to the county attorney. The Mental Health Board shall, upon the motion of the county attorney, or may upon its own motion, conduct a hearing to determine whether the individual is mentally ill and dangerous and consequently not a proper subject for release. Such hearing shall be conducted in accordance with the procedures established for hearings under the Nebraska Mental Health Commitment Act. The subject of such hearing shall be accorded all rights guaranteed to the subject of a petition under the act.

Source: Laws 1981, LB 95, § 26; Laws 2003, LB 724, § 10; R.S.Supp.,2003, § 83-1079; Laws 2004, LB 1083, § 57.

71-938. Mental Health Board; person released from treatment; compliance with conditions of release; conduct hearing; make determination.

The Mental Health Board shall, upon the motion of the county attorney, or may upon its own motion, hold a hearing to determine whether a person who has been ordered by the board to receive inpatient or outpatient treatment is adhering to the conditions of his or her release from such treatment, including the taking of medication. The subject of such hearing shall be accorded all rights guaranteed to a subject under the Nebraska Mental Health Commitment Act, and such hearing shall apply the standards used in all other hearings held pursuant to the act. If the Mental Health Board concludes from the evidence at the hearing that there is clear and convincing evidence that the subject is mentally ill and dangerous, the board shall so find and shall within forty-eight hours enter an order of final disposition providing for the treatment of such person in accordance with section 71-925.

Source: Laws 1981, LB 95, § 27; R.S.1943, (1999), § 83-1080; Laws 2004, LB 1083, § 58.

71-939. Escape from treatment facility or program; notification required; contents; warrant; execution; peace officer; powers.

When any person receiving treatment at a treatment facility or program for persons with mental illness or substance dependence pursuant to an order of a court or Mental Health Board is absent without authorization from such treatment facility or program, the administrator or program director of such treatment facility or program shall immediately notify the Nebraska State Patrol and the court or clerk of the Mental Health Board of the judicial district from which such person was committed. The notification shall include the person's name and description and a determination by a psychiatrist, clinical director, administrator, or program director as to whether the person is believed to be currently dangerous to others. The clerk shall issue the warrant of the board directed to the sheriff of the county for the arrest and detention of such person. Such warrant may be executed by the sheriff or any other peace officer. Pending the issuance of the warrant of the Mental Health Board, any peace officer may seize and detain such person when the peace officer has probable cause to believe that the person is reported to be absent without authorization as described in this section. Such person shall be returned to the treatment facility or program or shall be taken to a facility as described in section 71-919 until he or she can be returned to such treatment facility or program.

Source: Laws 1969, c. 215, § 10, p. 835; Laws 1976, LB 806, § 19; R.S.1943, (1994), § 83-308.02; Laws 1996, LB 1155, § 112; R.S.1943, (1999), § 83-1071; Laws 2004, LB 1083, § 59.

71-940. Person with mental illness or substance dependence; committed under other state's laws; return to other state; procedure; warrant issued.

The Governor may, upon demand from officials of another state, deliver to the executive authority of another state or his or her designee any person who is absent without authorization from a treatment facility or program for persons with mental illness or substance dependence to which such person has been committed under the laws of the other state either through civil commitment, as a result of being found not responsible for a criminal act by reason of insanity or mental illness, or as a result of being found not competent to stand trial for a criminal charge. The demand shall be accompanied by a certified copy of the commitment and sworn statement by the administrator of the treatment facility or program stating that (1) the person is absent without authorization, (2) the person is currently dangerous to himself, herself, or others, and (3) the demanding state is willing to accept the person back for further treatment. If the Governor is satisfied that the demand conforms to law, the Governor shall issue a warrant under seal of this state authorizing the return of such person to the demanding state at the expense of the demanding state.

Source: Laws 1996, LB 1155, § 113; R.S.1943, (1999), § 83-1072; Laws 2004, LB 1083, § 60.

71-941. Person with mental illness or substance dependence; arrested under warrant; notice; rights; writ of habeas corpus; hearing.

(1) A person arrested upon a warrant pursuant to section 71-940 shall not be delivered to a demanding state until he or she is notified of the demand for his or her surrender and has had an opportunity to apply for a writ of habeas corpus. If an application is filed, notice of the time and place for hearing on the writ shall be given to the county attorney of the county where the arrest was made. The person arrested shall have the right to counsel and the right to have counsel appointed for him or her if the person is indigent. Pending the determination of the court upon the application for the writ, the person detained shall be maintained in a suitable facility as described in section 71-919 or a hospital for persons with mental illness.

(2) At a hearing on a writ of habeas corpus, the State of Nebraska shall show that there is probable cause to believe that (a) such person is absent without authorization from a treatment facility or program for persons with mental illness or substance dependence to which he or she was committed located in the demanding state, (b) the demanding state has reason to believe that such person is currently dangerous to himself, herself, or others, and (c) the demanding state is willing to accept the person back for further treatment.

Source: Laws 1996, LB 1155, § 114; R.S.1943, (1999), § 83-1073; Laws 2004, LB 1083, § 61.

71-942. Person with mental illness, substance dependence, or personality disorder; dangerous sex offender; located outside state; demand return; procedure.

The Governor may appoint an agent to demand of the executive authority of another state any person who is located in such other state, who was receiving treatment at a treatment facility or program in this state pursuant to the Nebraska Mental Health Commitment Act, the Sex Offender Commitment Act, or section 29-1823, 29-2203, or 29-3701 to 29-3704, and who is absent without authorization from such treatment facility or program. The demand shall be accompanied by a certified copy of the order of commitment and a sworn statement by the administrator of the treatment facility or program stating that (1) the person is absent without authorization, (2) the administrator or program director of such treatment facility or program believes that such person is currently dangerous to himself, herself, or others, and (3) the treatment facility or program is willing to accept the person back for further treatment. This section does not prevent extradition under the Uniform Criminal Extradition Act if such act applies.

Source: Laws 1996, LB 1155, § 115; R.S.1943, (1999), § 83-1074; Laws 2004, LB 1083, § 62; Laws 2006, LB 1199, § 39.

Cross References

Sex Offender Commitment Act, see section 71-1201.
Uniform Criminal Extradition Act, see section 29-758.

71-943. Subjects' rights during proceedings against them.

In addition to the rights granted subjects by any other provisions of the Nebraska Mental Health Commitment Act, such subjects shall be entitled to the rights provided in sections 71-943 to 71-960 during proceedings concerning the subjects under the act.

Source: Laws 1976, LB 806, § 57; Laws 2000, LB 884, § 10; R.S.Supp.,2002, § 83-1047; Laws 2004, LB 1083, § 63.

71-944. Subject's rights; written notice of the time and place of hearing; reasons alleged for treatment; procedure.

A subject shall, in advance of the Mental Health Board hearing conducted under section 71-924 or 71-1208, be entitled to written notice of the time and place of such hearing, the reasons alleged for believing that he or she is mentally ill and dangerous or a dangerous sex offender requiring inpatient or outpatient treatment ordered by the Mental Health Board, and all rights to which such subject is entitled under the Nebraska Mental Health Commitment Act or the Sex Offender Commitment Act. The notice requirements shall be deemed satisfied by personal service upon the subject of the summons or notice of time and place of the hearing and copies of the petition and list of rights required by sections 71-923 and 71-924 or sections 71-1207 and 71-1208. If the subject has counsel and if the physician or mental health professional on the board determines that the nature of the alleged mental disorder or personality disorder, if true, is such that it is not prudent to disclose the label of the mental disorder or personality disorder to the subject, then notice of this label may be disclosed to the subject's counsel rather than to the subject. When the subject does not have counsel, the subject has a right to the information about his or her mental illness or personality disorder, including its label. The clerk shall issue the summons by order of the Mental Health Board.

Source: Laws 1976, LB 806, § 58; Laws 1981, LB 95, § 18; Laws 2000, LB 884, § 11; R.S.Supp.,2002, § 83-1048; Laws 2004, LB 1083, § 64; Laws 2006, LB 1199, § 40.

Cross References

Sex Offender Commitment Act, see section 71-1201.

71-945. Subject's rights; representation by counsel; appointment of counsel if indigent.

A subject shall have the right to be represented by counsel in all proceedings under the Nebraska Mental Health Commitment Act or the Sex Offender Commitment Act. Counsel for a subject who is in custody shall have full access to and the right to consult privately with the subject at all reasonable times. As soon as possible after a subject is taken into emergency protective custody under section 71-919, or after the filing of a petition under section 71-921 or 71-1205, whichever occurs first, and before the Mental Health Board hearing conducted under section 71-924 or 71-1208, the board shall determine whether the subject is indigent. If the subject is found to be indigent, the board shall certify that fact to the district or county court by causing to be delivered to the clerk of such court a certificate for appointment of counsel as soon as possible after a subject is taken into emergency protective custody or such petition is filed.

Source: Laws 1976, LB 806, § 59; Laws 1981, LB 95, § 19; Laws 2000, LB 884, § 12; R.S.Supp.,2002, § 83-1049; Laws 2004, LB 1083, § 65; Laws 2006, LB 1199, § 41.

Cross References

Sex Offender Commitment Act, see section 71-1201.

71-946. Appointment of counsel; procedure.

The appointment of counsel under section 71-945 shall be in accordance with the following procedures:

(1) Except in counties having a public defender, upon the receipt from the Mental Health Board of a certificate for the appointment of counsel, the clerk of the district court shall notify the district judge or the county judge of the county in which the proceedings are pending of the receipt of such certificate. The judge to whom the certificate was issued shall appoint an attorney to represent the person concerning whom an application is filed before the Mental Health Board, whereupon the clerk of the court shall enter upon the certificate the name of the attorney appointed and deliver the certificate of appointment of counsel to the Mental Health Board. The clerk of the district court or the clerk of the county court shall also keep and maintain a record of all appointments which shall be conclusive evidence thereof. All appointments of counsel under the Nebraska Mental Health Commitment Act or the Sex Offender Commitment Act may be made at any time or place in the state; and

(2) In counties having a public defender, upon receipt from the Mental Health Board of a certificate for the appointment of counsel, the clerk of the district court shall notify the public defender of his or her appointment to

represent the person and shall enter upon the certificate the name of the attorney appointed and deliver the certificate of appointment of counsel to the Mental Health Board.

Source: Laws 1976, LB 806, § 60; Laws 2000, LB 884, § 13; R.S.Supp.,2002, § 83-1050; Laws 2004, LB 1083, § 66; Laws 2006, LB 1199, § 42.

Cross References

Sex Offender Commitment Act, see section 71-1201.

71-947. Appointed counsel; fees; reimbursement of costs incurred; procedure.

Counsel appointed as provided in subdivision (1) of section 71-946 shall apply to the court in which his or her appointment is recorded for fees for services performed. Such counsel may also apply to the court to secure separate professional examination of the person for whom counsel was appointed and shall be reimbursed for costs incurred in securing such separate examination or examinations or in having other professional persons as witnesses before the Mental Health Board. The court, upon hearing the application, shall fix reasonable fees, including reimbursement of costs incurred. The county board of the county in which the application was filed shall allow the account, bill, or claim presented by the attorney for services performed under the Nebraska Mental Health Commitment Act or the Sex Offender Commitment Act in the amount determined by the court. No such account, bill, or claim shall be allowed by the county board until the amount thereof has been determined by the court.

Source: Laws 1976, LB 806, § 61; Laws 2000, LB 884, § 14; R.S.Supp.,2002, § 83-1051; Laws 2004, LB 1083, § 67; Laws 2006, LB 1199, § 43.

Cross References

Sex Offender Commitment Act, see section 71-1201.

71-948. Subject's rights; independent evaluation and assistance in proceedings; fees and expenses.

A subject or the subject's counsel shall have the right to employ mental health professionals of his or her choice to independently evaluate the subject's mental condition and testify for and otherwise assist the subject in proceedings under the Nebraska Mental Health Commitment Act or the Sex Offender Commitment Act. If the subject is indigent, only one such person may be employed except with leave of the Mental Health Board. Any person so employed by a subject determined by the board to be indigent, except a subject represented by the public defender, shall apply to the board for expenses reasonably necessary to such person's effective assistance of the subject and for reasonable fees for services performed by such person in assisting the subject. The board shall then fix reasonable fees and expenses, and the county board shall allow payment to such person in the full amount fixed by the board.

Source: Laws 1976, LB 806, § 62; Laws 1994, LB 1210, § 161; R.S.1943, (1999), § 83-1052; Laws 2004, LB 1083, § 68; Laws 2006, LB 1199, § 44.

Cross References

Sex Offender Commitment Act, see section 71-1201.

71-949. Counsel for subject; rights; enumerated; discovery; appeal from denial of discovery; when.

Counsel for a subject, upon request made to the county attorney at any time after the subject has been taken into emergency protective custody under the Nebraska Mental Health Commitment Act or the Sex Offender Commitment Act, or after the filing of a petition under section 71-921 or 71-1205, whichever occurs first, shall have the right to be provided with (1) the names of all witnesses expected to testify in support of the petition, (2) knowledge of the location and access at reasonable times for review or copying of all written documents including

reports of peace officers, law enforcement agencies, and mental health professionals, (3) access to all other tangible objects in the possession of the county attorney or to which the county attorney has access, and (4) written records of any treatment facility or mental health professional which or who has at any time treated the subject for mental illness, substance dependence, or a personality disorder, which records are relevant to the issues of whether the subject is mentally ill and dangerous or a dangerous sex offender and, if so, what treatment disposition should be ordered by the Mental Health Board. The board may order further discovery at its discretion. The county attorney shall have a reciprocal right to discover items and information comparable to those first discovered by the subject. The county court and district court shall have the power to rule on objections to discovery in matters which are not self-activating. The right of appeal from denial of discovery shall be at the time of the conclusion of the Mental Health Board hearing.

Source: Laws 1976, LB 806, § 63; Laws 1981, LB 95, § 20; R.S.1943, (1999), § 83-1053; Laws 2004, LB 1083, § 69; Laws 2006, LB 1199, § 45.

Cross References

Sex Offender Commitment Act, see section 71-1201.

71-950. Continuances; liberally granted.

Continuances shall be liberally granted at the request of the subject. Continuances may be granted to permit the subject to obtain voluntary treatment at a private facility.

Source: Laws 1976, LB 806, § 64; Laws 1985, LB 252, § 6; R.S.1943, (1999), § 83-1054; Laws 2004, LB 1083, § 70.

71-951. Mental Health Board hearings; closed to public; exception; where conducted.

All Mental Health Board hearings under the Nebraska Mental Health Commitment Act shall be closed to the public except at the request of the subject and shall be held in a courtroom or at any convenient and suitable place designated by the Mental Health Board. The board shall have the right to conduct the proceeding where the subject is currently residing if the subject is unable to travel.

Source: Laws 1976, LB 806, § 65; Laws 2000, LB 884, § 15; R.S.Supp.,2002, § 83-1055; Laws 2004, LB 1083, § 71.

Annotations

Mental Health Board hearings are closed to the public except at the request of the subject. In re Interest of Michael M., 6 Neb. App. 560, 574 N.W.2d 774 (1998).

71-952. Subject's rights; appear in person and testify in own behalf; present witnesses and evidence.

A subject shall appear personally and be afforded the opportunity to testify in his or her own behalf and to present witnesses and tangible evidence in defending against the petition at the hearing.

Source: Laws 1976, LB 806, § 66; Laws 1981, LB 95, § 21; R.S.1943, (1999), § 83-1056; Laws 2004, LB 1083, § 72.

71-953. Subject's rights; compulsory process to obtain testimony of witnesses.

A subject shall be entitled to compulsory process to obtain the testimony of witnesses in his or her favor.

Source: Laws 1976, LB 806, § 67; R.S.1943, (1999), § 83-1057; Laws 2004, LB 1083, § 73.

71-954. Subject's rights; confront and cross-examine adverse witnesses and evidence.

A subject shall have the right at a hearing held under the Nebraska Mental Health Commitment Act or the Sex Offender Commitment Act to confront and cross-examine adverse witnesses and evidence equivalent to the rights of confrontation granted by Amendments VI and XIV of the United States Constitution and Article I, section 11, of the Constitution of Nebraska.

Source: Laws 1976, LB 806, § 68; Laws 1981, LB 95, § 22; Laws 2000, LB 884, § 16; R.S.Supp.,2002, § 83-1058; Laws 2004, LB 1083, § 74; Laws 2006, LB 1199, § 46.

Cross References

Sex Offender Commitment Act, see section 71-1201.

Annotations

Pursuant to this section, the subject of a petition under the Nebraska Mental Health Commitment Act has the right to confront and cross-examine adverse witnesses and evidence equivalent to the rights granted under the Confrontation Clauses of the U.S. and Nebraska Constitutions. In the absence of a waiver by the subject of a petition for commitment of his or her right to confrontation, in order to admit the telephonic testimony of a mental health professional during a civil commitment hearing, the State must demonstrate that (1) such testimony is necessary to further an important public policy and (2) the mental health professional is truly unavailable as a witness, thus necessitating telephonic testimony. The requirements of a demonstration of an important public policy and necessity are conjunctive, and the absence of a demonstration of either precludes the admission of the telephonic testimony. In re Interest of S.B., 263 Neb. 175, 639 N.W.2d 78 (2002).

71-955. Hearings; rules of evidence applicable.

The rules of evidence applicable in civil proceedings shall apply at all hearings held under the Nebraska Mental Health Commitment Act. In no event shall evidence be considered which is inadmissible in criminal proceedings.

Source: Laws 1976, LB 806, § 69; Laws 1981, LB 95, § 23; Laws 2000, LB 884, § 17; R.S.Supp.,2002, § 83-1059; Laws 2004, LB 1083, § 75.

Annotations

The transcript of the proceeding before a Mental Health Board may not be treated as evidence before the board, the district court, or this court unless the facts in the transcript are offered as evidence, are not objected to, and are received by the trier of fact. In re Interest of Kinnebrew, 224 Neb. 885, 402 N.W.2d 264 (1987).

This statute makes the general rules of evidence applicable to proceedings under the Mental Health Commitment Act. In re Interest of Blythman, 208 Neb. 51, 302 N.W.2d 666 (1981).

This section does not mandate Miranda-type warnings precede a psychiatric interview by a doctor. Kraemer v. Mental Health Board of the State of Nebraska, 199 Neb. 784, 261 N.W.2d 626 (1978).

71-956. Subject's rights; written statements; contents.

A subject shall be entitled to written statements by the Mental Health Board as to the evidence relied on and reasons (1) for finding clear and convincing evidence at the subject's hearing that he or she is mentally ill and dangerous or a dangerous sex offender and that neither voluntary hospitalization nor other treatment alternatives less restrictive of the subject's liberty than inpatient or outpatient treatment ordered by the Mental Health Board are available or would suffice to prevent the harm described in section 71-908 or subdivision (1) of section 83-174.01 and (2) for choosing the particular treatment specified by its order of final disposition. The Mental Health Board shall make similar written findings when it orders a subject held in custody rather than released on conditions pending hearings to determine whether he or she is mentally ill and dangerous or a dangerous sex offender and in need of treatment ordered by the Mental Health Board or pending the entry of an order of final disposition under section 71-925 or 71-1209.

Source: Laws 1976, LB 806, § 70; Laws 1981, LB 95, § 24; R.S.1943, (1999), § 83-1060; Laws 2004, LB 1083, § 76; Laws 2006, LB 1199, § 47.

71-957. Proceedings shall be of record; reporter; expenses and fees.

All proceedings held under the Nebraska Mental Health Commitment Act or the Sex Offender Commitment Act shall be of record, and all oral proceedings shall be reported verbatim by either a qualified shorthand reporter or by tape-recording equipment equivalent in quality to that required in county courts by section 25-2732. The written findings of the Mental Health Board shall be part of the subject's records and shall be available to the parties in the case and to the treatment facility where the subject is receiving treatment pursuant to a commitment order of the Mental Health Board under section 71-925 or 71-1209. Any qualified shorthand reporter who reports proceedings presided over by a board or otherwise than in his or her capacity as an official district court stenographic reporter shall apply to the court for reasonable expenses and fees for services performed in such hearings. The court shall fix reasonable expenses and fees, and the county board shall allow payment to the reporter in the full amount fixed by the court.

Source: Laws 1976, LB 806, § 71; Laws 2000, LB 884, § 18; R.S.Supp.,2002, § 83-1061; Laws 2004, LB 1083, § 77; Laws 2006, LB 1199, § 48.

Cross References

Sex Offender Commitment Act, see section 71-1201.

71-958. Qualified mental health professional; provide medical treatment to subject; when.

Any qualified mental health professional, upon being authorized by the administrator of the treatment facility having custody of the subject, may provide appropriate medical treatment for the subject while in custody, except that a subject shall not be subjected to such quantities of medication or other treatment within such period of time prior to any hearing held under the Nebraska Mental Health Commitment Act or the Sex Offender Commitment Act as will substantially impair his or her ability to assist in his or her defense at such hearing.

Source: Laws 1976, LB 806, § 72; Laws 2000, LB 884, § 19; R.S.Supp.,2002, § 83-1062; Laws 2004, LB 1083, § 78; Laws 2006, LB 1199, § 49.

Cross References

Mistreatment of mentally ill person, penalty, see section 83-356.
Sex Offender Commitment Act, see section 71-1201.

71-959. Subject in custody or receiving treatment; rights; enumerated.

A subject in custody or receiving treatment under the Nebraska Mental Health Commitment Act or the Sex Offender Commitment Act has the right:

(1) To be considered legally competent for all purposes unless he or she has been declared legally incompetent. The Mental Health Board shall not have the power to declare an individual incompetent;

(2) To receive prompt and adequate evaluation and treatment for mental illness, personality disorders, and physical ailments and to participate in his or her treatment planning activities to the extent determined to be appropriate by the mental health professional in charge of the subject's treatment;

(3) To refuse treatment medication, except (a) in an emergency, such treatment medication as is essential in the judgment of the mental health professional in charge of such treatment to prevent the subject from causing injury to himself, herself, or others or (b) following a hearing and order of a Mental Health Board, such treatment medication as will substantially improve his or her mental illness or personality disorder or reduce the risk posed to the public by a dangerous sex offender;

(4) To communicate freely with any other person by sealed mail, personal visitation, and private telephone conversations;

(5) To have reasonably private living conditions, including private storage space for personal belongings;

(6) To engage or refuse to engage in religious worship and political activity;

(7) To be compensated for his or her labor in accordance with the federal Fair Labor Standards Act, 29 U.S.C. 206, as such section existed on January 1, 2004;

(8) To have access to a patient grievance procedure; and

(9) To file, either personally or by counsel, petitions or applications for writs of habeas corpus for the purpose of challenging the legality of his or her custody or treatment.

Source: Laws 1976, LB 806, § 76; Laws 2000, LB 884, § 21; R.S.Supp.,2002, § 83-1066; Laws 2004, LB 1083, § 79; Laws 2006, LB 1199, § 50.

Cross References

Sex Offender Commitment Act, see section 71-1201.

Annotations

The determination of what constitutes "prompt and adequate" treatment, as those terms are used in subsection (2) of this section, will inherently be a factual determination to be made based on the evidence and circumstances presented in each particular case. Navarette v. Settle, 10 Neb. App. 479, 633 N.W.2d 588 (2001).

71-960. Subject; waive rights; manner.

A subject may waive any of the proceedings or rights incident to proceedings granted him or her under the Nebraska Mental Health Commitment Act or the Sex Offender Commitment Act by failing to request any right expressly required to be requested but, in the case of all other such rights, only if the record reflects that such waiver was made personally, intelligently, knowingly, understandingly, and voluntarily by the subject and such subject's legal guardian or conservator, if any. Such rights may otherwise be denied only by a Mental Health Board or court order for good cause shown after notice to the subject, the subject's counsel, and such subject's guardian or conservator, if any, and an opportunity to be heard. If the Mental Health Board determines that the subject is not able to waive his or her rights under this section, it shall be up to the discretion of the subject's counsel to exercise such rights. When the subject is not represented by counsel, the rights may not be waived.

Source: Laws 1976, LB 806, § 74; Laws 1996, LB 1155, § 109; Laws 2000, LB 884, § 20; R.S.Supp.,2002, § 83-1064; Laws 2004, LB 1083, § 80; Laws 2006, LB 1199, § 51.

Cross References

Sex Offender Commitment Act, see section 71-1201.

71-961. Subject's records; confidential; exceptions.

(1) All records kept on any subject shall remain confidential except as otherwise provided by law. Such records shall be accessible to (a) the subject, except as otherwise provided in subsection (2) of this section, (b) the subject's legal counsel, (c) the subject's guardian or conservator, if any, (d) the Mental Health Board having jurisdiction over the subject, (e) persons authorized by an order of a judge or court, (f) persons authorized by written permission of the subject, (g) agents or employees of the Department of Health and Human Services upon delivery of a subpoena from the department in connection with a licensing or licensure investigation by the department, (h) individuals authorized to receive notice of the release of a sex offender pursuant to section 83-174, (i) the Nebraska State Patrol or the department pursuant to section 69-2409.01, or (j) the Office of Parole Administration if the subject meets the requirements for lifetime community supervision pursuant to section 83-174.03.

(2) Upon application by the county attorney or by the administrator of the treatment facility where the subject is in custody and upon a showing of good cause therefor, a judge of the district court of the county where the Mental Health Board proceedings were held or of the county where the treatment facility is located may order that the records not be made available to the subject if, in the judgment of the court, the availability of such records to the subject will adversely affect his or her mental illness or personality disorder and the treatment thereof.

(3) When a subject is absent without authorization from a treatment facility or program described in section 71-939 or 71-1223 and is considered to be dangerous to others, the subject's name and description and a statement that the subject is believed to be considered dangerous to others may be disclosed in order to aid in the subject's apprehension and to warn the public of such danger.

Source: Laws 1976, LB 806, § 78; Laws 1996, LB 1055, § 17; Laws 1996, LB 1155, § 111; Laws 1997, LB 307, § 230; R.S.1943, (1999), § 83-1068; Laws 2004, LB 1083, § 81; Laws 2006, LB 1199, § 52; Laws 2007, LB296, § 463.

71-962. Violations; penalty.

Any person who willfully (1) files or causes to be filed a certificate or petition under the Nebraska Mental Health Commitment Act or the Sex Offender Commitment Act, knowing any of the allegations thereof to be false, (2) deprives a subject of any of the rights granted the subject by either act or section 83-390, or (3) breaches the confidentiality of records required by section 71-961 shall be guilty of a Class II misdemeanor in addition to any civil liability which he or she may incur for such actions.

Source: Laws 1976, LB 806, § 79; Laws 1977, LB 41, § 63; Laws 2000, LB 884, § 22; R.S.Supp.,2002, § 83-1069; Laws 2004, LB 1083, § 82; Laws 2006, LB 1199, § 53.

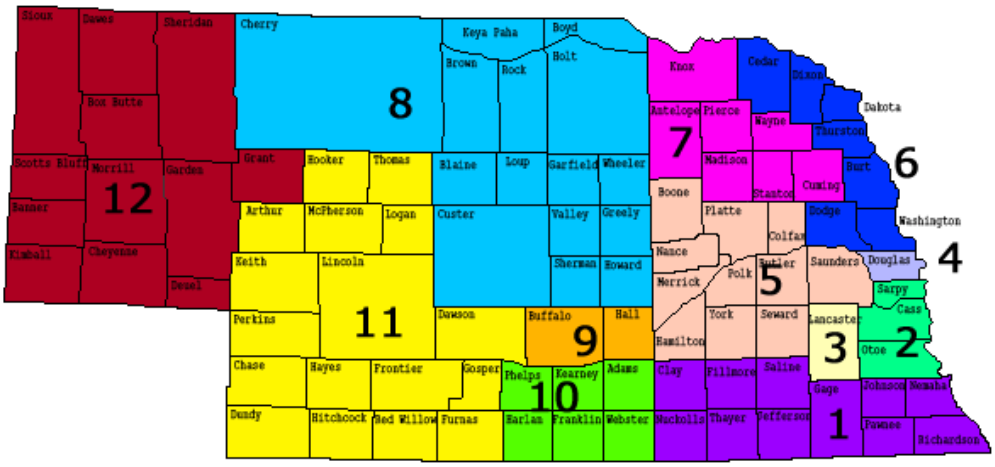
Cross References

Sex Offender Commitment Act, see section 71-1201.

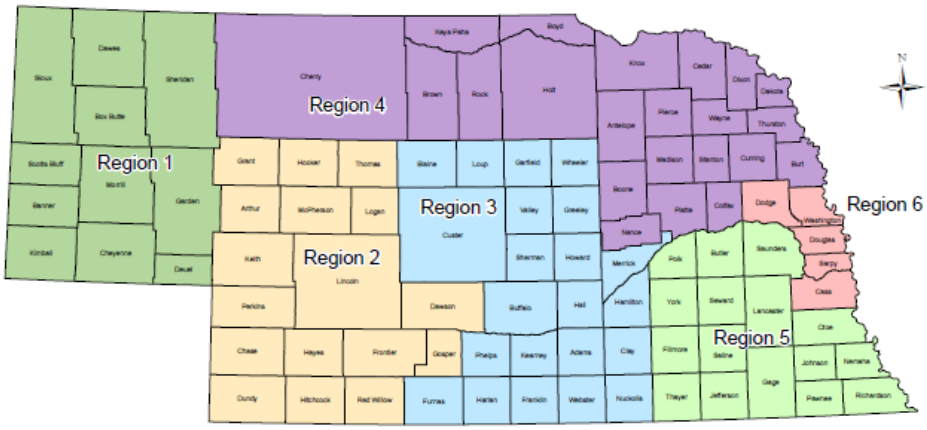
Annotations

The Nebraska Mental Health Commitment Act provides for a criminal penalty for any person who willfully breaches the confidentiality of records as required by section 83-1068, in addition to any civil liability which may be incurred by such acts. In re Interest of Michael M., 6 Neb. App. 560, 574 N.W.2d 774 (1998).

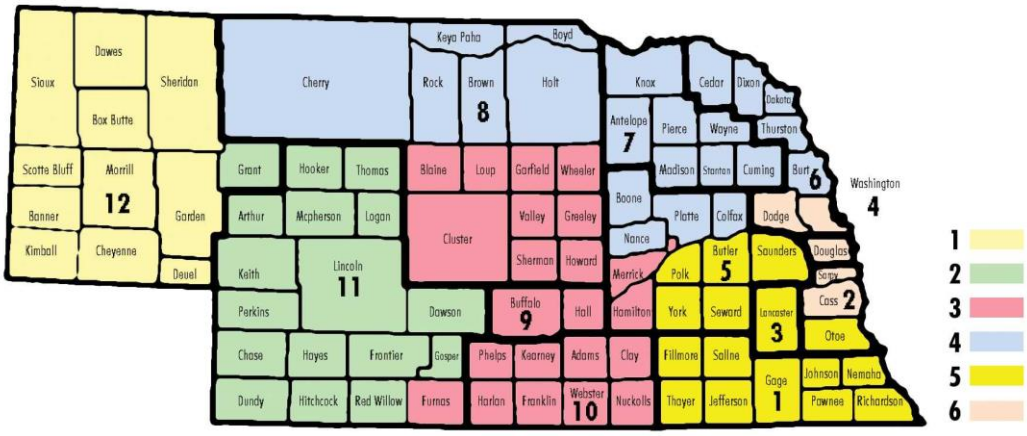
APPENDIX B
NEBRASKA JUDICIAL AND REGIONAL BEHAVIORAL HEALTH AUTHORITY MAPS



Nebraska Judicial District Map



Nebraska Behavioral Health Regional Map



Nebraska Judicial & Behavioral Health Regional Map

APPENDIX C
GLOSSARY OF TERMS

Addiction or Mental Health Only Services: Programs that "either by choice or lack of resources (staff or financial), cannot accommodate patients" who have co-occurring disorders that require "ongoing treatment, however stable the illness and however well-functioning the patient." (ASAM)

Administrator: The administrator or other chief administrative officer of a treatment facility or his or her designee (71-904).

ASAM: American Society of Addiction Medicine/Placement Criteria

Behavioral Health Disorder: means mental illness or alcoholism, drug abuse, problem gambling, or other addictive disorder (71-804).

Behavioral Health Region: means a Regional Behavioral Health Authority established in section 71-807

(1) Region 1 shall consist of Sioux, Dawes, Box Butte, Sheridan, Scotts Bluff, Morrill, Garden, Banner, Kimball, Cheyenne, and Deuel counties;
(2) Region 2 shall consist of Grant, Hooker, Thomas, Arthur, McPherson, Logan, Keith, Lincoln, Perkins, Chase, Hayes, Frontier, Dawson, Gosper, Dundy, Hitchcock, and Red Willow counties;
(3) Region 3 shall consist of Blaine, Loup, Garfield, Wheeler, Custer, Valley, Greeley, Sherman, Howard, Buffalo, Hall, Phelps, Kearney, Adams, Clay, Furnas, Harlan, Hamilton, Merrick, Franklin, Webster, and Nuckolls counties;
(4) Region 4 shall consist of Cherry, Keya Paha, Boyd, Brown, Rock, Holt, Knox, Cedar, Dixon, Dakota, Thurston, Wayne, Pierce, Antelope, Boone, Nance, Madison, Stanton, Cuming, Burt, Colfax, and Platte counties;
(5) Region 5 shall consist of Polk, Butler, Saunders, Seward, Lancaster, Otoe, Fillmore, Saline, Thayer, Jefferson, Gage, Johnson, Nemaha, Pawnee, York, and Richardson counties; and
(6) Region 6 shall consist of Dodge, Washington, Douglas, Sarpy, and Cass counties.

Behavioral Health Services: means services, including, but not limited to, consumer-provided services, support services, inpatient and outpatient services, and residential and nonresidential services, provided for the prevention, diagnosis, and treatment of behavioral health disorders and the rehabilitation and recovery of persons with such disorders (71-804)

Civil Protective Custody (CPC): City police, county sheriffs, officers of the Nebraska State Patrol, and any other such law enforcement officer with power to arrest for traffic violations may take a person who is intoxicated and in the judgment of the officer dangerous to himself, herself, or others, or who is otherwise incapacitated, from any public or quasi-public property. An officer removing an intoxicated person from public or quasi-public property shall make a reasonable effort to take such intoxicated person to his or her home or to place such person in any hospital, clinic, alcoholism center, or with a medical doctor as may be necessary to preserve life or to prevent injury. Such effort at placement shall be deemed reasonable if the officer contacts those facilities or doctors which have previously represented a willingness to accept and treat such individuals and which regularly do accept such individuals. If such efforts are unsuccessful or are not feasible, the officer may then place such intoxicated person in civil protective custody, except that civil protective custody shall be used only as long as is necessary to preserve life or to prevent injury, and under no circumstances for longer than twenty-four hours (53-1, 121)

Community-based Behavioral Health Services or Community-based Services: means behavioral health services that are not provided at a regional center (71-804)

Co-Occurring Disorders (COD): Refers to co-occurring substance-related and mental disorders. Persons said to have COD have one or more substance-related disorders as well as one or more mental disorders. At the individual level, COD exist when at least one disorder of each type can be established independent of the other and is not simply a cluster of symptoms resulting from a single disorder. (Center for Substance Abuse Treatment)

Crisis Center – Region 5: A Crisis Center is designed to provide custody, screening, emergency mental health evaluation, and crisis intervention to individuals placed in emergency protective custody under the auspices of Nebraska Mental Health Commitment Act by law enforcement. Crisis Stabilization services include immediate, short-term, individualized, crisis-oriented treatment and recovery needed to stabilize acute symptoms of mental illness, alcohol and/or other drug abuse, and/or emotional distress. Individuals in need exhibit a psychiatric and/or substance abuse crisis as defined under the Commitment Act at risk for harm to self/others and need short-term, protected, supervised services. The intent of the service is to treat and support the individual throughout the crisis; provide crisis assessment and interventions; medication management; linkages to needed behavioral health services; and assist in transition back to the individual's typical living situation. (Service Definition)

Crisis Stabilization: Crisis Stabilization is intended to provide immediate, short-term, individualized, crisis-oriented treatment and recovery needed to stabilize acute symptoms of mental illness, alcohol and/or other drug abuse, and/or emotional distress. Individuals in need exhibit a psychiatric and/or substance abuse crisis with a moderate to high risk for harm to self/others and need short-term, protected, supervised, residential placement. The intent of the service is to treat and support the individual throughout the crisis; provide crisis assessment and interventions; medication management; linkages to needed behavioral health services; and assist in transition back to the individual's typical living situation. (Service Definition)

Developmental Disability (DD): (83-1205-Developmental Disabilities Services Act)
Developmental disability shall mean:
(1) Intellectual disability; or
(2) A severe, chronic disability other than an intellectual disability or mental illness which:
- (a) Is attributable to a mental or physical impairment other than a mental or physical impairment caused solely by mental illness;
- (b) Is manifested before the age of twenty-two years;
- (c) Is likely to continue indefinitely; and
- (d) Results in:
  - (i) In the case of a person under three years of age, at least one developmental delay; or
  - (ii) In the case of a person three years of age or older, a substantial limitation in three or more of the following areas of major life activity, as appropriate for the person's age:
    - (A) Self-care;
    - (B) Receptive and expressive language development and use;
    - (C) Learning;
    - (D) Mobility;
    - (E) Self-direction;
    - (F) Capacity for independent living; and
    - (G) Economic self-sufficiency.

*Other definitions in state statutes relating to developmental disabilities:
71-1107. Developmental disability, defined.

Developmental disability means an intellectual disability or a severe chronic cognitive impairment, other than mental illness, that is manifested before the age of twenty-two years and is likely to continue indefinitely.
71-1110. Intellectual disability, defined.
Intellectual disability means a state of significantly sub average general intellectual functioning existing concurrently with deficits in adaptive behavior which originates in the developmental period.
71-1113. Severe chronic cognitive impairment, defined.
Severe chronic cognitive impairment means clinically significant difficulties in the ability to remember, think, perceive, apply sound judgment, and adequately use deductive reasoning not attributable to a mental illness.

DHHS: means the Department of Health and Human Services (71-804)

Director: means the Director of the Division of Behavioral Health (71-804)

Division: means the Division of Behavioral Health (71-804)

Dual Diagnosis Capable (DDC) Programs: Programs that address co-occurring mental and substance-related disorders in their policies and procedures, assessment, treatment plan, program content and discharge planning. Even where such programs are geared primarily toward treating substance use or mental health disorders, program staff is able to address the interaction between mental and substance-related disorders and their effect on the person's readiness to change-as well as relapse and recovery environment issues-through individual and group program content. (ASAM)

Dual Diagnosis Enhanced (DDE) Programs: Programs which have a higher level of integration of substance abuse and mental health treatment services. These programs are able to provide unified substance abuse and mental health treatment to consumers who are compared to those treatable in DDC programs, more symptomatic and/or functionally impaired as a result of their co-occurring mental disorder. Enhanced-level services place their primary focus on the integration of services for mental and substance-related disorders in their staffing, services and program content." (ASAM)

Emergency Protective Custody (EPC): A law enforcement officer who has probable cause to believe that a person is mentally ill and dangerous or a dangerous sex offender and that the harm described in section 71-908 or subdivision (1) of section 83-174.01 is likely to occur before Mental Health Board proceedings under the Nebraska Mental Health Commitment Act or the Sex Offender Commitment Act may be initiated to obtain custody of the person may take such person into emergency protective custody, cause him or her to be taken into emergency protective custody, or continue his or her custody if he or she is already in custody. Such person shall be admitted to an appropriate and available medical facility, jail, or Department of Correctional Services facility as provided in subsection (2) of this section. Each county shall make arrangements with appropriate facilities inside or outside the county for such purpose and shall pay the cost of the emergency protective custody of persons from such county in such facilities. A mental health professional who has probable cause to believe that a person is mentally ill and dangerous or a dangerous sex offender may cause such person to be taken into custody and shall have a limited privilege to hold such person until a law enforcement officer or other authorized person arrives to take custody of such person. (71-919)

Frequency of Danger: A factor when considering risks of dangerousness. Future violence is best predicted by past violence, as mentioned in likelihood of violence. The frequency of occurrence is a clear indicator that a pattern has been set and may be reoccurring.

Imminence of Danger: how soon the danger might occur, is contained in the statute's description as "near future." Each Mental Health Board should have a working consensus of the definition of imminent—whether it is defined as right now, or within twenty-four hours, the most commonly used time frame. Having this time definition set before being placed under pressure to make a decision regarding a commitment is helpful. The sooner violence may occur, the greater the risk of danger due to not having a chance to mitigate circumstances or provide protection.

Likelihood of Dangerousness: The probability of occurrence of violence. While the best predictor of violence is past history of violence, research has shown that there are eight demographic elements which correlate statistically with an increased risk of violence:

1. Age: Violence peaks in the late teens and early 20's
2. Gender: Males are more violent than females. However, among the SPMI mentally ill population (Severely and Persistently Mentally Ill), the ratio of violent and aggressive acts is the same for males and females
3. Social Class: Lower socio-economic class members experience more street violence
4. IQ: Individuals with lower IQ's demonstrate more violence which may be related to an inability to talk out concerns or articulate needs
5. Education: Lower levels of educational achievement are associated with more violence
6. Employment: Risk of violence increases with job instability
7. Residence: Risk of violence increases with frequent changes of residence
8. Substance abuse: Use of marijuana, alcohol, and other drugs increases the risk of violent behavior three-fold; especially use of stimulants such as methamphetamine which reduce inhibitions and increase paranoia

Magnitude of Danger: Concerns the level of danger presented. For example, threats to harm people would be considered more dangerous than threats to harm property; threats of physical harm to others would be more serious than psychological threats. The use of a weapon escalates the risk of danger, of course, but the choice of weapon must be taken into consideration. The harm posed by a gun would be greater than that posed by a knife because a gun is five times more likely to cause death than a knife.

Medical Assistance Program: The medical assistance program is established, which shall also be known as Medicaid. (68-903)

Medicaid: The Legislature finds that (1) many low-income Nebraska residents have health care and related needs and are unable, without assistance, to meet such needs, (2) publicly funded medical assistance provides essential coverage for necessary health care and related services for eligible low-income Nebraska children, pregnant women and families, aged persons, and persons with disabilities, (3) publicly funded medical assistance alone cannot meet all of the health care and related needs of all low-income Nebraska residents, (4) the State of Nebraska cannot sustain a rate of growth in medical assistance expenditures that exceeds the rate of growth of General Fund revenue, (5) policies must be established for the medical assistance program that will effectively address the health care and related needs of eligible recipients and effectively moderate the growth of medical assistance expenditures, and (6) publicly funded medical assistance must be integrated with other public and private health care and related initiatives providing access to health care and related services for Nebraska residents. (68-904)

Medication-Assisted Treatment (MAT): MAT is the use of medications, in combination with counseling and behavioral therapies, to provide a whole-patient approach to the treatment of substance use disorders. Research shows that when treating substance-use disorders, a combination of medication and behavioral therapies is most successful. Medication assisted treatment (MAT) is clinically driven with a focus on individualized patient care.

Mental Health Board: A board created under section 71-915

Mental Health Professional: A person licensed to practice medicine and surgery or psychology in this state under the Uniform Licensing Law or an advanced practice registered nurse licensed under the Advanced Practice Registered Nurse Act who has proof of current certification in a psychiatric or mental health specialty. (Section 71-906)
This definition is in relation to who is qualified by law to submit a certificate regarding an individual's mental health status for a Mental Health Board proceeding. It is not intended to include all levels of professionals commonly referred to as mental health professionals. For the purposes of this document, those qualified to submit the certificate are referred to as Mental Health Professionals (MHP).

Mentally Ill: Person having a psychiatric disorder that involves a severe or substantial impairment of a person's thought processes, sensory input, mood balance, memory, or ability to reason which substantially interferes with such person's ability to meet the ordinary demands of living or interferes with the safety or well-being of others (71-907)

Mentally Ill and Dangerous: A person who is mentally ill or substance dependent and because of such mental illness or substance dependence presents:

1. A substantial risk of serious harm to another person or persons within the near future as manifested by evidence of recent violent acts or threats of violence or by placing others in reasonable fear of such harm; or
2. A substantial risk of serious harm to himself or herself within the near future as manifested by evidence of recent attempts at, or threats of, suicide or serious bodily harm or evidence of inability to provide for his or her basic human needs, including food, clothing, shelter, essential medical care, or personal safety. (71-908)

Annotations

1. Requirements of section
    - Involuntary commitment as a mentally ill dangerous person is improper when, although a person is clearly mentally ill, there is no showing of dangerousness. Petersen v. County Board of Mental Health, 203 Neb. 622, 279 N.W.2d 844 (1979).
    - Showing that a person is a spendthrift and improvident is insufficient to demonstrate dangerousness as required by this statute. Petersen v. County Board of Mental Health, 203 Neb. 622, 279 N.W.2d 844 (1979).
    - The requirements of this section, which defines a mentally ill dangerous person, are met when medical diagnoses of paranoid schizophrenia and an unprovoked assault and threatening behavior are shown by clear and convincing proof. Lux v. Mental Health Board of Polk County, 202 Neb. 106, 274 N.W.2d 141 (1979).
2. Evidentiary issues
    - There is no definite time-oriented period to determine whether an act is recent for the purposes of this section. Each case must be decided on the basis of the surrounding facts and circumstances. In re Interest of Kochner, 266 Neb. 114, 662 N.W.2d 195 (2003).
    - To meet the definition of a mentally ill dangerous person, the State must show that the person suffers from a mental illness and that the person presents a substantial risk of harm to others or to himself or herself. In re Interest of Kochner, 266 Neb. 114, 662 N.W.2d 195 (2003).
    - A person who is mentally retarded does not fall within the definition of "mentally ill dangerous person" unless there is a secondary diagnosis of mental illness. In re Interest of Wickwire, 259 Neb. 305, 609 N.W.2d 384 (2000).

- Actions and statements of a person alleged to be mentally ill and dangerous which occur prior to the hearing are probative of the subject's present mental condition. However, in order for a past act to have any evidentiary value, it must form some foundation for a prediction of future dangerousness and be, therefore, probative of that issue. In re Interest of Rasmussen, 236 Neb. 572, 462 N.W.2d 621 (1990).
- In proving the dangerousness of a mentally ill person as manifested by "evidence of inability to provide for his basic human needs," within the meaning of this section, expert testimony may be used to prove such a condition. In re Interest of Kinnebrew, 224 Neb. 885, 402 N.W.2d 264 (1987).
- An act occurring five years prior to the mental health commitment hearing is recent within the meaning of this section where: (a) There is evidence that the act is still probative of the subject's future dangerousness; (b) the subject has not had an opportunity to commit a more recent act because he has been in confinement; and (c) there is reliable medical evidence that there is a high probability of repetition of such act by the subject. Under Mental Health Commitment Act, the determination of whether an act of violence is recent must be decided on the basis of all the surrounding facts and circumstances. In re Interest of Blythman, 208 Neb. 51, 302 N.W.2d 666 (1981).
- An act or threat is "recent" within the meaning of this section, if the time interval between it and the hearing of the Mental Health Board is not greater than that which would indicate processing of the complaint was carried on with reasonable diligence under the circumstances existing having due regard for the rights and welfare of the alleged mentally ill dangerous person and the protection of society in general. Hill v. County Board of Mental Health, Douglas County, 203 Neb. 610, 279 N.W.2d 838 (1979).
- Although this section refers to "recent violent acts," commitment may be based upon evidence of only one violent act or threat. Lux v. Mental Health Board of Polk County, 202 Neb. 106, 274 N.W.2d 141 (1979).

3. Standard of proof
    - The State must prove by clear and convincing evidence that an individual poses a substantial risk of harm to others or to himself to have that individual declared mentally ill and dangerous under the Nebraska Mental Health Commitment Act. In re Interest of Dickson, 238 Neb. 148, 469 N.W.2d 357 (1991).
    - Evidence must be clear and convincing to support a finding that a person is mentally ill and dangerous. In re Interest of Rasmussen, 236 Neb. 572, 462 N.W.2d 621 (1990).
4. Constitutionality
    - The definitions of mentally ill dangerous persons in the Nebraska Mental Health Commitment Act and the statutes governing persons acquitted of a crime on grounds of insanity are constitutional and do not violate equal protection guarantees. Tulloch v. State, 237 Neb. 138, 465 N.W.2d 448 (1991).
5. Appeal
    - An order adjudicating an individual as a mentally ill dangerous person pursuant to this section and ordering that person retained for an indeterminate amount of time is an order affecting a substantial right in a special proceeding from which an appeal may be taken. In re Interest of Saville, 10 Neb. App. 194, 626 N.W.2d 644 (2001).

<u>Outpatient Treatment</u>: Treatment ordered by a Mental Health Board directing a subject to comply with specified outpatient treatment requirements, including, but not limited to, (1) taking prescribed medication, (2) reporting to a mental health professional or treatment facility for treatment or for monitoring of the subject's condition, or (3) participating in individual or group therapy or educational, rehabilitation, residential, or vocational programs. (71-906)

Paraphilia's: Feature recurrent, intense, sexually arousing fantasies, sexual urges, or behaviors, generally involving non-human objects, suffering or humiliation of oneself or one's partner, children, or other non-consenting persons, that occurs over a period of at least 6 months.
Individuals with exhibitionism, pedophilia and voyeurism make up the majority of apprehended sex offenders.

> Exhibitionism involves the exposure of one's genitals to a stranger. Sometimes the individual master bates while exposing himself. If the person acts on these urges, there is generally no attempt at further sexual activity with the stranger.
> Voyeurism involves the act of observing unsuspecting individuals, usually strangers, who are naked, in the process of disrobing or engaging in sexual activity. The act of looking ("peeping") is for the purpose of achieving sexual excitement and generally no sexual activity with the observed person is sought. The behavior often is accompanied by masturbation.
> Pedophilia involves sexual activity with a pre-pubescent child (generally age 13 years or younger). The individual with pedophilia must be age 16 years or older and at least 5 years older than the child. For individuals in late adolescence with pedophilia, no precise age difference is specified. People with pedophilia generally report an attraction to children of a particular age range. Some prefer males, some females, some both. Some are also attracted to adults. The course is usually chronic, especially in those attracted to males. The recidivism rate for persons with a preference for males is roughly twice that for those who prefer females. (Pedophilia is often associated with co-occurring antisocial or schizotypal personality disorder.)
> Sexual sadism involves acts in which the individual derives sexual excitement from the psychological or physical suffering (including humiliation) of the non-consenting person. The activity is likely to be repeated until the person is apprehended. Usually the severity of the sadistic acts increases over time. When sexual sadism is severe, and especially when associated with antisocial personality disorder, individuals my seriously injure or kill their victims. (DSM)

Peace Officer or Law Enforcement Officer: A sheriff, a jailer, a marshal, a police officer, or an officer of the Nebraska State Patrol.

Personality Disorder: An enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment. Antisocial personality disorder represents a pervasive pattern of disregard for, and violation of, the rights of others that begins in childhood or early adolescence and continues into adulthood. Deceit and manipulation are central features. There is also a failure to conform to social norms with respect to lawful behaviors, impulsivity, irritability and aggressiveness, reckless disregard for the safety of others, consistent irresponsibility and a lack of remorse for their actions. Schizotypal personality disorder is a pervasive pattern of social and interpersonal deficits marked by acute discomfort with, and reduced capacity for, close relationships as well as cognitive or perceptual distortions and eccentricities of behavior, beginning in early adulthood. Individuals with schizotypal personality disorder often have ideas of reference, odd beliefs, odd thinking, suspiciousness, odd behavior, lack of close friends, and excessive social anxiety. (DSM)

Public behavioral health system: means the statewide array of behavioral health services for children and adults provided by the public sector or private sector and supported in whole or in part with funding received and administered by DHHS, including behavioral health services provided under the Medical Assistance Program (71-804)

Quadrants of Care: A conceptual framework referred to as 'Quadrants of Care' classifies COD care into four quadrants based on relative symptom severity, not diagnosis. The model provides a framework for understanding the range of co-occurring conditions and a potential need for treatment. (Center for Substance Abuse Treatment) The four quadrants are:

1. Low addiction/low mental illness severity
2. Low addition/high mental illness
3. High addiction/low mental illness
4. High addition/high mental illness

Recovery: Recovery is a process of healing the mind, body, and spirit; inclusive of transformation of the individuals with behavioral health conditions (consumers), family and friends, communities, and care systems to equip the person with choices and the rights of all citizens. This transformation or change can influence individual goals, roles, skills, attitudes that result in moving from hopelessness to hopeful life, dysfunctional relationships to quality relationships, and from illness to wellness.

Regional Center: A state hospital for the mentally ill as designated in section 83-305. A state operated 24-hour psychiatric facility for persons with mental illness.

Regional Center Behavioral Health Services or Regional Center Services: Behavioral health services provided at a regional center.

Relapse: The return to active substance use in a person with a diagnosed substance use disorder or the return of disabling psychiatric symptoms after a period of remission related to a nonaddictive mental disorder. Relapse is both an anticipated event in the course of recovery and a process in which warning signs appear prior to an individual's actual recurrence of impairment. (Center for Substance Abuse Treatment)

Remission: The absence of distress or impairment due to a substance use or mental disorder. An individual in remission no longer meets DSM-IV criteria for the previously diagnosed disorder but may well benefit from relapse prevention services. (Center for Substance Abuse Treatment)

Severe Emotional Disturbance (SED): Serious Emotional Disturbance is an Axis I diagnosable mental disorder in children and adolescents that is persistent and results in functional impairment in two or more life domains.

Subject (Mental Health Commitment Act): Any person concerning whom a certificate or petition has been filed under the Nebraska Mental Health Commitment Act. Subject does not include any person less than eighteen years of age unless such person is an emancipated minor. (71-912)

Subject (Sex Offender Commitment Act): Subject means any person concerning whom (a) a certificate has been filed under section 71-1204, (b) a certificate has been filed under section 71-919 and such person is held pursuant to subdivision (2)(b) of section 71-919, or (c) a petition has been filed under the Sex Offender Commitment Act. Subject does not include any person under eighteen years of age unless such person is an emancipated minor. (71-1203)

Substance Dependent: A behavioral disorder that involves a maladaptive pattern of repeated use of controlled substances, illegal drugs, or alcohol, usually resulting in increased tolerance, withdrawal, and compulsive using behavior and including a cluster of cognitive, behavioral, and physiological symptoms involving the continued use of such substances despite significant adverse effects resulting from such use. (71-913)

Treatment Facility (Mental Health Commitment Act): A facility which is licensed to provide services for persons who are mentally ill or substance dependent or both. (71-914)

Treatment Facility (Sex Offender Commitment Act): A facility which provides services for persons who are dangerous sex offenders. (71-1203)

APPENDIX D

TITLE 206 BEHAVIORAL HEALTH SERVICES REGULATIONS

The Division of Behavioral Health's Title 206 Regulations can be found at the following link:

HTTP://DHHS.NE.GOV/PAGES/REG_T206.ASPX

APPENDIX E
MENTAL STATUS EXAMINATION

APA Practice Guideline for the Psychiatric Evaluation of Adults – 2nd Edition 2006

1. *Appearance and general behavior*. In describing the patient's appearance, factors such as approximate age, body habits, dress, grooming, hygiene, and distinguishing features (e.g., scars, tattoos) may be noted. The patient's general behavior, level of distress, degree of eye contact, and attitude toward the interviewer are also considered.
2. *Motor activity*. The patient's level of psychomotor activity is noted, as in the presence of any gait abnormalities or purposeless, repetitive, or unusual postures, or movements (e.g., tremors, dyskinesia, akathisia, mannerisms, tics, stereotypes, catatonic posturing, echopraxia, apparent responses to hallucinations).
3. *Speech*. Characteristics of the patient's speech are described and may include consideration of rate, rhythm, volume, amount, accent, inflection, fluency, and articulation.
4. *Mood and affect*. The patient's expressions of mood and affect are noted. Although the use and definitions of the terms *mood* and *affect* vary, mood is typically viewed as referring to the patient's internal, subjective, and more sustained emotional state, whereas affect relates to the patient's externally observable and more changeable emotional state (71, 73). Affect is often described in terms of its range, intensity, stability, appropriateness, and congruence with the topic being discussed in the interview.
5. *Thought processes*. Features of the patient's associations and flow of ideas are described, such as vagueness, incoherence, circumstantiality, tangeniality, neologisms, preservation, and flight of ideas, loose or idiosyncratic associations, and self-contradictory statements.
6. *Thought content.* The patient's current thought content is assessed by noting the patient's spontaneously expressed worries, concerns, thoughts, and impulses, as well as through specific questioning about commonly observed symptoms of specific mental disorders. These symptoms include delusions (e.g., erotomania or delusions of persecution, passivity, grandeur, infidelity, infestation, poverty, somatic illness, guilt, worthlessness, thought insertion, thought withdrawal, or thought broadcasting), ideas of reference, overvalued ideas, ruminations, obsessions, compulsions, and phobias. Assessment of suicidal, homicidal, aggressive, or self-injurious thoughts, feelings, or impulses is essential for determining the patient's level of risk to self or others as part of the clinical formulation. If such features are present, details are elicited regarding their intensity and specificity, when they occur, and what prevents the patient from acting on them (11, 74-79).
7. *Perceptual disturbances*. Hallucinations (i.e., a perception in the absence of a stimulus and illusions (i.e., an erroneous perception in the presence of a stimulus) may occur in any sensory modality (e.g., auditory, visual, tactile, olfactory, gustatory). Other perceptual disturbances that patients may experience include depersonalization and de-realization.
8. *Sensorium and cognition*. Systematic assessment of cognitive functions is an essential part of the general psychiatric evaluation, although the level of detail necessary and the appropriateness of particular formal tests will depend on the purpose of the evaluation and the psychiatrist's clinical judgment. Evaluation of the patient's sensorium includes a description of the level of consciousness and its stability. Elements of the patient's cognitive status that may be assessed include orientation (e.g., person, place, time, situation), attention and concentration, and memory (e.g., registration, short-term long-term). Arithmetic calculations may be used to assess concentration or knowledge; other aspects of the patient's fund of knowledge may also be assessed as appropriate to socio-cultural and educational background. Additional aspects of the cognitive examination may include assessment of level of intelligence, language functions (e.g., naming, comprehension, repetition, reading, writing), drawing (e.g., copying a figure or drawing a clock face), abstract reasoning (e.g., explaining

similarities or interpreting proverbs), and executive functions (e.g., list making, inhibiting impulsive answers, resisting distraction, recognizing contradictions).

9. *Insight.* The patient's insight into his or her current situation is typically assessed by inquiring about the patient's awareness of any problems and their implications. Patients may or may not recognize that psychosis or other symptoms may reflect an underlying illness or that their behavior affects their relationships with other individuals. They also may or may not recognize the potential benefits of treatment. Another element of insight involves the patient's motivation to change his or her health risk behaviors. Such motivation often fluctuates over time from denial and resistance to ambivalence to commitment, a sequence that has been referred to as "stages of change" (80-82). The stages, which are not necessarily discrete, have been labeled *precontemplation* (denial, minimization); *contemplation* (musing or thinking about doing something); *preparation* (actually getting ready to do something); *action* (implementing concrete actions to deal with the problem); and *maintenance* (acting to ensure that the changes are maintained) (83). Patients who are not quite ready to change may vacillate about modifying their behaviors before actually committing to change and acting on it. Assessing stages of change as part of the evaluative process leads to stage-appropriate educational and therapeutic interventions that attempt to help patients move to move adaptive stages in a patient-centered manner (84-86).
10. *Judgment*. The quality of the patient's judgment has sometimes been assessed by asking for the patient's responses to hypothetical situations (e.g., smelling smoke in a theater). However, in assessing judgment, it is generally more helpful to learn about the patient's responses and decision-making in terms of his or her own self-care, interactions, and other aspects of his or her recent or current situation and behavior. If poor judgment is present, a more detailed explication of the patient's decision-making processes may help differentiate the potential causes of this impairment."

APPENDIX F
OVERARCHING PRINCIPLES TO ADDRESS THE NEEDS OF PERSONS WITH COD

Principle 1: Co-occurring disorders are to be expected in all behavioral health settings, and system planning must address the need to serve people with COD in all policies, regulations, funding mechanisms, and programming.

Principle 2: An integrated system of mental health and addiction services that emphasizes continuity and quality is in the best interest of consumers, providers, programs, funders, and systems.

Principle 3: The integrated system of care must be accessible from multiple points of entry (i.e., no wrong door) and be perceived as caring and accepting by the consumer.

Principle 4: The system of care for COD should not be limited to a single "correct" model or approach.

Principle 5: The system of care must reflect the importance of the partnership between science and service, and support both the application of evidence and consensus-based practices for persons with COD and evaluation of the efforts of existing programs and services.

Principle 6: Behavioral health systems must collaborate with professionals in primary care, human services, housing, criminal justice, education, and related fields in order to meet the complex needs of persons with COD.

Principle 7: Co-occurring disorders must be expected when evaluating any person, and clinical services should incorporate this assumption into all screening, assessment, and treatment planning.

Principle 8: Within the treatment context, both co-occurring disorders are considered primary.

Principle 9: Empathy, respect, and belief in the individual's capacity for recovery are fundamental provider attitudes.

Principle 10: Treatment should be individualized to accommodate the specific needs, personal goals, and cultural perspectives of unique individuals in different stages of change.

Principle 11: The special needs of children and adolescents must be explicitly recognized and addressed in all phases of assessment, treatment planning, and service delivery.

Principle 12: The contribution of the community to the course of recovery for consumers with COD and the contribution of consumers with COD to the community must be explicitly recognized in program policy, treatment planning, and consumer advocacy.

APPENDIX G
SUICIDE STATISTICS

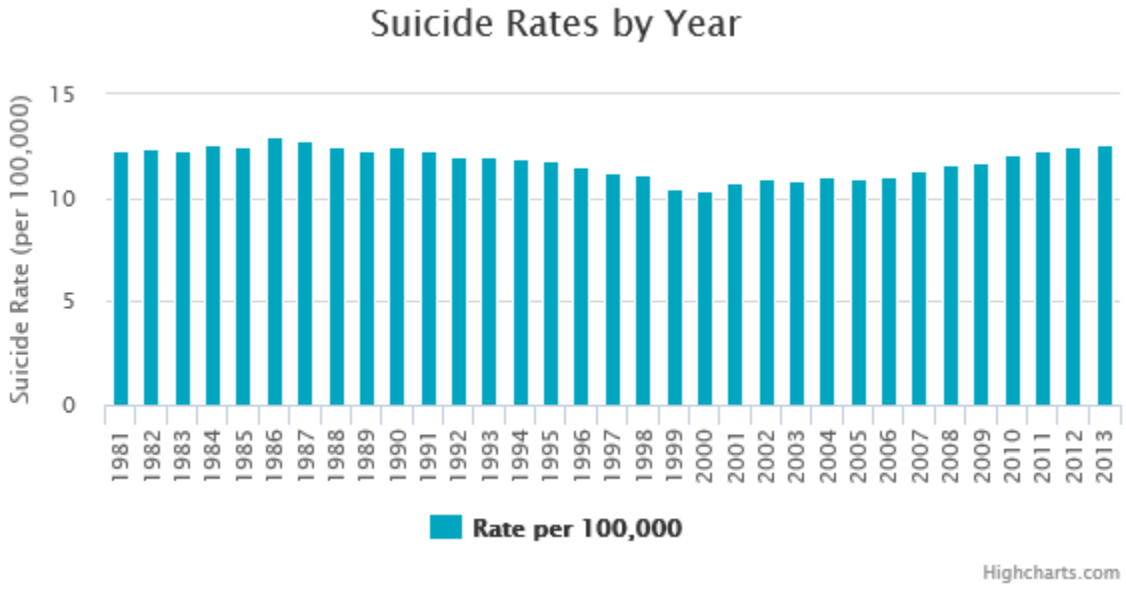
American Foundation for Suicide Prevention
WWW.AFSP.ORG

AFSP's latest data on suicide is taken from the Centers for Disease Control and Prevention (CDC) Data & Statistics Fatal Injury Report for 2013.

Suicide Deaths:
The Centers for Disease Control and Prevention (CDC) collects data about mortality in the U.S., including deaths by suicide. In 2013 (the most recent year for which full data are available), 41,149 suicides were reported, making suicide the 10th leading cause of death for Americans **(Figure 1).** In that year, someone in the country died by suicide every 12.8 minutes.

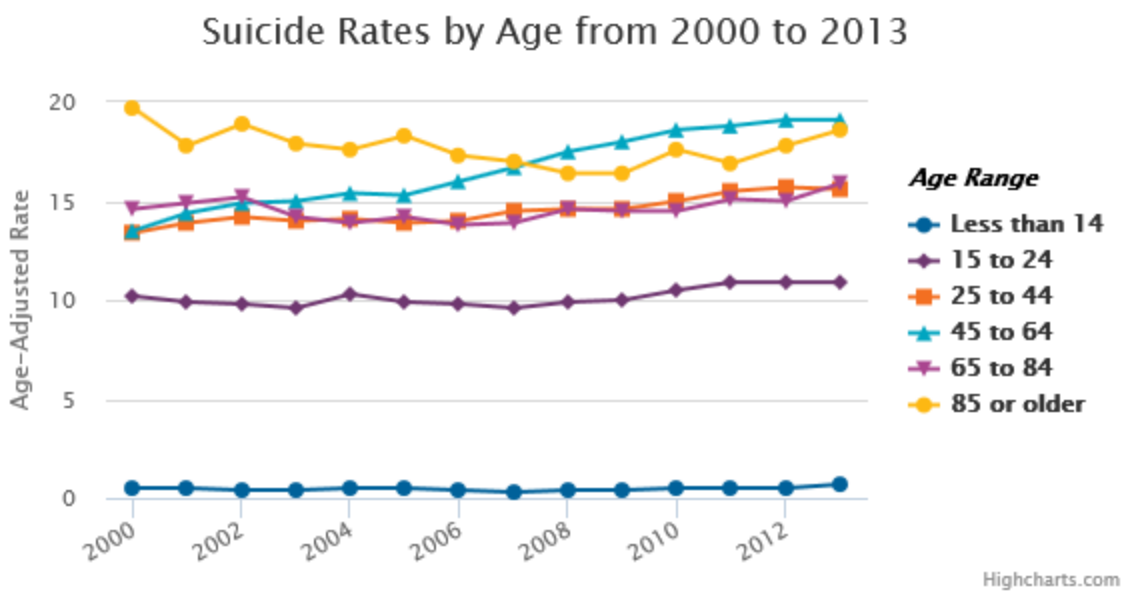
To measure changes in the prevalence of suicide over time, the CDC calculates the country's suicide rate each year. The suicide rate expresses the number of suicide deaths that occur for every 100,000 people in the population for which the rate is reported.

From 1986 to 2000, suicide rates in the U.S. dropped from 12.5 to 10.4 suicide deaths per 100,000 people in the population. Over the next 12 years, however, the rate generally increased and by 2013 stood at 12.6 deaths per 100,000 **(Figure 2).**

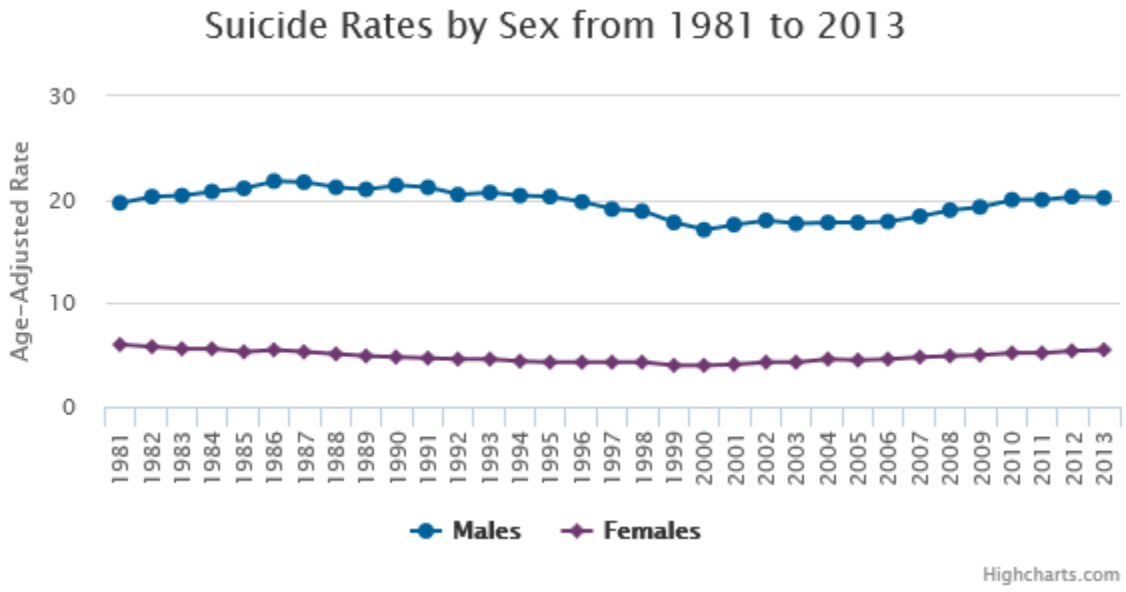


Suicide death rates vary considerably among different groups of people. The CDC reports suicide rates by four key demographic variables: age, sex, race/ethnicity, and geographic region/state.

Suicide Rates by Age:
In 2013, the highest suicide rate (19.1) was among people 45 to 64 years old. The second highest rate (18.6) occurred in those 85 years and older. Younger groups have had consistently lower suicide rates than middle-aged and older adults. In 2013, adolescents and young adults aged 15 to 24 had a suicide rate of 10.9 **(Figure 3).**

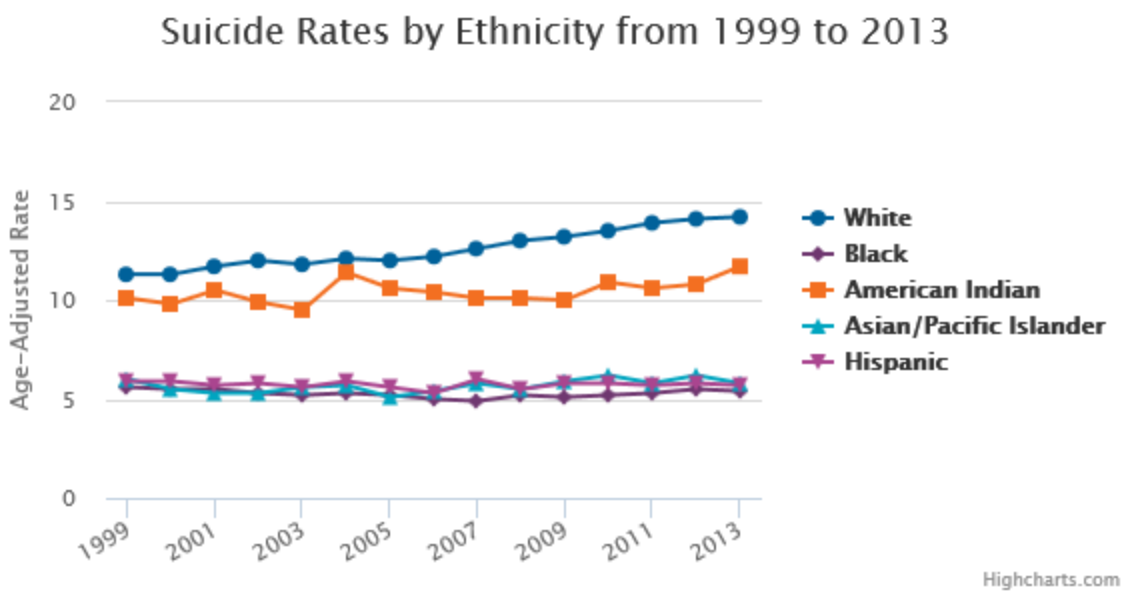


Suicide Rates by Sex:
For many years, the suicide rate has been about 4 times higher among men than among women **(Figure 4).** In 2013, men had a suicide rate of 20.2, and women had a rate of 5.5. Of those who died by suicide in 2013, 77.9% were male and 22.1% were female.

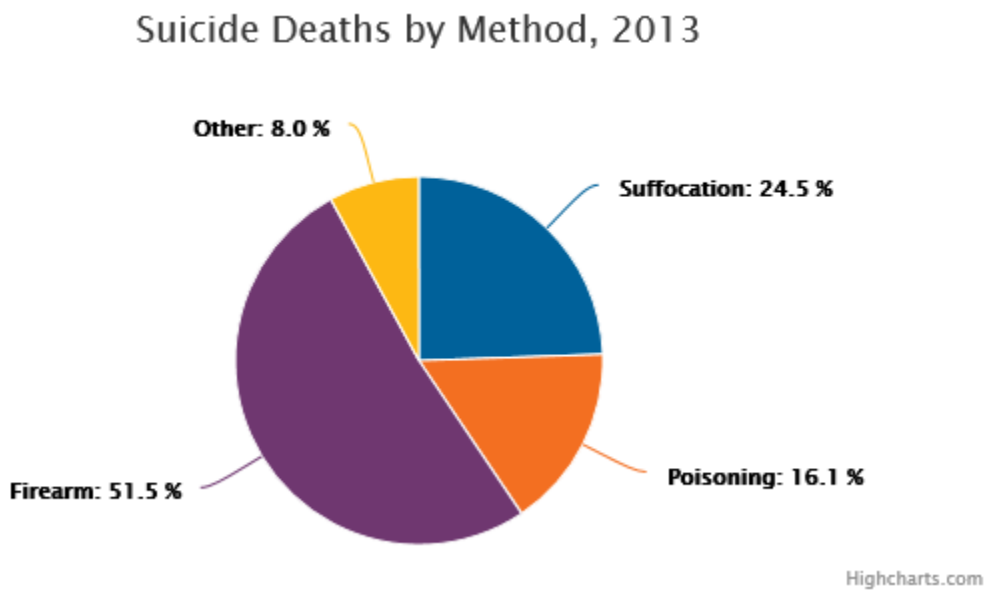


Suicide Rates by Race/Ethnicity:
In 2013, the highest U.S. suicide rate (14.2) was among Whites and the second highest rate (11.7) was among American Indians and Alaska Natives **(Figure 5).** Much lower and roughly similar rates were found among Asians and Pacific Islanders (5.8), Blacks (5.4) and Hispanics (5.7).

Note that the CDC records Hispanic origin separately from the primary racial or ethnic groups of White, Black, American Indian or Alaskan Native, and Asian or Pacific Islander, since individuals in all of these groups may also be Hispanic.



Suicide Methods:
In 2013, firearms were the most common method of death by suicide, accounting for a little more than half (51.4%) of all suicide deaths. The next most common methods were suffocation (including hangings) at 24.5% and poisoning at 16.1% **(Figure 7).**



Economic Impact of Completed Suicides:
The economic cost of suicide death in the U.S. was estimated in 2010 to be more than $44 billion annually. With the burden of suicide falling most heavily on adults of working age, the cost to the economy results almost entirely from lost wages and work productivity.

Suicide Attempts:
No complete count is kept of suicide attempts in the U.S.; however, the CDC gathers data each year from hospitals on non-fatal injuries resulting from self-harm behavior.

In 2013, the most recent year for which data is available, 494,169 people visited a hospital for injuries due to self-harm behavior, suggesting that approximately 12 people harm themselves (not necessarily intending to take their lives) for every reported death by suicide. Together, those harming themselves made an estimated total of more than 650,000 hospital visits related to injuries sustained in one or more separate incidents of self-harm behavior.

Because of the way these data are collected, we are not able to distinguish intentional suicide attempts from non-intentional self-harm behaviors. But we know that many suicide attempts go unreported or untreated, and surveys suggest that at least one million people in the U.S. each year engage in intentionally inflicted self-harm.

As with suicide deaths, rates of attempted suicide vary considerably among demographic groups. While males are 4 times more likely than females to die by suicide, females attempt suicide 3 times as often as males. The ratio of suicide attempts to suicide death in youth is estimated to be about 25:1, compared to an about 4:1 in the elderly.

APPENDIX H
FREQUENTLY ASKED QUESTIONS REGARDING SUICIDE (AFSP)

1. **What percentage of college students who kill themselves are male? Why do you think more/ less boys than girls kill themselves?**
   Seventy-five to 80 percent are boys although more girls attempt suicide. Boys are more involved than girls in all forms of aggressive and violent behavior.

2. **I've heard that suicides are more frequent around the holidays? Is this true, and if so, how much do they increase at that time?**
   Suicides are not more frequent during the holidays. It appears that the rates are the highest in April, and the summer months, June and July.

3. **It is often said that a suicidal person goes through a period where he seeks for help from other people. Does this then mean that it could be ultimately the fault of other people (because they don't appear concerned enough) that one decides to kill him/herself?**
   Not a fair conclusion, although it could be a contributing factor in some cases particularly with elderly, terminally ill people.

4. **What is the biggest cause of suicide among college students?**
   Ninety-five percent are suffering from mental illness, usually depression. If depressed, substance abuse, anxiety, impulsivity, rage, hopelessness and desperation increase the risk.

5. **Apart from talking to a suicidal person and encouraging him/her to go for counseling, what else can we do to prevent this?**
   Going with someone to the counselor often helps. If the person won't listen to you, you may need to talk to someone who might influence him or her. Saving a life is more important than violating a confidence.

6. **People often get uncomfortable when one discloses something as intimate and frightening as suicidal thoughts. What do you think can be done to reduce this stigma, either of suicidal people, or of depressive patients? Can people actually "change" their minds and accept someone who is suicidal?**
   As people recognize that suicidal behavior is the result of a medical condition not a sign of weakness or character defect it will change.

7. **What is the most frequent method of suicide? Is the most frequent method different for men and women?**
   Fifty-two percent of all people who kill themselves do so with a firearm, accounting for almost 17,000 deaths each year in the U.S. Use of a firearm is the number one method in those aged 35 and up.

APPENDIX I
LOCUS RISK ASSESSMENT

American Association of Community Psychiatrists (2010). Level of Care Utilization System for Psychiatric and Addiction Services. Retrieved from:
HTTP://WWW.COMM.PSYCH.PITT.EDU/FIND.HTML.

Level of Care Utilization Systems for Psychiatric and Addiction Services (LOCUS)

Risk can be assessed according to the potential for severity and occurrence, as delineated by the LOCUS parameters developed by the American Association of Community Psychiatrists. The LOCUS rates potential for harm to self or others from minimal potential to extreme potential. The LOCUS rating system follows.

Minimum Risk of Harm

a. No indication of suicidal or homicidal thoughts or impulses, and no history of suicidal or homicidal ideation, and no indication of significant distress.
b. Clear ability to care for self now and in the past

Low Risk of Harm

a. No current suicidal or homicidal ideation, plan, intentions or severe distress, but may have had transient or passive thoughts recently or in the past.
b. Occasional substance use without significant episodes of potentially harmful behaviors.
c. Periods in the past of self-neglect without current evidence of such behavior.

Moderate Risk of Harm

a. Significant current suicidal or homicidal ideation without intent or conscious plan and without past history.
b. No active suicidal/homicidal ideation, but extreme distress and/or a history of suicidal/homicidal behavior exists.
c. History of chronic impulsive suicidal/homicidal behavior or threats, but current expressions do not represent significant change from usual behavior.
d. Binge or excessive use of substances resulted in potentially harmful behaviors in the past, but there have been no recent episodes.
e. Some evidence of self-neglect and/or decrease in ability to care for oneself in current environment.

Serious Risk of Harm

a. Current suicidal or homicidal ideation with expressed intentions and/or past history of carrying out such behavior but without means for carrying out the behavior, or with some expressed inability or aversion to doing so, or with ability to contract for safety.
b. History of chronic impulsive suicidal/homicidal behavior or threats with current expressions or behavior representing a significant elevation from usual behavior.
c. Recent pattern of excessive substance use resulting in loss of self-control and clearly harmful behaviors with no demonstrated ability to abstain from use.
d. Clear compromise of ability to care adequately for oneself or to be adequately aware of environment.

Extreme Risk of Harm

a. Current suicidal or homicidal behavior or such intentions with a plan and available means to carry out this behavior:
    - Without expressed ambivalence or significant barriers to doing so, or
    - With a history of serious past attempts which are not of a chronic, impulsive or consistent nature, or

- In presence of command hallucinations or delusions which threaten to override usual impulse control.

b. Repeated episodes of violence toward self or others, or other behaviors resulting in harm while under the influence of intoxicating substances with pattern of nearly continuous and uncontrolled use.
c. Extreme compromise of ability to care for oneself or to adequately monitor environment with evidence of deterioration in physical condition or injury related to these deficits.

APPENDIX J
AGGRESSIVE BEHAVIOR SCALE

The following list of behaviors ranges from mild at number (a) to serious danger at number (d).

Verbal Aggression

(a) Makes loud noises, shouts angrily;
(b) Yells mild personal insults, e.g. “You’re stupid!”
(c) Curses viciously, uses foul language in anger, makes moderate threats to others or self; or
(d) Makes clear threats of violence toward others or self, i.e. "I’m going to kill you!” or requests help to control self.

Physical Aggression against Objects

(a) Slams door, scatters clothing, makes a mess;
(b) Throws objects down, kicks furniture without breaking it, marks the wall;
(c) Breaks objects, smashes windows; or
(d) Sets fires, throws objects dangerously.

Physical Aggression against Self

(a) Hits or scratches skin, hits self on arms or body, pinches self, pulls hair (with no or minor injury);
(b) Bangs head, hits fist into object, throws self onto floor or into objects (hurts self without serious injury);
(c) Small cuts or bruises, minor burns; or
(d) Mutilates self, makes deep cuts, bites that bleed, internal injury, fractures, loss of consciousness, loss of teeth.

Physical Aggression against Others

(a) Makes threatening gestures, swings at people, grabs at clothes;
(b) Strikes, kicks, pushes, pulls hair (without injury);
(c) Attacks others causing mild/moderate physical injury (bruises, sprains, welts); or
(d) Attacks others causing severe physical injury (broken bones, deep lacerations, internal injury).

APPENDIX K
EMERGENCY PROTECTIVE CUSTODY ADMISSIONS PROCEDURE

EMERGENCY PROTECTIVE CUSTODY ADMISSIONS PROCEDURE

PURPOSE: To provide emergency care to persons requiring psychiatric evaluation who are under police custody, and to facilitate communication between health care providers and law enforcement agencies

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PROCEDURE:
If Law Enforcement believes person to be mentally ill and dangerous AND harm likely to occur prior to MHB proceeding:

1. Law Enforcement issues emergency Protective Custody (EPC) certificates. The Law Enforcement Agency will provide the nursing staff with a copy of the EPC certificate when the patient is brought to the hospital. The copy must be placed in the patient's chart.
2. The Law Enforcement Agency will notify the hospital before bringing the patient to the hospital whenever possible. The patient will always be brought into the hospital through the Emergency Department (ED) door.
3. Nursing staff will notify on-call mental health provider by pager, if they were not already notified by the Law Enforcement Agency.
4. A medical provider must be contacted using the regular procedure when a patient with an EPC order presents to the ED.
5. Medical stability will be established by a medical assessment and treatment rendered as necessary.
6. Treatment of serious medical conditions takes priority over mental health evaluations.
7. A mental health provider will conduct an evaluation and suicide risk assessment. The mental health provider will share their conclusions and professional opinion with the medical provider and law enforcement.
8. All EPC patients will be entered into the network management system.
9. Medically unstable patients may need to be admitted to the hospital. These patients may require a guard at their bedside if they are out of control and pose potential for harm to themselves or others. Law enforcement is responsible for providing this protection. Nursing is responsible to provide for medical needs including one to one care as indicated. Law Enforcement personnel are to be used for security and flight risk reasons only.
10. The Region's Emergency System Coordinator will be notified by phone or by voicemail of admissions within 24 hours, including weekends.
11. Patients under suicide precautions must be charted on every fifteen minutes using the safety room observation sheet. It may be necessary to assign a nurse to stay with the patient at all times.
12. Discharge orders must be written by the medical provider to dismiss or transfer a patient from the hospital. Law Enforcement Agencies may provide additional instructions as needed.
13. EPC orders can only be lifted by the County Attorney or the Board of Mental Health. Clarify the origin of all orders to lift an EPC.
14. If EPC patient is going to MHB hearing, the EPC unit (Crisis Center) If a patient is committed for either Inpatient or Outpatient services, Crisis Center staff must pre-authorize those services. If the service recommended for commitment is Inpatient level of care.

APPENDICES L - U
FORMS

Note: The original forms are available on the web at:
HTTP://DHHS.NE.GOV/BEHAVIORAL_HEALTH/PAGES/BEH_COMMIT_COMMIT.ASPX
Please check periodically for updated/new forms.

L. *Emergency Admittance Pursuant to Certificate of a Peace Officer & Attachment A. Mental Health Emergency Assessment*

M. *Mental Health Professional Certificate*

N. *Mental Health Board Order*

O. *Warrant of Inpatient Admission Form*

P. *Outpatient Commitment*

Q. *Provider Treatment Plan Recommendations to Mental Health Board*

R. *Notice of Release*

S. *Warrant to Take Custody Of Outpatient Pending Hearing*

T. *Warrant of Arrest*

U. *Reporting the Order of Commitment*

APPENDIX L
EMERGENCY ADMITTANCE PURSUANT TO CERTIFICATE OF A PEACE OFFICER

EMERGENCY ADMITTANCE PURSUANT TO CERTIFICATE OF A PEACE OFFICER

To facility authorized by §71-919 to hold the individual who is the subject in custody:

Name of Facility: _____

Address:_____

This is to inform you that I, _____, _____,
(Name of Peace Officer) (Badge Number)

have taken into custody_____
(Name and Address of Subject Taken into Custody)

_____

_____

on the _____day of_____. I have personally observed this

subject or I have been informed by

_____
(Name and Address of a Witness)

_____,
who is a reliable person, and I believe that this subject is a mentally ill and dangerous person as described below:

For Mentally Ill (check applicable areas):

( ) Mentally Ill and Dangerous
( ) Substance Dependent

For Dangerous (check applicable areas):

( ) Dangerous Towards Others - A substantial risk of serious harm to another person or persons within near future, as manifested by evidence of recent violent acts or threats of violence or by placing others in reasonable fear of such harm, or

( ) Dangerous to Self - A substantial risk of serious harm to himself or herself within the near future, as manifested by evidence of recent attempts at, or threats of, suicide or serious bodily harm; or evidence of inability to provide for his or her basic human needs, including food, clothing, shelter, essential medical care, or personal safety.

The dangerousness indicated above is, in my opinion, likely to occur before Mental Health Board proceedings can be invoked unless this facility holds the subject in custody pursuant to this Certificate.

What behavior(s) indicate that this person is mentally ill :_____

_____

_____

_____

_____

_____

What behavior(s) indicate that this person is dangerous: _____

_____

_____

_____

_____

_____

( ) Additional police report will be submitted (Reference this placement/admittance)

( ) Additional information on the subject's behavior is included in a separate sheet identified as Attachment A which is attached hereto and incorporated herein by reference (Mental Health Emergency Assessment form).

I am therefore causing this person to be admitted to your facility.

Date:_____ Signed _____ Badge #_____
(Peace Officer)

_____ (_____) _____
Name/Address of Law Enforcement Agency Phone

_____ _____
County

This certificate or a copy thereof must be forwarded immediately to the County Attorney.
(Neb. Rev. Stat. §71-919)

ATTACHMENT A TO EMERGENCY ADMITTANCE PURSUANT TO CERTIFICATE OF A PEACE OFFICER

Attachment A

Mental Health Emergency Assessment

(Supplemental Document to Emergency Admittance pursuant to Certificate of a Peace Officer)

Client Name:_____ Therapist's Name:_____
Date:_____ Time:_____ Location:_____
DOB:_____ Age:_____ Gender:_____ Marital Status:_____
Address: _____
Phone Number:_____ Social Security Number:_____
Employment Status:_____

Emergency Contact Person:_____
Relationship:_____ Phone Number:_____
Social support system:_____
_____
Outpatient Therapist:_____ Phone Number:_____

Chief complaint/symptoms:_____
_____
_____
_____
Affect/Mood:_____
Delusional__ Hallucinating__ Disorganized___ Paranoid___ Manic___ Depressed___ Anxious___ Angry__
Orientation: 1 2 3 4 LOC: _____ Insight/judgment: _____ Memory: _____
Intoxicated? Yes___ No___ Substance used/amt:_____
History of substance use:_____
_____
Psychiatric history:_____
_____
Physical conditions/illness:_____
_____
Medications:_____
_____

Suicide/Homicide:

Ideation:_____
Plan:_____
Intent:_____
Gestures:_____
Accessibility:_____
Previous attempts/gestures:_____
Family history of suicide:_____
Violence history:_____
_____
Intent to harm others:_____
Signature_____ Date_____ 20___
(LMHP, NP, PhD, MD)
(Attach this form to EPC Certificate)

APPENDIX M
MENTAL HEALTH PROFESSIONAL CERTIFICATE

Mental Health Professional Certificate

(To be immediately forwarded to the county attorney upon completion) Neb. Rev. Stat. § 71-927.

TO: _____ COUNTY ATTORNEY,

OF _____ COUNTY, NEBRASKA

_____, is under my care as a result of an Emergency
(Name & Address of Subject)
Protective Custody placement, upon the certificate of a Law Enforcement Officer. The subject's evaluation was completed on _____ (a.m./ p.m.) on the _____day of _____, 20____.

☐ _____
(Name & Address of Subject's spouse, legal counsel, guardian or conservator, and next of kin, if known)

☐ _____
(Name & Address of anyone providing psychiatric or other care or treatment to the subject, if known)

☐ _____
(Name & Address of any other person who may have knowledge of the subject's mental illness or substance abuse dependence who may be called as a witness at a Mental Health Board hearing with respect to the subject, if known)

☐ _____
(Name & Address of the medical facility in which the subject is being held for emergency protective custody and evaluation)

As a qualified mental health professional I certify that I have evaluated the subject since the subject was admitted for emergency protective custody and evaluation. It is my opinion that the above subject currently meets diagnostic criteria for the following mental disorders which are recognized utilizing criteria set out in most recent edition of the DSM.
Diagnosis: _____

_____

The above diagnosis is within a reasonable degree of psychiatric, psychological certainty and the Subject presents a substantial risk of serious harm within the near future to himself/herself, or others as a result of the above mental illness in the following ways:
_____

_____

_____

It is therefore my opinion, within a reasonable degree of psychiatric, psychological certainty, that _____ is a mentally ill and dangerous person as defined by Neb. Rev. Stat. § 71-908.

Name of Facility: _____

Address of Facility: _____

BY: _____
(Name Certifying Mental Health Care Professional)

ADDRESS: _____

DATE: _____, 20_____

☐ An evaluation was completed within 36 hours of admission and this certificate was executed within 24 hours after completion of the evaluation.

Case number:_____

Name:_____

APPENDIX N
MENTAL HEALTH BOARD ORDER

Mental Health Board Order

BEFORE THE MENTAL HEALTH BOARD OF THE _____
JUDICIAL DISTRICT

IN THE INTEREST OF	)	
	)	CASE NO. _____
	)	
_____	)	ORDER
Alleged to be a Mentally	)	(Inpatient)
Ill and Dangerous Person	)	
Subject	)	

This matter comes on for hearing on the _____ day of _____, 20___, before the _____ Judicial District Mental Health Board.

The (Deputy) County Attorney, _____, was present along with the subject and the subject's counsel, _____.
The subject acknowledged receipt of a copy of the Petition, Notice of Hearing, and list of Rights and then admitted/denied the allegations of the Petition.

The matter is submitted to the Mental Health Board upon information filed herein, the testimony elicited, and the evidence that was adduced. Upon consideration thereof, the Board finds that there is clear and convincing evidence that the allegations in the petition are true and relies on the following:

_____
_____
_____

The Mental Health Board further finds by clear and convincing evidence that the subject is mentally ill and dangerous person and neither voluntary hospitalization nor other treatment alternatives less restrictive of the subject's liberty than a Mental Health Board ordered treatment disposition would suffice to prevent the substantial risk of harm as described in section 71-908.

Having considered all treatment alternatives, the Board orders the subject placed in the custody of Nebraska Department of Health and Human Services (NDHHS) for appropriate treatment. NDHHS or its designee shall prepare and implement an individualized treatment plan for the subject. NDHHS or its designee shall document and report the subject's progress under such plan.

The individualized treatment plan shall contain a statement of (a) the nature of the subject's mental illness or substance dependence. (b) the least restrictive treatment alternative consistent

with the clinical diagnosis of the subject, and (c) intermediate and long-term treatment goals for the subject and a projected timetable for the attainment of such goals.

A copy of the individualized treatment plan shall be filed with the Mental Health Board for review and inclusion in the subject's file and served upon the county attorney, the subject, the subject's counsel, and the subject's legal guardian or conservator, if any, within five working days after the entry of the board's order. Treatment shall be commenced within two working days after preparation of the plan.

The subject shall be notified by the Mental Health Board when the board has changed the treatment order or has ordered the discharge of the subject from commitment.

NDHHS or its designee shall submit periodic progress reports to the Mental Health Board detailing the subject's progress under such plan and any modifications to the plan. The initial progress report shall be filed with the Mental Health Board for review and inclusion in the subject's file and served upon the county attorney, the subject's counsel and the subject's legal guardian or conservator, if any, no later than ten days after submission of the subject's individualized treatment plan. Such periodic progress reports shall be so filed and served no less frequently than every ninety days for a period of one year following submission of the subject's individualized treatment plan and every six months thereafter.

Other:
_____
_____
_____

Legal settlement is found to be _____.

Dated: _____.

MENTAL HEALTH BOARD OF THE
_____ JUDICIAL DISTRICT,

_____
Chairperson

_____
Member/Alternate

_____
Member/Alternate

APPENDIX O
WARRANT OF INPATIENT ADMISSION

MENTAL HEALTH BOARD OF _____ COUNTY, NEBRASKA
Neb. Rev. Stat § 71-927, 71-928

IN THE INTEREST OF	)	CASE NO. _____
	)	
_____	)	
Alleged to be a Mentally	)	WARRANT OF ADMISSION
Ill and Dangerous Person	)	(Inpatient)

To: Administrator/Director of_____, an inpatient treatment facility located at _____ (Address).

At a proper hearing before the _____ County Mental Health Board on the _____ day of _____, 200___, (subject's Name) _____ was found to be a mentally ill and dangerous person and in need of custody and treatment. (See attached Mental Health Board Order).
You are hereby authorized to receive and keep said subject as a patient.

You are hereby authorized to transfer physical custody of said subject to any other inpatient treatment facility as may be appropriate and necessary without further order of the Mental Health Board.

The legal settlement of the subject, if known, is found to be in _____ County. Dated this _____ day of _____, 20___.

Chairperson Board of Mental Health
By _____

You have received this warrant and a copy. The original is official notification of your authorization to take custody of the above named person. Please complete the information below and return the completed copy to:
Chairperson Mental Health Board, _____County
Address _____
City _____

ACCEPTANCE OF PATIENT

The above named subject was received by me this _____ day of _____.

_____
Director

_____
Institution

Upon delivery of the subject by Sheriff or other duly appointed individual, said subject
□ was or □ was not accompanied by another individual.
If accompanied, the name of the individual is _____.

APPENDIX P
OUTPATIENT COMMITMENT ORDER

BEFORE THE MENTAL HEALTH BOARD OF THE

_____ JUDICIAL DISTRICT

IN THE INTEREST OF	)	
	)	CASE NO. _____
	)	
_____	)	ORDER
Alleged to be a Mentally	)	(Outpatient)
Ill and Dangerous Person	)	
Subject	)	

This matter comes on for hearing on the _____ day of _____, 200__, before the _____ Judicial District Mental Health Board.

The (Deputy) County Attorney, _____, was present along with the subject and the subject's counsel, _____.
The subject acknowledged receipt of a copy of the Petition, Notice of Hearing, and list of Rights and then admitted/denied the allegations of the Petition.

The matter is submitted to the Mental Health Board upon information filed herein, the testimony elicited, and the evidence that was adduced. Upon consideration thereof, the Board finds that there is clear and convincing evidence that the allegations in the petition are true and relies on the following:
_____
_____
_____

The Mental Health Board further finds by clear and convincing evidence that the subject is mentally ill and dangerous person and neither voluntary hospitalization nor other treatment alternatives less restrictive of the subject's liberty than a Mental Health Board ordered treatment disposition would suffice to prevent the substantial risk of harm as described in section 71-908.

Having considered all treatment alternatives, the Board orders the subject placed in the custody of _____ (name and address of outpatient treatment facility) for appropriate outpatient treatment. Said outpatient treatment facility shall prepare and implement an individualized treatment plan for the subject. Said outpatient treatment facility shall document and report the subject's progress under such plan.

The individualized treatment plan shall contain a statement of (a) the nature of the subject's mental illness or substance dependence. (b) the least restrictive treatment alternative consistent with the clinical diagnosis of the subject, and (c) intermediate and long-term treatment goals for the subject and a projected timetable for the attainment of such goals.

A copy of the individualized treatment plan shall be filed with the Mental Health Board for review and inclusion in the subject's file and served upon the county attorney, the subject, the subject's counsel, and the subject's legal guardian or conservator, if any, within five working days after the entry of the board's order. Treatment shall be commenced within two working days after preparation of the plan.

The subject shall be notified by the Mental Health Board when the board has changed the treatment order or has ordered the discharge of the subject from commitment.

Said outpatient treatment facility shall submit periodic progress reports to the Mental Health Board detailing the subject's progress under such plan and any modifications to the plan. The initial progress report shall be filed with the Mental Health Board for review and inclusion in the subject's file and served upon the county attorney, the subject's counsel and the subject's legal guardian or conservator, if any, no later than ten days after submission of the subject's individualized treatment plan. Such periodic progress reports shall be so filed and served no less frequently than every ninety days for a period of one year following submission of the subject's individualized treatment plan and every six months thereafter.

Pursuant to NRS Sec. 71-933, said outpatient treatment facility shall report to the board and the county attorney if (a) the subject is not complying with his or her individualized treatment plan, (b) the subject is not following the conditions set by the board, (c) the treatment plan is not effective, or (d) there has been a significant change in the subject's mental illness or substance dependence. The county attorney shall have the matter investigated to determine whether there is a factual basis for the report.

Other:
_____

_____

_____

Legal settlement is found to be _____.

Dated: _____.

MENTAL HEALTH BOARD OF THE
_____ JUDICIAL DISTRICT,

_____
Chairperson

_____
Member/Alternate

_____
Member/Alternate

APPENDIX Q

PROVIDER TREATMENT PLAN RECOMMENDATIONS TO MENTAL HEALTH BOARD

(Inpatient or Outpatient Provider) Neb. Rev. Stat. § 71-933

Name of Person: _____

☐ Initial ☐ Supplemental

To:
The Mental Health Board of the _____ Judicial District, _____ County, Nebraska

As a qualified mental health professional in compliance with Neb. Rev. Stat. § 71-906, it is my opinion that this person meets diagnostic criteria for the following mental disorders and is in need of treatment as stipulated below:

Diagnosis: _____

☐ **Treatment Plan Attached or**

The least restrictive treatment alternative would be: _____
_____
_____

(Intermediate and long term and projected timelines to achieve goals (specify inpatient versus non-inpatient treatment goals):

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

☐ Consumer Signature _____
☐ Refused to Sign

Clinician Signature: _____

Case Number: _____
Name: _____

Progress since the last report: _____
_____
_____
_____
_____
_____

Continuity of Care

☐ The undersigned will **continue** to be the provider of record for this person and will continue to provide care until such time as the care has been transferred to another provider.

Provide reports to Mental Health Board every 90 days for a period of a year and every six months thereafter.

☐ The undersigned has made arrangements to **transfer** the care of this person to:

(Provider Named) _____
(Address) _____(Phone)_____
The first appointment is scheduled for (Date) _____at (Time)_____

The undersigned agrees to continue caring for this person until care is initiated with the new provider and the new provider has filed an acceptance of transfer with the Board of Mental Health.

Clinician Name: (print) _____

Title: _____ Phone: _____Fax: _____

Facility: _____

City, State, Zip: _____

Signature: _____Date: _____

Noncompliance with this treatment form requires the administrator or program director to immediately notify State Patrol if AWOL and the clerk of the Mental Health Board of the Judicial District from which the individual is committed.

APPENDIX R
NOTICE OF RELEASE

Notice of Release
(NAS Sec 71-937)

Name of Treatment Facility: _____

Address:_____

Name of Subject:_____

Case Number:_____

To: The Mental Health Board of the _____ Judicial District, _____ County, Nebraska.

To: _____County Attorney,

_____County, Nebraska.

The above named person has been under our care for treatment of _____ _____. We are releasing this person from our treatment facility.

Administrator or Program Director _____

Dated this_____day of _____, 20___.

APPENDIX S
WARRANT TO TAKE CUSTODY OF OUTPATIENT PENDING RE-HEARING

MENTAL HEALTH BOARD OF _____ COUNTY, NEBRASKA

IN THE INTEREST OF	)	Case No. _____
	)	
	)	WARRANT TO TAKE
_____,	)	CUSTODY OF
Alleged to be a Mentally	)	OUTPATIENT
Ill and Dangerous Person	)	PENDING REHEARING
	)	(NRS Sec. 71-934)

TO: Law enforcement officer (specify law enforcement agency here): _____

The county attorney has filed a motion for reconsideration of the conditions set forth by the board of mental health regarding the above subject pursuant to NRS Sec. 71-933(c), which matter is set for further hearing at _____(location) on the ___ day of _____, 200__, at ____ o'clock __.m.. **A copy of the motion for hearing and a list of the rights provided by the Nebraska Mental Health Commitment Act is attached hereto.**

The Mental Health Board has made a preliminary determination, pursuant to NRS Sections 71-933(d) and 71-934, that the subject currently poses a threat of danger to himself or herself or others prior to such further hearing, and that outpatient treatment is not appropriate.

You are hereby ordered to take custody of the subject pending hearing in the above matter and transport the subject to:

_____

(specify name and address of treatment facility or public or private hospital with available capacity)

You are further ordered to personally serve this warrant upon the subject, the subject's counsel, and the subject's legal guardian or conservator, if any.

No person may be held in custody for more than seven days except upon a continuance granted by the Board in accordance with NRS Sec. 71-934

Chairperson, Board of Mental Health

By:_____

APPENDIX T
WARRANT OF ARREST

MENTAL HEALTH BOARD OF _____ COUNTY, NEBRASKA

IN THE INTEREST OF	)	CASE NO. _____
	)	WARRANT OF ARREST
Alleged to be a Mentally	)	
Ill and Dangerous Person	)	

TO THE SHERIFF OF _____ COUNTY, NEBRASKA:

The clerk of the District Court for _____ County, Nebraska has received notice pursuant to Neb. Rev. Stat. § 71-939 (Reissue 2004) that (Subject's Name) _____, having been found to be a mentally ill and dangerous person and committed to (Facility)_____, is absent without authorization from that treatment facility or program.

You are hereby commanded to take into custody (Subject's Name) _____ and return him or her to the above-named treatment facility or program or take (Subject's Name) _____ to an appropriate facility until he or she can be returned to such treatment facility or program. This person shall not be placed in a jail.

This warrant may be executed by the Sheriff for _____ County, Nebraska or any other peace officer.

Signed and Sealed this _____ day of _____, 20__.

Clerk of the District Court
By _____

-RETURN-

State of Nebraska)
Lancaster County)

The above warrant came into my hands on _____, 20__, at (Location) _____, and I now return it executed, by placing (Subject' Name) _____, at (Facility) _____.

Dated this _____ day of _____, 20__.
_____, Sheriff

By _____
Deputy

Fees: Services & Return _____
Warrant _____
Mileage _____
Total _____

APPENDIX U
REPORTING THE ORDER OF COMMITMENT

To Nebraska Department of Health and Human Services and Nebraska State Patrol
By Clerks of the District Courts per requirement of Neb. Rev. Stat: 69-2409.01

REPORTING THE ORDER OF COMMITMENT IS NOW ELECTRONIC AND AVAILABLE ONLINE:
HERE IS THE LINK TO THE ELECTRONIC COMMITMENT REPORTING APPLICATION (ECRA): HTTPS://ECMP.NEBRASKA.GOV/APPNET/LOGIN.ASPX

INSTRUCTION FOR COMPLETING
THE ELECTRONIC COMMITMENT APPLICATION IS AVAILABLE ONLINE:
HERE IS THE LINK TO THE INSTRUCTIONS:
HTTP://DHHS.NE.GOV/BEHAVIORAL_HEALTH/DOCUMENTS/DRAFT-11-15-2012-ELECTRONICCOMMITMENTREPORT-MANUAL.PDF

APPENDIX V
FREQUENTLY ASKED QUESTIONS

Partially Adapted from Nebraska Advocacy Services "A Guide to Nebraska's Mental Health Commitment Act"

1. What is the overarching role/responsibility of the Mental Health Board?

Mental Health Board members serve as part of a system of checks and balances, guarding an individual's personal rights while ensuring due process and protecting public safety. The board obtains information through questioning those at the hearing, the mental health/substance abuse professionals, legal representatives and most importantly the person appearing before them. Based on that evidence, an objective decision can be made whether *clear and convincing evidence* has been presented that a *substantial risk of serious harm* exists within the *near future*.

The mental health commitment process involves three decisions. First, a determination must be made whether a person is mentally ill and/or substance dependent. The second decision in the process to commit or discharge is assessing for risk of dangerousness to self or others as a result of the mental illness or substance dependence. Using the give factors of magnitude, likelihood, imminence, frequency, and situation, a determination can be reached more readily. Finally, if a committal is deemed necessary, by law placement must be to the *least* restrictive level of care which would successfully treat the mental illness/substance dependence and prevent harm to self or others. Under federal requirements, the commitment must be made to the most integrated setting available in which the individual can be safely served. The "most integrated setting" is one "a setting that enables individuals with disabilities to interact with non-disabled persons to the fullest extent possible." 28C.F.R. pt. 35, App. A, p. 450. See Olmstead v. L.C. Zimring (1999).

The Mental Health Commitment Act was not created to punish behavior caused by mental illness. Rather, by mandating treatment for those either unable or unwilling to seek treatment on their own, due to mental condition or diagnosis, the Act protects their safety, the safety of society, and provides an individual with treatment which can lead to an improved quality of life.

2. What are the rights of persons in need of treatment?

Under the Nebraska Mental Health Commitment Act, a person who is in custody or receiving treatment has the right to:

i. Be considered legally competent for all purposes unless he or she has been declared legally incompetent. The Mental Health Board does not have the power to declare someone incompetent.
ii. Receiving prompt and adequate evaluations and treatment for any mental illness and physical ailments. They must also be given the opportunity to participate in the planning of their treatment to the extent that the mental health professional in charge of the person's treatment deems such input appropriate.
iii. Refuse treatment except for such treatment:
    1. In an emergency. In this case, medication is essential in the judgment of the mental health professional in charge of the person's treatment to prevent the person from causing harm to himself, herself, or others.

2. Following a hearing and order of a Mental Health Board. In this case, the person is required to take medication that will substantially improve his or her mental illness.

iv. Communicate freely with others by sealed mail, personal visitation, and private telephone conversations.

v. Reasonably private living conditions. This must include private storage space for personal belongings.

vi. Engage or refuse to engage in religious worship and political activity.

vii. Be compensated for their labor as stated in the federal Fair Labor Standards Act, 29 U.S.C. 206, as amended.

viii. Have access to a patient grievance procedure.

ix. File, either personally or through counsel, petitions or applications for writs of habeas corpus in order to challenge the legality of his or her custody or treatment. Neb. Rev. Stat. §71-959 (2004).

In addition to the rights granted subjects by any other provisions of the Nebraska Mental Health Commitment Act, such subjects shall be entitled to the rights provided in sections 71-943 to 71-960 during proceedings concerning the subjects under the act.

3. What is the Mental Health Commitment Act and what does it do?

The Mental Health Commitment Act is designed to provide treatment for people who are "mentally ill and dangerous … because of such mental illness or substance dependence." Nebraska public policy encourages people to seek mental health treatment voluntarily. However, if people who are "mentally ill and dangerous because of such mental illness" do not seek treatment voluntarily, the Act will require them to go through a Mental Health Board proceeding. This proceeding may result in their receiving treatment on an involuntary basis. "Neb. Rev. Stat. §71-902 et seq. (2004).

4. What training do Mental Health Board members need to serve on the Mental Health Board?

As a part of LB1083, changes were made in training requirements for Mental Health Board Members. Under the new legislation, Mental Health Board Members must be trained **prior to serving on the Board.** Another change is that members must satisfactorily complete Mental Health Board Training at least once every <u>four</u> years.

5. What is a "mentally ill and dangerous person?"

Nebraska law considers a "mentally ill and dangerous person," as someone who:

- Is mentally ill or substance dependent and because of this mental illness or substance dependence, presents a "substantial risk of serious harm to:
  - Another person or persons within the near future as manifested by evidence of recent violent acts or threats of violence or by placing others in reasonable fear of such harm;" or
  - Himself or herself within the near future as manifested by evidence of recent attempts at, or threats of, suicide or serious bodily harm or evidence of inability to provide for his or her basic human needs, including food, clothing, shelter, essential medical care, or personal safety." Neb. Rev. Stat. §71-908 (2004).

6. **What are the ways in which a person may be involuntarily committed to a mental health care facility under the Mental Health Commitment Act?**

   a. Emergency Protective Custody
   A law enforcement officer who has probable cause to believe that a person may be mentally ill and dangerous due to a mental illness may take the person into custody and have the person admitted to a medical treatment facility with a written certificate. A mental health professional may also hold a person for the law enforcement officer if the professional has probable cause to believe the person is mentally ill and dangerous due to a mental illness. In either situation, the law enforcement officer must write a certificate stating the officer's belief that the person is mentally ill and dangerous. The certificate must also contain information of the person's behavior that would support the officer's belief. A copy of the certificate must be immediately sent to the county attorney.

   If a law enforcement officer takes a person into emergency protective custody, a mental health professional will evaluate the person as soon as possible. This evaluation must be conducted no later than 36 hours after admission. The person who performs the evaluation must be a mental health professional:

   - Licensed to practice medicine and surgery under the Uniform Credentialing Act of Nebraska ("UCA"), or
   - Licensed to practice psychology in this state under the UCA, or
   - An advanced practice registered nurse licensed under the Advance Practice Registered Nurse Practice Act who has proof of current certification in a psychiatric or mental health specialty.

   But may not be any of the following:
   - The mental health professional who had the person taken into custody.
   - A member or alternate member of the Mental Health Board that will preside over the person's mental health commitment proceeding.

   If, after the evaluation, the mental health professional finds that the person is not mentally ill and dangerous, the person must be released immediately. However, if the mental health professional finds the person is mentally ill and dangerous due to the mental illness, he or she will execute a written certificate within 24 hours after completing the evaluation. A copy of the certificate will be immediately sent to the county attorney, Neb. Rev. Stat. § 71-919 (2004)

   b. County Attorney Receives Complaint
   If a person believes someone is mentally ill and dangerous due to the mental illness, they may communicate this to the county attorney or they may have a law enforcement officer file a certificate with the county attorney. If the county attorney agrees that the person is mentally ill and dangerous due to the mental illness and that neither voluntary hospitalization nor less restrictive treatment options are appropriate, the county attorney will file a petition with the clerk of the district court, Neb. Rev. Stat §71-921 (2004).

7. **Are there other ways in which a person may be committed to a mental health treatment facility that do not fall under the Mental Health Commitment Act?**

   Yes. There are two other situations in which a person may be committed to a mental health treatment facility. Each situation is described below.

a. Transfer from Correctional Facility
   Prisoners may need mental health treatment while they are in custody. If they do need such treatment, they may be transferred to a mental health treatment facility. Generally, Correctional Services will appoint a physician or psychologist to examine whether the prisoner has a need for mental health treatment and whether the correctional facility can provide him or her with adequate treatment. If adequate treatment cannot be provided in the correctional facility, the prisoner may be transferred to a mental health treatment facility. Neb. Rev. Stat. §§83-180 (2008). However, in administering health services the Department of Corrections "shall provide a community standard of health care to all inmates." § 83-4,155.
b. Voluntary Admission through Guardian
   A guardian may voluntarily admit his or her ward to a mental health treatment facility without having a hearing before a judge or the Mental Health Board, Neb. Rev. Stat. §30-2628 (Cum. Supp. 2004). The guardian acts as a third party who is looking to protect the best interests of the ward when the ward is not competent to make such decisions. Therefore, it is not necessary that the ward agree to be admitted to a mental health treatment facility when the guardian deems it necessary.

8. Can a person voluntarily commit himself or herself to a mental health treatment facility?

Yes. If the person voluntarily applies for admission to a treatment facility, he or she must provide a written request if he or she wishes to be discharged. The person will be unconditionally discharged within 48 hours after delivering a written request to the hospital, treatment facility, or program. However, action may be taken under the Nebraska Mental Health Commitment Act to continue the custody of the person, Neb. Rev. Stat. §71-918 (2004).

9. How are Mental Health Board proceedings initiated?

Mental Health Board proceedings begin once the county attorney has filed a petition or has received notification from a law enforcement officer that a person has been taken into emergency protective custody. The county attorney will file a petition as soon as is reasonably practicable once he or she has received notification. After the county attorney files a petition, the clerk of the district court will set a hearing date within seven calendar days of when the person was taken into custody, Neb. Rev. Stat. §§71-922, 71-923 (2004).

The county attorney will file a petition to have a person committed to a mental health treatment facility if he or she agrees that the person is mentally ill and dangerous due to a mental illness and that neither voluntary hospitalization nor a less restrictive form of treatment in a more integrated setting is appropriate. The petition will be filed with the clerk of the district court in any county within:

a. The judicial district in which the person is located.
b. The judicial district in which the person's alleged behavior occurred prompting the basis for the petition or
c. Another judicial district in the State of Nebraska if authorized, upon good cause shown, by a district judge of the judicial district in which the person is located neb. Rev. Stat §71-921 (2004).

The petition may include a request for emergency protective custody and evaluation of the person before the Mental Health Board hearing begins. If the court or chairperson of the Mental Health Board has probable cause to believe that the person is mentally ill and dangerous due to a mental illness, a warrant directing the sheriff to take custody of the person may be issued.

If the person is already in emergency protective custody, a copy of the certificate must be filed with the petition. The person will be held in the nearest appropriate and available medical facility and will not be placed in jail, Neb. Rev. Stat. §71-922 (2004).

Once a petition is filed, the clerk of the district court will have a summons fixing the time and place for a hearing prepared and issued to the sheriff for service. The sheriff will personally serve the summons to the subject and if the subject is a minor or is incapacitated, to the subject's guardian. Copies of the petition, the list of the person's rights, and a notice of the names, addresses, and phone numbers of mental health professionals in the area who may evaluate the person before the hearing will be served along with the summons. The summons will also include the time and place of the hearing which is to commence within seven calendar days. If the person does not appear as required by the summons, a warrant may be issued, Neb. Rev. Stat. §71-923 (2004).

If the person fails to appear at a hearing after being served a summons, the Mental Health Board may issue a warrant to take the person into custody, Neb. Rev. Stat. §71-923 (2004).

10. What Happens at a Mental Health Board Hearing?

The Mental Health Board will conduct a hearing to determine if there is "clear and convincing evidence" that the person is mentally ill and dangerous due to a mental illness and if neither, voluntary hospitalization nor a less restrictive treatment alternative in a more integrated setting is possible.

When the hearing begins, the Mental Health Board must ask if the person has received a copy of the petition and a list of rights. *(See "What are the rights of persons in need of treatment" (page 9)).* The Mental Health Board must also ask if the person has read and understood the petition and rights. If there is a part of the petition or rights that the person has not read or understood, the Mental Health Board must explain to the person the unread parts or portions not understood.

The Mental Health Board must also ask the person whether he or she admits or denies the allegations contained in the petition. If the person admits the allegations, the Mental Health Board will enter a treatment order. However, if the person denies the allegations of the petition, the Board will continue with the hearing. Neb. Rev. Stat. §§71-924; 71-925 (2004).

a. Person is not found to be mentally ill and dangerous
   If the Mental Health Board determines that there is not clear and convincing evidence that the person is mentally ill and dangerous, then the person must be unconditionally discharged and the petition dismissed. Neb. Rev. Stat. §§71-925 (2004).
b. Person is found to be mentally ill and dangerous due to a mental illness

If the Mental Health Board determines that there is clear and convincing evidence that the person is mentally ill and dangerous due to a mental illness but that a voluntary hospitalization or some less restrictive alternative is possible, the board will either:

i. Dismiss the petition and unconditionally discharge the person or
ii. Suspend the proceedings for up to 90 days to allow the person to seek voluntary treatment. Neb. Rev. Stat. §§71-925 (2004).
iii. Suspended proceedings:

If the proceedings are suspended during the 90-day period, the county attorney may apply with the board to reinstate the proceedings. After giving notice to the person who is the subject of the proceedings, is or her counsel (if any), and his or her guardian (if any), the Mental Health Board

will hear the application. However, if no application is filed or pending after the 90 day period, the board will dismiss the petition and order an unconditional discharge of the person. Neb. Rev. Stat. §71-925 (2004).

If the Mental Health Board determines there is clear and convincing evidence that the person is mentally ill and dangerous due to a mental illness and that voluntary hospitalization or a less restrictive treatment is *not* possible, within 48 hours the board will:

a. Order the person to receive outpatient treatment or
b. Order the person to receive inpatient treatment. Neb. Rev. Stat. §71-925 (2004).

11. If it is determined that inpatient treatment is necessary, can the decision be appealed?

Yes. Either the person subject to the commitment or the county attorney may appeal a treatment order of the Mental Health Board to the district court. Final district court orders may then be appealed to the Court of Appeals pursuant to the procedure in criminal cases. Once a final judgment is made, it will be certified and will become a part of the records of the Mental Health Board with respect to that person. Neb. Rev. Stat. §71-930 (2004).

12. What treatment will a person receive?

a. Placement considerations for treatment: If the Mental Health Board orders a person to receive inpatient treatment, but the person has not yet been admitted for treatment, the person may petition for a rehearing based on improvement in his or her condition. This improvement would need to show that inpatient treatment would no longer be necessary or appropriate.

   If the Mental Health Board does order treatment, the board must consider all treatment alternatives. In doing so, the board must impose the least restraint possible on the person. Inpatient treatment should be considered as a last resort. Both the county attorney and the person may offer proposed treatment orders that the board may choose to adopt. If the board adopts the proposed treatment, it may enter a proposed order without a full hearing.

   The Mental Health Board may also request the Department of Health and Human Services (DHHS) or any other person or public or private entity to advise it before entering a treatment order and may also require the person to undergo a psychiatric or psychological evaluation. Neb. Rev. Stat. §71-925 (2004).

b. Treatment Plan: If it has been determined that the person is in need of treatment once the hearing has been concluded, the Mental Health Board will designate a person or agency to prepare and oversee an individualized treatment plan for the person. The designated person or agency responsible for the plan must also record the progress of the patient and report such progress to the Mental Health Board. Neb. Rev. Stat. §71-932 (2004).

   i. Contents of the treatment plan: The individualized treatment plan must contain the following:
      1. The nature of the subject's mental illness or substance dependence;
      2. The least restrictive treatment alternative appropriate for the person; and
      3. Intermediate and long-term treatment goals with a timetable denoting when those goals are to be reached §71-931 (2004).

ii. Copies of the treatment plan: The treatment plan will be filed with the Mental Health Board and will be included in the person's Mental Health Board file. Within five working days after the entry of the board's order, a copy of the plan must also be served upon:
    1. The county attorney
    2. The person
    3. The person's counsel and
    4. The person's legal guardian or conservator (if any). Neb. Rev. Stat. §71-931 (2004).

iii. Implementation of the treatment plan: Once a treatment plan has been prepared, treatment shall begin within two working days. Neb. Rev. Stat. §71-931 (2004).

iv. What the person in need of treatment is entitled to know: The person in need of treatment is entitled to know the contents of the treatment plan and what he or she must do to meet the requirements of the plan. The person will be notified when the Mental Health Board has changed the treatment needs of the person or has ordered the person to be discharged. Neb. Rev. Stat. §71-931 (2004).

c. Progress Reports: The person or agency responsible for preparing and overseeing the person's treatment plan must submit periodic progress reports to the Mental Health Board. The Mental Health Board may distribute copies of the progress report to other interested persons.

i. Contents of the progress report: Each progress report will state a summary of the progress made toward the goals in the treatment plan. The report will also state whether the treatment plan has been modified.

ii. Copies of progress reports: Progress reports must be filed with the Mental Health Board. The Mental Health Board will review the reports and will include them in the person's file. Progress reports will also be served upon the county attorney, the person in need of treatment, the person's counsel, and the person's legal guardian or conservator (if any) within ten days of the submission of the person's individualized treatment plan when inpatient treatment is required Neb. Rev. Stat. §71-932 (2004).

iii. Frequency of filing progress reports: Progress reports must be filed and served at least every 90 days for one year after the first treatment plan has been submitted. After one year, progress reports must be filed and served every six months. Neb. Rev. Stat. §71-932 (2004).

iv. Review hearing: After the filing of each progress report, the person in need of treatment, the person's counsel, or the person's legal guardian or conservator (if any) may request and is entitled to:
    1. A review hearing by the Mental Health Board and
    2. Seek from the board an order of discharge from commitment or change in treatment ordered by the board
    3. If a request is made, the Mental Health Board must schedule the hearing within 14 calendar days of receiving the written request. Neb. Rev. Stat. §71-935 (2004).

The Mental Health Board may also schedule a review hearing:

1. At any time pursuant to Neb. Rev. Stat. §§71-937, 938 (2004).
2. Upon the request of the person, the person's counsel, the person's legal guardian or conservator (if any), the county attorney, the official, agency, or other person or entity designated by the Mental Health Board to prepare and oversee the person's individualized treatment plan or
3. Upon the board's own motion Neb. Rev. Stat. §71-935 (2004).

The board will immediately discharge the person or enter a new treatment order when anyone is able to show, or it is documented through the periodic reports, that:

1. Cause no longer exists for care or treatment of the person or
2. A less restrictive treatment alternative exists for the period. Neb. Rev. Stat. §71-935 (2004).

d. Change in treatment: At times, persons may need to have their treatment changed so that they will receive treatment that is more or less restrictive than their current treatment.

i. If a person is committed to outpatient treatment, the treatment provider must submit a report to the Mental Health Board and the county attorney if:

1. The person is not following his or her individualized treatment plan.
2. The person is not following the conditions set by the Mental Health Board.
3. The current treatment is not effective.
4. There has been a significant change in the person's mental illness or substance dependence. Neb. Rev. Stat. §71-933 (2004).

Once the county attorney receives the report, he or she will determine if there is a factual basis for the report. If there is no factual basis for the report, no further action will be taken and the board will be notified of this finding. If factual basis is found for the report and it is necessary for the Mental Health Board to intervene to protect the person, the county attorney may file a motion for reconsideration and have the matter set for hearing. The county attorney may apply for a warrant to take the person into custody immediately while awaiting rehearing from the board. Neb. Rev. Stat. §71-933 (2004). The Mental Health Board will hold a hearing to examine whether the current treatment plan is appropriate to safely and adequately address the person's needs. The Mental Health Board will then decide whether the current treatment plan will be continued, modified, or ended. Neb. Rev. Stat. §71-934 (2004).

ii. If an administrator of a treatment facility determines that a person may be safely and properly discharged or placed on convalescent leave, the administrator shall immediately submit a written notice to the Mental Health Board of the judicial district where the person was committed. The Mental Health Board will forward the notice onto the county attorney. The board will then conduct a hearing to determine whether the person is mentally ill and dangerous due to a mental illness. Neb. Rev. Stat. §§71-936, 71-937 (2004). In the hearing, the board will determine whether the person is complying with the conditions of their release from treatment, including taking their medications. If the board finds through clear and convincing evidence that the person is mentally ill and dangerous due to a mental illness, the board must enter an order of final disposition within 48 hours. Neb. Rev. Stat. §71-938 (2004). If the need for treatment no longer exists or if treatment can be provided in a less restrictive manner, the Mental Health Board must order an immediate discharge of the person or change the treatment. If a change in treatment occurs, due process protection will apply to the person. Neb. Rev. Stat. §§71-935 (2004).

13. What are the board's responsibilities in reassessing level of care decisions?

Section 71-925 (6) states: A treatment order by the Mental Health Board under this section shall represent the appropriate available treatment alternative that imposes the least possible restraint upon the liberty of the subject. The board shall consider all treatment alternatives, including any treatment programs or conditions suggested by the subject, the subject's counsel, or other interested person. Inpatient hospitalization or custody shall only be considered as a treatment alternative of last resort.

The county attorney and the subject may jointly offer a proposed treatment order for adoption by the board. The board may enter the proposed order without a full hearing.

When a commitment has been made, a Mental Health Board has the option of re-evaluating a level of care decision. If a person is not cooperating, not following conditions of release or not following an outpatient treatment plan, which may include their not taking the prescribed medication, then the treating mental health professional can inform either the board or the county attorney and a new hearing may be held.

Re-assessment of a level of care decision may also be necessary when a committed person, while waiting for an opening at a Regional Center or residential substance abuse program, has been receiving treatment at a crisis center/hospital. If the board finds that (1) the person could no longer be considered mentally ill and dangerous; or (2) no longer substance dependent and dangerous; or (3) that no cause exists for care or treatment; or (4) that a less restrictive alternative exists--the board may order immediate discharge or change the treatment disposition per Neb. Rev. Stat. 71-935 Neb. Rev. Stat. 71-937 removes the language requiring seven days' notice in advance of a release by a treatment facility.

14. What are the Board's options in outpatient community-based services?

Mental Health Board members must look at least restrictive levels of care, which meet the behavioral health needs of the person. Outpatient commitments should be considered in most cases, as they are less restrictive and less traumatic to the person. Commitment may be made to more than one service, if needed, such as community support and medication management. The Mental Health Board may commit the person to a community-based service.

15. What are the Board's options for inpatient treatment services?

As a result of the passage of LB1083, Mental Health Boards are to commit mentally ill and dangerous persons to Nebraska Health and Human Services for inpatient (Acute and Sub Acute) care. DHHS, through community-based hospitals, and the state six behavioral health regions and the state hospital, will provide the level of care necessary as determined by the Mental Health Board upon reviewing the Professional Affidavit, testimony, and other pertinent information presented at the Mental Health Board hearing.

16. Can a board force an individual to take medication?

Yes, but only if standards of proof are met in a separate proceeding that guarantees due process of law. Section 71-959(3) provides that a subject has a right to refuse medication except "following a hearing and order of a Mental Health Board, such treatment medication as will substantially improve his or her mental illness."

The foregoing provision, enacted in 2004, simply brought Nebraska's statutes in line with U.S. Constitutional requirements as articulated by the U.S. Supreme Court in Mills v. Rogers, 457 U.S. 291 (1982) and Washington v. Harper, 494 U.S. 210 (1990). The Mills case involved the rights of an individual committed to treatment through a civil process similar to the Nebraska Mental Health Commitment Act. These two cases stand for the proposition that it is unconstitutional in our country to medicate someone against their will, without first providing them with a Due Process hearing on the issue of forced medication.

This proposition was more recently articulated in Sell v. U.S., 539 U.S. 166 (2003), a criminal case in which the defendant was found to be not competent to stand trial and a danger to himself and others. Mr. Sell refused to take medication to make him competent to stand trial on felony charges. The Court held that under the Constitution, the government may administer drugs to render an individual competent to stand trial, if a due process hearing is given and the state's reasons are more compelling than the subject's reasons for refusing. The Sell decision also sheds light on what issues an impartial hearing body such as the Mental Health Board should consider when weighing the issue of forced medication, including:

- Whether the medication is medically appropriate
- Whether any alternative treatments are likely to succeed
- The likelihood and severity of drug side effects
- The likelihood of long term impact on the patient's health
- Whether the medication is likely to produce significant improvements
- Whether the refusal to take the drug puts the patient or others at risk.

Constitutional rights apply to all citizens of the US. Moreover, civilly committed patients have the same Constitutional protections as do criminal defendants. Mills stands for the proposition that civilly committed patients enjoy Due Process protections in this regard. The same considerations that were applied in Sell are also applicable to Mental Health Board hearings on forced medication decisions. Basic Due Process protections would include a right to notice of the hearing, the medication that the State wishes to administer and an opportunity to defend his or her refusal to take that particular medication.

It should be clear from the foregoing that an attempt by the Mental Health Board to include "boilerplate" language in a commitment order granting the blanket authority to force medicate without first addressing the issues covered in this memo will not pass constitutional scrutiny. The subject is entitled to a due process hearing on these issues before a forced medication order can be entered in order to be consistent with the statutory and constitutional scheme.

17. Can law enforcement access the Mental Health Board's File or other documents held by the Mental Health Board?

Neb. Rev. Stat. Sec.71961 (1) provides:
All records kept on any subject shall remain confidential except as otherwise provided by law. Such records shall be accessible to (a) the subject, except as otherwise provided in subsection (2) of this section, (b) the subject's legal counsel, (c) the subject's guardian or conservator, if any, (d) the Mental Health Board having jurisdiction over the subject, (e) persons authorized by an order of a judge or court, (f) persons authorized by written permission of the subject (g) agents or employees of the Department of Health and Human Services Regulation and Licensure upon delivery of a subpoena from the department in connection with a licensing or licensure investigation by the department, or (h) the Nebraska State Patrol or the Department of Health and Human Services pursuant to section 69-2409.01

The phase "all records kept on any subject" is not specifically delineated in statute, but reasonably includes records in the possession of the Mental Health Board as well as the file and other documents maintained by clerk of the district court (see71-917).

Nothing in the statutes gives any law enforcement agency automatic access to such confidential records, absent one of the exceptions set forth in 71-961 (1). Put another way, without one of the exceptions in 71-961(1) having first been met, the Mental Health Board has no authority to release its

records to law enforcement. Note that per subsection (e), the Board can be authorized to release information per a court order. A court order is not a subpoena. If a law enforcement agent presents a subpoena for records in the possession of the Board that alone would *not* authorize release.

Pursuant to section 69-2409.01, the mental health board, by and through the Clerk of the District Court must provide the Nebraska State Patrol notice of "information as may be necessary for the sole purpose of determining whether an individual is disqualified from purchasing or possessing a handgun pursuant to state or federal law." "Clerks of the various courts shall furnish to the Department of Health and Human Services and Nebraska State Patrol, as soon as practicable but within thirty days after an order of commitment or discharge is issued or after removal or firearm-related disabilities." Section 69-2409.01 also specifies that clerks of the various courts shall provide to DHHS and NSP "all information necessary to set up and maintain the data base required by this section." The LB 512 amendment to 69-2409.01 that takes effect January 1, 2012 requires NSP to develop its own data base for this purpose.

18. How are Mental Health Boards created?

According to 71-905, "Mental Health Board" means a board created under section 71-915. Synopsis of NRS Sec. 71-915: The presiding judge in each district court judicial district shall create at least one but not more than three Mental Health Boards in such district and shall appoint sufficient members and alternate members to such boards. Terms are for 4 years but the presiding judge may remove members/alternates at his discretion.

19. Do members of the Mental Health Board have immunity?

Members of the MHB shall have the same immunity as judges of the District Court.

20. What is the composition of the Mental Health Board?

Each MHB shall consist of a licensed attorney. The attorney shall be chairperson of the board. Other board members will be any two of the following but not more than one from each category:

- Physician
- Psychologist
- Psychiatric nurse
- Licensed independent clinical social worker
- Licensed clinical social worker
- Licensed independent mental health practitioner who is not a social worker
- Layperson with a demonstrated interest in mental health and substance dependency issues. Neb. Rev. Stat. 71-915(2)

Members/alternates shall take an oath to support the US and Nebraska Constitution and to faithfully discharge the duties of the office.

21. What powers do the Mental Health Boards hold?

MHB shall have the power to issue subpoenas, to administer oaths, and to do any act necessary and proper for the board to carry out its duties.

22. How many members of the Mental Health Board must be present to hold a hearing?

No MHB hearing shall be conducted unless three members or alternate members are present and able to vote. Any action taken at any MHB hearing shall be by a majority vote.

23. What paperwork regarding inventory is required?

MHB shall file an annual inventory statement with the county board of all county personal property in its custody.

24. How is a Mental Health Board member compensated?

Members of the MHB shall be compensated and reimbursed for actual and necessary expenses, not including charges for meals, by the county served by such board. Compensation shall be at an hourly rate determined by the presiding district court judge, except that compensation shall not be less than fifty dollars for each hearing of the board.

25. What training is required of Mental Health Board members?

DHHS shall provide training to members/alternates. No person shall remain on a MHB or be eligible for appointment unless he/she has attended and satisfactorily completed such training pursuant to rules and regulations adopted by DHHS. Members/alternates shall be reimbursed for any actual and necessary expenses incurred in attending such training in an amount determined by the presiding judge of the district court.

26. Does DHHS provide forms and copies of rules and regulations to the Mental Health Board?

DHHS shall provide the MHB's with blank forms and copies of rules and regulations of the department that will enable the MHB's to carry out their powers and duties.

During the summer of 2011, DHHS Division of Behavioral Health completed four training events (Norfolk, Omaha, Grand Island, Sydney) with 208 participants that culminated in a continuing legal education workshop for the Nebraska County Attorney Association Annual Conference (Lincoln). The participants in these training events offered more frequently asked questions as follows:

27. What resources are used to pay for persons without health insurance, if those individuals with mental illness or substance dependence agree to a 90 day continuance and seek services voluntarily?

It depends upon that individual's ability to pay for services and the services they seek voluntarily. DHHS does not pay for voluntary hospital care, but DHHS directs monies through contracts with the appropriate Regional Behavioral Health Authority to pay for other non-hospital based services in the most integrated setting in our communities.

28. When a mental health board commits a person to the custody of DHHS, where should law enforcement take him or her?

It depends upon the region in which the person is committed, but the "facility" is likely a crisis center or a local hospital, where the individual who is potentially dangerous due to a mental illness, was admitted for evaluation.

29. Why is police presence required in order to execute an emergency protective custody?

Only the police, acting under proper legal authority, can suspend individual constitutional rights to place a person in custody. Physicians may 'hold' an individual in the case of a medical emergency, e.g. dangerous due to mental illness, and contact the county attorney for legal authority to have police take the person into custody.

30. Who pays the costs for emergency protective custody?

According to statutes referenced below, the counties pay for the costs of emergency protective custody, unless the Nebraska Legislature appropriates funds for the partial "support for the cost of maintenance and treatment of persons in emergency protective custody under the treatment pursuant to an order of commitment by a district court or mental health board." In past years the Nebraska Legislature has provided such partial support through the Nebraska Healthcare Cash Fund appropriation.

71-808. Regional behavioral health authority; established; regional governing board; matching funds; requirements.

(3) Each county in a behavioral health region shall provide funding for the operation of the behavioral health authority and for the provision of behavioral health services in the region. The total amount of funding provided by counties under this subsection shall be equal to one dollar for every three dollars from the General Fund. The division shall annually certify the total amount of county matching funds to be provided. At least forty percent of such amount shall consist of local and county tax revenue, and the remainder shall consist of other nonfederal sources. The regional governing board of each behavioral health authority, in consultation with all counties in the region, shall determine the amount of funding to be provided by each county under this subsection. Any General Funds transferred from regional centers for the provision of community-based behavioral health services after July 1, 2004, and funds received by a regional behavioral health authority for the provision of behavioral health services to children under section 71-826 shall be excluded from any calculation of county matching funds under this subsection.

71-919. Mentally ill and dangerous person; dangerous sex offender; emergency protective custody; evaluation by mental health professional.

(1) A law enforcement officer who has probable cause to believe that a person is mentally ill and dangerous or a dangerous sex offender and that the harm described in section 71-908 or subdivision (1) of section 83-174.01 is likely to occur before mental health board proceedings under the Nebraska Mental Health Commitment Act or the Sex Offender Commitment Act may be initiated to obtain custody of the person may take such person into emergency protective custody, cause him or her to be taken into emergency protective custody, or continue his or her custody if he or she is already in custody. Such person shall be admitted to an appropriate and available medical facility, jail, or Department of Correctional Services facility as provided in subsection (2) of this section. Each county shall make arrangements with appropriate facilities inside or outside the county for such purpose and shall pay the cost of the emergency protective custody of persons from such county in such facilities. A mental health professional who has probable cause to believe that a person is mentally ill and dangerous or a dangerous sex offender may cause such person to be taken into custody and shall have a limited privilege to hold such person until a law enforcement officer or other authorized person arrives to take custody of such person.

71-926. Subject; custody pending entry of treatment order.

(1) At the conclusion of a mental health board hearing under section 71-924 and prior to the entry of a treatment order by the board under section 71-925, the board may (a) order that the subject be retained in custody until the entry of such order and the subject may be admitted for treatment pursuant to such order or (b) order the subject released from custody under such conditions as the board deems necessary and appropriate to prevent the harm described in section 71-908 and to assure the subject's appearance at a later disposition hearing by the board. A subject shall be retained in custody under this section at the nearest appropriate and available medical facility and shall not be placed in a jail. Each county shall make arrangements with appropriate medical facilities inside or outside the county for such purpose and shall pay the cost of the emergency protective custody of persons from such county in such facilities.

APPENDIX W

FIREARMS - REMOVING COMMITTED PERSONS FROM RESTRICTED USE LIST GRANTING RELIEF OF COMMITTED PERSONS FIREARM DISABILITY IN NEBRASKA

Persons committed by Mental Health Boards can be granted relief of their firearm restrictions upon petition to boards of mental health, and upon agreement of the board, will be removed from those persons restricted. This relief is granted only by the mental health boards and only to persons having been committed as described in the following sections of Nebraska statutes. It is the responsibility of the individual subject to the commitment to petition ALL boards to relieve firearm disability before the Nebraska State Patrol and the Department of Health and Human Services will remove the individual from the list of restricted persons.

NRS 71-963. Firearm-related disabilities; petition to remove; mental health board; review hearing; evidence; decision; appeal; petition granted; effect.

(1) Upon release from commitment or treatment, a person who, because of a mental health-related commitment or adjudication occurring under the laws of this state, is subject to the disability provisions of 18 U.S.C. 922(d)(4) and (g)(4) or is disqualified from obtaining a certificate to purchase, lease, rent, or receive transfer of a handgun under section 69-2404 or a permit to carry a concealed handgun under the Concealed Handgun Permit Act may petition the mental health board to remove such disabilities.
(2)(a) Upon the filing of the petition, the subject may request and, if the request is made, shall be entitled to, a review hearing by the mental health board. The mental health board shall grant a petition filed under subsection (1) of this section if the mental health board determines that:
(i) The subject will not be likely to act in a manner dangerous to public safety; and
(ii) The granting of the relief would not be contrary to the public interest.
(b) In determining whether to remove the subject's firearm-related disabilities, the mental health board shall receive and consider evidence upon the following:
(i) The circumstances surrounding the subject's mental health commitment or adjudication;
(ii) The subject's record, which shall include, at a minimum, the subject's mental health and criminal history records;
(iii) The subject's reputation, developed, at a minimum, through character witness statements, testimony, or other character evidence; and
(iv) Changes in the subject's condition, treatment, treatment history, or circumstances relevant to the relief sought.
(3) If a decision is made by the mental health board to remove the subject's firearm-related disabilities, the clerks of the various courts shall immediately send as soon as practicable but within thirty days an order to the Nebraska State Patrol and the Department of Health and Human Services, in a form and in a manner prescribed by the Department of Health and Human Services and the Nebraska State Patrol, stating its findings, which shall include a statement that, in the opinion of the mental health board, (a) the subject is not likely to act in a manner that is dangerous to public safety and (b) removing the subject's firearm-related disabilities will not be contrary to the public interest.
(4) The subject may appeal a denial of the requested relief to the district court, and review on appeal shall be de novo.
(5) If a petition is granted under this section, the commitment or adjudication for which relief is granted shall be deemed not to have occurred for purposes of section 69-2404 and the Concealed Handgun Permit Act and, pursuant to section 105(b) of Public Law 110-180, for purposes of 18 U.S.C. 922(d)(4) and (g)(4).

Source: Laws 2011, LB512, Sec. 8.

NRS 69-2409.01. Data base; created; disclosure; limitation; liability; prohibited act; violation; penalty.

(1) For purposes of sections 69-2401 to 69-2425, the Nebraska State Patrol shall be furnished with only such information as may be necessary for the sole purpose of determining whether an individual is disqualified from purchasing or possessing a handgun pursuant to state law or is subject to the disability provisions of 18 U.S.C. 922(d)(4) and (g)(4). Such information shall be furnished by the Department of Health and Human Services. The clerks of the various courts shall furnish to the Department of Health and Human Services and Nebraska State Patrol, as soon as practicable but within thirty days after an order of commitment or discharge is issued or after removal of firearm-related disabilities pursuant to section 71-963, all information necessary to set up and maintain the data base required by this section. This information shall include (a) information regarding those persons who are currently receiving mental health treatment pursuant to a commitment order of a mental health board or who have been discharged, (b) information regarding those persons who have been committed to treatment pursuant to section 29-3702, and (c) information regarding those persons who have had firearm-related disabilities removed pursuant to section 71-963. The mental health board shall notify the Department of Health and Human Services and the Nebraska State Patrol when such disabilities have been removed. The Department of Health and Human Services shall also maintain in the data base a listing of persons committed to treatment pursuant to section 29-3702. To ensure the accuracy of the data base, any information maintained or disclosed under this subsection shall be updated, corrected, modified, or removed, as appropriate, and as soon as practicable, from any data base that the state or federal government maintains and makes available to the National Instant Criminal Background Check System. The procedures for furnishing the information shall guarantee that no information is released beyond what is necessary for purposes of this section.
(2) In order to comply with sections 69-2401 and 69-2403 to 69-2408 and this section, the Nebraska State Patrol shall provide to the chief of police or sheriff of an applicant's place of residence or a licensee in the process of a criminal history record check pursuant to section 69-2411 only the information regarding whether or not the applicant is disqualified from purchasing or possessing a handgun.
(3) Any person, agency, or mental health board participating in good faith in the reporting or disclosure of records and communications under this section is immune from any liability, civil, criminal, or otherwise, that might result by reason of the action.
(4) Any person who intentionally causes the Nebraska State Patrol to request information pursuant to this section without reasonable belief that the named individual has submitted a written application under section 69-2404 or has completed a consent form under section 69-2410 shall be guilty of a Class II misdemeanor in addition to other civil or criminal liability under state or federal law.
Source: Laws 1996, LB 1055, § 1; Laws 1997, LB 307, § 112; Laws 2011, LB512, § 3.

Division of Behavioral Health Response:

1. If a consumer has been denied ownership of a handgun because of a mental health commitment the consumer can ask the Division of Behavioral Health to release the names of the Mental Health Boards to the consumer or consumer's legal representative for the purpose of petitioning the boards for the removal of firearm disability resulting from those commitments.
2. Because the information is covered under HIPAA and 42 CFR Part 2, the Division shall provide for a release of information form through the mail, or electronically. Removal of Firearm Disability Request Form
3. The consumer must complete the form and have the form witnessed and the original form returned to the Division. See address below.

4. Division of Behavioral Health, upon receipt of a properly completed form, will release the names of the Mental Health Board or Boards under which the Division of Behavioral Health has a commitment record.
5. It is the responsibility of the individual subject to the commitment to petition ALL boards to relieve firearm disability before the Nebraska State Patrol and the Department of Health and Human Services will remove the individual from the list of restricted persons. The individual may represent themselves at hearing, or have legal counsel. All expenses are that of the individual seeking relief.

APPENDIX X
SEX OFFENDER COMMITMENT ACT

Accessed from: **HTTP://NEBRASKALEGISLATURE.GOV/LAWS/LAWS-INDEX/CHAP71-FULL.HTML**
(April 20, 2011)

71-1201. Act, how cited.

Sections 71-1201 to 71-1226 shall be known and may be cited as the Sex Offender Commitment Act.

Source: Laws 2006, LB 1199, § 57.

71-1202. Purpose of act.

The purpose of the Sex Offender Commitment Act is to provide for the court-ordered treatment of sex offenders who have completed their sentences but continue to pose a threat of harm to others. It is the public policy of the State of Nebraska that dangerous sex offenders be encouraged to obtain voluntary treatment. If voluntary treatment is not obtained, such persons shall be subject to involuntary custody and treatment only after Mental Health Board proceedings as provided by the Sex Offender Commitment Act. Such persons shall be subjected to emergency protective custody under limited conditions and for a limited period of time.

Source: Laws 2006, LB 1199, § 58.

Annotations

The Sex Offender Commitment Act applies specifically to convicted sex offenders who have completed their jail sentences but continue to pose a threat of harm to others. In re Interest of G.H., 279 Neb. 708, 781 N.W.2d 438 (2010).

The Sex Offender Commitment Act is not excessive in relation to its assigned nonpunitive purpose, which is to protect the public and provide treatment to dangerous sex offenders who are likely to reoffend. In re Interest of J.R., 277 Neb. 362, 762 N.W.2d 305 (2009).

71-1203. Terms, defined.

For purposes of the Sex Offender Commitment Act:

(1) The definitions found in sections 71-905, 71-906, 71-907, 71-910, 71-911, and 83-174.01 apply;

(2) Administrator means the administrator or other chief administrative officer of a treatment facility or his or her designee;

(3) Outpatient treatment means treatment ordered by a Mental Health Board directing a subject to comply with specified outpatient treatment requirements, including, but not limited to, (a) taking prescribed medication, (b) reporting to a mental health professional or treatment facility for treatment or for monitoring of the subject's condition, or (c) participating in individual or group therapy or educational, rehabilitation, residential, or vocational programs;

(4) Subject means any person concerning whom (a) a certificate has been filed under section 71-1204, (b) a certificate has been filed under section 71-919 and such person is held pursuant to subdivision (2)(b) of section 71-919, or (c) a petition has been filed under the Sex Offender Commitment Act. Subject does not include any person under eighteen years of age unless such person is an emancipated minor; and

(5) Treatment facility means a facility which provides services for persons who are dangerous sex offenders.

Source: Laws 2006, LB 1199, § 59.

Annotations

The explicit purpose of the Sex Offender Commitment Act is to protect the public from sex offenders who continue to pose a threat of harm to others. In re Interest of J.R., 277 Neb. 362, 762 N.W.2d 305 (2009).

71-1204. Emergency protective custody; dangerous sex offender determination; written certificate; contents.

(1) A mental health professional who, upon evaluation of a person admitted for emergency protective custody under section 71-919, determines that such person is a dangerous sex offender shall execute a written certificate as provided in subsection (2) of this section not later than twenty-four hours after the completion of such evaluation. A copy of such certificate shall be immediately forwarded to the county attorney.

(2) The certificate shall be in writing and shall include the following information:

(a) The subject's name and address, if known;

(b) The name and address of the subject's spouse, legal counsel, guardian or conservator, and next of kin, if known;

(c) The name and address of anyone providing psychiatric or other care or treatment to the subject, if known;

(d) The name and address of any other person who may have knowledge of the subject's mental illness or personality disorder who may be called as a witness at a Mental Health Board hearing with respect to the subject, if known;

(e) The name and address of the medical facility in which the subject is being held for emergency protective custody and evaluation;

(f) The name and work address of the certifying mental health professional;

(g) A statement by the certifying mental health professional that he or she has evaluated the subject since the subject was admitted for emergency protective custody and evaluation; and

(h) A statement by the certifying mental health professional that, in his or her clinical opinion, the subject is a dangerous sex offender and the clinical basis for such opinion.

Source: Laws 2006, LB 1199, § 60.

71-1205. Person believes another to be a dangerous sex offender; notify county attorney; petition; when; contents.

(1) Any person who believes that another person is a dangerous sex offender may communicate such belief to the county attorney. The filing of a certificate by a law enforcement officer under section 71-919 shall be sufficient to communicate such belief. If the county attorney concurs that such person is a dangerous sex offender and that neither voluntary hospitalization nor other treatment alternatives less restrictive of the subject's liberty than inpatient or outpatient treatment ordered by a Mental Health Board is available or would suffice to prevent the harm described in subdivision (1) of section 83-174.01, the county attorney shall file a petition as provided in this section.

(2) The petition shall be filed with the clerk of the district court in any county within: (a) The judicial district in which the subject is located; (b) the judicial district in which the alleged behavior of the subject occurred which constitutes the basis for the petition; or (c) another judicial district in the State of Nebraska, if authorized, upon good cause shown, by a district judge of the judicial district in which the subject is located. In such event, all proceedings before the Mental Health Board shall be conducted by the Mental Health Board serving such other county and all costs relating to such proceedings shall be paid by the county of residence of the subject. In the order transferring such cause to another county, the judge shall include such directions as are reasonably necessary to protect the rights of the subject.

(3) The petition shall be in writing and shall include the following information:

(a) The subject's name and address, if known;

(b) The name and address of the subject's spouse, legal counsel, guardian or conservator, and next of kin, if known;

(c) The name and address of anyone providing psychiatric or other care or treatment to the subject, if known;

(d) A statement that the county attorney has probable cause to believe that the subject of the petition is a dangerous sex offender;

(e) A statement that the beliefs of the county attorney are based on specific behavior, acts, criminal convictions, attempts, or threats which shall be described in detail in the petition; and

(f) The name and address of any other person who may have knowledge of the subject's mental illness or personality disorder and who may be called as a witness at a Mental Health Board hearing with respect to the subject, if known.

Source: Laws 2006, LB 1199, § 61.

71-1206. Mental Health Board proceedings; commencement; petition; custody of subject; conditions; dismissal; when.

(1) Mental Health Board proceedings shall be deemed to have commenced upon the earlier of (a) the filing of a petition under section 71-1205 or (b) notification by the county attorney to the law enforcement officer who took the subject into emergency protective custody under section 71-919 or the administrator of the treatment facility having charge of the subject of the intention of the county attorney to file such petition. The county attorney shall file such petition as soon as reasonably practicable after such notification.

(2) A petition filed by the county attorney under section 71-1205 may contain a request for the emergency protective custody and evaluation of the subject prior to commencement of a Mental Health Board hearing pursuant to such petition with respect to the subject. Upon receipt of such request and upon a finding of probable cause to believe that the subject is a dangerous sex offender as alleged in the petition, the court or chairperson of the Mental Health Board may issue a warrant directing the sheriff to take custody of the subject. If the subject is already in emergency protective custody under a certificate filed under section 71-919, a copy of such certificate shall be filed with the petition. The subject in such custody shall be held in an appropriate and available medical facility, jail, or Department of Correctional Services facility. A dangerous sex offender shall not be admitted to a medical facility for emergency protective custody unless a medical or psychiatric emergency exists requiring treatment not available at a jail or correctional facility. Each county shall make arrangements with appropriate facilities inside or outside the county for such purpose and shall pay the cost of the emergency protective custody of persons from such county in such facilities.

(3) The petition and all subsequent pleadings and filings in the case shall be entitled In the Interest of . . . . . , Alleged to be a Dangerous Sex Offender. The county attorney may dismiss the petition at any time prior to the commencement of the hearing of the Mental Health Board under section 71-1208, and upon such motion by the county attorney, the Mental Health Board shall dismiss the petition.

Source: Laws 2006, LB 1199, § 62.

71-1207. Petition; summons; hearing; sheriff; duties; failure to appear; warrant for custody.

Upon the filing of the petition under section 71-1205, the clerk of the district court shall cause a summons fixing the time and place for a hearing to be prepared and issued to the sheriff for service. The sheriff shall personally serve upon the subject and the subject's legal guardian or custodian, if any, the summons and copies of the petition, the list of rights provided by sections 71-943 to 71-960, and a list of the names, addresses, and telephone numbers of mental health professionals in the immediate vicinity by whom the subject may be evaluated prior to his or her hearing. The summons shall fix a time for the hearing within seven calendar days after the subject has been taken into emergency protective custody. The failure of a subject to appear as required under this section shall constitute grounds for the issuance by the Mental Health Board of a warrant for his or her custody.

Source: Laws 2006, LB 1199, § 63.

71-1208. Hearing; Mental Health Board; duties.

A hearing shall be held by the Mental Health Board to determine whether there is clear and convincing evidence that the subject is a dangerous sex offender as alleged in the petition. At the commencement of the hearing, the board shall inquire whether the subject has received a copy of the petition and list of rights accorded him or her by sections 71-943 to 71-960 and whether he or she has

read and understood them. The board shall explain to the subject any part of the petition or list of rights which he or she has not read or understood. The board shall inquire of the subject whether he or she admits or denies the allegations of the petition. If the subject admits the allegations, the board shall proceed to enter a treatment order pursuant to section 71-1209. If the subject denies the allegations of the petition, the board shall proceed with a hearing on the merits of the petition.

Source: Laws 2006, LB 1199, § 64.

71-1209. Burden of proof; Mental Health Board; hearing; orders authorized; conditions; rehearing.

(1) The state has the burden to prove by clear and convincing evidence that (a) the subject is a dangerous sex offender and (b) neither voluntary hospitalization nor other treatment alternatives less restrictive of the subject's liberty than inpatient or outpatient treatment ordered by the Mental Health Board are available or would suffice to prevent the harm described in subdivision (1) of section 83-174.01.

(2) If the Mental Health Board finds that the subject is not a dangerous sex offender, the board shall dismiss the petition and order the unconditional discharge of the subject.

(3) If the Mental Health Board finds that the subject is a dangerous sex offender but that voluntary hospitalization or other treatment alternatives less restrictive of the subject's liberty than treatment ordered by the Mental Health Board are available and would suffice to prevent the harm described in subdivision (1) of section 83-174.01, the board shall (a) dismiss the petition and order the unconditional discharge of the subject or (b) suspend further proceedings for a period of up to ninety days to permit the subject to obtain voluntary treatment. At any time during such ninety-day period, the county attorney may apply to the board for reinstatement of proceedings with respect to the subject, and after notice to the subject, the subject's counsel, and the subject's legal guardian or conservator, if any, the board shall hear the application. If no such application is filed or pending at the conclusion of such ninety-day period, the board shall dismiss the petition and order the unconditional discharge of the subject.

(4) If the subject admits the allegations of the petition or the Mental Health Board finds that the subject is a dangerous sex offender and that neither voluntary hospitalization nor other treatment alternatives less restrictive of the subject's liberty than inpatient or outpatient treatment ordered by the board are available or would suffice to prevent the harm described in subdivision (1) of section 83-174.01, the board shall, within forty-eight hours, (a) order the subject to receive outpatient treatment or (b) order the subject to receive inpatient treatment. If the subject is ordered by the board to receive inpatient treatment, the order shall commit the subject to the custody of the Department of Health and Human Services for such treatment.

(5) A subject who (a) is ordered by the Mental Health Board to receive inpatient treatment and (b) has not yet been admitted for such treatment pursuant to such order may petition for a rehearing by the Mental Health Board based on improvement in the subject's condition such that inpatient treatment ordered by the board would no longer be necessary or appropriate.

(6) A treatment order by the Mental Health Board under this section shall represent the appropriate available treatment alternative that imposes the least possible restraint upon the liberty of the subject. The board shall consider all treatment alternatives, including any treatment program or conditions suggested by the subject, the subject's counsel, or other interested person. Inpatient hospitalization or custody shall only be considered as a treatment alternative of last resort. The county attorney and the subject may

jointly offer a proposed treatment order for adoption by the board. The board may enter the proposed order without a full hearing.

(7) The Mental Health Board may request the assistance of the Department of Health and Human Services or any other person or public or private entity to advise the board prior to the entry of a treatment order pursuant to this section and may require the subject to submit to reasonable psychiatric and psychological evaluation to assist the board in preparing such order. Any mental health professional conducting such evaluation at the request of the Mental Health Board shall be compensated by the county or counties served by such board at a rate determined by the district judge and reimbursed for mileage at the rate provided in section 81-1176.

Source: Laws 2006, LB 1199, § 65.

Annotations

Under subsection (1)(b) of this section, the State's burden to prove that "neither voluntary hospitalization nor other treatment alternatives less restrictive of the subject's liberty than inpatient or outpatient treatment ordered by the Mental Health Board are available or would suffice" was not met when the State provided evidence only of the treatment that would be recommended if the subject were to remain within the Department of Correctional Services. In re Interest of O.S., 277 Neb. 577, 763 N.W.2d 723 (2009).

71-1210. Subject; custody pending entry of treatment order.

(1) At the conclusion of a Mental Health Board hearing under section 71-1208 and prior to the entry of a treatment order by the board under section 71-1209, the board may (a) order that the subject be retained in custody until the entry of such order and the subject may be admitted for treatment pursuant to such order or (b) order the subject released from custody under such conditions as the board deems necessary and appropriate to prevent the harm described in subdivision (1) of section 83-174.01 and to assure the subject's appearance at a later disposition hearing by the board. A subject shall be retained in custody under this section at an appropriate and available medical facility, jail, or Department of Correctional Services facility. A dangerous sex offender shall not be admitted to a medical facility for emergency protective custody unless a medical or psychiatric emergency exists requiring treatment not available at a jail or correctional facility. Each county shall make arrangements with appropriate facilities inside or outside the county for such purpose and shall pay the cost of the emergency protective custody of persons from such county in such facilities.

(2) A subject who has been ordered to receive inpatient or outpatient treatment by a Mental Health Board may be provided treatment while being retained in emergency protective custody and pending admission of the subject for treatment pursuant to such order.

Source: Laws 2006, LB 1199, § 66.

71-1211. Dangerous sex offender; board; issue warrant; contents; immunity.

If the Mental Health Board finds the subject to be a dangerous sex offender and commits the subject to the custody of the Department of Health and Human Services to receive inpatient treatment, the department shall secure placement of the subject in an appropriate inpatient treatment facility to receive such treatment. The board shall issue a warrant authorizing the administrator of such treatment facility to

receive and keep the subject as a patient. The warrant shall state the findings of the board and the legal settlement of the subject, if known, or any available information relating thereto. Such warrant shall shield every official and employee of the treatment facility against all liability to prosecution of any kind on account of the reception and detention of the subject if the detention is otherwise in accordance with the Sex Offender Commitment Act, rules and regulations adopted and promulgated under the act, and policies of the treatment facility.

Source: Laws 2006, LB 1199, § 67.

71-1212. Inpatient treatment; subject taken to facility; procedure.

When an order of a Mental Health Board requires inpatient treatment of a subject within a treatment facility, the warrant filed under section 71-1211, together with the findings of the Mental Health Board, shall be delivered to the sheriff of the county who shall execute such warrant by conveying and delivering the warrant, the findings, and the subject to the treatment facility. The administrator, over his or her signature, shall acknowledge the delivery on the original warrant which the sheriff shall return to the clerk of the district court with his or her costs and expenses endorsed thereon. If neither the sheriff nor deputy sheriff is available to execute the warrant, the chairperson of the Mental Health Board may appoint some other suitable person to execute the warrant. Such person shall take and subscribe an oath or affirmation to faithfully discharge his or her duty and shall be entitled to the same fees as the sheriff. The sheriff, deputy sheriff, or other person appointed by the Mental Health Board may take with him or her such assistance as may be required to execute the warrant. No female subject shall be taken to a treatment facility without being accompanied by another female or relative of the subject. The administrator in his or her acknowledgment of delivery shall record whether any person accompanied the subject and the name of such person.

Source: Laws 2006, LB 1199, § 68.

71-1213. Mental Health Board; execution of warrants; costs; procedure.

(1) If a Mental Health Board issues a warrant for the admission or return of a subject to a treatment facility and funds to pay the expenses thereof are needed in advance, the board shall estimate the probable expense of conveying the subject to the treatment facility, including the cost of any assistance that might be required, and shall submit such estimate to the county clerk of the county in which such person is located. The county clerk shall certify the estimate and shall issue an order on the county treasurer in favor of the sheriff or other person entrusted with the execution of the warrant.

(2) The sheriff or other person executing the warrant shall include in his or her return a statement of expenses actually incurred, including any excess or deficiency. Any excess from the amount advanced for such expenses under subsection (1) of this section shall be paid to the county treasurer, taking his or her receipt therefore, and any deficiency shall be obtained by filing a claim with the county board. If no funds are advanced, the expenses shall be certified on the warrant and paid when returned.

(3) The sheriff shall be reimbursed for mileage at the rate provided in section 33-117 for conveying a subject to a treatment facility under this section. For other services performed under the Sex Offender Commitment Act, the sheriff shall receive the same fees as for like services in other cases.

(4) All compensation and expenses provided for in this section shall be allowed and paid out of the treasury of the county by the county board.

Source: Laws 2006, LB 1199, § 69.

71-1214. Treatment order of Mental Health Board; appeal; final order of district court; appeal.

The subject of a petition or the county attorney may appeal a treatment order of the Mental Health Board under section 71-1209 to the district court. Such appeals shall be de novo on the record. A final order of the district court may be appealed to the Court of Appeals in accordance with the procedure in criminal cases. The final judgment of the court shall be certified to and become a part of the records of the Mental Health Board with respect to the subject.

Source: Laws 2006, LB 1199, § 70.

71-1215. Treatment order; individualized treatment plan; contents; copy; filed; treatment; when commenced.

(1) Any treatment order entered by a Mental Health Board under section 71-1209 shall include directions for (a) the preparation and implementation of an individualized treatment plan for the subject and (b) documentation and reporting of the subject's progress under such plan.

(2) The individualized treatment plan shall contain a statement of (a) the nature of the subject's mental illness or personality disorder, (b) the least restrictive treatment alternative consistent with the clinical diagnosis of the subject, and (c) intermediate and long-term treatment goals for the subject and a projected timetable for the attainment of such goals.

(3) A copy of the individualized treatment plan shall be filed with the Mental Health Board for review and inclusion in the subject's file and served upon the county attorney, the subject, the subject's counsel, and the subject's legal guardian or conservator, if any, within five working days after the entry of the board's order. Treatment shall be commenced within two working days after preparation of the plan.

(4) The subject shall be entitled to know the contents of the individualized treatment plan and what the subject must do in order to meet the requirements of such plan.

(5) The subject shall be notified by the Mental Health Board when the Mental Health Board has changed the treatment order or has ordered the discharge of the subject from commitment.

Source: Laws 2006, LB 1199, § 71.

71-1216. Person responsible for subject's individualized treatment plan; periodic progress reports; copies; filed and served.

The person or entity designated by the Mental Health Board under section 71-1215 to prepare and oversee the subject's individualized treatment plan shall submit periodic reports to the Mental Health Board of the subject's progress under such plan and any modifications to the plan. The Mental Health Board may distribute copies of such reports to other interested parties as permitted by law. With respect to

a subject ordered by the Mental Health Board to receive inpatient treatment, such initial report shall be filed with the Mental Health Board for review and inclusion in the subject's file and served upon the county attorney, the subject, the subject's counsel, and the subject's legal guardian or conservator, if any, no later than ten days after submission of the subject's individualized treatment plan. With respect to each subject committed by the Mental Health Board, such reports shall be so filed and served no less frequently than every ninety days for a period of one year following submission of the subject's individualized treatment plan and every six months thereafter.

Source: Laws 2006, LB 1199, § 72.

71-1217. Outpatient treatment provider; duties; investigation by county attorney; warrant for immediate custody of subject; when.

(1) Any provider of outpatient treatment to a subject ordered by a Mental Health Board to receive such treatment shall report to the board and to the county attorney if (a) the subject is not complying with his or her individualized treatment plan, (b) the subject is not following the conditions set by the Mental Health Board, (c) the treatment plan is not effective, or (d) there has been a significant change in the subject's mental illness or personality disorder or the level of risk posed to the public. Such report may be transmitted by facsimile, but the original of the report shall be mailed to the board and the county attorney no later than twenty-four hours after the facsimile transmittal.

(2)(a) Upon receipt of such report, the county attorney shall have the matter investigated to determine whether there is a factual basis for the report.

(b) If the county attorney determines that there is no factual basis for the report or that no further action is warranted, he or she shall notify the board and the treatment provider and take no further action.

(c) If the county attorney determines that there is a factual basis for the report and that intervention by the Mental Health Board is necessary to protect the subject or others, the county attorney may file a motion for reconsideration of the conditions set forth by the board and have the matter set for hearing.

(d) The county attorney may apply for a warrant to take immediate custody of the subject pending a rehearing by the board under subdivision (c) of this subsection if the county attorney has reasonable cause to believe that the subject poses a threat of danger to himself or herself or others prior to such rehearing. The application for a warrant shall be supported by affidavit or sworn testimony by the county attorney, a mental health professional, or any other informed person. The application for a warrant and the supporting affidavit may be filed with the board by facsimile, but the original shall be filed with the board not later than three days after the facsimile transmittal, excluding holidays and weekends. Sworn testimony in support of the warrant application may be taken over the telephone at the discretion of the board.

Source: Laws 2006, LB 1199, § 73.

71-1218. Outpatient treatment; hearing by board; warrant for custody of subject; subject's rights; board determination.

The Mental Health Board shall, upon motion of the county attorney, or may, upon its own motion, hold a hearing to determine whether a subject ordered by the board to receive outpatient treatment can be

adequately and safely served by the individualized treatment plan for such subject on file with the board. The Mental Health Board may issue a warrant directing any law enforcement officer in the state to take custody of the subject and directing the sheriff or other suitable person to transport the subject to a treatment facility or public or private hospital with available capacity specified by the board where he or she will be held pending such hearing. No person may be held in custody under this section for more than seven days except upon a continuance granted by the board. At the time of execution of the warrant, the sheriff or other suitable person designated by the board shall personally serve upon the subject, the subject's counsel, and the subject's legal guardian or conservator, if any, a notice of the time and place fixed for the hearing, a copy of the motion for hearing, and a list of the rights provided by the Sex Offender Commitment Act. The subject shall be accorded all the rights guaranteed to a subject by the act. Following the hearing, the board shall determine whether outpatient treatment will be continued, modified, or ended.

Source: Laws 2006, LB 1199, § 74.

71-1219. Mental Health Board; review hearing; order discharge or change treatment disposition; when.

(1) Upon the filing of a periodic report under section 71-1216, the subject, the subject's counsel, or the subject's legal guardian or conservator, if any, may request and shall be entitled to a review hearing by the Mental Health Board and to seek from the board an order of discharge from commitment or a change in treatment ordered by the board. The Mental Health Board shall schedule the review hearing no later than fourteen calendar days after receipt of such request. The Mental Health Board may schedule a review hearing (a) at any time pursuant to section 71-1221 or 71-1222, (b) upon the request of the subject, the subject's counsel, the subject's legal guardian or conservator, if any, the county attorney, the official, agency, or other person or entity designated by the Mental Health Board under section 71-1215 to prepare and oversee the subject's individualized treatment plan, or the mental health professional directly involved in implementing such plan, or (c) upon the board's own motion.

(2) The board shall immediately discharge the subject or enter a new treatment order with respect to the subject whenever it is shown by any person or it appears upon the record of the periodic reports filed under section 71-1216 to the satisfaction of the board that (a) the subject's mental illness or personality disorder has been successfully treated or managed to the extent that the subject no longer poses a threat to the public or (b) a less restrictive treatment alternative exists for the subject which does not increase the risk that the subject will commit another sex offense. When discharge or a change in disposition is in issue, due process protections afforded under the Sex Offender Commitment Act shall attach to the subject.

Source: Laws 2006, LB 1199, § 75.

71-1220. Regional center or treatment facility; administrator; discharge of involuntary patient; notice.

When the administrator of any regional center or treatment facility for the treatment of dangerous sex offenders determines that any involuntary patient in such facility may be safely and properly discharged or placed on convalescent leave, the administrator of such regional center or treatment facility shall immediately notify the Mental Health Board of the judicial district from which such patient was committed.

Source: Laws 2006, LB 1199, § 76.

71-1221. Mental Health Board; notice of release; hearing.

A Mental Health Board shall be notified in writing of the release by the treatment facility of any individual committed by the Mental Health Board. Such notice shall immediately be forwarded to the county attorney. The Mental Health Board shall, upon the motion of the county attorney, or may upon its own motion, conduct a hearing to determine whether the individual is a dangerous sex offender and consequently not a proper subject for release. Such hearing shall be conducted in accordance with the procedures established for hearings under the Sex Offender Commitment Act. The subject of such hearing shall be accorded all rights guaranteed to the subject of a petition under the act.

Source: Laws 2006, LB 1199, § 77.

71-1222. Mental Health Board; person released from treatment; compliance with conditions of release; conduct hearing; make determination.

The Mental Health Board shall, upon the motion of the county attorney, or may upon its own motion, hold a hearing to determine whether a person who has been ordered by the board to receive inpatient or outpatient treatment is adhering to the conditions of his or her release from such treatment, including the taking of medication. The subject of such hearing shall be accorded all rights guaranteed to a subject under the Sex Offender Commitment Act, and such hearing shall apply the standards used in all other hearings held pursuant to the act. If the Mental Health Board concludes from the evidence at the hearing that there is clear and convincing evidence that the subject is a dangerous sex offender, the board shall so find and shall within forty-eight hours enter an order of final disposition providing for the treatment of such person in accordance with section 71-1209.

Source: Laws 2006, LB 1199, § 78.

71-1223 . Escape from treatment facility or program; notification required; contents; warrant; execution; peace officer; powers.

When any person receiving treatment at a treatment facility or program for dangerous sex offenders pursuant to an order of a court or Mental Health Board is absent without authorization from such treatment facility or program, the administrator or program director of such treatment facility or program shall immediately notify the Nebraska State Patrol and the court or clerk of the Mental Health Board of the judicial district from which such person was committed. The notification shall include the person's name and description and a determination by a psychiatrist, clinical director, administrator, or program director as to whether the person is believed to be currently dangerous to others. The clerk shall issue the warrant of the board directed to the sheriff of the county for the arrest and detention of such person. Such warrant may be executed by the sheriff or any other peace officer. Pending the issuance of the warrant of the Mental Health Board, any peace officer may seize and detain such person when the peace officer has probable cause to believe that the person is reported to be absent without authorization as described in the section. Such person shall be returned to the treatment facility or program or shall be taken to a facility as described in section 71-919 until he or she can be returned to such treatment facility or program.

Source: Laws 2006, LB 1199, § 79.

71-1224. Rights of subjects.

In addition to the rights granted subjects by any other provisions of the Sex Offender Commitment Act, such subjects shall be entitled to the rights provided in sections 71-943 to 71-960 during proceedings concerning the subjects under the act.

Source: Laws 2006, LB 1199, § 80.

71-1225. Mental Health Board hearings; closed to public; exception; where conducted.

All Mental Health Board hearings under the Sex Offender Commitment Act shall be closed to the public except at the request of the subject and shall be held in a courtroom or at any convenient and suitable place designated by the Mental Health Board. The board shall have the right to conduct the proceeding where the subject is currently residing if the subject is unable to travel.

Source: Laws 2006, LB 1199, § 81.

71-1226. Hearings; rules of evidence applicable.

The rules of evidence applicable in civil proceedings shall apply at all hearings held under the Sex Offender Commitment Act. In no event shall evidence be considered which is inadmissible in criminal proceedings.

Source: Laws 2006, LB 1199, § 82.

APPENDIX Y - AA
DANGEROUS SEX OFFENDER FORMS

Note: The original forms are available on the web at:
HTTP://DHHS.NE.GOV/BEHAVIORAL_HEALTH/PAGES/BEH_COMMIT_COMMIT.ASPX

Please check periodically for updated/new forms.

Y. *Mental Health Professional Certificate-Dangerous Sex Offender*

Z. *Emergency Admittance Pursuant to Certificate of a Peace Officer-Dangerous Sex Offender*

AA. *Emergency Protective Custody Admission*

APPENDIX Y

MENTAL HEALTH PROFESSIONAL CERTIFICATE

(DANGEROUS SEX OFFENDER)

(To be immediately forwarded to the county attorney upon completion-NO later than 24 hours after completion) Neb. Rev. Stat. § 71-1204.

TO: _____ COUNTY ATTORNEY,

OF _____ COUNTY, NEBRASKA

_____, is under my care as a result of an Emergency

(Name & Address of Subject)

Protective Custody placement, upon the certificate of a Law Enforcement Officer. The subject's

evaluation was completed on _____ (a.m./ p.m.) on the _____day of _____, 200___.

☐ _____

(Name & Address of Subject's spouse, legal counsel, guardian or conservator, and next of kin, if known)

☐ _____

(Name & Address of anyone providing psychiatric or other care or treatment to the subject, if known)

☐ _____

(Name & Address of any other person who may have knowledge of the subject's mental illness or personality disorder who may be called as a witness at a Mental Health Board hearing with respect to the subject, if known)

☐ _____

(Name & Address of the medical facility in which the subject is being held for emergency protective custody and evaluation)

As a qualified mental health professional I certify that I have evaluated the subject since the subject was admitted for emergency protective custody and evaluation. It is my opinion that the above subject is a dangerous sex offender and the clinical basis for such opinion is as follows:

_____

The above diagnosis is within a reasonable degree of psychiatric, psychological certainty and the Subject presents a substantial risk of serious harm within the near future to himself/herself, or others as a result of the above mental illness/personality disorder in the following ways:

It is therefore my opinion, within a reasonable degree of ☐ psychiatric, ☐ psychological certainty, that _____ is a dangerous sex offender as defined by Neb. Rev. Stat. § 83-174.01.

Name of Facility:

Address of Facility:

BY: _____

(Name Certifying Mental Health Care Professional)

ADDRESS: _____

DATE: _____, 20____.

☐ An evaluation was completed within 36 hours of admission and this certificate was executed within 24 hours after completion of the evaluation.

APPENDIX Z
EMERGENCY ADMITTANCE PURSUANT TO CERTIFICATE OF A PEACE OFFICER
(DANGEROUS SEX OFFENDER)

To facility authorized by §71-919 to hold the individual who is the subject in custody:

Name of Facility:_____

Address:_____

_____ _____, Nebraska_____

This is to inform you that I,_____, _____,

(Name of Peace Officer) (Badge Number)

have taken into custody_____

(Name and Address of Subject Taken into Custody)

_____

_____

on the _____day of_____. I have personally observed this subject

or I have been informed by _____

(Name and Address of a Witness)

_____,

who is a reliable person, and I believe that this subject is a dangerous sex offender as described below:

Dangerous Sex Offender (Summary of person's behavior supporting such allegations)

_____

_____

_____

_____

The dangerousness indicated above is, in my opinion, likely to occur before Mental Health Board proceedings can be invoked unless this facility holds the subject in custody pursuant to this Certificate.

( ) Additional police report will be submitted (Reference this placement/admittance)

( ) Additional information on the subject's behavior is included in a separate sheet identified as Attachment A which is attached hereto and incorporated herein by reference (Mental Health Professional Certificate).

I am therefore causing this subject to be admitted to your facility.

Date:_____ Signed _____ Badge #_____

(Peace Officer)

_____ (_____) _____

Name/Address of Law Enforcement Agency Phone

_____

County

This certificate or a copy thereof must be forwarded immediately to the County Attorney.

(Neb. Rev.Stat. §71-919)

APPENDIX AA
EMERGENCY PROTECTIVE CUSTODY ADMISSIONS PROCEDURE FOR DANGEROUS SEX OFFENDER REQUIRING MEDICAL OR PSYCHIATRIC EVALUATION

Unless a medical or psychiatric emergency exists for which treatment at a medical facility is required, a person taken into emergency protective custody who has a prior conviction for a sex offense (sect. 29-4003) shall be admitted to a jail or Department of Correctional Services facility.

EMERGENCY PROTECTIVE CUSTODY ADMISSIONS PROCEDURE FOR DANGEROUS SEX OFFENDER

PURPOSE: To provide emergency care to persons/subjects requiring psychiatric evaluation who are under police custody & BELIEVED TO BE A DANGEROUS SEX OFFENDER, and to facilitate communication between health care providers and law enforcement agencies

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PROCEDURE:

If Law Enforcement believes person to be mentally ill <u>and</u> a dangerous sex offender AND the individual is in need of psychiatric and/or medical treatment prior to MHB proceeding:

1. Law Enforcement issues EMERGENCY ADMITTANCE PURSUANT TO CERTIFICATE OF A PEACE OFFICER **(Dangerous Sex Offender) and transported to a Community Hospital/Crisis Center.**

2. The Law Enforcement Agency will provide the Hospital/Crisis Center staff with a copy of the EPC certificate (EMERGENCY ADMITTANCE PURSUANT TO CERTIFICATE OF A PEACE OFFICER) **(Dangerous Sex Offender)** when the subject is brought to the hospital. The copy must be placed in the subject's chart.

3. The Law Enforcement Agency will notify the hospital as soon as possible prior to the subject's arrival whenever feasible. Hospital staff will notify mental health provider, if they were not already notified by the Law Enforcement Agency.

4. Sex offenders must be treated at the hospital in the same manner of any other subject (i.e., A medical provider must be contacted using the regular procedure when a subject with an EPC-Sex Offender order presents to the ER (Emergency Room).

5. Medical/psychiatric stability will be established by a medical/psychiatric assessment and treatment rendered as necessary.

7. All EPC subjects will be entered into the network management system.

8. Medically unstable subjects will be admitted to the hospital if ordered by attending physician. These subjects may require a guard at their bedside if they are out of control and pose potential for harm to themselves or others. Law enforcement is responsible for providing this protection. The hospital is responsible for identifying medical/psychiatric needs and addressing them with the level of care necessary to maintain safety and promote stability.

9. The Region's Emergency System Coordinator will be notified by phone or by voicemail by contracted hospital staff of admissions within 24 hours, including weekends. Phone numbers are available from the respective Regional Behavioral Health Office or Regional Program Administrator.

10. Sex offenders with psychiatric/medical conditions must be cared for in the same manner as any other subject in emergency protective custody or under a Mental Health Board commitment.

11. Discharge orders must be written by the medical provider to dismiss or transfer a subject from the hospital. Law Enforcement Agencies may provide additional instructions as needed.

12. EPC-Sex Offender orders can only be lifted by the County Attorney or the Board of Mental Health. Clarify the origin of all orders to lift an EPC.

13. If EPC-Sex Offender subject is going to MHB hearing, the EPC unit (Crisis Center/Hospital) will preauthorize. If a subject is committed for either Inpatient or Outpatient services, Crisis Center/Hospital staff must pre-authorize those services. If the service recommended for commitment is inpatient level of care, HHS, Division of Behavioral Health will determine the location of the service provider.

APPENDIX BB. REFERENCES

PUBLICATIONS

The National Council: HTTP://WWW.THENATIONALCOUNCIL.ORG/WP-CONTENT/UPLOADS/2013/05/TRAUMA-INFOGRAPHIC.PDF

SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach: HTTP://WWW.SCATTERGOODFOUNDATION.ORG/SITES/DEFAULT/FILES/SAMHSA_CONCEPT_OF_TRAUMA_AND_GUIDANCE.PDF

WEBSITES

American Foundation for Suicide Prevention – WWW.AFSP.ORG/

Bazelon Center for Mental Health Law – WWW.BAZELON.ORG

Center for Psychiatric Rehabilitation – WWW.BU.EDU/CPR/

Council of State Government Re-Entry Policy Council – WWW.REENTRYPOLICY.ORG

Criminal Justice/Mental Health Consensus Project Justice Center, Council of State Governments – CONSENSUSPROJECT.ORG/

Legal Action Center – WWW.LAC.ORG

Medication Assisted Treatment for Substance Abuse Disorders – DPT.SAMHSA.GOV/PATIENTS/MAT.ASPX

Mental Health America – WWW.NMHA.ORG

National Alliance on Mental Illness – WWW.NAMI.ORG

National Association of State Alcohol & Drug Abuse Directors – NASADAD.ORG/

National Association of State Mental Health Program Director – NASMHPD.ORG

National Conference of State Legislatures – WWW.NCSL.ORG

Nebraska Advocacy Services – WWW.NEBRASKAADVOCACYSERVICES.ORG

Nebraska Network of Care for Behavioral Health – DHHS.NE.GOV/BEHAVIORAL_HEALTH/PAGES/NETWORKOFCARE_INDEX.ASPX

Substance Abuse and Mental Health Services Administration – WWW.SAMHSA.GOV

For additional assistance please contact:

Mental Health Board Training Coordinator

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Or

Emergency Systems Coordinator

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Department of Health & Human Services
DHHS
N E B R A S K A