NEBRASKA

BEHAVIORAL HEALTH

DEPT. OF HEALTH AND HUMAN SERVICES

NEBRASKA MENTAL HEALTH BOARD REFERENCE MANUAL

A Legal and Clinical Overview of Nebraska Commitment Laws

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Contents

I. Purpose of the Manual

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. This manual is designed for the dual purposes of providing sufficient information to prepare board of mental health members for their role and to provide a document that can be referenced when a question arises.

This manual contains two perspectives, legal and clinical. Mental health commitments are where the law and medicine intersect and work together. However, both areas require extensive background knowledge and training, and tend to have specialized terminology that can be difficult to navigate for someone not working in that field. The goal of this manual is to provide foundational knowledge in these areas. However, as the world changes and grows so does the law and medical science. Therefore, it is encouraged that this manual not be the end of the reader's journey but rather the start.

Please note:

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 in the Appendix III and are available on the Division's website at: https://dhhs.ne.gov/Pages/Mental-Health-Commitment.aspx

This manual is issued to inform, but not to offer legal advice, and has been prepared by the Department of Health and Human Services Division of Behavioral Health.

II. Legal Overview

The legal overview section of this Manual will provide information about the laws in Nebraska. However, the laws are subject to revision. The statutory references are provided in APPENDIX I: NEBRASKA STATUTES with links to the statutes published on the Nebraska Legislature's website.[1] Please check the Nebraska Legislature's website to review the most current version of the statutes referenced throughout this section.

A. Mental Health Commitment Act §§ 71-901 to 71-963

1. Introduction to the MHA

a) Historical Background

The Mental Health Commitment Act of 1976 was the starting point for Nebraska's current Mental Health Commitment Act. The 1976 Act was enacted following a decade of legal development of commitment jurisprudence. By the late 1970's, nearly every state had revised its commitment laws. The new laws, like Nebraska's 1976 Mental Health Commitment Act, saw a shift towards a narrower criteria for commitment and a movement towards encouraging voluntary treatment.

The Nebraska Legislature enacted the Mental Health Commitment Act of 1976 in response to the *Doremus v. Farrell* decision. *Doremus v. Farrell*[2] was a federal court decision that declared several provisions of Nebraska's civil commitment laws[3] unconstitutional for failure to provide sufficient commitment standards and procedural safeguards. Prior to 1976, Nebraska commitment laws did not specify a standard of proof for commitment proceedings,[4] and the disposition options at the time were extremely limited. The mental health boards could either order someone be committed to a state mental hospital or released.[5] In response to these limitations, the mental health boards would often develop their own networks for providing treatment alternatives, which made the outcome of commitment proceedings vary depending on location.

The Mental Health Commitment Act of 1976, narrowed the standards for commitment and increased procedural safeguards. The 1976 Act required clear and convincing proof for commitment proceedings.[6] Further, the 1976 Act expanded treatment options to include "outpatient treatment, consultation, chemotherapy, or any other program or set of conditions."[7] The statute also encouraged people to seek

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[1] https://nebraskalegislature.gov/laws/browse-statutes.php

[2] Doremus v. Farrell, 407 F.Supp. 509 (D. Neb. 1975).

[3] These statutes were identified as Neb. Rev. Stat. §§ 83-325, 83-328 and 83-306(4), which have been repealed.

[4] Geoffrey W. Peters et al., *Administrative Civil Commitment: The Nebraska Experience and Legislative Reform under the Nebraska Mental Health Commitment Act of 1976,* 10 Creighton Law Review 243, 254 (1976), https://dspace2.creighton.edu/xmlui/bitstream/handle/10504/73607/Teply_10CreightonLRev243.pdf?sequence=1&isAllowed=y.

[5] Id a 256.

[6] Id at 245.

[7] Id at 256.

voluntary treatment. However, the 1976 Act continued to take an administrative approach rather than legal approach to the commitment process.[8]

The Nebraska Mental Health Commitment Act has seen many revisions and updates throughout the years, reflecting changes in both the understanding of mental health conditions and changes in policy, such as deinstitutionalization.

The trend in Nebraska since 2004 has been a focus on community-based treatment services, including crisis response services. Crisis response services are designed to provide therapeutic treatment to an individual experiencing a mental health crisis such as psychosis or suicidal ideation.

Crisis response services are provided by licensed mental health professionals. In most cases, crisis response services are initiated by law enforcement and occurs wherever the crisis is occurring. Recent data from the Division of Behavioral Health (DBH) shows a downward trend in the number of individuals placed in emergency protective custody (see Figure 1: Quarterly counts are aggregated from monthly counts. As a result, consumers may be counted more than once. Consumers may have multiple occurrences of EPC status. Counts of consumers with EPC status are based on data pulled from the DBH Centralized Data System (CDS); counts of MHB commitments are based on data submitted by the Regional Emergency Coordinators. Figure 1 below).

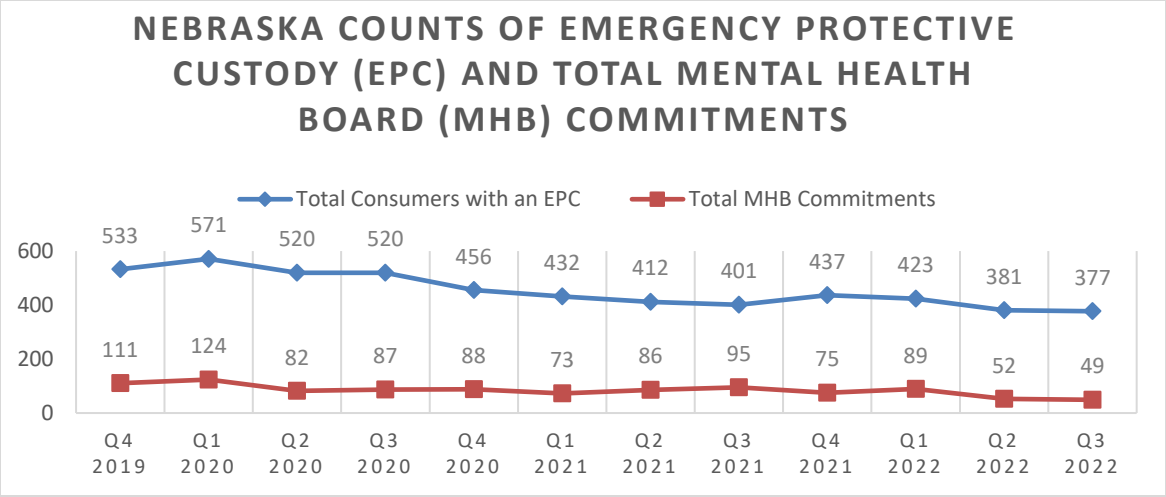

Figure 1: Quarterly counts are aggregated from monthly counts. As a result, consumers may be counted more than once. Consumers may have multiple occurrences of EPC status. Counts of consumers with EPC status are based on data pulled from

[8] Id.

the DBH Centralized Data System (CDS); counts of MHB commitments are based on data submitted by the Regional Emergency Coordinators.

b) Purpose

The MHCA's purpose is the protection of individuals with a mental illness who are not capable of caring for their selves in a safe manner and protecting the safety of the public. It is a complex law which when misused violates an individuals' right to autonomy. Undeniably, a mental health commitment should only be imposed as a last resort when other options have been explored and exhausted. Under the leadership of the Nebraska Department of Health and Human Services (NDHHS) Division of Behavioral Health (DBH) and the Regional Behavioral Health Authorities, Nebraska continues to decrease the number of individuals committed to mental health treatment. The trend began in 2004 with changes implemented to the behavioral health system (See Figure 2 below). Since 2004, Nebraska has continued to offer and expand community-based treatment services, including crisis response services. Crisis response services can encourage an individual to seek voluntary treatment, thereby avoiding the individual being taken into

Neb. Rev. Stat. § 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.

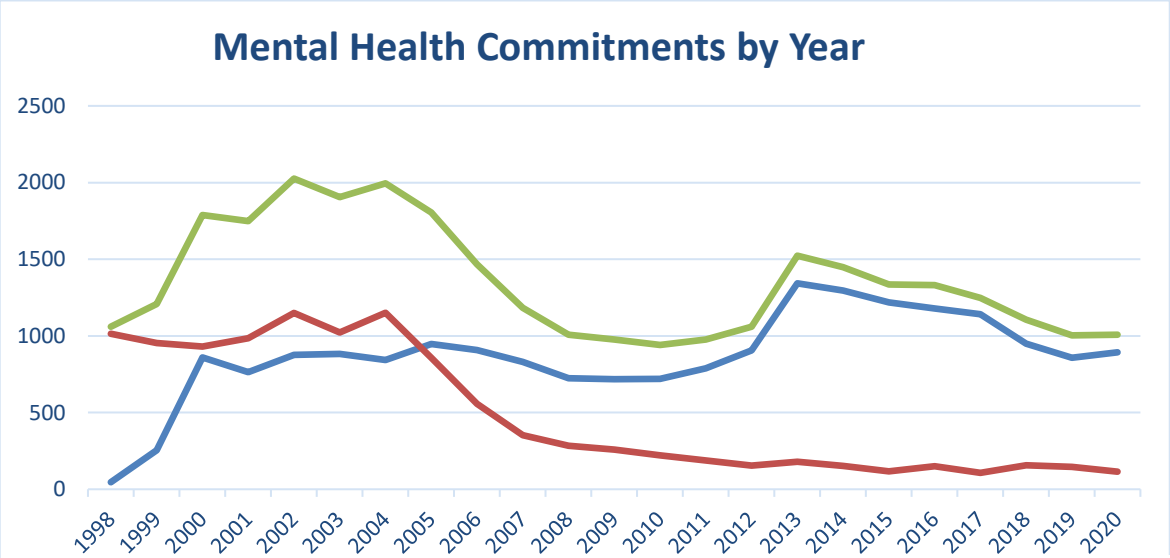

Figure 2: Commitment counts are based on commitment date for board of mental health commitments and date of admission for regional center commitments.

emergency protective custody. This practice is in line with the MHCA purpose, which is fully set forth on the right.

c) Definitions/Terms

Generally, terms and their definitions for purposes of the Nebraska Mental Health Commitment Act (MHCA) can be found at Neb. Rev. Stat. §§ 71-904 to 71-914, and Neb. Rev. Stat. § 71-804. This section will discuss some of the definitions and their meaning in the context of the MHCA.

As a general matter, throughout the MHCA, the term "subject" is used. Throughout the text of this manual the term "subject" will be used when statute is quoted or referenced. Otherwise, this manual will use the term "person."

Neb. Rev. Stat. §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.

Perhaps the most important phrase under the MHCA is "mentally ill person" because it is the nail upon which the applicability of the MHCA hangs. Under the MHCA, a mentally ill person is defined by Neb. Rev. Stat. § 71-907 (set forth in full on the left) as someone who has a "psychiatric disorder that involves a severe or substantial impairment." The distinction of a psychiatric disorder is important because it excludes things like developmental or intellectual disabilities, dementia, and other illnesses due to a general medical condition.

So what is a "psychiatric disorder"? The MHCA does not define "psychiatric disorder;" therefore, we look to the plain meaning.[9] Medical reference books generally define "psychiatric disorders" as follows:

> Psychiatric disorders are defined as disorders of the psyche—that is, conditions that affect thoughts, feelings, or behaviors. By definition, such mental disturbances must be sufficient to produce significant distress in the patient or impairment in role or other functioning.[10]

However, clinicians generally follow the Diagnostic and Statistical Manual of Mental Disorders, which uses the term "mental disorder," which is defined as follows:

[9] Courts interpret statutes by looking to the language's plain, ordinary, and popular meaning within the context of the statute. Sometimes the courts will turn to legislative history to determine legislative intent where the language has been the subject of litigation or the language is ambiguous. *See* Daniel Hassing, *A Matter of Interpretation*, 2 Neb. L. Rev. Bull. 17 (2010), http://lawreview.unl.edu/?p=729.

[10] Lee Goldman & Andrew Schafer, Goldman-Cecil Medicine at 2305 (26th Ed. 2020).

> 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 or disability in social, occupational, or other important activities.[11]

For clinical discussion of mental disorders see Section III.C.1 below.

Neb. Rev. Stat. § 71-908 also includes within its definition of a mentally ill and dangerous person, a person who is substance dependent. Under the MHCA, a person who is substance dependent means a person with:

> 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.[12]

The next element to address with the MHCA is dangerousness. Neb. Rev. Stat. § 71-908 states the person must be a "substantial risk of serious harm" to another or to himself/herself "because of [their] mental illness or substance dependence." 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.

> 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 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 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.

The Neb. Rev. Stat. § 71-908 also states that a person is considered mentally ill and dangerous if, because of mental illness or substance dependence, the person presents a substantial risk of serious

[11] Diagnostic and Statistical Manual of Mental Disorders: Text Revised, Fifth Ed., DSM-5-TR (2022).
[12] Neb. Rev. Stat. § 71-913.

harm "within the near future" as manifested by evidence of "recent" acts, threats, or attempts. The law does not further define those terms, nor does it give a definite time period. The Nebraska Supreme Court has held that for each case, the question of whether sufficient evidence of recent acts exists, "must be decided on the basis of the surrounding facts and circumstances."[13] For further discussion of case law on this topic see Section II.D below.

2. Mental Health Boards

Mental health boards are created pursuant to Neb. Rev. Stat. § 71-915(1) by a presiding district court judge in each judicial district (the Nebraska Judicial District map is provided in Appendix II). The judge can form up to three boards and appoint members to each board. Board members serve for four-year terms. This Section of the Manual will provide information about the role of the boards, as well as the duties and powers of the boards.

a) Role of Mental Health Boards

The mental health boards have an important role in the commitment process as finders of fact. Each board member is required to complete appropriate training provided by the Department of Health and Human Services prior to being able to serve on a mental health board.[14] Each board must contain the following:

- an attorney licensed to practice in the state of Nebraska
- any two of the following, but not more than 1 from each category:
    - Physician
    - Psychologist
    - Psychiatric nurse
    - Licensed clinical social worker or licensed independent clinical social worker
    - Licensed independent mental health

> **Neb. Rev. Stat. § 71-915(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.

[13] In re Interest of Kochner, 266 Neb. 114 (2003).
[14] Neb. Rev. Stat. § 71-916(1).

practitioner who is not a social worker
- Layperson[15] with demonstrated interest in mental health and substance dependency issues.[16]

For a mental health board hearing to be conducted, there must be at least three members or alternate members present and able to vote.[17] Any action of a board requires a majority vote.

As a fact finder, the board must determine whether there is clear and convincing evidence presented at hearing that the person is mentally ill and dangerous as alleged in the petition.[18] Essentially, the role of the board is to consider the admissibility and credibility of the evidence presented and to weigh the evidence to determine if the State has met their burden of proof. Mental health board hearings are subject to the rules of evidence, which determine what evidence the mental health board can consider when making its findings and set standards for parties to establish the credibility of evidence (see Section II.A.3.c)(1)(a) below for more information on the Rules of Evidence). In a mental health board proceeding, the State has the burden of presenting clear and convincing evidence that the subject of the proceeding is mentally ill and dangerous.[19] The process and procedures of mental health board hearings are discussed in depth in Section II.A.3. below.

b) Duties of the Board

Members and alternate members of a mental health board are required to take an oath to support the Constitution of the United States and Constitution of Nebraska, and to faithfully discharge the duties[20] of the office according to law. The mental health board is required to inquire at the commencement of a hearing if the person alleged to be mentally ill has received a copy of the petition and list of rights accorded to them (the individual's rights are set forth in Section II.A.3.b) below), and whether the person understood their rights.

Each mental health board must prepare and file an annual inventory statement with the county board of its county, including a list of all county personal property in its custody or possession. [21]

Board members and alternate members must attend and complete the mental health board training provided by DHHS at least once every four years.[22]

c) Powers of the Board

The powers of a mental health board are set out in Neb. Rev. Stat. § 71-915, which states, "[t]he

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[15] A layperson is anyone who is not a lawyer, physician, psychologist, psychiatric social worker, psychiatric nurse, or clinical social worker within the meaning of Neb. Rev. Stat. § 71-915(2), according to the Nebraska Supreme Court in *In re Interest of A.M.* 281 Neb. 482 (2011).
[16] Neb. Rev. Stat. § 71-915(2).
[17] Neb. Rev. Stat. § 71-915(3).
[18] Neb. Rev. Stat. § 71-924.
[19] Neb. Rev. Stat. § 71-925(1).
[20] Neb. Rev. Stat. § 71-915(2).
[21] Neb. Rev. Stat. § 71-915(4).
[22] Title 206 NAC § 6.

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."

3. Actions under the MHCA

a) Initiating Action

"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."[23]

(1) Emergency Protective Custody

A law enforcement officer may take an individual into emergency protective custody under Neb. Rev. Stat. § 71-920, or the county attorney may file a petition under Neb. Rev. Stat. § 71-921 requesting the person alleged to be mentally ill and dangerous be taken into emergency protective custody. The mental health board or court must find probable cause exists to believe the individual is mentally ill and dangerous as alleged in the petition before a warrant may issue directing the sheriff to take the person into custody.[24] If the person is in emergency protective custody when the petition is filed, a copy of the certificate filed under Neb. Rev. Stat. § 71-919 shall be filed with the petition.

When the subject is in emergency protective custody, the hearing on the petition must be within 7 calendar days of the date the subject was taken into custody.[25]

(2) Petition

A Proceeding under the Mental Health Commitment Act is commenced by the filing of a petition by the county attorney. Any person who believes another person is mentally ill and dangerous may inform the appropriate county attorney of their belief and request the county attorney file a petition under the Mental Health Commitment Act. In the event that a law enforcement officer takes a mentally ill and dangerous person into emergency protective custody, such law enforcement officer will proceed to notify the county attorney of such action.

A petition is filed in the judicial district where the subject is located, in the judicial district where the alleged behavior that is the basis of the petition occurred, or another judicial district in Nebraska if authorized by a district judge of the judicial district in which the person is located (a map of the Judicial Districts is below in Appendix II).[26] The petition must include the following:

- The subject's name and address, if known;

[23] Neb. Rev. Stat. § 71-922(1).
[24] Neb. Rev. Stat. § 71-922(2).
[25] Neb. Rev. Stat. §71-923.
[26] Neb. Rev. Stat. § 71-921.

- The name and address of the subject's spouse, legal counsel, guardian and/or conservator, and next-of-kin, if known;
- The name and address of anyone providing psychiatric or other care or treatment to the subject, if known;
- A statement that the county attorney has probable cause to believe that the subject of the petition is mentally ill and dangerous;
- 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
- 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, if known.[27]

The petition filed by the county attorney may contain a request for the emergency protective custody and evaluation of the subject prior to a hearing on the petition.[28] If the court or mental health board chairperson finds there is probable cause to believe the subject is mentally ill and dangerous, then they may issue a warrant directing the sheriff to take the subject into emergency protective custody. If the subject is in emergency protective custody when the petition is files, a copy of the certificate for emergency protective custody must be filed with the petition.

Anyone who files or causes to be filed a petition under MHCA, knowing the allegations are false, and the subject is deprived of any rights under the MHCA or SOCA, or breaches confidentiality, may be guilty of a Class II misdemeanor and civilly liable.[29]

After the petition is filed, the clerk prepares the summons with the time and place for hearing and issues the summons to the sheriff for personal service on the subject.[30] In addition to the summons, the sheriff shall serve a copy of the petition, the list of rights provided by Neb. Rev. Stat. § 71-943 to 71-960, and a list of the names and contact information for mental health professionals by whom the subject may be evaluated prior to hearing.[31]

The county attorney may move to dismiss the petition at any time prior to the commencement of the mental health board hearing under Neb. Rev. Stat. § 71-924, in which case the mental health board shall dismiss the petition.[32]

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[27] Neb. Rev. Stat. § 71-921.
[28] Neb. Rev. Stat. § 71-922(2).
[29] Neb. Rev. Stat. § 71-962.
[30] Neb. Rev. Stat. § 71-923. Service on an individual, generally, requires delivery of a summons to the person, their residence, or mailing via certified mail to their address. *See* Neb. Rev. Stat. § 25-508.01 et seq.
[31] Neb. Rev. Stat. § 71-923.
[32] Neb. Rev. Stat. § 71-922(3).

b) Individual Rights

Some rights may be denied to the person alleged to be mentally ill and dangerous, the subject, by a mental health board or court order for good cause shown, but only after notice has been given and the subject has had an opportunity to be heard.[33] An individual alleged to be mentally ill and dangerous under the MHCA has Constitutional rights, rights granted by the MHCA, and rights specific to being in custody.

(1) Procedural rights

An individual who is alleged to be mentally ill and dangerous under the MHCA has the following rights pursuant to Neb. Rev. Stat. §§ 71-943 to 71-960:

- To written notice of the time and place of hearing.
- To notice of the reasons alleged for believing the subject is a mentally ill and dangerous person who requires mental health board-ordered treatment.
- To receive a copy of the petition.
- To a list of their rights.
- To information about their mental illness or personality disorder, including its label, when the subject does not have counsel.
- To inquiry by the board as to whether the subject has read and understood the petition and list of rights.
- To be represented by a lawyer in all proceedings, or to appointment of counsel at the county's expense if the subject is determined by the board to be indigent.
- To an independent evaluation by physicians or clinical psychologists of the subject's choice, and to have them testify and provide assistance on the subject's behalf. If the subject is indigent, the subject has the right to have the board pay the reasonable cost of an evaluation and one professional's assistance on the subject's behalf.
- To have continuances liberally granted.
- To closed hearings unless the subject requests that they be open to the public.
- To be present at all hearings and present witnesses and information in defense against the allegations in the petition.
- To subpoena witnesses to testify on the subject's behalf.
- To confront and cross examine witnesses and evidence.
- To have rules of evidence applicable in civil proceedings apply to board hearings.
- To testify or refuse to testify on their own behalf.
- To be free of such quantities of medication or other treatments prior to any board hearing as would substantially impair their ability to assist in their

[33] Neb. Rev. Stat. § 71-960.

defense at the hearing.

- 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.
- To have the board's written findings made part of the person's record.
- To have all proceedings be of record.
- 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.

Counsel is appointed to represent the subject following a determination the subject is indigent by the mental health board. [34] Upon such finding, the mental health board will deliver a certificate for appointment of counsel to the clerk of the district or county court. The certificate shall be delivered as soon as possible after the individual is taken into emergency protective custody or a petition is filed. In counties with a public defender, the clerk will notify the public defender of the appointment to represent the subject.[35] If the county does not have a public defender, the clerk will then notify the district judge or county judge of the certificate, and the judge will then appoint an attorney to represent the person.[36]

As stated above, the subject has the right to information about the subject's mental illness or personality disorder, including its label, when the subject is unrepresented by counsel. If the subject has counsel and the physician or mental health professional on the board determines that the nature of the subject's mental illness or personality disorder is such that it is not prudent to disclose the label of the mental illness or personality order to the subject, then the label may be disclosed to subject's counsel instead.[37]

(2) Rights while in custody

The rights of an individual while in custody pursuant to the MHCA are set forth in Neb. Rev. Stat. § 71-959, which includes the following rights:

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

[34] Neb. Rev. Stat. § 71-945.
[35] Neb. Rev. Stat. § 71-946(2).
[36] Neb. Rev. Stat. § 71-946(1).
[37] Neb. Rev. Stat. § 71-944.

Hearing Process, Generally

1. The hearing is called to order: "We are on the record in case number …"
2. Entry of Appearances: attorneys state their names and who they represent
3. The Person stipulates to or denies allegations
   a. If subject admits, the board will proceed to enter a treatment order
   b. If subject denies, the hearing will proceed to presentation of evidence
4. Opening Statements: parties have an opportunity to summarize the evidence and issues
5. Presentation of Evidence
   a. Witnesses provide testimony
   b. Evidence is offered into the record
6. Closing arguments: parties have an opportunity to summarize the evidence and issues, and make their final arguments.
7. The mental health board enters an order

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.

c) The Initial Hearing

(1) The process/Procedural Overview

"Many of the issues at the heart of mental health law are legal, not clinical, in nature. Legal issues should not be permitted to masquerade as clinical ones; indeed, rather than deference, the law

should adopt a healthy skepticism toward claims of clinical expertise."[38]

A proceeding under the MHCA is a legal proceeding wherein the rights of an individual are at stake. While clinical experts are important to the proceedings, the clinical experts are not the ultimate decision-makers. It is the members of the mental health board who must review the evidence presented and determine if the State has met its burden to prove by clear and convincing evidence that the subject is mentally ill and dangerous and that commitment is the least restrictive option for treatment.[39]

The initial hearing, which is referenced in Neb. Rev. Stat. § 71-924, will begin with the mental health board calling the hearing to order and stating the case caption and number for the record. All proceedings shall be of record, and all oral proceedings shall be reported verbatim.[40]

The mental health board is required at the commencement of the hearing to inquire if the subject received a copy of the petition and list or rights accorded by Neb. Rev. Stat. § 71-943 to 71-960 and whether the subject has read and understood them.[41] The board will explain to the subject any portion of the petition or list of rights the subject had not read or understood. The board will then inquire of the subject if they admit or deny the allegations in the petition. If the subject admits the allegations, the board will proceed to enter a treatment order. If the subject denies, the hearing shall proceed to presentation of evidence by the parties as to the merits of the petition.

Hearings are held in a courtroom or any convenient and suitable placed designated by the board. The board may conduct the proceeding where the person is currently residing if they are unable to travel. Practically, the county attorney may file a motion for transportation, and the mental health board may need to enter a transportation order in advance if the subject is inpatient at one of the state hospitals or incarcerated.

All mental health board hearings under the MHCA are closed to the public, unless the person alleged to be mentally ill and dangerous requests otherwise. [42] This is to protect the privacy rights of the subject because there will be presentation of the subject's medical information during the hearing. At the beginning of the hearing the person alleged to be mentally ill and dangerous can either stipulate to the allegations or deny the allegations in the petition. If there is a stipulation, the mental health board must still consider evidence about the least restrictive treatment options unless there is an agreement about a treatment plan. If there is a denial, the hearing will proceed to presentation of evidence by the state/county attorney.

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[38] David B. Wexler & Bruce J. Winik, Therapeutic Jurisprudence as a New Approach to Mental Health Law Policy Analysis and Research, 45 U. Miami L. Rev. 979, 983 (1991), https://repository.law.miami.edu/cgi/viewcontent.cgi?article=1948&context=umlr.
[39] Neb. Rev. Stat. § 71-925(1).
[40] Neb. Rev. Stat. § 71-957.
[41] Neb. Rev. Stat. § 71-924.
[42] Neb. Rev. Stat. § 71-951.

Overall, the mental health board is in charge of the mode and order of interrogating witnesses and presenting evidence with an eye towards presenting evidence efficiency, avoiding needless use of time, and protecting witnesses from harassment or undue embarrassment.[43] As stated above, the hearing is a legal proceeding, which means that the rules of evidence are applicable to hearings held under the MHCA.[44] The rules of evidence are codified at Neb. Rev. Stat. §§ 27-101 to 27-1301 (*See* Appendix III.B). The rules can be complex, but generally address the qualifications of witnesses, the relevance of evidence, and the reliability of evidence.

(a) Rules of Evidence

(i) Qualifications of Witnesses

Generally, every person can serve as a witness. However, the person serving as a witness and providing testimony must have personal knowledge about the subject of their testimony. For example, someone who saw an accident can testify about what they saw happen. Every witness is required to declare they will be truthful prior to providing testimony.[45] A witness's credibility is open to attack by any party.[46] The witness's credibility can be attacked or supported by evidence about the witness's character for truthfulness or evidence of past conduct of the witness.[47] An expert witness with scientific or specialized knowledge may be called, but their expertise must be established on the record.[48] For MHCA proceedings, generally, expert witnesses will consist of medical professionals, such as psychiatrists. An expert may testify in terms of opinion or inference and give their reasoning therefore, including disclosing the underlying facts or data they relied upon.[49]

(ii) Relevance

"Relevant evidence means evidence having any tendency to make the existence of any fact that is of consequence to the determination of the action more probable or less probable than it would be without evidence."[50] Relevant information may be excluded if its probative value is outweighed by the danger of unfair prejudice, confusion of the issues, or if it will cause undue delay or is repetitive evidence.[51]

(iii) Reliability of Evidence

There are numerous evidence rules designed to ensure the evidence presented is reliable whether the evidence is testimony or tangible items, including, but not limited to, documents, photographs, video,

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[43] Neb. Rev. Stat. § 27-611.
[44] Neb. Rev. Stat. § 71-955.
[45] Neb. Rev. Stat. § 27-603.
[46] Neb. Rev. Stat. § 27-607.
[47] Neb. Rev. Stat. § 27-608.
[48] Neb. Rev. Stat. § 27-702.
[49] Neb. Rev. Stat. § 27-705.
[50] Neb. Rev. Stat. § 27-401.
[51] Neb. Rev. Stat. § 27-403.

etc. The rules generally exclude evidence that is hearsay and evidence without authentication, and requiring the complete and original writing, recording, or photograph.

Hearsay is a statement, including an oral or written assertion or nonverbal conduct if it is intended to be an assertion, other than one made by the declarant while testifying during the hearing, which is offered into evidence to prove the truth of the matter asserted.[52] A statement is not hearsay if it meets the definitions of Neb. Rev. Stat. § 27-801(4)(a) or (b). Hearsay statements are not admissible unless the statement meets an exception provided by the Nebraska Evidence Rules.[53] For example, statements made of the purposes of a medical diagnosis or treatment, may be admissible pursuant to Neb. Rev. Stat. § 27-803(4).

(b) Presentation of Evidence

Tangible evidence—such as documents, recordings, and photographs—may be offered into evidence at any time. Oftentimes the parties will agree to the admissibility of certain evidence in advance of the hearing. This can save time during the hearing itself because the parties will not have to take the time to establish foundation, relevance, and authenticity for these items. The parties can do this because they are required to share their evidence and list of witnesses prior to the hearing.

[52] Neb. Rev. Stat. § 27-801.
[53] Neb. Rev. Stat. § 27-802. Hearsay exceptions are found at Neb. Rev. Stat. § 27-803- 805.

Where there isn't an advance agreement, usually evidence will be offered in conjunction with testimony of someone knowledgeable. For example, a psychiatrist may testify about a report they wrote and then the report would be offered into evidence. The other party has the opportunity to object when evidence is offered and the board will consider the objection before deciding if the evidence is admitted.

When a witness is called, the party calling the witness has the first opportunity to ask questions. This is called direct examination. Generally, the questions will start by establishing who the witness is and the basis of their knowledge. The questions will generally be open-ended. Once the first party has completed their questioning, the other party will have an opportunity to cross-examine the witness. Cross-examination is generally done by asking leading questions with a yes or no answer. Cross-examination is limited to the scope of the questions asked on direct examination. The purpose of cross-examination is often to challenge the credibility of the witness or the truth of their statements. Once cross-examination is finished, the first party will have an opportunity to ask further questions to redirect the testimony of the witness. This is the process followed for each witness called during a hearing.

Example of evidence being offered:

Attorney: Did you record the video marked as Exhibit A?

Witness: Yes.

Attorney: When did you make the recording?

Witness: January 1, 2022, while the events occurred.

Attorney: Did you edit the recording after recording it?

Witness: No.

Attorney: Is "Exhibit A" a complete and accurate copy of the recording you made on January 1, 2022?

Witness: Yes.

Attorney: We would like to offer "Exhibit A" into evidence.

(2) The Role of Attorneys

An attorney in Nebraska is required by the Rules of Professional Conduct to represent their client competently and diligently.[54] The Comment to Neb. Ct. R. of Prof. Cond. § 3-501.3 states: "[a] lawyer should pursue a matter on behalf of a client despite opposition … and take whatever lawful and ethical measures are required to vindicate a client's cause or endeavor. A lawyer must also act with commitment and dedication to the interests of the client and with zeal in advocacy upon the client's behalf. A lawyer is not bound, however, to press for every advantage that might be realized for a client." A proceeding under the MHCA will involve the county attorney who filed the petition, the attorney representing the person alleged to be mentally ill and dangerous, and possibly an attorney for the Department of Health and Human Services.

The person alleged to be mentally ill and dangerous is entitled to an attorney to represent them in proceedings (see Section II.A.3.b) above). The attorney is appointed because if the person is

[54] Neb. Ct. R. of Prof. Cond. § 3-501.3. The Nebraska Rules of Professional Conduct govern attorneys licensed to practice in Nebraska. The Rules can be found online at https://supremecourt.nebraska.gov/supreme-court-rules/chapter-3-attorneys-and-practice-law.

experiencing symptoms of a mental illness or substance dependence, those symptoms can affect their ability to advocate for their self. If the attorney determines their client has diminished capacity, the attorney must, as much as possible, "maintain a normal client-lawyer relationship with the client."[55] When determining whether a client has diminished capacity, the attorney should take into consideration the client's ability to articulate their reason for making a decision, the variability of their state of mind, their ability to understand the consequences of a decision, and the consistency of a decision with the known values of the client.[56] The normal client-lawyer relationship requires a lawyer to abide by a client's decisions concerning the objectives of representation and to consult with the client about the means of pursuing those objectives.[57] Where the lawyer reasonably believes there is a risk of substantial physical, financial, or other harm to the client because of the diminished capacity, the lawyer may take protective action, including making a request for appointment of a guardian ad litem, conservator, or guardian for the client.[58] The lawyer should consider whether the appointment of a guardian ad litem, guardian or conservator is necessary to protect the interests of the client.[59]

Counsel for the subject has the right to information about witnesses, written documentation, tangible objects, and written records of any treatment facility or mental health professional who has treated the subject.[60]

One of the functions of an attorney is to call witnesses to support their case and to cross examine the witnesses called by the other parties. The questioning is very formal because of the requirements of the Nebraska Evidence Rules (see Section II.A.3.c)(1)(a) above). The questions asked of witnesses must be designed to produce relevant information, which will be entered into the hearing record as evidence. Attorneys who call a witness will generally ask open-ended questions because leading questions are generally not meant to be used on direct examination.[61] An attorney cross-examining a witness will tend to ask leading questions. A witness is allowed to use a writing to refresh their memory while testifying.[62]

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[55] In the context of Neb. Ct. R. of Prof. Cond. § 3-501.14, "diminished capacity" means a reduction in the capacity to make adequately considered decisions in connection with the representation because of mental impairment. Rule 3-501.14, still requires the attorney to treat the client with diminished capacity as the attorney would treat any client, and to consult with the client about the case. As Comment 1 to Rule 3-501.14 states, "a client with diminished capacity often has the ability to understand, deliberate upon, and reach conclusions about matters affecting the client's own well-being."

[56] Neb. Ct. R. of Prof. Cond. § 3-501.14, Comment 6.

[57] Neb. Ct. R. of Prof. Cond. § 3-501.2 (a).

[58] "In taking any protective action, the lawyer should be guided by such factors as the wishes and values of the client to the extent known, the client's best interests and the goals of intruding into the client's decision making [sic] autonomy to the least extent feasible, maximizing client capacities and respecting the client's family and social connections." Comment 5 to Neb. Ct. R. of Prof. Cond. § 3-501.14.

[59] Neb. Ct. R. of Prof. Cond. § 3-501.14, Comment 7.

[60] Neb. Rev. Stat. § 71-949.

[61] Neb. Rev. Stat. § 27-611(3). An open-ended question is generally a broad question (e.g., how are you?). A leading question is designed to limit the scope of the answer (e.g., how were you at 10:00 a.m.?).

[62] Neb. Rev. Stat. § 27-612. The writing must be available to the adverse party to inspect in advance.

(3) Determination of Dangerousness

Neb. Rev. Stat. § 71-908 states:

> 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.

The statute can be broken into the following questions:

1. Probability: Is the risk substantial?
2. Magnitude: Is the harm serious?
3. Imminence: Is the harm likely to occur in the near future?
4. Evidence: Is there evidence of recent acts?
5. Causation: Is the substantial risk because of the mental illness or substance dependence?

(a) Probability: Is the Risk Substantial?

Neb. Rev. Stat. § 71-908 uses the phrase "substantial risk" to denote that the risk must be more probable than not to meet the definition. The statute does not define the phrase and there is no precedent to define it; therefore, the plain language is used to interpret the meaning of this phrase. Merriam-Webster defines "substantial" as "consisting of or relating to substance; not imaginary or illusory."[63] Thus, a "substantial risk" would be based on substance and reality rather than imagination. The Nebraska Supreme Court in *Rasmussen* found that "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."[64] The Court further stated that "[a]n 'indication of a strong possibility' does not, as a matter of law support a finding that Rasmussen would not continue to take his medication" when determining that he did not pose a substantial risk of harm to himself. Thus, there needs to be more than an indication of strong possibility for it to be a "substantial risk."

[63] https://www.merriam-webster.com/dictionary/substantial.
[64] In re Interest of Rasmussen, 236 Neb. 572, 462 N.W.2d 621 (1990).

(b) Evidence: Is there evidence of recent acts?

A person cannot be committed for treatment by a mental health board until the board has determined the person meets the definition of mentally ill and dangerous as set out in Neb. Rev. Stat. § 71-908.[65] This determination requires more than a clinical opinion. There must be evidence that the subject "has actually been dangerous in the recent past and that such danger was manifested by an overt act or attempt or threat to do substantial harm to himself or to another."[66]

In *Lux v. Mental Health Board of Polk County*, the Nebraska Supreme Court considered a case wherein an individual with paranoid delusions, Lux, was committed in 1977 by a mental health board upon evidence that he was diagnosed with "Paranoid State, including assaultive and homicidal ideation" and that he had strangled his father without provocation in 1976. The assault was because Lux believed his father would not tell him the truth "about any theft and development of mechanical systems whose theory [he] was working on." The Court held that evidence of one recent act is sufficient

In *Petersen v. County Board of Mental Health*,[67] the Nebraska Supreme Court considered a case wherein an individual was diagnosed with a schizophrenia and at hearing the evidence at hearing presented was about a verbal argument with his mother and sister. At the hearing, the sister testified she was not afraid of physical harm from her brother. The Court wrote in the opinion, "[i]t would be pure speculation to assume that the incidents … related approach the level of 'evidence of recent violent acts or threats of violence or by placing others in reasonable fear of such harm.' The Court went on to consider if there was evidence of an inability to provide for basic human needs on the basis of evidence of spendthrift behavior with his money. The Court found this behavior did not rise to the level of being a dangerous person who presents a risk of harm to himself as evidenced by an inability to provide for basic human needs.

Possibly the most litigated issue related to "recent acts" is what constitutes a "recent" act. The Nebraska Supreme Court addressed the matter in *Hill v. County Board of Mental Health* and said that there is no way to establish a definite time-oriented period for the purposes of Neb. Rev. Stat. § 71-908.[68] The Court stated that a narrow interpretation of "recent" would not be practical because being in custody would likely prevent someone from committing an act of violence. Thus, the Court held:

> The term recent should be given a reasonable construction. We hold that an act or threat is `recent' within the meaning of section 83-1009, R. S.

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[65] In re Interest of Verle O., 13 Neb. App. 256, 691 N.W.2d 177 (2005)(Verle pled no contest to attempted first degree sexual assault on a child in 1993. In 2002, he was committed by the mental health board upon clinical evidence of his diagnosis of pedophilia and narcissistic personality disorder. The Supreme Court held that evidence of recent actions was required and remanded the matter to the board for rehearing.)

[66] In re Interest of Verle O., 13 Neb. App. 256, 691 N.W.2d 177 (2005) citing In re Interest of Blythman, 208 Neb. 51, 302 N.W.2d 666 (1981).

[67] Petersen v. County Board of Mental Health, 203 Neb. 622, 279 N.W.2d 844 (1979).

[68] Hill v. County Board of Mental Health, 203 Neb. 610 (1979).

> Supp., 1978, 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.[69]

In 1981, the Nebraska Supreme heard *In re Interest of Blythman* and articulated the following factors in their opinion for determining if a past act was recent:

> An act occurring five years prior to the mental health commitment hearing is recent where:
> - There is evidence that the act is still probative of the subject's future dangerousness,
> - The subject has not had an opportunity to commit a more recent act because he has been in confinement, and
> - There is reliable medical evidence that there is a high probability of repetition of such act by the subject. [70]

In context of the case, Blythman was convicted as a juvenile for stabbing a girl at school and in 1974 for fondling a minor. He was in custody under the Nebraska Sexual Sociopath Act (repealed in 1979) until he was committed in 1979 under the Mental Health Commitment Act. On appeal, he argued the past convictions from five years prior "recent" and an interpretation holding they were recent would permit involuntary civil commitment regardless of the remoteness of an act or threat of violence. The Court stated that it could not say as a matter of law that an act which occurred 5 years ago is too remote to be probative, particularly, where the subject has not had an opportunity to commit a more recent act due to commitment. In Blythman's case the testimony of the psychiatrists at the hearing was based on the past incidents and recent examination, and Blythman did not present evidence to demonstrate the previous acts were too remote to be probative or to demonstrate Blythman would not reoffend.

(c) Causation: Is the risk of harm because of the mental illness or substance dependence?

It is important to note that the Nebraska Supreme Court also found that "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."[71]

(4) Least Restrictive Alternative

As discussed above, the state has the burden to prove by clear and convincing evidence that neither voluntary hospitalization nor other treatment alternatives less restrictive of the subject's liberty than

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[69] Id at 617.
[70] In re Interest of Blythman, 208 Neb. 51, 302 N.W.2d 666 (1981).
[71] In re Interest of Rasmussen, 236 Neb. 572, 462 N.W.2d 621 (1990).

inpatient or outpatient treatment ordered by the mental health board are available or would suffice to prevent the harm described in Neb. Rev. Stat. § 71-908.[72] The mental health board is required to provide in its order finding a person is mentally ill and dangerous a written statement to the subject providing the evidence relied on and reasons why the board found there were no less restrictive treatment alternatives.[73] The board must consider all treatment alternatives, including any treatment program or conditions suggested by the subject, subject's counsel, or other interested person; and inpatient hospitalization or custody should be considered as a treatment alternative of last resort.[74]

(5) Orders after the Hearing

"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."[75]

(a) Dismissal

If the board finds the subject is not mentally ill and dangerous, the board will dismiss the petition and order the discharge of the subject.

If the board finds the subject is mentally ill and dangerous, but that voluntary hospitalization or other treatment alternatives less restrictive of the subject's liberty are available and would suffice to prevent the harm that makes them "dangerous," then the board may dismiss the petition and order the unconditional discharge of the subject.[76]

(b) Commitment

If the subject admits the allegations or the board finds the subject is mentally ill and dangerous and that there are no less restrictive treatment alternatives, the board shall within 48 hours order the subject to receive outpatient treatment or order the subject to receive inpatient treatment and committing the subject into the custody of DHHS.[77] If the board commits the subject to the custody of DHHS to receive inpatient treatment, DHHS working in collaboration with the Behavioral Health Regions will secure placement of the subject in an appropriate and available inpatient treatment facility.

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[72] Neb. Rev. Stat. § 71-925(1); the harm described in Neb. Rev. Stat. § 71-908 I that of the person presenting a substantial risk of serious harm to their self or to another person.
[73] Neb. Rev. Stat. § 71-956.
[74] Neb. Rev. Stat. § 71-925(4).
[75] Neb. Rev. Stat. § 71-926(1).
[76] Neb. Rev. Stat. § 71-925(3).
[77] Neb. Rev. Stat. § 71-925(4).

If the subject ordered to inpatient treatment has not been admitted into a treatment facility, the subject may petition for rehearing on the basis that their condition is improved such that inpatient treatment is no longer necessary or appropriate.[78]

When the mental health board orders a subject to be committed, the board will enter a treatment order.[79] A treatment order will represent the appropriate available treatment alternative that imposes the least possible restraint on the subject's liberty. Inpatient hospitalization or custody is a treatment alternative of last resort. Any treatment order will include directions for the preparation and implementation of an individualized treatment plan (*See* Section II.A.3.d)(2) below), and documentation and reporting of the subject's progress under the plan.[80] The intent of a treatment order is to order a level of care for the subject and not to direct a subject to a specific treatment provider or facility.

Following the hearing, when placement for treatment is secured, the board will issue a warrant authorizing the administrator of a treatment facility to receive and keep the subject (*See* Appendix III.H. Warrant of Admission for an example).[81] The warrant will include the findings of the mental health board. Upon receipt of the warrant, findings, and the subject, the administrator of the facility shall acknowledge the delivery on the warrant. Additionally, the administrator shall note on the acknowledgment if the subject was accompanied by another person and, if so, the person's name. Where the subject is female, the subject cannot be taken to a treatment facility without being accompanied by another female or relative.[82]

The Department of Health and Human Services has general control over the admission of patients and residents to all institutions over which it has jurisdiction pursuant to Neb. Rev. Stat. § 83-109. When a state hospital does not have the capacity to immediately admit someone committed by a mental health board, DHHS is required to make a record at the time of application and admit the person at the earliest practicable date. If at any time it is necessary, for lack of capacity or other cause, admission is limited to the following:

a. Patients whose care in the state hospital is necessary in order to protect the public health and safety;
b. Defendants who are determined by a court to be incompetent to stand trial and who remain lodged in the county jail;
c. 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;
d. Patients who are most likely to be benefited by treatment in the state hospitals, regardless of whether such patients are committed by a mental health board or

[78] Neb. Rev. Stat. § 71-925(5).
[79] Neb. Rev. Stat. § 71-925(6).
[80] Neb. Rev. Stat. § 71-931.
[81] Neb. Rev. Stat. § 71-927.
[82] Neb. Rev. Stat. § 71-928.

whether such patients seek voluntary admission to one of the state hospitals; and

e. When cases are equally meritorious, in all other respects, patients who are indigent.[83]

(6) Voluntary Treatment

If the board finds the subject is mentally ill and dangerous, but that voluntary hospitalization or other treatment alternatives less restrictive of the subject's liberty are available and would suffice to prevent the harm that makes them "dangerous," then the board may suspend further proceedings for a period of up to 90 days to permit the subject to engage in voluntary treatment.[84]

d) Post Hearing

(1) Appeal rights

An order of a mental health board adjudicating an individual as mentally ill and dangerous pursuant to Neb. Rev. Stat. 71-908 is an appealable order.[85]

A treatment order entered by a mental health board pursuant to Neb. Rev. Stat. § 71-925 may be appealed to the district court, and the district court's order may be appealed to the Court of Appeals.[86] The district court reviews the mental health board "de novo on the record," which means the order will be affirmed unless it is unsupported by clear and convincing evidence as demonstrated by reviewing the record (i.e., the transcript/recording of the hearing and the evidence entered into the record).[87]

(2) Creation of the Individualized Treatment Plan

The individualized treatment plan shall contain a statement about the nature of the subject's mental illness or substance dependence, the least restrictive treatment alternative consistent with the clinical diagnosis of the subject, and the intermediate and long-term treatment goals for the subject with a projected timetable for the attainment of the goals.[88] Within 5 working days of the board's order, the individualized treatment plan must be filed with the mental health board, and copies provided to the county attorney, the subject, subject's counsel, and the subject's legal guardian or conservator, if any. Treatment must commence within 2 working days after the preparation of the plan.

(3) Elopement

Elopement from a treatment facility or program is a real risk for persons who are involuntarily receiving treatment under a mental health board order. If a person elopes, meaning they leave the facility or

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[83] Neb. Rev. Stat. § 83-338 (revised April 2022 via LB921). LB921 also assigned beds at the LRC to specific patients, which are set forth at Neb. Rev. Stat. § 83-338(2).
[84] Neb. Rev. Stat. § 71-925(3).
[85] In re Interest of Saville, 10 Neb. App. 194 (2001)(Saville appealed from the district court's order affirming the dispositional order of the mental health board and the Court had to consider if the order was an appealable order
[86] Neb. Rev. Stat. § 71-930
[87] In re Interest of Saville, 10 Neb. App. 194 (2001).
[88] Neb. Rev. Stat. § 71-931(2).

program without authorization, then the administrator or program director is required to immediately notify the Nebraska State Patrol and the court or clerk of the mental health board.[89] "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 will then issue a warrant of the board to the sheriff for the arrest and detention of the subject. Upon apprehension of the subject, the subject will be returned to the treatment facility or program or shall be taken to a facility described in Neb. Rev. Stat. § 71-919 until they can be returned to the treatment facility or program.

(4) Involuntary Medication

For the clinical perspective on involuntary medication see Section **Error! Reference source not found.**.

A person in custody or receiving treatment under the MHCA or SOCA has the right "[t]o 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."[90] The Nebraska Legislature enacted Neb. Rev. Stat. § 71-959(3)(b) in 2004 following several decisions by the U.S. Supreme Court, which articulated the rights of an individual committed to treatment through a civil process to a due process hearing before having medication involuntarily administered.[91]

In *Sell v. U.S.*, the Supreme Court articulated the findings necessary for involuntary administration of medication, including the following:

- The government has an *important* governmental interest at stake (e.g., restoring competence to stand trial; to render the individual non-dangerous);
- Involuntary medication will *significantly further* the state's interests and the administration of the drugs is substantially unlikely to have side effects that will impair the individual's ability to assist counsel with their defense;
- Involuntary medication is *necessary* to further the state's interests, thereby showing there are no alternative, less intrusive treatments likely to achieve substantially the same results;
- The administration of drugs is medically appropriate (i.e., it's in the patient's best medical interests).[92]

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[89] Neb. Rev. Stat. §§ 71-939 and 71-961.
[90] Neb. Rev. Stat. § 71-959 (3).
[91] *See* Mills v. Rogers, 457 U.S. 291 (1982), Washington v. Harper, 494 U.S. 210 (1990), and Sell v. U.S., 539 U.S. 166 (2003).
[92] 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.)

Even though *Sell v. U.S.* was a criminal matter, constitutional rights apply to all U.S. citizens. Therefore, civilly committed patients have the same constitutional protections as criminal defendants. Basic Due process protections include a right to notice of the hearing, information about the medication the state wishes to administer, and an opportunity to be heard, to present evidence as to the reason for the individual's refusal to take the medication.

(5) Review Hearings

A review hearing can be scheduled in the following situations:

- Upon the mental health board's own motion
- Upon receipt of notice of the release by the treatment facility of a committed individual
- Upon receipt of a report that the subject is not following conditions set by the board
- Upon request of the following:
    - the subject, subject's counsel, or subject's legal guardian or conservator, if any
    - the county attorney
    - The person or entity overseeing the individualized treatment plan
    - The mental health professional involved in implementing the individualized treatment plan[93]

(a) Changes to Treatment plan

The mental health board may, on its own motion or on a motion of the county attorney, hold a hearing to determine if outpatient treatment can be adequately and safely provided to the subject. The subject can be taken into temporary custody pending the results of such hearing upon issuance of a warrant by the board. However, the subject should not be held in custody for more than seven days without further order of the board. When executing the warrant, the sheriff or other suitable person will serve notice of the hearing, a copy of the motion and a list of rights upon the subject, subject's counsel, and the subject's legal guardian or conservator, if any.[94]

Upon receipt of a periodic report, the subject, subject's counsel, or the subject's guardian or conservator, if any, may request and is entitled to a review hearing. The subject may request discharge from commitment or a change in ordered treatment. The hearing will be scheduled by the mental health board within 14 calendar days after receiving the request.

The mental health board may enter a new treatment order with respect to the subject when the board is satisfied that a less restrictive treatment alternative exists for the subject.[95]

(b) Progress Reports

Once the individualized treatment plan is prepared, the person ordered to oversee the plan must submit periodic reports about the subject's progress under the plan and any modifications to the mental health

[93] Neb. Rev. Stat. § 71-935(1).
[94] Neb. Rev. Stat. § 71-934.
[95] Neb. Rev. Stat. § 71-935(2).

board. Progress reports must be submitted every 90 days or less within the first year following submission of the individualized treatment plan. After the first year, progress reports are required every six months.[96]

If the subject ordered into outpatient treatment is not complying with the individualized treatment plan, the provider will report the noncompliance to the mental health board and county attorney. Additionally, the provider will report if the subject is not following the conditions set by the mental health board order, if the treatment plan is not effective, or if there is a significant change in the subject's mental illness or substance dependence.[97] The county attorney will then investigate the report to determine if there's a factual basis. If the county attorney determines there isn't a factual basis, then the county attorney will inform the board and treatment provider of the determination and take no further action.

If the county attorney determines the mental health board needs to intervene to protect the subject or others, the county attorney may file a motion for reconsideration of the conditions set by the board of mental health.[98] The motion will be set for hearing and will be considered by the mental health board. If the county attorney believes the subject poses a threat of danger to their self or others, the county attorney may apply for a warrant to take immediate custody of the subject prior to the rehearing. The application for warrant must have a supporting affidavit of the county attorney, mental health professional, or another informed person.

(c) Discharge

When the administrator of any regional center or treatment facility for mental illness or substance dependence determines any involuntary patient may be safely and properly discharged or placed on convalescent leave, the administrator shall immediately notify the mental health board that committed the patient.[99] The mental health board shall order the immediate discharge of the subject whenever it is shown by any person or it appears on the record of the periodic progress reports to the board's satisfaction that the subject no longer needs care or treatment.[100] The state must prove by clear and convincing evidence that the subject remains mentally ill and dangerous at review hearings to prevent discharge.[101]

The mental health board must be notified in writing of the subject's release from a treatment facility. A copy of the notice will be forwarded to the county attorney. The board may upon its own motion or

[96] Neb. Rev. Stat. § 71-932.
[97] Neb. Rev. Stat. § 71-933(1).
[98] Neb. Rev. Stat. § 71-933(2)(c).
[99] Neb. Rev. Stat. § 71-936.
[100] Neb. Rev. Stat. § 71-935(2).
[101] *See* In re Interest of Dickson, 238 Neb. 148 (Neb. 1991).

upon the motion of the county attorney, hold a hearing to determine if the subject is mentally ill and dangerous and, consequently, that release is not appropriate.[102]

4. Tribal Orders/Courts

Within the State of Nebraska there are several active tribal courts that have their own jurisdictions and laws. A map of the tribal lands in Nebraska is provided in Appendix II. Nebraska mental health boards and courts do not have to recognize tribal hold orders or commitment orders.[103] However, for reference the Nebraska tribal laws are discussed below.

- The Winnebago Tribe has a Mental Health Commitment Act,[104] Winnebago Tribal Code §§ 7-101 to 7-106, which allows for a petition for commitment to be filed by a Public Health Service or Indian Health Service physician, registered nurse, mental health official, social services official, substance abuse counselor, tribal prosecutor or an interested person. The basis for commitment is that the subject is a mentally ill, an alcoholic, or a drug addict who can reasonable expected in the near future to cause serious physical harm to their self, others, or property, or who because of their condition, is unable to attend to their basic physical needs such as food, clothing, or shelter which will cause serious harm in the near future.
- The Omaha Tribal Code (2013)[105] allows for involuntary commitments to treatment facilities for mentally ill, alcoholic, or drug or chemically dependent persons who present a substantial risk of serious harm to another person or unborn child, or substantial risk of serious harm to the person within the near future.[106] The application for treatment has to set forth why involuntary treatment is the only available treatment alternative that will prevent the harm alleged.
- The Santee Sioux Nation of Nebraska has laws allowing for involuntary treatment of mentally ill persons under the Involuntary Treatment of Mentally Ill Persons Act and persons engaged in alcohol or drug abuse under the Alcohol and Drug Abuse Treatment Act.[107]
- The Ponca Tribe of Nebraska Code[108] does not have a mental health commitment statute.
- The Sac and Fox Nation of Missouri is present in Kansas, Nebraska, and Missouri. Unfortunately, the complete tribal code is not available online.[109]

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[102] Neb. Rev. Stat. § 71-937.

[103] LB1247 was introduced in the second session of the 107th Legislature, in January 2022, which would have provided for recognition of tribal mental health and dangerous sex offender commitment orders. LB1247 was postponed indefinitely in April 2022.

[104] The Winnebago Tribal Code can be found online at http://www.winnebagotribe.com/index.php/government/tribal-court

[105] The Omaha Tribal Code is available online at https://www.omahatribe.com/public-documents/.

[106] Omaha Tribal Code §§21-1-3 and 21-1-5.

[107] Santee Sioux Nation of Nebraska Law and Order Code Title II, Chapters 1 & 2 (2013). The Santee Sioux Neb. Law & Order Code is available online at https://narf.org/nill/codes/santee_sioux_nation/index.html.

[108] The Ponca Tribe of Nebraska Code is available online at https://www.poncatribe-ne.org/tribal-documents/law-and-order-code/.

[109] The tribal code of the Sac and Fox Nation of Missouri is partially published online at https://www.sacandfoxks.com/entities/tribal-court.

- The Iowa Tribe of Kansas and Nebraska does not publish its tribal code online.

B. Developmental Disabilities COCA §§ 71-1101 to 71-1134

1. Introduction to the Developmental Disabilities Court-Ordered Custody Act

Mental health boards do not handle civil commitment proceedings under the Developmental Disabilities Court-Ordered Custody Act (DDCOCA). An overview of DDCOCA is included in this Manual because of the overlap that occurs when an individual has a developmental disability and a mental illness. A case may be filed under one act and, upon review, dismissed and filed under the other because of the diagnosis and needs of the individual. Therefore, a basic understanding may be necessary for a mental health board member to understand the commitment history of an individual.

a) Purpose

The purpose of the Developmental Disabilities Court-Ordered Custody Act (DDCOCA) is "to provide a procedure for court-ordered custody and treatment for a person with developmental disabilities when he or she poses a threat of harm to others."[110] The public policy behind the DDCOCA to "encourage persons with developmental disabilities to voluntarily choose their own services."[111]

b) Definition/Terms

Definitions of terms for DDCOCA are found in Neb. Rev. Stat. § 71-1105 to 71-1116. However, the key terms are discussed in this section.

"Developmental Disability" within the meaning of DDCOCA means a severe, chronic disability, including an intellectual disability, other than mental illness, which:

1. Is attributable to a mental or physical impairment unless the impairment is solely attributable to a severe emotional disturbance or persistent mental illness;
2. Is manifested before the age of twenty-two years;
3. Is likely to continue indefinitely;
4. Results in substantial functional limitation in one of each of the following areas of adaptive functioning:
    a. Conceptual skills, including language, literacy, money, time, number concepts, and self-direction;
    b. Social skills, including interpersonal skills, social responsibility, self-esteem, gullibility, wariness, social problem solving, and the ability to follow laws and rules and to avoid being victimized; and
    c. Practical skills, including activities of daily living, personal care, occupational skills, health care, mobility, and the capacity for independent living; and
5. Reflects in the individual's need for a combination and sequence of special, interdisciplinary, or generic services, individualized support, or other forms of assistance that are of lifelong or extended duration and are individually planned and coordinated.[112]

[110] Neb. Rev. Stat. § 71-1103.
[111] Neb. Rev. Stat. § 71-1102.
[112] Neb. Rev. Stat. § 71-1107.

An "intellectual disability" means "significantly subaverage general intellectual functioning which is associated with significant impairments in adaptive functioning manifested before the age of twenty-two years. Significant subaverage general intellectual functioning shall refer to a score of seventy or below on a properly administered and valid intelligence quotient test."[113]

Threat of harm to others means a 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; or
- By the use of an explosive, having damaged or destroyed property, put another person at risk of harm, or injured another person.[114]

2. Actions under DDCOCA

a) Initiating Action

An action for civil commitment under DDCOCA is initiated by the Attorney General or the county attorney filing a petition in the district court of the county where the subject resides or the county in which an alleged act constituting a threat of harm to others occurs.[115] The petition must include a factual basis to support the allegation that the subject has a developmental disability and poses a threat of harm to others. The petition must be served on:

- the subject
- the subject's attorney, if any,
- the subject's guardian, if any,
- the subject's closest relative, if known,
- any other person having custody and control of the subject, if known, and
- the department.[116]

When a petition is filed under DDCOCA, the court shall set a time and date for a hearing, and shall issue notice of hearing. The hearing will be held within 90 days of the filing of the petition, unless the subject is in emergency custody pursuant to Neb. Rev. Stat. § 71-1119.[117]

[113] Neb. Rev. Stat. § 71-1108.01.
[114] Neb. Rev. Stat. § 71-1115
[115] Neb. Rev. Stat. § 71-1117.
[116] Neb. Rev. Stat. § 71-1121.
[117] Neb. Rev. Stat. § 71-1122.

The court may order an examination and evaluation of the subject to be completed by the department prior to the hearing, and the results will be provided to all the parties.

The petition may include a request to have a subject taken into emergency custody and held pending a hearing on the petition.[118] The petition, if it includes a request for emergency custody, must be supported by an affidavit or sworn testimony that establishes probable cause to believe the subject is eighteen years of age or older, the subject is a person with a developmental disability, the subject poses a threat of harm to others, and if the application is not granted, substantial harm to others is likely to occur before a trial and disposition of the matter can be completed. If the court finds there is probable cause to order the subject taken into emergency custody, the order will include directions to the sheriff or other peace office to take the subject into custody and deliver the subject to the program ordered by the court upon the recommendation of the department. Within 7 days of the order, the department must evaluate the subject to determine if the subject is a person with a developmental disability and that they pose a threat of harm to others. The subject has the right to request a hearing be held within 10 days of an order placing the subject in emergency custody.[119] If such an expedited hearing is requested, the Nebraska Evidence Rules do not apply at that hearing. The hearing on the petition, must be held as soon as practicable but not later than 45 days from the date the subject was taken into emergency custody.[120]

b) Individual Rights

A person alleged to have a developmental disability and pose a threat of harm to others has the rights set forth in Neb. Rev. Stat. § 71-1118, which are as follows:

- The right to be represented by legal counsel and to have counsel appointed if the subject cannot afford to pay the cost of counsel;
- The right to have a guardian ad litem appointed to act on the subject's behalf if the court determines that he or she is unable to assist in his or her own defense;
- The right to have a timely hearing on the merits of the petition before a district court judge;
- The right to have reasonable continuances, for good cause shown, in order to properly prepare for a hearing on the petition;
- The right to testify, subpoena witnesses, require testimony before the court, and offer evidence;
- The right to confront and cross-examine witnesses;
- The right to have an expert witness of the subject's own choice evaluate the subject, testify, and provide recommendations to the court and to have such expert paid for by the county if the subject cannot afford the costs of such expert; and

[118] Neb. Rev. Stat. § 71-1119.
[119] Neb. Rev. Stat. § 71-1120.
[120] Neb. Rev. Stat. § 71-1122.

- The right to have a transcript prepared for the purpose of an appeal, to appeal a final decision of the court, and to have the costs of such transcript and appeal paid by the county if the subject cannot afford such costs.

c) Adjudication Hearing

At the hearing on the petition, the court will ask for the subject to respond to the petition.

> The subject may admit or deny the allegations of the petition or choose to not answer. If the subject denies the allegations of the petition, the court shall proceed to conduct a hearing on the petition. If the subject is unable to understand the nature and possible consequences of the proceedings or chooses to not answer, the court shall enter a denial of the allegations of the petition on the subject's behalf and shall proceed to conduct a hearing on the petition. If the subject admits to the allegations of the petition, the court shall determine whether the admission is free and voluntary and, if the court finds a factual basis to support the admission, may find the subject to be a person in need of court-ordered custody and treatment.[121]

If the subject denies the allegations, the petitioner has the burden to prove by clear and convincing evidence that the subject is a person in need of court-ordered custody and treatment.[122] If the court finds the subject is not a person in need of court-ordered custody and treatment, the petition will be dismissed and the subject released from emergency custody. If the court finds the subject is a person in need of court-ordered custody and treatment, the court shall order the department to evaluate the subject and submit a plan for custody and treatment of the subject in the least restrictive alternative within 30 days. The matter will then be set for a dispositional hearing.

The plan for custody and treatment must be provided to all parties prior to the dispositional hearing. The plan will include:

- A history of the subject's past treatment, if any;
- A comprehensive evaluation of the subject's developmental disabilities;
- A risk analysis;
- The treatment and staffing requirements of the subject;
- Appropriate terms and conditions to provide custody and treatment of the subject in the least restrictive alternative; and
- An appropriate treatment program that is capable of providing and willing to provide treatment

[121] Neb. Rev. Stat. § 71-1123.
[122] Neb. Rev. Stat. § 71-1124.

in accordance with the plan.[123]

d) Disposition Hearing

At the dispositional hearing, the court will consider the plan submitted by the department, the arguments of the parties, and any other relevant evidence.[124] The Nebraska Evidence Rules do not apply during the dispositional hearing. The court shall approve the plan unless it is shown by a preponderance of the evidence that the plan is not the least restrictive alternative for the subject. Following the dispositional hearing, the court will issue an order of disposition placing custody of the subject with the department and setting forth the treatment plan for the subject. The order will include a duration of the order, which will not exceed one year.

e) Post-Hearing

After the dispositional hearing, a review hearing will occur at least annually but may also occur upon request. Before an annual review hearing, the department must submit an updated plan for custody and treatment of the subject.[125] At the hearing, the state will have the burden of showing that court-ordered custody and treatment continued to be necessary by clear and convincing evidence. The court may continue or modify the court-ordered custody and treatment or may vacate such custody and treatment and dismiss the matter.

A review hearing can be requested at any time if it appears the subject no longer poses a threat of harm to others or if it appears the plan needs to be modified.[126] A request is made by motion filed by any party. It will be the burden of the party filing the motion to show by a preponderance of the evidence that the subject no longer poses a threat of harm to others. If the motion requests a modification because the plan for custody and treatment is not sufficient to protect society or the subject or the circumstance upon which the plan was based have changed significantly. The filing party will have the burden of showing by clear and convincing evidence that the court-ordered custody and treatment of the subject should be modified or vacated.

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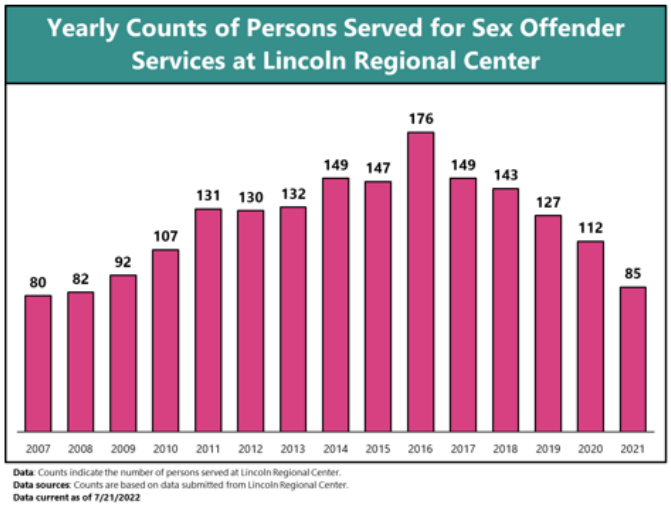
[123] Neb. Rev. Stat. § 71-1125.
[124] Neb. Rev. Stat. § 71-1126.
[125] Neb. Rev. Stat. § 71-1127.
[126] Neb. Rev. Stat. § 71-1128.

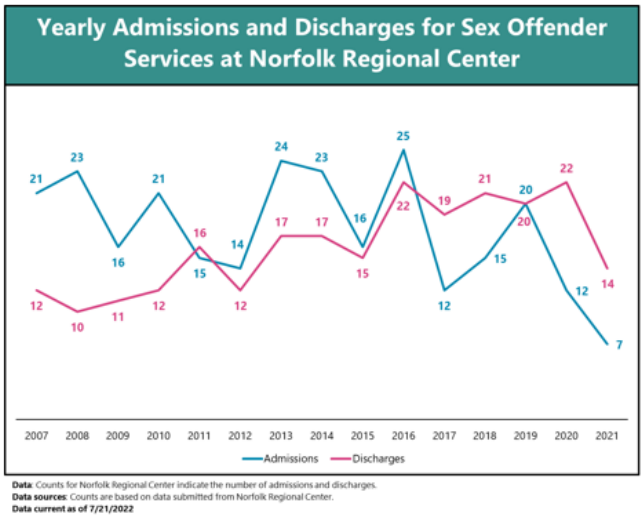
C. Sex Offender Commitment Act §§ 71-1201 to 71-1226

1. Introduction to the SOCA

a) Historical Background

Currently, twenty states, the District of Columbia, and the federal government have laws that authorize civil commitment of sex offenders who would otherwise be released after serving their prison terms.[127] Modern laws providing for the civil commitment of sex offenders, according to a paper prepared by the Congressional Research Service, "are a reincarnation of what are generally referred to as "sexual psychopath" laws. Beginning in the 1930s, states started to enact sexual psychopath laws, which….reflected the growing belief that sexual psychopaths could be identified and treated [rather than incarcerated]….[However, by the 1970s,] there was growing intolerance for the idea of treating sex offenders after a series of treated and released sex offenders committed additional sex crimes."[128] Most states repealed these laws in response to the backlash.





Beginning in 1990, with a law passed in Washington State, several states began to pass new legislation aimed at the civil commitment of sexual offenders after they had already served their term of incarceration under criminal sentencing laws.

The current version of Nebraska's Sex Offender Commitment Act was passed in 2006 as part of a broader bill tightening sex offender registration standards, enhancing penalties for certain types of sexual assault, and other related provisions.[129] The bill was likely in response to the Adam Walsh Child Protection and Safety Act

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[127] Sullum, Jacob. Civil Commitment of Sex Offenders Pretends Prisoners Are Patients, Reason Magazine, https://reason.com/2021/02/10/civil-commitment-of-sex-offenders-pretends-prisoners-are-patients/ (accessed June 27, 2022).
[128] Congressional Research Service, Civil Commitment of Sexually Dangerous Persons, July 2, 2007, pp. 2-3.
[129] See LB 1199 (2006)

of 2006 (P.L. 109-248), passed by the 109th Congress and signed into law by President George W. Bush. The legislation, among many other provisions, provided grants to states for the purpose of establishing, enhancing, or operating civil commitment programs for sexually dangerous persons.[130] The law also gave the U.S. Attorney General (or his or her designee) the power to civilly commit federal inmates who are found to be sexually dangerous persons.[131]

Nebraska's current SOCA focuses on the commitment of "dangerous sex offenders," a term which is defined in Nebraska law and explained in more detail in section (c) below.

b) Purpose

The SOCA's purpose 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."[132] In the bill creating the SOCA, the legislature further declared that "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."[133]

Like the Mental Health Commitment Act, involuntary commitment of dangerous sex offenders is a serious restraint on the committed person's liberty. A mental health board considering whether to commit a person alleged to be a dangerous sex offender must carefully consider the evidence presented and find that the evidence is clear and convincing[134] that the person is a dangerous sex offender before entering any order involuntarily committing that person.

Note that only persons who are eighteen years of age or older can be the subject of a SOCA petition, unless the person is an emancipated minor.[135] In Nebraska, a minor who is at least sixteen years old may petition the district court for an order of emancipation.[136]

c) *Definitions*

This section will discuss the meaning of several terms of art used throughout the SOCA. The most important term to understand when a petition under SOCA is filed with the Mental Health Board is the term "dangerous sex offender." The SOCA incorporates[137] the definition of dangerous sex offender found

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[130] Congressional Research Service, Civil Commitment of Sexually Dangerous Persons, July 2, 2007, p. 8.
[131] Id.
[132] Neb. Rev. Stat. § 71-1202.
[133] Id.
[134] A term that will be further explained below.
[135] See Neb. Rev. Stat. § 71-1203(4).
[136] Neb. Rev. Stat. § 43-4802. The Nebraska courts also have a helpful information page about the emancipation of minors at https://supremecourt.nebraska.gov/self-help/families-children/emancipation#:~:text=You%20must%20be%20at%20least,person%20who%20is%20supporting%20you
[137] See Neb. Rev. Stat. § 71-1203 ("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").

at Neb. Rev. Stat. § 83-174.01. This statute provides two different ways that a person may be found to be a dangerous sex offender.

The first definition contains three elements, but also incorporates additional definitions within each element. Under subsection (a) of § 83-174.01, "dangerous sex offender" means:

1. a person who suffers from a mental illness which makes the person likely to engage in repeat acts of sexual violence;
2. who has been convicted of one or more sex offenses; and
3. who is substantially unable to control his or her criminal behavior.

Now let's look at what each of the underlined terms means. The term "mental illness" is the same as that used at Neb. Rev. Stat. § 71-907 in the Mental Health Commitment Act,[138] which defines mentally ill as "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."

The term "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."[139]

The term "sex offense" is defined as "any of the offenses listed in section 29-4003 for which registration as a sex offender is required." Those offenses are listed as follows:

A. 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;

B. False imprisonment of a minor pursuant to section 28-314 or 28-315;

C. Sexual assault pursuant to section 28-319 or 28-320;

D. Sexual abuse by a school employee pursuant to section 28-316.01;

E. Sexual assault of a child in the second or third degree pursuant to section 28-320.01;

F. Sexual assault of a child in the first degree pursuant to section 28-319.01;

G. Sexual abuse of a vulnerable adult or senior adult pursuant to subdivision (1)(c) of section 28-386;

H. Incest of a minor pursuant to section 28-703;

I. Pandering of a minor pursuant to section 28-802;

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[138] *See* Neb. Rev. Stat. § 83-174.01(3) ("Person who suffers from a mental illness means an individual who has a mental illness as defined in section 71-907.").
[139] Neb. Rev. Stat. § 83-174.01(6).

J. Visual depiction of sexually explicit conduct of a child pursuant to section 28-1463.03 or subdivision (2)(b) or (c) of section 28-1463.05;

K. Knowingly possessing any visual depiction of sexually explicit conduct which has a child as one of its participants or portrayed observers pursuant to subsection (1) or (4) of section 28-813.01;

L. Criminal child enticement pursuant to section 28-311;

M. Child enticement by means of an electronic communication device pursuant to section 28-320.02;

N. Debauching a minor pursuant to section 28-805; or

O. Attempt, solicitation, aiding or abetting, being an accessory, or conspiracy to commit an offense listed above.

There is a second way for a person to be found a dangerous sex offender. Under subsection (b) of § 83-174.01, "dangerous sex offender" means:

1. a person with a personality disorder which makes the person likely to engage in repeat acts of sexual violence;
2. who has been convicted of two or more sex offenses; and
3. who is substantially unable to control his or her criminal behavior.

Again, this definition incorporates additional terms. The definition of sex offense and substantially unable to control his or her criminal behavior are the same as described above. This subsection, in contrast to subsection (a), uses the term "a person with a personality disorder," which the law simply defines as "an individual diagnosed with a personality disorder."[140] This subsection also uses the term "likely to engage in repeat acts of sexual violence," which 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."[141]

Importantly, the county attorney filing the petition regarding a subject must prove that the subject is a dangerous sex offender by "clear and convincing" evidence. Nebraska courts generally define "clear and convincing" as follows: "[c]lear and convincing evidence means the amount of evidence which produces in the trier of fact a firm belief or conviction about the existence of a fact to be proved and, further, that it is more than a preponderance of the evidence, but less than proof beyond a reasonable doubt."[142]

In these cases, the Mental Health Board is the trier of fact, meaning that it is the board members' job to determine what the facts are based on the evidence presented by both the county attorney and the subject's attorney. Evidence that a person is a dangerous sex offender will vary from case to case, but in many cases likely will include such things as court records showing the subject was convicted of a sex

[140] Neb. Rev. Stat. § 83-174.01(4).
[141] Neb. Rev. Stat. § 83-174.01(2).
[142] *In re Interest of Justine J. & Sylissa J.*, 288 Neb. 607, 615 (2014).

offense, police reports, and psychologist or other mental health professional's evaluations and/or testimony regarding the subject.

2. Actions under the SOCA

a) Initiating an Action

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.[143]

(1) Emergency Protective Custody

Nebraska statute gives a law enforcement officer the power to take a person into emergency protective custody if the officer has probable cause to believe the person is either mentally ill and dangerous or a dangerous sex offender.[144] If a mental health professional evaluating a person taken into emergency protective custody determines that the person is a dangerous sex offender, he or she must execute a written certificate "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."[145]

(2) Petition

Only the county attorney may file a petition alleging that an individual is a dangerous sex offender.[146] The petition is 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."[147]

The petition must include the following information:

- The subject's name and address, if known;
- The name and address of the subject's spouse, legal counsel, guardian and/or conservator, and next-of-kin, if known;
- The name and address of anyone providing psychiatric or other care or treatment to the subject, if known;
- A statement that the county attorney has probable cause to believe that the subject of the petition is a dangerous sex offender;

[143] Neb. Rev. Stat. § 71-1206(1).
[144] Neb. Rev. Stat. § 71-919.
[145] Neb. Rev. Stat. § 71-1204.
[146] Neb. Rev. Stat. § 71-1205.
[147] Neb. Rev. Stat. § 71-1205(2).

- 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
- 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, if known.[148]

The county attorney may move to dismiss the petition at any time prior to the commencement of the mental health board hearing under Neb. Rev. Stat. § 71-1208, and upon such motion by the county attorney, the mental health board shall dismiss the petition.[149]

b) Individual Rights

A subject under SOCA proceedings has the same rights as those provided to subjects under the Mental Health Commitment Act[150], as well as all those rights afforded under the U.S. and Nebraska constitutions. These rights are discussed in more detail in section II.A.3.b above.

c) Hearings under SOCA

(1) Adjudication

The first hearing the board must conduct when a SOCA petition is filed is described at Neb. Rev. Stat. § 71-1208. This statute provides that "[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." As noted previously, clear and convincing evidence is "the amount of evidence which produces in the trier of fact a firm belief or conviction about the existence of a fact to be proved."[151]

At the beginning of this hearing, the board must "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 [of the Mental Health Commitment Act] and whether he or she has read and understood them. The board shall [also] explain to the subject any part of the petition or list of rights which he or she has not read or understood.[152]

A number of outcomes are possible following this first hearing. Neb. Rev. Stat. § 71-1209 outlines the possible orders that the board may issue.

1. If the board finds, after hearing the evidence presented, that the subject is not a dangerous sex offender, the board must dismiss the petition and order the unconditional discharge of the subject.[153]

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[148] Neb. Rev. Stat. § 71-1205(3).
[149] Neb. Rev. Stat. § 71-1206(2).
[150] *See* Neb. Rev. Stat. § 71-1224 ("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.")
[151] *In re Interest of Justine J. & Sylissa J.*, 288 Neb. 607, 615 (2014)
[152] Neb. Rev. Stat. § 71-1208.
[153] Neb. Rev. Stat. § 71-1209(2).

2. If the board finds, after hearing the evidence presented, that the subject is a dangerous sex offender, then it has a separate duty to determine the proper treatment order for the subject that is the least possible restraint on the liberty of the subject.[154] The treatment order must reflect the most appropriate available treatment alternative; and, the board must 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."[155]

3. In light of those requirements, the board has several paths it can take in developing a treatment order for subjects it has found to be dangerous sex offenders:

    a. Voluntary Hospitalization: The board may determine 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.[156] If the board makes this finding, then it must either:
        i. dismiss the petition and order the unconditional discharge of the subject; or
        ii. suspend further proceedings for a period of up to ninety (90) days to permit the subject to obtain voluntary treatment.[157]
            1. During this 90-day period, the county attorney may apply to the board for reinstatement of the proceedings; if the county attorney does so, the board must set a hearing on the application to determine if the proceedings should be reinstated.
            2. If the county attorney does not submit an application for reinstatement within 90 days, then the board must dismiss the petition and order the unconditional discharge of the subject at the conclusion of the 90 day period.[158]

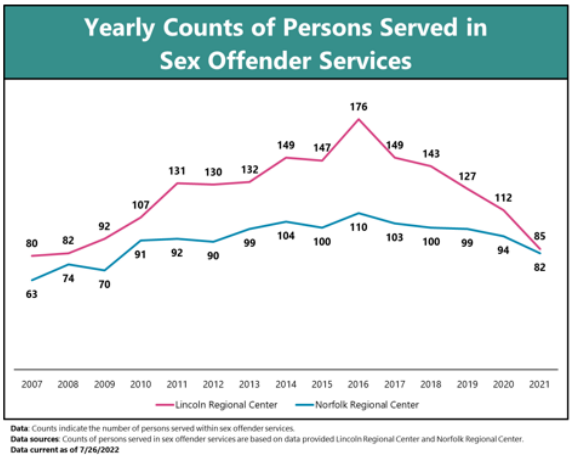
    b. Outpatient Treatment: The board may order outpatient treatment if the subject admits that the allegations of the petition are true, or if the board, after a contested hearing, finds that the subject is a dangerous sex offender and also finds that "neither voluntary hospitalization nor other treatment alternatives less restrictive of the subject's liberty

[154] Neb. Rev. Stat. § 71-1209(6).
[155] *Id.*
[156] Neb. Rev. Stat. § 71-1209(3); the harm described in subdivision (1) of section 83-174.01 is that the subject is "likely to engage in repeat acts of sexual violence" and "is substantially unable to control his or her criminal behavior."
[157] Neb. Rev. Stat. § 71-1209(3)(a)-(b).
[158] Neb. Rev. Stat. § 71-1209(3)(b).

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."[159] If the board makes these findings, it may order the subject to receive outpatient treatment, and must enter (meaning write and sign) such an order within 48 hours of the hearing.

c. Inpatient Treatment: The board may also order inpatient treatment if the subject admits that the allegations of the petition are true, or if the board, after a contested hearing, finds that the subject is a dangerous sex offender and also finds 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."[160] If the board orders the subject to receive inpatient treatment, it must again enter such an order within 48 hours of the hearing.
    i. In addition, if the board orders the subject to receive inpatient treatment, then it must commit the subject to the custody of the Department of Health and Human Services for such treatment.[161]

In drafting a treatment order, the board may, if it desires, 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 … and may require the subject to submit to reasonable psychiatric and psychological evaluation to assist the board in preparing such order."[162]



Also, any treatment order entered by the board pursuant to Neb. Rev. Stat. § 71-1209 must 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."[163] In its treatment order, the board must designate a person or entity responsible for preparing and overseeing the subject's individualized treatment plan.[164]

[159] Neb. Rev. Stat. § 71-1209(4).
[160] *Id.*
[161] Neb. Rev. Stat. § 71-1209(4)(b).
[162] Neb. Rev. Stat. § 71-1209(7).
[163] Neb. Rev. Stat. § 71-1215(1).
[164] Neb. Rev. Stat. § 71-1216.

(2) Custody

The mental health board has the power to order a subject into custody and to issue warrants directing law enforcement to take the subject into custody at certain points in a SOCA proceeding. In most cases, a subject can be taken into custody without a hearing, *but* a hearing must be held to determine if the custody should continue, either within a set timeframe dictated by statute, or as soon as practicable given the subject's constitutionally protected liberty interests.

- Custody pending treatment order: After the adjudication hearing, at which the board has found that a subject is a dangerous sex offender, but before the board issues a treatment order, the board may order one of two things:
    - The board may order that the subject be retained in custody until the entry of a treatment order and the subject may be admitted for treatment pursuant to such order;[165] or
    - The board may 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.[166]
- Custody on motion of county attorney: A subject undergoing outpatient treatment under a treatment order of the board can be ordered into custody by the board in a couple different scenarios:
    - If the county attorney files a motion for custody, the board must 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.[167]
        - In this event, the board may also 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."[168]
        - A subject taken into custody under this section (Neb. Rev. Stat. § 71-1218) cannot be held more than seven days "except upon a continuance granted by the board."[169]
    - The board itself may also order, on its own motion, 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.

[165] Neb. Rev. Stat. § 71-1210(1)(a).
[166] Neb. Rev. Stat. § 71-1210(1)(b).
[167] Neb. Rev. Stat. § 71-1218.
[168] *Id.*
[169] *Id.*

  - The subject, the subject's counsel, and the subject's legal guardian or conservator, if any, must be given 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.
  - At the end of the hearing, the board must determine whether the subject's outpatient treatment will be continued, modified, or ended.
- Warrant upon report of outpatient provider: Neb. Rev. Stat. § 71-1217 requires the outpatient treatment provider for a subject to make reports to the board and the county attorney in certain cases, specifically:
  - If the subject is not complying with his or her individualized treatment plan;
  - If the subject is not following the conditions set by the mental health board;
  - If the treatment plan is not effective; and
  - If there has been a significant change in the subject's mental illness or personality disorder or the level of risk posed to the public.[170]
- The county attorney will investigate to determine if there is a factual basis for the report.
  - If not, the county attorney will notify the board that there is no factual basis for the report or that no further action is warranted.[171]
  - On the other hand, if the county attorney determines 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.[172]
- If the county attorney determines intervention by the board is necessary, the county attorney may also apply for a warrant to take immediate custody of the subject pending a rehearing by the board "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."[173]
  - If the county attorney makes application for a warrant, the application to the board for a warrant must be supported "by affidavit or sworn testimony by the county attorney, a mental health professional, or any other informed person."[174]

(3) Review Hearings

Once a subject has been adjudicated by the board as being a dangerous sex offender and has entered a commitment and/or treatment order, periodic review hearings may be held by the board to get updates on the subject's treatment progress. There are several reasons a review hearing may be scheduled, and in some cases setting the hearing is mandatory. The different triggering events for a review hearing are outlined below:

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[170] Neb. Rev. Stat. § 71-1217(1)(a)-(d).
[171] Neb. Rev. Stat. § 71-1217(2)(b).
[172] Neb. Rev. Stat. § 71-1217(2)(c).
[173] Neb. Rev. Stat. § 71-1217(2)(d).
[174] *Id.*

Mandatory Review Hearings

- As noted above, under Neb. Rev. Stat. § 71-1216, the person or entity designated by the board as responsible for preparing and overseeing the subject's individualized treatment plan must periodically submit progress reports to the board, and also to the county attorney, the subject, the subject's attorney, and the subject's legal guardian or conservator, if any.
    - Upon the filing of any periodic progress report, "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."[175]
    - If the board receives such a request or motion, the board must schedule the review hearing within 14 calendar days of receiving the request.[176]
- Also, under Neb. Rev. Stat. § 71-1221, the board and the county attorney must be notified in writing of the release by the treatment facility of any individual committed to the facility by the mental health board. If the county attorney in response files a motion for review hearing, the board must "conduct a hearing to determine whether the individual is a dangerous sex offender and consequently not a proper subject for release."[177]
- Lastly, under Neb. Rev. Stat. § 71-1222, the board must "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," if the county attorney files a motion for such a hearing.

Voluntary Review Hearings

The board may (but is not required to) schedule a review hearing under the following circumstances:

- Upon its own motion 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;[178]
- Upon its own motion to determine whether a subject a facility intends to release is a proper subject for release;[179]
- 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

[175] Neb. Rev. Stat. § 71-1219(1) (emphasis added)
[176] *Id.*
[177] Neb. Rev. Stat. § 71-1221.
[178] Neb. Rev. Stat. §§ 71-1219(1)(a) and 71-1222.
[179] Neb. Rev. Stat. §§ 71-1219(1)(a) and 71-1221.

such plan";[180] or

- Upon its own motion for any other reason.[181]

[180] Neb. Rev. Stat. § 71-1219(1)(b).
[181] Neb. Rev. Stat. § 71-1219(1)(c).

D. Precedent Setting Cases

U.S. SUPREME COURT CASES

United States vs. Comstock (2010),[182] addressed the issue of whether Congress had exceeded its authority under the Necessary and Proper Clause in enacting a civil commitment statute.

> Facts: In 2006, the government instituted proceedings in Federal District Court against 5 federal detainees who pled guilty in federal court to possession of child pornography, or sexual abuse of a minor. The government claimed the individuals had engaged in sexually violent conduct or child molestation in the past and were sexually dangerous to others. The detainees moved to dismiss the civil commitment proceeding.
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> Held: 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.

Olmstead v. L.C. (1999),[183] the U.S. Supreme Court considered the question whether the proscription of discrimination may require placement of persons with mental disabilities in community settings rather than in institutions, using the Americans with Disabilities Act (ADA) of 1990, 42 U.S.C.S. § 12131 to 12134, as reference.

> Facts: Two individuals with mental illnesses and intellectual and developmental disorders voluntarily admitted to a Georgia mental institution were confined for treatment in a psychiatric unit. Their treatment providers concluded eventually that each of the individuals could be cared for appropriately in community-based programs. Nevertheless, they remained institutionalized. They brought suit alleging the State violated Title II of the ADA, which prohibits discrimination.
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> Held: The Court held that public entities must provide community-based services to persons with disabilities when (1) such services are appropriate; (2) the affected persons do not oppose community-based treatment; and (3) community-based services can be reasonably accommodated, taking into account the resources available to the public entity and the needs of

[182] United States v. Comstock, 560 U.S. 126 (2010)
[183] Olmstead v. L.C. by Zimring, 527 U.S. 581, 119 S.Ct. 2176 (1999).

others who are receiving disability services from the entity.

The Supreme Court explained that its holding "reflects two evident judgments." First, "institutional placement of persons who can handle and benefit from community settings perpetuates unwarranted assumptions that persons so isolated are incapable of or unworthy of participating in community life." Second, "confinement in an institution severely diminishes the everyday life activities of individuals, including family relations, social contacts, work options, economic independence, educational advancement, and cultural enrichment."[184]

HISTORIC NEBRASKA CASES

Hill v. County Board of Mental Health, Douglas County (1979),[185] examined the question of what "recent" meant within the context of the Mental Health Commitment Act, which provides that a substantial risk of harm should be demonstrated by evidence of "recent" acts by the subject.

Facts: Hill was an individual who was first committed to LRC in 1959 at age 6. 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 months, 4 months, and 6 weeks, respectively, of the hearing.

Rationale: The court argued that to interpret "recent" narrowly would require "the discontinuance of treatment and release [of committed individuals] in order to afford an opportunity for a more recent act of violence before any rehearing and further commitment could take place." 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.'"

Held**:** The court held 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

[184] https://www.ada.gov/olmstead/olmstead_about.htm
[185] Hill v. County Board of Mental Health, 203 Neb. 610 (1979).

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."

Lux v. Mental Health Board of Polk County (1979),[186] examined the question of whether "recent violent acts" meant evidence of multiple acts of violence were required within the context of the Mental Health Commitment Act.

Facts: Lux was 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.

Held: 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.

In re Interest of Blythman (1981),[187] examined the question of whether an action occurring five years previous to the hearing was "recent" within the context of the Mental Health Commitment Act.

Facts: Blythman was 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 under the Nebraska Sexual Sociopath Act (repealed in 1979). Blythman was convicted as a juvenile for stabbing a girl at school and convicted as an adult in 1974 of fondling a minor. 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 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. He was committed by order of the mental health board following evidence of his past convictions and evaluations by psychiatrists. He appealed the commitment asserting there was insufficient evidence of recent acts or threats of violence because his convictions were not recent within the meaning of the Mental Health Commitment Act.

Held: The Court held that under the 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. "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;

[186] Lux v. Mental Health Board of Polk County, 202 Neb. 106, 274 N.W.2d 141 (1979)

[187] In re Interest of Blythman, 208 Neb. 51, 302 N.W.2d 666 (1981).

(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.

In re Interest of Rasmussen (1990),[188] dealt with an appeal where the Court found there was plain error where there was insufficient evidence that the subject was dangerous at the time of the hearing.

> Facts: In 1989, an Omaha police office responded to a disturbance call that a man was inhabiting a sewer drain. Rasmussen was found by the police officer wearing only pants and shoes in the roadway. The police officer asked Rasmussen to show his hands and Rasmussen ignored the requests. Rasmussen proceeded to jump in the back of a passing truck at which time the police officer took him into custody. Rasmussen was taken to Douglas County Hospital for emergency admittance. The mental health board entered an order committing Rasmussen after a commitment hearing. Rasmussen appealed the order.
>
> Held: The court found that 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. The evidence at hearing indicated a strong possibility, which does not, as a matter of law, support a finding that at the time of the hearing the individual's condition was such that he lacked the ability to provide for basic human needs, personal safety, or that the individual posed a substantial risk of harm to himself.

NEBRASKA CASES 2000-2010

In re Interest of Wickwire (2000)[189] the Nebraska Supreme Court considered whether mental retardation fulfilled the "mentally ill" requirement for civil commitment under the Commitment Act.

> Facts: In 1998, Wickwire was living in a Region V, an agency that provides residential services to people with developmental disabilities, group home. Wickwire had an IQ of 40 and was considered to be mentally retarded. He 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. At the commitment hearing, psychiatrists from 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 Board dismissed the petition because the evidence showed Wickwire was not mentally ill.

[188] In re Interest of Rasmussen, 236 Neb. 572, 462 N.W.2d 621 (1990).
[189] In re Interest of Wickwire, 259 Neb. 305, 609 N.W.2d 384 (Neb. 2000).

Held: 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 the Interest of Albert (August 24, 2001), an appeal to the Platte County District Court was brought questioning the validity of a mental health board order when two of the board members had not completed the mandatory training.

Facts: 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.

Held: the mental health board order was declared null and void because two of the three board members had not completed mental health board training as required by Neb. Rev. Stat. § 71-916 within the two preceding years.

In re Interest of S.B. (2002),[190] Addressed the right to confront witnesses in civil commitment proceedings pursuant to Neb. Rev. Stat. § 71-954.

Facts: In 2000, the State filed a petition pursuant to the Mental Health Commitment Act alleging S.B. was a mentally ill, an alcoholic, and/or drug-abusing person who was a danger to himself or others because S.B was hearing voices and had a physical confrontation with his parents. The board ordered a 90-day continuance to allow S.B. to seek voluntary treatment. However, he was taken into custody months later while trying to gain access to Offutt Air Force Base and the State filed a motion to reinstate proceedings. At the hearing on the motion the State called a psychiatrist as a witness. The psychiatrist was permitted to testify at the hearing telephonically via speaker telephone over the objection of S.B. S.B.'s counsel had the opportunity to cross-examine the witness and did so. The mental health board issues an order committing S.B. to inpatient treatment at a state hospital. S.B. appealed. The District Court reversed the mental health board and the State appealed.

Held: 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.

[190] In re Interest of S.B., 263 Neb. 175, 639 N.W.2d 78 (Neb. 2002).

In re Interest of E.M. (2005),[191] examined Neb. Rev. Stat. § 83-1045.02 (transferred to Neb. Rev. Stat. § 71-932), 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."

> Facts: 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.
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> Held: "The 'seven days' language of Neb. Rev. Stat. § 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."

In re Interest of Verle O. (2005),[192] the Nebraska Court of Appeals considered whether a plea of no contest to an assault could be used as evidence of a recent violent act under the Mental Health Commitment Act.

> Facts: 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 Neb. Rev. Stat. § 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. Neb. Rev. Stat. § 27-410 states that a defendant's statements made in connection with a plea are not admissible in any civil action, case or proceeding against that defendant.
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> 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. However, evidence of the prior conviction, including the allegations of the complaint as well as the journal entries memorializing the acceptance of the no contest plea and the sentence, was properly received by the mental health board.

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[191] In re Interest of E.M., 13 Neb. App. 287 (Neb. App., 2005).

[192] **In re Interest of Verle O.** (2005), 13 Neb. App. 256 (Neb. App., 2005).

Winters v. O'Neill (2006),[193] Winters challenged his confinement at the NRC pending transfer to LRC on the grounds that it violated his constitutional rights.

> Facts: 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.
>
> Held: 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. Winters did not demonstrate that a violation of a constitutional right occurred. Neither differences of opinion nor medical malpractice state an actionable Constitutional violation. The defendants' motion for summary judgment will be granted, case dismissed.

In re Interest of R.P. (2007),[194] the Nebraska Court of Appeals considered an appeal wherein the defendant stipulated to being mentally ill and dangerous, and then challenged the commitment for not having sufficient evidence of dangerousness and that inpatient treatment was least restrictive alternative.

> Facts: 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."
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> Held: Citing *In re Interest of E.M.* (see above), the court found no merit to R.P.'s assignment of error that the district court erred in affirming the board's order that R.P. was mentally ill and

[193] Winters v. O'Neill, 2006 WL 12663 (D. Neb., 2006).
[194] In re Interest of R.P., 2007 WL 1532327 (Neb. App., 2007).

dangerous, because he stipulated to such, and finding inpatient commitment the least restrictive alternative where there was evidence presented that when R.P. was in outpatient treatment he failed to meet the terms of the outpatient commitment order.

In re Interest of D.C. (2007),[195] the Court of Appeals considered what objections must be raised and what errors must be asserted on appeal to be considered by the appellate court.

Facts: D.C. was found guilty of a sexual offense as a juvenile in 1983, he pled no contest to sexual assault in 2003, and he was convicted of sexual assault of a child in 2004. D.C. was sentenced to five years imprisonment for the 2004 conviction and was scheduled to be released April 16, 2006. A deputy county attorney filed a petition for civil commitment April 12, 2006. At the hearing, evidence was entered related to evaluations and the past convictions and no contest plea, and the evaluating psychologist testified that D.C. presented a strong risk of reoffending due to his criminal history and lack of interest in 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.

Held: D.C.'s assignment of error regarding the Board's finding that D.C. was mentally ill was without merit. D.C. did not assert that the 2004 sentencing order was improperly received as evidence, which the court determined was fatal to his claim of insufficient proof of recent acts of violence. D.C. argued that the district court erred in finding the least restrictive option was inpatient commitment, but the Court of Appeals did not consider this because D.C. did not include a corresponding assignment of error in his brief.

NEBRASKA CASES AFTER 2010

In re Interest of C.R. (2011),[196] the Nebraska Supreme Court considered a constitutional challenge to the Developmental Disabilities Court-Ordered Custody Act.

Facts: C.R., an adult with a developmental disability, was charged with sexual assault in May of 2007. C.R. was determined incompetent to stand trial and was committed to the Lincoln Regional Center (LRC). In October of 2009, the state filed a petition under DDCOCA. C.R. moved the district court to declare DDCOCA violates due process, is unconstitutional, because under DDCOCA (1) the State is not required to prove that a person with developmental disabilities poses a risk of future harm to others before the court imposes involuntary custody or treatment and (2) the State is not required to prove a nexus between a person's developmental disability

[195] In re Interest of D.C., 2007 WL 2372613 (Neb. App., 2007).
[196] In re Interest of C.R., 793 N.W.2d 330 (Neb. 2011).

and his prior actions that required involuntary commitment.

Rationale: DDCOCA "does not require proof of future harm before a court determines that the subject is in need of court-ordered custody and treatment" under Neb. Rev. Stat. § 71-1115. DDCOCA is distinct from the Mental Health Commitment Act. 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.

Held: The Court found that the Developmental Disabilities Court-Ordered Custody Act provided procedures and evidentiary standards that protect an individual's constitutionally protected liberty interest.

D.I. v. Gibson et al. (2015),[197] 291 Neb. 554 (2015). The Supreme Court of Nebraska considered Neb. Rev. Stat. § 71-1207 of the Sex Offender Commitment Act, which states the mental health board "shall" hold a hearing within seven days.

Facts: 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 outlined 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."

Held: 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."

[197] D.I. v. Gibson et al., 291 Neb. 554 (Neb. 2015).

In re Interest of D.I. (2011),[198] the Nebraska Supreme Court the court considered whether the mental health board's denial of a motion for reconsideration was an appealable order that conferred jurisdiction with the appellate court.

> Facts: D.I. was committed under Sex Offender Commitment Act (see the facts below for *In re Interest of D.I.* (2018)). He filed a motion for reconsideration pursuant to Neb. Rev. Stat. § 71-1219, which allows for a subject to request a review hearing, alleging that cause no longer existed to keep him in secure inpatient treatment. A hearing was held on the motion during with the state's psychiatrist testified that D.I. had not progressed because he refused to recognize he had done anything wrong and D.I. insisted he would repeat the problematic behavior. The board denied the motion and on appeal the district court affirmed. D.I. appealed to the Nebraska Supreme Court.
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> Rationale: SOCA does not explicitly provide for an appeal from denial of a motion for review under Neb. Rev. Stat. § 71-1219. Therefore, the Supreme Court only has jurisdiction to hear the appeal if the order entered after the review hearing is a final, appealable order under Neb. Rev. Stat. §§ 25-1901 and 25-1902.
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> Held: Denial of a motion for reconsiderations under Neb. Rev. Stat. § 71-1219 is a final, appealable order because it includes a determination that results in either continued commitment or release of a subject. However, the mental health board did not err when it determined D.I. continued to be a dangerous sex offender.

In re Interest of D.I. (2018),[199] the Nebraska Court of appeals considered an appeal from an order entered by a mental health board following a review hearing requesting discharge or a change in treatment plan. The Court affirmed because the evidence showed D.I. was a danger because he did not perceive he had done anything wrong.

> Facts: D.I. was charged with five counts of sexual assault of a child and convicted of one count of sexual assault of a child in 2004. He was then committed to a secure inpatient sex offender treatment in December 2006. During D.I.'s sentence, a county attorney filed a petition before the Douglas County mental health board alleging D.I. was a dangerous sex offender. The Board found he was. D.I. has challenged the commitment via review hearings in November 2009 and March 2016. He filed a motion for review hearing in 2017 requesting discharged or a change in treatment. At the review hearing a psychologist testified that D.I. had progressed slowly in treatment because he denied his behavior was sexually motivated and expressing concern that he may repeat such behaviors because he did not see them as wrong. The board found D.I. continued to meet the definition of a dangerous sex offender. D.I. appealed and the district

[198] In re Interest of D.I., 281 Neb. 917 (2011).
[199] In re Interest of D.I., 2018 WL 6839726 (Neb. App., 2018).

court affirmed. D.I. appealed again and argued the initial commitment was entered on insufficient evidence and that the board considered evidence that should not have been admitted, including the psychologist's testimony.

Held: D.I. did not appeal the original commitment order within 30 days, therefore, he could not challenge the sufficiency of evidence in this appeal. The testimony of the psychologist was admissible because her "opinion was supported by facts and data reasonably relied upon by experts in the field and was based on more than mere subjective belief or unsupported speculation."

Martinez v. Dawson (2020),[200] the Nebraska Court of Appeals considered an appeal from denial of a writ of habeas corpus filed by an individual committed under the Sex Offender Commitment Act (SOCA).

Facts: Martinez was criminally charged in Texas with one count of burglary of habitation and one count of sexual assault in 1988. He pled guilty to the burglary charge and the sexual assault charge was dropped. His conviction required him to register with the Texas Sex Offender Registry, however. Subsequently, Martinez was convicted in Nebraska in 2010, 2013, and 2016 for failing to register as a sex offender in Nebraska. In 2018, the mental health board found Martinez was a dangerous sex offender under SOCA and that inpatient treatment was the least restrictive treatment alternative. In 2019, Martinez file a petition for writ of habeas corpus challenging his commitment on the basis that he was not convicted of a sexual offense. The district court dismissed. Martinez appealed.

Habeas corpus is a special civil proceeding providing a summary remedy to persons illegally detained. Under Nebraska law, an action for habeas corpus is a collateral attack on a judgment of conviction. This means a habeas petition is not filed in the action where the commitment order was entered, but is a new, separate action. Only a void judgment may be collaterally attacked, absent statutory authority.

Held: A writ of habeas corpus may not be used as a substitute for an appeal, thus the court cannot review the mental health board's determination on the merits, and a writ will not lie upon the ground of mere errors and irregularities in the judgment.

[200] Martinez v. Dawson, No. A-19-696 (Neb. App., 2020).

E. Guardianship and Powers of Attorney

As members of a mental health board, it is likely you will encounter individuals with a court-appointed guardian or agent appointed by power of attorney. This section is intended to provide base information about the guardianship process and powers of attorney in the State of Nebraska.

1. Definitions

The statutes for guardianship are located in the Nebraska Probate Code. Within the context of the Nebraska Probate Code the following definitions are important.

- Conservator: a person appointed by the court to administer the property of an adult.[201]
- Estate: the property of the ward, including both real and personal property or any interest therein and anything else that may be the subject of ownership.[202]
- Guardian: any person appointed to protect a ward and may include the Public Guardian; a person appointed by the court to make decisions regarding the person of an adult.[203]
- Incapacitated person: any person who is impaired by reason of mental illness, mental deficiency, physical illness or disability, chronic use of drugs, chronic intoxication, or other cause (except minority) to the extent that the person lacks sufficient understanding or capacity to make or communicate responsible decisions concerning himself or herself.
- Interested person: children, spouses, those persons who would be the heirs if the ward or person alleged to be incapacitated died without leaving a valid will who are adults and any trustee of any trust executed by the ward or person alleged to be incapacitated.
    - Heirs: those persons, including the surviving spouse, who are entitled under the statutes of intestate succession, *see* Neb. Rev. Stat. §§ 30-2302 and 30-2303, to the property of a deceased person.
- Protective Proceeding: a proceeding under Neb. Rev. Stat. § 30-2630 to determine that a person cannot effectively manage or apply their estate to necessary ends, either because the person lacks the ability or is otherwise inconvenienced, or because the person is a minor, and to secure administration of the person's estate by a conservator or other appropriate relief.
- Protected person: a minor or other person for whom a conservator has been appointed of other protective order has been made.
- Ward: a person for whom a guardian has been appointed by a court.

2. Guardianship

Guardianship is the process whereby an interested person, usually a family member, may petition the court for an order to act on behalf of an incapacitated adult, person in need of protection or a minor

[201] Neb. Rev. Stat. § 30-3902(2).
[202] Neb. Rev. Stat. § 30-2209(36).
[203] Neb. Rev. Stat. §§ 30-2601(6) and 30-3902(3).

child. This section will focus on adult guardianship proceedings. It is important to note that guardianship is a broad term that covers several types of guardianship. The guardianship types are as follows:

- Full Guardianship: where a guardian appointed to make all decisions in all areas of a person's life. If no conservator is appointed, the guardian has some of the responsibilities of a conservator.
- Limited Guardianship: where a guardian is appointed to make decisions in specific areas the ward has been found by the court to be incapable of handling on their own.
- Temporary Guardianship: where a guardian is appointed to address an emergency for a period of 90 days.

a) The Guardianship Appointment Process

(1) Out-of-State Guardianships/Conservatorships

If an individual has a court-appointed guardian by order of a court outside of Nebraska, then a guardianship proceeding cannot be brought in Nebraska because the court of this state would not have jurisdiction.[204] Except a proceeding could be brought for emergency appointment of a temporary guardian, appointed for a term of ninety days or less, where the person is physically present in Nebraska.[205] If a guardian has been appointed in another state, the guardian appointed in the other state may register the guardianship order in Nebraska by filing it as a foreign judgment in a court in any appropriate county of Nebraska.[206] An appropriate county includes a county where the ward is physically located and each county wherein the ward has real property or an interest in real property.

(2) Initiating the proceeding

Guardianships can be initiated by someone filing a petition for appointment of a temporary guardian due to emergency circumstances or filing a petition for appointment of a permanent guardian. A petition for guardianship may be filed where the person alleged to be incapacitated resides or where the person is located at the time of filing.[207]

Neb. Rev. Stat. § 30-2626 allows for a temporary guardian to be appointed for a period of 90 days when a person alleged to be incapacitated has no guardian and an emergency exists, or where an appointed guardian is not effectively performing their duties and the court finds the welfare of the ward requires immediate action. The court may exercise the powers of a guardian or may enter an ex-parte order appointing a temporary guardian.[208] The petitioner must serve the parties with a copy of the petition and notice of the appointment and the ward's right to request an expedited hearing.[209] An expedited hearing may be help on the petition and ex-parte order, if the person alleged to be incapacitated or any

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[204] Neb. Rev. Stat. § 30-3911 and, generally, the Nebraska Uniform Adult Guardianship and Protective Proceedings Jurisdiction Act, Neb. Rev. Stat. §§ 30-3901 to 30-3923.
[205] Neb. Rev. Stat. § 30-3910.
[206] Neb. Rev. Stat. § 30-3918. Filing a foreign judgment requires filing a certified copy.
[207] Neb. Rev. Stat. § 30-2618.
[208] An ex parte order is an order granted without waiting for a hearing to be held on the motion or petition.
[209] Neb. Rev. Stat. § 30-2625(d).

interested person makes a request. If an expedited hearing is requested, the hearing will be held within 10 business days of the request. At the hearing, the petitioner will have the burden of proving by a preponderance of the evidence that the temporary guardianship is necessary to address the emergency. The temporary guardianship may be extended for successive 90 day periods upon good cause shown, or the temporary guardian may be removed at any time. A temporary guardian is intended to exercise their powers in a limited manner and for a limited period of time.[210]

A verified petition, a petition signed under oath, for appointment of a permanent guardian may be filed by a person alleged to be incapacitated or "any person interested" in their welfare.[211] The petition must contain specific allegations with regard to each of the areas set forth in Neb. Rev. Stat. § 30-2619.01 and allege that the person alleged to be incapacitated "lacks sufficient understanding to make or communicate responsible decisions concerning [their] own person."

Upon filing of the petition, the court will set a date for hearing, and may appoint a guardian ad litem to advocate for the best interests of the person alleged to be incapacitated. The court may appoint a court visitor[212] and direct such visitor to conduct an evaluation of the allegations of incapacity pursuant to Neb. Rev. Stat. § 30-2619.01. The court visitor is to interview or examine the person alleged to be incapacitated in their usual residence, unless it is necessary to conduct the interview or exam elsewhere.[213] The report of the visitor must be filed within 60 days of the filing of the petition and copies made available to the guardian ad litem, the person alleged to be incapacitated, and the petitioner. The report must contain the following:

- a record of the interviews,
- evidence obtained by the visitor,
- recommendations about the need for a guardian in specific areas,
- the visitor's opinion as to the appropriateness of the nominated guardian,
- recommendations as to other appropriate candidates to serve as guardian, and
- the visitor's opinion on the needed duration of the guardianship[214]

The court may appoint a physician to examine the person alleged to be incapacitated and, if appointed, such physician shall submit their report in writing to the court.

Notice of the hearing is require to be provided to the person alleged to be incapacitated and their spouse, parents, adult children, and any appointed guardian or conservator.[215] In the absence of any of the foregoing people, notice must be provided to at least one of the closest adult relatives of the person

[210] In re Guardianship & Conservatorship of Larson, 270 Neb. 837, 708 N.W.2d 262 (2006).
[211] Neb. Rev. Stat. § 30-2619.
[212] A court visitor must meet the qualifications set forth in Neb. Rev. Stat. § 30-2624 to be appointed.
[213] Neb. Rev. Stat. § 30-2619.02.
[214] Neb. Rev. Stat. § 30-2619.03.
[215] Neb. Rev. Stat. § 30-2625(b).

alleged to be incapacitated, if any can be found. The person alleged to be incapacitated is entitled to the following list of rights:

- Right to request appointment of an attorney
- Right to present evidence on their own behalf
- Right to request the power of the guardian, if appointed, be limited by the court
- Right to be notified regarding how to contact the temporary guardian, if appointed
- Right to compel attendance of witnesses
- Right to cross-examine witnesses, including a court-appointed physician
- Right to appeal any final order
- Right to request the hearing be closed to the public[216]

The report of the visitor and other evidence will be considered by the court during the hearing on the petition for appointment of a guardian.

A guardianship is terminated upon the death of the guardian or ward, upon a determination that the guardian is incapacitated, or upon removal or resignation of the guardian.[217] On petition of a ward or any person interest in the ward's welfare, the court may remove a guardian if it is in the best interests of the ward.[218] The petition may be based on allegations that the guardian is not acting in the ward's best interests or that the ward is no longer incapacitated. A guardian is also entitled to petition the court to resign. Prior to entry of an order removing the guardian, accepting resignation of the guardian, or ordering that a ward's incapacity has terminated, the court may send a visitor to the residence of the guardian and ward to observe conditions and submit a written report to the court.

(3) Proving incapacity and Least Restrictive Alternative

The court may appoint a guardian if it is satisfied by clear and convincing evidence that the person alleged to be incapacitated is in fact incapacitated and appointment of a guardian is necessary or desirable as the least restrictive alternative available for providing continuing care or supervision of the person.[219] An incapacitated person is someone "who is impaired by reason of mental illness, mental deficiency, physical illness or disability, chronic use of drugs, chronic intoxication, or other cause to the extent that the person lack sufficient understanding or capacity to make or communicate responsible decisions concerning [their self]."[220]

The court and parties involved in a guardianship proceeding should be mindful that guardianship affects the ward's independence and autonomy. Therefore, guardianship should only be ordered where there is no alternative. Consideration of alternatives to guardianship is required by Neb. Rev. Stat. § 30-2620(a).

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[216] List from Neb. Rev. Stat. § 30-2625.
[217] A court can appoint a standby guardian in advance to assume the guardianship responsibilities in the event of the death or incapacity of a guardian pursuant to Neb. Rev. Stat. § 30-2619.
[218] Neb. Rev. Stat. § 30-2623.
[219] Neb. Rev. Stat. § 30-2620(a).
[220] Neb. Rev. Stat. § 30-2601(1).

Some alternatives may include appointment of a conservator, application to Social Security for appointment of a representative payee, or execution of a power of attorney (if the person has capacity to execute a power of attorney).

(4) Guardian Requirements

Any competent person or the Public Guardian may be appointed guardian of a person alleged to be incapacitated, with some exceptions for care providers.[221] There is a priority for appointment of guardians in the event multiple persons would like to be appointed. Highest priority is given to persons nominated by the allegedly incapacitate person. Nominated persons are followed by spouses, adult children, and parents of the allegedly incapacitated person, in that order.[222] Importantly, a guardian must be willing to serve. A guardian must accept the appointment in writing and file the same with the court.[223]

Before anyone may be appointed guardian of an incapacitated person, they are required to complete a national criminal history record check, a check of the Abuse and Neglect Registries for adults and children, a sex offender registry check, and credit check, and to provide certified copies of the results to the court a least 10 days prior to the hearing for appointment of a guardian.[224] For an emergency temporary guardianship, the background checks are not required. In other situations, the court may waive the background checks upon good cause shown. A guardian is required to complete a training program approved by the Public Guardian within 3 months of their appointment.[225]

b) Appointment of the Public Guardian

The Public Guardian is the guardian of last resort, which means the Public Guardian is appointed where there is no other appropriate or willing person to serve as guardian. The procedure for appointing the Public Guardian is governed by Nebraska Court Rule § 6-1443 et seq. An individual filing a petition for appointment of the Public Guardian as either temporary or permanent guardian will nominate the Public Guardian in the petition and provide notice of nomination to the Public Guardian once the petition is filed. Within 14 days of receipt of the notice, the Public Guardian must file an acknowledgement of nomination and verification of caseload capacity. If the Public Guardian does not have caseload capacity, good cause shall be presumed to deny the appointment.

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[221] Neb. Rev. Stat. § 30-2627, "it shall be unlawful for any agency providing residential care in an institution or community-based program, or any owner, part owner, manager, administrator, employee, or spouse of an owner, part owner, manager, administrator, or employee of any nursing home, room and board home, assisted-living facility, or institution engaged in the care, treatment, or housing of any person physically or mentally handicapped, infirm, or aged to be appointed guardian of any such person residing, being under care, receiving treatment, or being housed in any such home, facility, or institution within the State of Nebraska."

[222] Neb. Rev. Stat. § 30-2627(b).

[223] Neb. Rev. Stat. § 30-2621 and Neb. Ct. R. § 6-1443(A).

[224] Neb. Rev. Stat. § 30-2602.02 and Neb. Ct. R. § 6-1449.

[225] Neb. Rev. Stat. § 30-2627(d).

Even if the Public Guardian does not have capacity at the time of filing, the petition can proceed. The Court will appoint a visitor consistent with Neb. Rev. Stat. § 30-2619.01 or guardian ad litem pursuant to Neb. Rev. Stat. § 30-2222(4) within 10 days of the filing of the Public Guardian's acknowledgment and verification of caseload capacity. Upon receipt of a copy of the report, the Public Guardian will file another verification of caseload capacity within 5 judicial days. If the report shows there is no one other than the Public Guardian to serve as guardian and the Public Guardian has capacity to take the case, then the Public Guardian will not accept any additional appointments while the case is pending that would cause its capacity to be exceeded.

The hearing on a petition for appointment of the Public Guardian will occur no less than 60 days and no more than 90 days after filing of the nomination. The Court must make the findings necessary for a guardianship, that the person is incapacitated and there is no less restrictive alternative to guardianship. For appointment of the Public Guardian the court must make additional findings. The additional findings include: that proper notice was given to the Public Guardian, the petitioner acted in good faith and due diligence to identify a guardian, appointment of the Public Guardian is necessary, and the visitor or guardian ad litem report has been completed and supports the appointment of the Public Guardian. If the Public Guardian does not have capacity to take the appointment, the court may order the case be placed on the Public Guardian's waitlist.

The Public Guardian can be appointed only after a finding that the appointment of the Public Guardian is necessary.[226] After appointment, the Public Guardian must make a reasonable effort to locate a successor guardian or conservator.[227] The Public Guardian has all the duties of a guardian provided by Neb. Rev. Stat. § 30-2626 and 30-2628.

c) Authorities & Duties of a Guardian

Generally, a guardian of an incapacitated person has the same powers, rights, and duties respecting their ward that a parent has over the parent's unemancipated minor child.[228] Neb. Rev. Stat. § 30-2628, states "a guardian has the following powers, except as may be specified by order of the court," which indicates the authorities of a guardian can be expanded by specific court orders beyond the authorities set forth in the Nebraska Probate Code. Specifically set forth in Neb. Rev. Stat. § 30-2628 are the following authorities and duties:

- To the extent that it is consistent with the terms of any order by a court of competent jurisdiction relating to detention or commitment of the ward, a guardian is entitled to custody of the person of their ward.
- A guardian may establish the ward's place of abode within the state of Nebraska or, with court permission, outside of Nebraska.
- The guardian shall make every reasonable effort to ensure placement is the least restrictive

[226] Neb. Rev. Stat. § 30-4112.
[227] Neb. Rev. Stat. § 30-4114.
[228] Neb. Rev. Stat. § 30-2628.

alternative.

- A guardian shall place their ward in a more restrictive environment only after careful evaluation of the need for such placement.
- The guardian may obtain a professional evaluation or assessment that more restrictive placement is in the best interest of the ward.
- If entitled to custody of their ward, a guardian shall make provision for the care, comfort, and maintenance of their wards and, whenever appropriate, arrange for the ward's training and education.
- A guardian must take reasonable care of the ward's clothing, furniture, vehicles, and other personal effects and commence protective proceedings if other property of the ward is in need of protection.
- A guardian may give any consents or approvals that may be necessary to enable the ward to receive medical, psychiatric, psychological, or other professional care, counsel, treatment or service.
- The guardian must consider and carry out the intent of the ward expressed prior to incompetency to the extent allowable by law.
- In the absence of an appointed conservator:
    - A guardian must prepare and file with the appointing court a complete inventory of the ward's estate, and must file an updated inventory annually with the court.
    - A guardian must keep suitable records of the guardian's administration of the ward's property and exhibit the same on request by an interested person.
    - Institute proceedings to compel any person under a duty to support the ward or to pay sums for the welfare of the ward to perform such duty.
    - Receive money and tangible property deliverable to the ward and applying such money and property for support, care, and education of the ward.
    - A guardian may not us a ward's funds for room and board which the guardian or the guardian's spouse, parent, or child has furnished the ward unless approved by a court order.
    - A guardian must exercise care to conserve any excess of money or tangible property for the ward's needs.
    - Exercise a settlor's powers with respect to revocation, amendment, or distribution of trust property when authorized by a court acting under Neb. Rev. Stat. § 30-3854(f).[229]
- A guardian is required to report on the condition of their ward and their estate, at least annually;
- If a conservator is appointed:
    - A guardian must deliver the ward's estate in excess of the funds expended to meet the ward's expenses for support, care and education to the conservator and provide an accounting for the funds expended.

[229] This authority would be in reference to a revocable trust established by the ward prior to incapacity. Therefore, the ward would have the powers of a settlor to revoke the trust. Neb. Rev. Stat. § 30-2628(a)(5)(iii) grants a guardian appointed to a settlor the authority to act on the settlor's behalf by court order.

- A guardian is entitled to receive reasonable sums for the guardian's services and for room and board furnished to the ward as agreed upon between the guardian and conservator, if the amounts are reasonable under the circumstances.
- A guardian may request the conservator expend the ward's estate by payment to third persons or institutions for the ward's care and maintenance.

In addition to the listed rights, the Nebraska Supreme Court has held that a guardian with full guardianship may be ordered to establish a visitation schedule for the ward where such visitation is in the ward's best interests.[230]

Pursuant to Neb. Rev. Stat. § 30-2620, the court can choose to order a full guardianship or limited guardianship. Where a court determines a guardianship is necessary, the guardianship should be limited unless the court finds by clear and convincing evidence a full guardianship is necessary. Whether a guardianship is full or limited can be determined by examining the Letters of Guardianship, including examining the endorsed powers. The Letters of Guardianship, generally include the following powers set forth in Neb. Rev. Stat. § 30-2620(a):

- Selecting the ward's place of abode within this state or, with court permission, outside of this state;
- Arranging for medical care for the ward;
- Protecting the personal effects of the ward;
- Giving necessary consent, approval, or releases on behalf of the ward;
- Arranging for training, education, or other habilitating services appropriate for the ward;
- Applying for private or governmental benefits to which the ward may be entitled;
- Instituting proceedings to compel any person under a duty to support the ward or to pay sums for the welfare of the ward to perform such duty, if no conservator has been appointed;
- Entering into contractual arrangements on behalf of the ward, if no conservator has been appointed; and
- Receiving money and tangible property deliverable to the ward and applying such money and property to the ward's expenses for room and board, medical care, personal effects, training, education, and habilitating services, if no conservator has been appointed, or requesting the conservator to expend the ward's estate by payment to third persons to meet such expenses.

Even though a guardian is allowed to receive money and apply it to the ward's expenses, a guardian is not allowed to withdraw cash from a ward's bank account or receive cash back from a transaction, without court permission.[231] Additionally, a guardian is not authorized to pay their self or attorney from the assets or income of the ward or sell real property belonging to the ward without a court order.[232]

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[230] In re Guardianship & Conservatorship of Karin P., 271 Neb. 917, 716 N.W.2d 681 (2006) (Placing the responsibility of establishing a visitation schedule on the guardian is anticipated by the statutory duties assigned to a guardian with full powers.)
[231] Neb. Ct. R. § 6-1443(E).
[232] Neb. Ct. R. § 6-1443(C).

As demonstrated in the list of authorities set forth in Neb. Rev. Stat. § 30-2628, if an incapacitated adult has a conservator appointed, then the authority of the guardian is restricted, especially with regards to the ward's property. A guardian's authority is similarly restricted if the incapacitated adult has designated an attorney in fact or agent under a valid power of attorney. Specifically, if an attorney in fact is designated and authorized by a valid power of attorney for health care, the agent's authority to make health care decisions supersedes the guardian's authority under Neb. Rev. Stat. § 30-2628(c). However, a court may revoke or set aside a valid power of attorney for health care in favor of a guardianship.[233]

(1) Selecting ward's place of abode

As stated above, a guardian may be granted the authority to select their ward's place of abode by the court. This authority has some restrictions, however. A guardian cannot change a ward's residence to a location outside of Nebraska without prior court permission. [234] Additionally, a guardian has the duty to make every reasonable effort to ensure a ward's placement is the least restrictive alternative. A guardian may authorize a more restrictive placement only after careful evaluation of the need for such placement.[235]

(2) Medical Treatment

In addition to being able to arrange for medical care as stated in Neb. Rev. Stat. § 30-2620, the guardian may give "any consents or approvals that may be necessary to enable the ward to receive medical, psychiatric, psychological, or other professional care, counsel, treatment or service." The guardian should consider and carry out the wishes of the ward expressed prior to incompetency when making such decisions.[236]

Under the Developmental Disabilities Court-Ordered Custody Act, Neb. Rev. Stat. §§ 71-1101 to 71-1134, a subject's guardian can consent to medical care or to a more restrictive setting, on a temporary basis, than what is ordered by the court to satisfies the subject's treatment needs.[237]

d) The role of a Guardian in a Commitment proceeding

Guardians are entitled to notice of any proceeding for commitment of their ward, including a copy of the summons and copies of the petition, list of rights, and list of names and contact information for mental health professionals in the immediate vicinity by whom the ward may be evaluated prior to hearing.[238] A guardian is also entitled to notice of an application to reinstate proceedings, a denial of rights for good cause shown, and a hearing, including time and place, a copy of any motion, and list of rights.[239] The guardian may waive any of the proceedings or rights incident to proceedings granted by

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[233] *See* In re Guardianship & Conservatorship of Mueller, 23 Neb. App. 430, 872 N.W.2d 906 (2015).
[234] Neb. Rev. Stat. § 30-2620(c).
[235] Neb. Rev. Stat. § 30-2628(a)(1).
[236] Neb. Rev. Stat. § 30-2628(a)(3).
[237] Neb. Rev. Stat. § 71-1132.
[238] Neb. Rev. Stat. § 71-923.
[239] Neb. Rev. Stat. §§ 71-925(3), 71-960, and 71-934.

the Nebraska Mental Health Commitment Act or the Sex Offender Commitment Act, but such waiver must be made personally, intelligently, knowingly, understandingly, and voluntarily.[240]

The guardian should receive a copy of the individualized treatment plan within five days of the mental health board's order, and copies of periodic progress reports.[241] The guardian is entitled to request a review hearing within 14 days to seek discharge or a change to the treatment plan.[242] As a general matter, a guardian is allowed to access all records kept on a person subject to civil commitment.[243]

It is important to remember that a guardian has the authority to make decisions for their ward and the responsibility to act in the ward's best interests. Thus, a guardian's role is to be informed of the proceedings and to work with the ward's counsel to communicate the ward's wishes, if any, and to advocate for the ward's best interests.

[240] Neb. Rev. Stat. § 71-960.
[241] Neb. Rev. Stat. §§ 71-931(3) and 71-932.
[242] Neb. Rev. Stat. § 71-935.
[243] Neb. Rev. Stat. § 71-961(1).

3. Powers of Attorney

Powers of attorney are a document that, when validly executed, can authorize a person to act on behalf of another. The documents can vary based on the stated purpose of the document and do not necessarily have to be identified as a power of attorney to be valid.[244] Some basic terminology for power of attorney documents are as follows:

- Principal: an adult who, when competent, confers upon another adult a power of attorney.
- Attorney in fact: (also referred to as an agent) is an adult properly designated and authorized by a power of attorney to make decisions for a principal, and includes a successor attorney in fact.
- Health Care: means any treatment, procedure, or intervention to diagnose, cure, care for, or treat the effects of disease, injury, and degenerative conditions. Health care includes mental health care.

Powers of attorney are governed by the Uniform Power of Attorney Act, Neb. Rev. Stat. §§ 30-4001 to 30-4045, and powers of attorney for health care must comply with Neb. Rev. Stat. §§ 30-3401 to 30-3432.

a) Power of Attorney

This section will discuss powers of attorney not including a power of attorney for health care. A power of attorney is durable in Nebraska unless otherwise expressed in the document.[245] Durability means the power of attorney does not terminate upon the incapacity of the principal. A power of attorney does not require the incapacity of the principal for it to be effective. Rather, a power of attorney becomes effective when executed, unless the power of attorney provides in the power of attorney that is becomes effective at a future date or upon occurrence of a future event or contingency.[246] A future contingency could include the incapacity of the principal. If incapacity is the trigger for a power of attorney, the determination of incapacity can be made by a person authorized by the principal or upon a determination in writing by a licensed physician or psychologist or the court or an appropriate governmental official.[247] Therefore, depending on the provisions of the power of attorney, it is possible for a principal who is capacitated to be action on their own behalf at the same time their agent under a power of attorney is acting on the principal's behalf. This is distinct from a power of attorney for health care, which is only effective upon the incapacity of the principal.

A power of attorney executed in another state is valid in Nebraska if, when the power of attorney was executed, the execution complied with the requirements of the state where the power of attorney was executed or in compliance with the requirements of a military power of attorney pursuant to 10 U.S.C.

[244] Neb. Rev. Stat. § 30-4002(8).
[245] Neb. Rev. Stat. § 30-4004.
[246] Neb. Rev. Stat. § 30-4009.
[247] Neb. Rev. Stat. § 30-4009(3).

1044b, as amended.[248] The statutory form for a power of attorney as set forth at Neb. Rev. Stat. § 30-4041 is appended hereto as Appendix III.A.

A power of attorney must set forth the authority granted to the agent pursuant to Neb. Rev. Stat. § 30-4024. If the grant of authority is "to do all the acts that [the] principal could do," then the agent has the general authority described in Neb. Rev. Stat. §§ 30-4027 to 30-4039. However, upon review, a power of attorney is subject to strict construction.[249] Additionally, a power of attorney may include nomination of a conservator or guardian of the principal for consideration by the court if protective or guardianship proceedings are brought for the principal after the power of attorney is executed.[250]

The duties of an agent are set forth in Neb. Rev. Stat. § 30-4014. Perhaps the most important duty is that the agent must act in accordance with the principal's reasonable expectations to the extent those expectations are known by the agent and, if not known, in the principal's best interest. The Nebraska Supreme Court has stated:

> An agent and principal are in a fiduciary relationship such that the agent has an obligation to refrain from doing any harmful act to the principal, to act solely for the principal's benefit in all matters connected with the agency, and to adhere faithfully to the instructions of the principal, even at the expense of the agent's own interest. An attorney in fact, under the duty of loyalty, always has the obligation to act in the best interest of the principal unless the principal voluntarily consents to the attorney in fact's engaging in an interested transaction after full disclosure.[251]

A power of attorney terminates upon the death of the principal, the principal's incapacity if the power of attorney is not durable, revocation by the principal; provision in the power attorney of a date or condition for termination; or upon the death, incapacity or resignation of the agent where there is no successor designated in the power of attorney.[252]

b) Power of Attorney for Health Care

In the context of mental health board proceedings, parties are likely to encounter a power of attorney for health care. A power of attorney for health care is distinct from other powers of attorney because it is only effective upon a determination that the principal is incapable of making medical decisions.

A power of attorney for health care may only be executed by an adult, 19 years of age or older or who is or has been married, who is competent. There is a rebuttable presumption that every adult is competent for purposes of executing a power of attorney for health care unless they have been

[248] Neb. Rev. Stat. § 30-4006(3).
[249] Heiden v. Adelung (In re Estate of Adelung), 306 Neb. 646, 947 N.W.2d 269 (Neb. 2020).
[250] Neb. Rev. Stat. § 30-4008.
[251] Heiden v. Adelung (In re Estate of Adelung), 306 Neb. 646, 947 N.W.2d 269 (Neb. 2020).
[252] Neb. Rev. Stat. § 30-4010.

adjudged incompetent or a guardian has been appointed for them.[253] The power of attorney for health care must be in writing and include the name of the principal and the attorney in fact; it must specifically authorize the agent to make health care decisions in the event the principal is incapable; show the date of execution and be witnessed by two adults or be signed and acknowledged in the presence of a notary public.[254] The statutorily provided form is provided in Appendix III.B.[255] The attorney in fact cannot be any of the following:

- The principal's attending physician or a member of the mental health treatment team of the principal
- An employee of the attending physician or member of the mental health treatment team who is unrelated to the principal by blood, marriage, or adoption
- An owner, operator, or employee of a health care provider in or of which the principal is a patient or resident who is unrelated to the principal by blood, marriage, or adoption
- A person serving as attorney in fact for ten or more principals who is unrelated to the principal by blood, marriage or adoption[256]

The witnesses to the execution of the power of attorney for health care cannot be "the principal's spouse, parent, child, grandchild, sibling, presumptive heir, known devisee, attending physician, mental health treatment team member, romantic or dating partner, or attorney in fact; or an employee of a life or health insurance provider for the principal."[257] A power of attorney for health care executed in another state that is valid according to the laws of the state where it was executed, shall be valid in in Nebraska according to the terms of the power of attorney for health care.[258]

The power of attorney for health care becomes effective upon a determination that the principal is incapable of making health care decisions.[259] Incapable means "an inability to understand and appreciate the nature and consequences of health care decisions, including the benefits of, risks of, and alternatives to any proposed health care or the inability to communicate in any manner an informed health care decision."[260] This definition does not apply to an advance directive under the Advance Mental Health Care Directives Act (see Section 4 below). A determination that a principal is incapable of making health care decisions must be made in writing by an attending physician and any physician consulted with respect to the determination that the principal is incapable of making decisions.[261] The physicians shall document the cause and nature of the principal's incapacity.

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[253] Neb. Rev. Stat. § 30-3403(2).
[254] Neb. Rev. Stat. § 30-3404.
[255] Neb. Rev. Stat. § 30-3408.
[256] Neb. Rev. Stat. § 30-3406.
[257] Neb. Rev. Stat. § 30-3405(1)(a).
[258] Neb. Rev. Stat. § 30-3408(4).
[259] Neb. Rev. Stat. § 30-3411.
[260] Neb. Rev. Stat. § 30-3412.
[261] Neb. Rev. Stat. § 30-3412.

Notice of a determination that the principal is incapable must be given by the attending physician to the principal (if the principal has the ability to comprehend such notice), the principal's attorney in fact, and to the principal's health care provider.[262] Upon receipt of notice, the attorney in fact must notify the principal's next of kin, unless the attorney in fact is the principal's most proximate next of kin or the principal has directed the attorney in fact not to provide notice.[263] If there is a dispute as to the principal's incapacity to make medical decisions, a petition may be filed in county court where the principal resides or in the county where the principal is located.[264] The court will then conduct a hearing within seven days of the petition being filed and issue a determination within seven days of the hearing.

A determination that the principal is incapable of making health care decisions is not made one time but, rather, the attending physician is to confirm the principal remains incapable before acting upon a health care decision made by an attorney in fact.[265]

A power of attorney for health care continues in effect until the principal's death, revocation by the principal[266], or until withdrawal of the attorney in fact and any successor.[267]

An attorney in fact under a power of attorney for health care has the authorities and duties as set forth in Neb. Rev. Stat. § 30-3417. An attorney in fact has the authority to make health care decisions on the principal's behalf subject to any instructions or limitations set forth in the power of attorney. Health care decisions include mental health care decisions.[268] Mental health care for purposes of a power of attorney for health care includes, but is not limited to, mental health care and treatment provided for in the Advance Mental Health Care Directives Act (see Section 4 below). An attorney in fact is entitled to receive information regarding the proposed health care, to receive and review medical and clinical records, and to consent to disclosure of records, unless the power of attorney for health care limits such rights.[269] However, an attorney in fact does not have authority to:

- Consent to an act or omission to which the principal could not consent to under law
- To make any decision for a pregnant principal that would result in the death of the principal's unborn child where it is probable the unborn child will develop to the point of live birth with continued application of health care
- To make decisions about withholding or withdrawing a life-sustaining procedure or withholding or withdrawing artificially administered nutrition and hydration[270]

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[262] Neb. Rev. Stat. § 30-3413.
[263] Neb. Rev. Stat. § 30-3414. Proximate next of kin in order: spouse, an adult child, either parent, an adult sibling, or next closest kin.
[264] Neb. Rev. Stat. § 30-3415.
[265] Neb. Rev. Stat. § 30-3419.
[266] Revocation of a power of attorney for health care is discussed in Neb. Rev. Stat. § 30-3420.
[267] Neb. Rev. Stat. § 30-3410.
[268] Neb. Rev. Stat. § 30-3402.
[269] Neb. Rev. Stat. § 30-3417(4).
[270] Neb. Rev. Stat. § 30-3417.

- Withhold or withdraw consent to routine care necessary to maintain patient comfort or the usual and typical provision of nutrition and hydration[271]

An attorney in fact may exercise the authority to make decisions about life-sustaining procedures and artificially administered nutrition and hydration only when the principal is suffering from a terminal condition or is in a persistent vegetative state and the power of attorney for health care explicitly grants such authority to the attorney in fact.[272] Definitions of terminal condition and vegetative state are as follows:

- A terminal condition means an incurable and irreversible medical condition cause by injury, disease, or physical illness which, to a reasonable degree of medical certainty, will result in death regardless of the continued application of medical treatment including life-sustaining procedures.[273]
- Persistent vegetative state shall mean a medical condition that, to a reasonable degree of medical certainty as determined in accordance with currently accepted medical standards, is characterized by a total and irreversible loss of consciousness and capacity for cognitive interaction with the environment and no reasonable hope of improvement.

An attorney in fact has the duty to consult with medical personnel, including the principal's attending physician, and then make health care decisions in accordance with the principal's wishes as expressed or as otherwise made known to the attorney in fact.[274] If the principal's wishes are not known and cannot be ascertained, the attorney in fact should make health care decisions in accordance with the principal's best interests, with due regard to the principal's religious and moral beliefs, if known. An attempted suicide by a principal shall not be construed as any indication of the principal's wishes with regard to their health care.[275]

4. Advance Directive for mental health care

In addition to a power of attorney, an individual may elect to execute an advance directive for health care. The advance directive may be included in a power of attorney for health care or be a separate document.[276] In 2020, the Nebraska legislature enacted the Advance Mental Health Care Directives Act, Neb. Rev. Stat. §§ 30-4401 to 30-4415. One of the purposes of the Advance Mental Health Care Directives Act was to "prevent unnecessary involuntary commitment and incarceration."[277] An additional purpose was to protect autonomy by allowing an individual to make an advance directive and, in so doing, direct their mental health care. It recognizes that "[a]n individual with capacity has the

[271] Neb. Rev. Stat. § 30-3418(3).
[272] Neb. Rev. Stat. § 30-3418(2).
[273] Neb. Rev. Stat. § 30-3402(14).
[274] Neb. Rev. Stat. § 30-3418(1).
[275] Neb. Rev. Stat. § 30-3431.
[276] Neb. Rev. Stat. § 30-3408(5).
[277] Neb. Rev. Stat. § 30-4402(2).

right to control decisions relating to the individual's mental health care unless [they are] subject to a court order involving mental health care under any other provision of law."[278]

The statute provides a form for an advance mental health care directive in Neb. Rev. Stat. § 30-4415 (see Appendix III.C. Advance Mental Health Care Directive). The requirements for an advance mental health care directive are set forth in Neb. Rev. Stat. § 30-4405. The advance directive must be in writing. It must be signed and dated by the principal or at the principal's direction if they are unable physically to sign in the presence of a notary public or two disinterested adults.[279] The document must state whether the document is revocable by the principal or if it is irrevocable during periods of incapacity. Otherwise, the document will be treated as revocable at any time.

An advance directive is triggered into efficacy upon a determination that the principal is incapacitated, unless otherwise stated in the advance directive.[280] To have capacity under the Advance Mental Health Care Directives Act means:

> having both (i) the ability to understand and appreciate the nature and consequences of mental health care decisions, including the benefits and risks of each, and alternatives to any proposed mental health treatment, and to reach an informed decision, and (ii) the ability to communicated in any manner such mental health care decision.[281]

An individual's capacity is evaluated in relation to the demands of a particular mental health care decision.[282] An advance mental health care directive anticipates changes in capacity. By making the mental health care directive irrevocable during incapacity of the principal, the principal can make a self-binding arrangement for mental health care, which will allow the principal to obtain mental health treatment in the event that an acute mental health episode renders the principal incapacitated and induces the principal to refuse treatment.[283]

In the advance directive, the principal may issue instructions, preferences, or both concerning the principal's mental health treatment. The directive may include consent to or refusal of specific types of mental health treatment, such as inpatient mental health treatment, psychotropic medication, or

[278] Neb. Rev. Stat. § 30-4403.
[279] A disinterested witness is someone who is not the principal's attending physician or member of the principal's mental health treatment team, the principal's spouse, parent, child, grandchild, sibling, heir or known devisee, romantic partner, attorney in fact for mental health care decisions, or the owner, operator, employee, or relative of an over or operator of a treatment facility where the principal is receiving care. Neb. Rev. Stat. § 30-4405(4).
[280] Neb. Rev. Stat. § 30-4409.
[281] Neb. Rev. Stat. § 30-4404(3)(a).
[282] Neb. Rev. Stat. § 30-4404(3)(b).
[283] Neb. Rev. Stat. § 30-4408.

electroconvulsive therapy.[284] A consent to electroconvulsive therapy must be specifically expressed. A principal may not consent to psychosurgery via an advance directive.

Essentially, the attorney in fact only has the authority granted by the advance directive. Specific grants of authority are not needed for an attorney in fact to consent to inpatient mental health treatment or psychotropic medication, if the principal's written grant of authority in the advance directive is sufficiently broad to encompass those decisions. An attorney in fact's decisions on the principal's behalf must be in good faith and consistent with the principal's instructions expressed in the advance directive. Where the advance directive is silent, the attorney in fact shall make decisions in accordance with the principal's instructions or preferences otherwise known to the attorney in fact.[285] In the absence of such instructions or preferences, the attorney in fact shall make decisions in the best interests of the principal. If, in the rare circumstance, the advance directive authorizes the attorney in fact to make decisions about the principal's mental health care when the principal is not incapacitated, then the principal's decisions will override the attorney in fact's decisions.[286]

Even with an irrevocable advance directive that consents to admission to an inpatient treatment facility, the treatment facility must obtain consent from the attorney in fact and, within 24 hours of principal's arrival at the facility, evaluate the principal's capacity by two licensed physicians and document their findings.[287] If the evaluating physicians determine the principal lacks capacity, then the principal shall be admitted. After 21 days from admission, if the principal has not regained capacity, the facility shall dismiss the principal from the facility's care unless the principal is detained pursuant to involuntary commitment. The principal can specify a time period for admission to an inpatient treatment facility that is less than 21 days.

Psychotropic medication may be forced on an incapacitated principal under an advance directive in situations set forth in Neb. Rev. Stat. § 30-4413. The advance mental health care must include a consent to administration of psychotropic medication and be irrevocable upon the incapacity of the principal. The attorney in fact must also consent to administration of psychotropic medication. Additionally, two health care professional (e.g., a licensed psychiatrist, physician, physician assistant, or advanced practice registered nurse) must recommend, in writing, treatment with the specific psychotropic mediation. If all the conditions are satisfied, then the psychotropic medication would be administered by or under direction of a licensed psychiatrist.

An advance mental health care directive is effective upon execution. It remains in effect until it expires according to its terms or until it is revoked by the principal. [288]

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[284] Neb. Rev. Stat. § 30-4406.
[285] Neb. Rev. Stat. § 30-4410.
[286] Neb. Rev. Stat. § 30-4411.
[287] Neb. Rev. Stat. § 30-4412.
[288] Neb. Rev. Stat. § 30-4407.

F. Handgun Registration Requirements & Issues

The Nebraska State Patrol has automated criminal history files to be utilized for, among other purposes, an instant criminal history record check on handgun purchasers.[289] Neb. Rev. Stat. § 69-2409.01[290] includes the following requirements:

- DHHS is to furnish the Nebraska State Patrol only with "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) or (g)(4).
- The clerks of the various courts shall furnish DHHS and the Nebraska State Patrol with the information as soon as practicable but within 30 days of the following orders:
    - An order of commitment or discharge, or
    - An order removing a firearm-related disability pursuant to Neb. Rev. Stat. § 71-963.
- The information provided shall include information regarding:
    - Persons subject to a mental health commitment order or who has been discharged;
    - Persons committed to treatment pursuant to Neb. Rev. Stat. § 29-3702;[291] and
    - Persons who have had firearm-related disabilities removed pursuant to Neb. Rev. Stat. § 71-963.
- The mental health board is required to notify DHHS and Nebraska State Patrol when a firearm-related disability is removed.
- DHHS shall maintain in the database a listing of person committed to treatment pursuant to Neb. Rev. Stat. § 29-3702.
- Any information maintained or disclosed shall be updated, corrected, modified or removed as appropriate, as appropriate, from any database that the state or federal government maintains and makes available to the National Instant Criminal Background Check System.

Pursuant to Neb. Rev. Stat. § 71-963, upon release from commitment or treatment, a following person may petition the mental health board to remove such firearm-related disabilities:

- Is subject to the disability provisions of 18 U.S.C. 922(d)(4) and (g)(4);[292]

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[289] Neb. Rev. Stat. § 69-2409.

[290] The full statute can be found online at https://nebraskalegislature.gov/laws/statutes.php?statute=69-2409.01

[291] Pursuant to Neb. Rev. Stat. §§ 29-3702 and 29-3701, following receipt of a verdict acquitting a defendant on the grounds of insanity, the court may hold a hearing to determine if the defendant is dangerous to their self or others by reason of mental illness or defect in the foreseeable future and, if so, can order the defendant to participate in an appropriate treatment program.

[292] 18 U.S.C. 922(d)(4) states that is shall be unlawful for any person to sell or otherwise dispose of any firearm or ammunition to any person who "has been adjudicated as a mental defective or has been committed to any mental institution." 18 U.S.C. 922(g)(4) states that is shall be unlawful for any person who has been adjudicated as a mental defective or who has been committed to a mental institution "to ship or transport in interstate or foreign commerce, or possess in or affecting commerce,

- Is disqualified from obtaining a certificate to purchase, lease, rent or receive transfer of a handgun under Neb. Rev. Stat. § 69-2404;[293] or
- Is disqualified from obtaining a permit to carry a concealed handgun under the Concealed Handgun Permit Act (Neb. Rev. Stat. §§ 69-2427 to 69-2449)

The Bipartisan Safer Communities Act of 2022 clarifies that mental health adjudication records for persons under 16 years old do not disqualify people from purchasing a firearm.[294] After the petition is filed, the petitioner may request and will be entitled to a review hearing by the mental health board. At the review hearing the petitioner must prove by clear and convincing evidence that they will not be likely to act in a manner dangerous to public safety and the relief, if granted, would not be contrary to public interest.

At the review hearing, the mental health board shall receive and consider evidence about the following:

- The circumstances surrounding the petitioner's mental health commitment or adjudication;
- The petitioner's record, which shall include, at a minimum, the petitioner's mental health and criminal history records;
- The petitioner's reputation, developed, at a minimum, through character witness statements, testimony, or other character evidence; and
- Changes in the petitioner's condition, treatment, treatment history, or circumstances relevant to the relief sought.

The mental health board will grant the petition if it determines the petitioner has proven by clear and convincing evidence that the firearm-related disability should be removed. If the petition is granted, the commitment or adjudication shall be deemed not to have occurred for purposes of Neb. Rev. Stat. § 69-2404, the Concealed Handgun Permit Act, and 18 U.SC. 922(d)(4) and (g)(4).

If the mental health board determines that the petitioner has not met the burden of proof, the board may deny the petition. The petitioner may appear a denial to the district court, which will review de novo on appeal.

The DHHS Division of Behavioral Health has a process for people to utilize to get information about their commitment history. Information about the process can be found online at https://dhhs.ne.gov/Pages/Committed-Persons-Firearm-Disability-Relief.aspx.

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any firearm or ammunition; or to receive any firearm or ammunition which has been shipped or transported in interstate or foreign commerce."

[293] Neb. Rev. Stat. § 69-2404 states, in relevant part, "[a]n applicant shall receive a certificate if he or she is twenty-one years of age or older and is not prohibited from purchasing or possessing a handgun by 18 U.S.C. 922."

[294] The Bipartisan Safer Communities Act of 2022 prohibits people from purchasing a firearm if they have a juvenile record that meets the existing criteria for a prohibited firearms purchaser. For a firearm purchaser under the age or 21, an immediate check will be required for the purpose of determining whether the individual has a disqualifying record. The Bipartisan Safer Communities Act can be found here.

III. Clinical Overview

A. Introduction: Building a Bridge

The purpose of the clinical overview section is to assist Nebraska mental health board members in understanding role of clinicians in evaluating and treating individuals subject to the Mental Health Commitment Act ("MHCA"), and to understand clinical language and diagnostic requirements. The disconnect between the legal and clinical frameworks is evidenced in the MHCA's use of the phrase "mentally ill" which is a phrase that clinicians do not use diagnostically. Great efforts have been made by professional mental health organizations to unify and destigmatize clinical language used for diagnosis and discussion of individuals with mental disorders and substance use disorders. As a result of the disconnection between the legal and clinical, mental health board members must contend with a situation where the legal framework and understanding have not kept pace with the changes and developments in clinical practice. The Clinical Overview is intended to help with navigation of this relationship.

Additionally, there is a fundamental difference in the goals of the mental health boards and mental health treatment providers. As discussed in the Legal Overview, the mental health board is weighing the liberty of the individual, the individual's treatment needs, and public safety concerns. A mental health treatment provider is to diagnose and provide treatment to alleviate symptoms that impair an individual's ability to function meaningfully in society. The need for the mental health treatment provider to participate in mental health board proceedings can cause tension to arise in the therapeutic relationship between the mental health treatment provider and the patient. However, their participating is necessary to provide their clinical expertise to the mental health board as the board considers whether an individual is dangerous to their self or other people.

This Clinical Overview will use the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition Text Revision, published by the American Psychiatric Association[295] throughout. Mental health board members may notice a lag in the adoption of the DSM-5-TR language and structure. The DSM-5-TR was published in 2022 and it may take practitioners time to become familiar with the changes made. Additionally, it is necessary to underscore for mental health board members that the DSM-5-TR is not designed to the technical needs of the courts. Thus, it is possible that the diagnostic information in the DSM-5-TR will be misused or misunderstood. "These dangers arise because of the imperfect fit between questions of ultimate concern to the law and the information contained in a clinical diagnosis." Mental health board members should be critical of expert testimony and seek clarity from testifying clinicians regarding their diagnostic impression and to be aware of variations in terminology.

B. Important Perspectives

1. Trauma Impact and Trauma-Informed Recovery

Trauma-informed recovery is a compassionate and holistic approach to healing that acknowledges the profound impact of trauma on individuals' lives. It recognizes that many people carry the weight of past

[295] Diagnostic and Statistical Manual of Mental Disorders (Fifth Ed. Text Revision) (2022). This may be referred to as the "DSM", "DSM-5-TR," and "DSM-TR."

traumas, which can manifest in various forms, including addiction, mental health struggles, and self-destructive behaviors.

Trauma can have a profound impact on an individual's behavior, often leading to a range of emotional and psychological responses. Traumatic experiences can disrupt a person's sense of safety, trust, and well-being, manifesting in various ways. These impacts on behavior can include: Hyperarousal and Hypervigilance, Avoidance and Withdrawal, Emotional Dysregulation, Re-Experiencing Symptoms, and Self-Destructive Behaviors.

When it comes to mental health commitments, it is essential to recognize that this process, in certain cases, can be a traumatic experience for individuals dealing with mental health challenges. The process includes a loss of autonomy, feelings of stigmatization, and in some cases, re-traumatization.

In trauma-informed recovery, empathy and understanding replace judgment and blame. It fosters a safe and supportive environment, empowering individuals to regain control over their lives. By addressing the root causes of suffering and promoting resilience, it enables survivors to rebuild their sense of self and hope for the future.

C. Mental Illness Diagnoses

1. Mental Disorders

The MHCA defines "mentally ill" for the purpose of civil commitment proceedings as follows:

> 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.[296]

THE DSM-5-TR does not use the phrase "mentally ill" but uses "mental disorder." The difference is, in part, because of the recognition that individuals should not be identified as "mentally ill" but, rather, as individuals experiencing the symptoms of a "mental disorder." The general definition of mental disorders in DSM-5- TR is:

> 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 associate with significant distress or disability 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

[296] Neb. Rev. Stat. § 71-907.

> deviance or conflict results from a dysfunction in the individual, as described above.[297]

The DSM-5-TR definition of mental disorder is clinically broader than the MHCA's definition of "mentally ill." The definition of "mentally ill" in the MHCA uses the general term "psychiatric disorder," but does not indicate specific diagnoses that may be the subject of civil commitment proceedings. Therefore, the mental health board will have to rely on clinical experts to provide information upon which the mental health board may determine if the individual meets the definition of "mentally ill" under the MHCA.

One of the diagnostic criteria that is relevant to the definition of "mentally ill" is "clinically significant distress or impairment" because it seems to address the part of the "mentally ill" definition that considers whether the disorder "involves a severe or substantial impairment." For diagnosis there must be a measure of severity for many mental disorders, which has been difficult to articulate. A "generic diagnostic criterion requiring distress or disability has been used to establish disorder thresholds, usually worded 'the disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning. Assessing whether this criterion is met, especially in terms of role function, Is an inherently difficult clinical judgment.'[298] Thus, the mental health board should ask probing questions of a mental health professional about the impact of the subject's condition on their ability to participate in social, work, and other important day-to-day activities (e.g., religious worship, grocery shopping, etc.).

a) A Brief Overview of Mental Disorders:

The DSM-5-TR has several diagnostic categories, and four of these categories are listed below as they are commonly the focus of civil commitment proceedings. Each of these DSM-5-TR diagnostic categories includes several specific diagnoses, and some but not all of these diagnoses could satisfy clinical aspects of Neb. Rev. Stat. § 71-907, including "impairment of a person's thought processes, sensory input, mood balance, memory, or ability to reason." The below is only meant to provide a brief overview of the particular disorders and the symptoms an individual may experience.

Several other mental disorders could be relevant in civil commitment proceedings including, but not limited to, posttraumatic stress disorder, dissociative disorders, catatonia, anxiety disorders, and substance/medication-induced mental disorders. Several DSM-5-TR disorders would not likely meet the standard for "mentally ill" under the MHCA including developmental disorders, antisocial personality disorder, delirium, disorders due to a general medical condition, and neurocognitive disorders.

(1) Schizophrenia Spectrum and Other Psychotic Disorders

[297] Diagnostic and Statistical Manual of Mental Disorders (Fifth Ed. Text Revision) at 13-14 (2022). The DSM-5-TR warns that "no definition can capture all aspects of the range of disorders contained in the DSM-5", but that a mental disorder must have these elements.

[298] Diagnostic and Statistical Manual of Mental Disorders (Fifth Ed. Text Revision) at 23 (2022).

This category includes schizophrenia, schizoaffective disorders, psychotic disorder due to another medical condition, other psychotic disorders, and schizotypal (personality) disorder. [299] These disorders are defined by abnormalities in one or more of the following five domains:

- **Delusions**: are fixed beliefs that cannot be changed even when presented with conflicting evidence or information.[300] It can be hard to differentiate strongly held beliefs (e.g., religious and supernatural beliefs) and delusions, especially in light of cultural differences and past traumatic experiences.
- **Hallucinations**: are perceptions of an individual that occur without external stimulation. For example, the patient hears a voice when there is no one in the room with them. Hallucinations may be auditory, visual, or a combination of both. Auditory hallucinations are the most common in schizophrenia and related disorders.
- **Disorganized thinking (speech):** generally, disorganized thoughts are inferred from observation of a patient's speech. The observed disorganization has to be severe enough that it interferes with the patient's ability to communicate effectively. Disorganization can present in a few different ways: patients may switch topics frequently, they may talk about topics unrelated to their situation, or they may speak in a way that is incomprehensible (e.g., what is referred to as "word salad"). This factor can vary greatly depending on the cultural and social background of the patient due to differing social norms.
- **Grossly disorganized or abnormal motor behavior** (including catatonia): identifying disorganized behavior is based on observation of the treatment provider of behavior that is inappropriate. For example, resistance to instructions, agitated movements, pacing, or catatonia. The behavior has to be of such severity that interferes with the individual's activities of daily living.
- **Negative symptoms**: the two negative symptoms prominent in schizophrenia are diminished emotional expression and avolition. Diminished emotional expression is a reduction in the expression of the individual's emotions via facial expression, intonation of speech, and movements that give emphasis to speech. Avolition is a decrease in motivated self-initiated purposeful activities. Other negative symptoms that may occur in schizophrenia are alogia (diminished speech), anhedonia (decreased ability to experience pleasure), and asociality (lack of interest in social interaction).

(2) Bipolar and Related Disorders

This category includes bipolar I disorder, bipolar II disorder, cyclothymic disorder, substance or medication-induced bipolar and related disorder, bipolar and related disorder due to another medical condition, other specified bipolar and related disorder, and unspecified bipolar and related disorder.

- Bipolar I disorder requires an individual to experience, in their lifetime one fully syndromal manic episode.
- Bipolar II disorder requires an individual to experience, in their lifetime, at least one major

[299] *Id* at 101.
[300] *Id*.

depressive episode and at least one hypomanic episode. It is evidence by an instability of mood that is accompanied by a serious impairment in work and social functioning.
- Cyclothymic disorder is a disorder wherein an adult experiences at least 2 years of hypomanic and depressive periods without ever fulfilling the criteria for an episode of mania, hypomania, or major depression.

Looking at the diagnoses for bipolar disorders requires an understanding of what is meant by the terms "manic episode," "depressive episode," and "hypomanic episode."

A manic episode is a "distinct period of abnormally and persistently elevated, expansive, or irritable mood and abnormally and persistently increased activity or energy, lasting at least 1 week and present most of the day, nearly every day (or any duration if hospitalization is necessary)."[301] Identification of a manic episode requires three or more of the following symptoms be present to a significant degree and represent a change in the individual's behavior:

- Inflated self-esteem or grandiosity,
- Decreased need for sleep,
- More talkative than usual or pressure to keep talking,
- Flight of ideas or subjective experience that thoughts are racing,
- Distractibility, as reported or observed,
- Increase in goal-directed activity or psychomotor agitation (i.e., purposeless activity), or
- Excessive involvement in activities that have a high potential for panful consequences.[302]

The mood disturbance must be sufficiently severe to cause marked impairment in social or work function or necessitate hospitalization to prevent harm to self or others, or there are psychotic features present for it to meet the definition of a manic episode.

A hypomanic episode is a "distinct period of abnormally and persistently elevated, expansive, or irritable mood and abnormally and persistently increased activity or energy, lasting at least 4 consecutive days and present most of the day, nearly every day."[303] The hypomanic episode is also determined by observation of at least 3 of the above symptoms. A hypomanic episode is also defined by observation that there is an unequivocal change in functioning that is uncharacteristic but is not severe enough to cause impairment in social or work function.[304]

A major depressive episode is defined by an induvial experiencing five or more of the following symptoms withing the same 2-week period:

- Depressed mood most of the day, nearly every day, as indicated by subjective report,
- Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day as indicated by subjective report or observation,
- Significant weight loss when not dieting or weight gain, or decrease or increase in appetite

[301] Id at 140.
[302] Id at 140
[303] Id.
[304] Id at 140-141.

nearly every day,
- Insomnia or hypersomnia (sleeping too much) nearly every day.
- Psychomotor agitation or retardation nearly every day as observed by others,
- Fatigue or loss of energy nearly every day,
- Feelings of worthlessness or excessive inappropriate guilt nearly every day,
- Diminished ability to think or concentrate, or indecisiveness, nearly every day, and
- Recurrent thoughts of death, recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.[305]

These symptoms must be severe enough that they cause clinically significant distress or impairment in social, work, or other areas of functioning.

(3) Depressive Disorders

Depressive disorders include disruptive mood dysregulation disorder, major depressive disorder (including major depressive episode), persistent depressive disorder, premenstrual dysphoric disorder, substance/medication-induced depressive disorder, depressive disorder due to another medical condition, other specified depressive disorder, and unspecified depressive disorder. The common feature of all of these disorders is the presence of sad, empty, or irritable mood, accompanied by related changes that significantly affect the individual's capacity to function (e.g., somatic and cognitive changes in major depressive disorder and persistent depressive disorder). What differs among them are issues of duration, timing, or presumed etiology.

Depression can lead to involuntary commitment when an individual's condition poses a serious threat to their own safety or others. If someone with depression expresses suicidal intentions or exhibits behavior that indicates imminent danger, mental health professionals may initiate involuntary commitment to ensure their immediate safety and provide the necessary treatment and support.

(4) Personality Disorders

DSM-5-TR describes 10 personality disorders including schizotypal personality disorder, antisocial personality disorder, and borderline personality disorder. A personality disorder is an enduring pattern of inner experience and behavior that deviates markedly from the norms and 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.

If someone with a personality disorder exhibits extreme and unpredictable behavior, becomes a threat to themselves through self-harm, or becomes a danger to others due to aggression or violence, mental health professionals and legal authorities may intervene to ensure their safety and provide appropriate treatment.

2. Treatment

a) Levels of Care

[305] Id at 141.

Management of individuals at risk of harming themselves and/or others includes the following phases. Medical stabilization should occur at a hospital and may include surgical management of trauma, treatment of acute exacerbations of chronic medical conditions, managing toxicologic issues including intentional or accidental ingestion of substances, and management of substance intoxication and withdrawal syndromes. Reducing immediate risk of harm to self and/or others and treatment planning should begin as soon as possible. Treatment planning is developed substantially following medical stabilization. After medical stabilization, psychiatric hospitalization is the primary venue for managing psychiatric emergencies and conducting risk assessments that inform ongoing treatment and transition planning.

Options for level of care aside from inpatient hospitalization include partial hospital (day program), intensive outpatient program (e.g., three days/week for three hours/day), and outpatient. Psychiatric inpatient hospitalization for further evaluation and initiation of treatment is frequently indicated for individuals with recent suicidal behavior (e.g., suicide attempt) or immediate high risk of suicide (e.g., individuals with moderate to severe suicidal ideation that includes a plan and intent). If individuals do not agree with plans for hospitalization, involuntary hospitalization may be necessary (civil commitment proceedings). Individuals in whom the risk of suicide is elevated but not immediate (e.g., those with depression and/or alcohol use who express a desire to commit suicide but who do not have a specific plan or intent) need aggressive treatment that generally can be administered in a partial hospital (day program) or in an outpatient clinic.

b) Safety Planning

The safety plan is a widely used therapeutic tool (*See* Appendix III.M. for an example Safety Plan). Clinicians should discuss a safety plan that specifies how individuals can cope with current and future suicidal ideation, and how their family or other supportive individuals can assist in creating a safe environment. The plan usually consists of a risk assessment, identification of environmental or emotional triggers, coping strategies, and identification of support systems in case ideation worsens. In addition, the extent to which individuals can commit to stay safe and use the safety plan provides additional information about their risk for suicidal behavior. Individuals who agree to adhere to a safety plan may still be at high risk; this agreement does not protect individuals or clinicians, and is not a substitute for thorough evaluation, sound clinical judgment, and meaningful therapeutic interaction, particularly with impulsive individuals.

Once immediate safety has been ensured, clinicians should address underlying factors, including precipitating events, ongoing life difficulties, and mental disorders. Precipitating events include the death of a loved one, loss of a job, breakup of a marriage, school or social failure, sexual identity crisis, or trauma. In addition, people may attempt suicide as an alternative to intolerable life circumstances, such as abusive relationships, occupational stresses, and chronic isolation. Referral for treatment is indicated, and engagement of community, religious, and family supports may also be helpful. Individuals discharged from inpatient psychiatric care are at high short-term risk, particularly if there is a break in the continuity of care.

c) Medication

Pharmacotherapy is an essential component of the treatment of several mental disorders, including the disorders that would meet the definition of "mentally ill" under the MHCA. Several medications used to treat mental disorders can impact the individual's dangerousness. Psychiatric medication is essential in psychiatric emergencies involving aggression and violence in the context of acute mental states such as mania and psychosis. Below is a quick overview of common medications for the treatment of mental disorders (a more extensive list may be found in Appendix IV.C.)

(1) Clozapine

Clozapine is an antipsychotic used in the treatment of patients with mood and psychotic disorders. Although the mechanism by which clozapine reduces suicide risk remains unclear, it has been proposed that it is related to the closer follow-up of patients on clozapine given the frequent blood draws required to monitor for neutropenia (decreased white blood cells).
Another proposed mechanism is that clozapine provides better control of psychotic symptoms thus mitigating suicidal behaviors that arise from psychosis (i.e. command auditory hallucinations).

(2) Ketamine and Esketamine

Ketamine and esketamine have been studied as treatment for acute suicidal ideation. Randomized trials indicate that a single infusion of ketamine can mitigate suicidal ideation within one hour, with benefits persisting for up to one week. Intranasal esketamine, in conjunction with an oral antidepressant, is approved by the US Food and Drug Administration for treating depressive symptoms in adults with unipolar major depression that includes acute suicidal ideation or behavior. If suicidal ideation improves after an initial dose of esketamine, individuals should nevertheless be assessed to decide whether hospitalization is clinically warranted. After four weeks of treatment with esketamine, its benefit should be evaluated to determine the need for ongoing treatment.

(3) Antidepressants

Individuals with acute unipolar major depression who manifest suicidal ideation or behavior are generally treated with antidepressants. Low quality evidence suggests that antidepressants may possibly decrease suicides, but the data supporting the use of antidepressants appear to be less compelling than the evidence for lithium. A class of antidepressants called serotonin selective reuptake inhibitors (SSRIs) appears to be safer when taken in overdose and are preferred in when suicide risk is elevated. Two other classes of antidepressants, tricyclic antidepressants and monoamine oxidase inhibitors, may be lethal in overdose and are often avoided. In addition, the serotonin norepinephrine reuptake inhibitor (SNRI) venlafaxine is often avoided for the same reason. However, many depressed individuals do not respond to initial treatment with an SSRI and may require pharmacotherapy that includes venlafaxine, tricyclics, or monoamine oxidase inhibitors. Individuals with suicidal ideation who are at risk of overdosing on any class of medication may need to be hospitalized.

(4) Buprenorphine

Buprenorphine, which is used to treat opioid use disorder, has been considered as a treatment for severe suicidal ideation. A single study demonstrated that improvement of suicidal ideation was greater with buprenorphine and was independent of treatment with antidepressants.

Buprenorphine is not routinely considered as a treatment option specifically for suicidal ideation but may be considered with individuals with opioid use disorder and suicidal ideation.

(5) Antipsychotics

Pharmacotherapy used to treat acute agitation and risk for violence typically includes three classes of medication: typical (first generation) antipsychotics, atypical (second generation) antipsychotics, and benzodiazepines. Haloperidol is a first generation antipsychotic and is one of the most frequently used antipsychotics in the treatment of acute agitation in a variety of settings. Haloperidol is available orally, intramuscularly, and intravenously which allows for administration options in a variety of acute and nonacute clinical scenarios. Given the potential for serious neurologic, cardiac, and other side effects, close medical monitoring is necessary.

(6) Atypical antipsychotics

Atypical antipsychotic medications such as olanzapine are also effective at reducing agitation and have different side effects than typical antipsychotics. Benzodiazepines, most commonly lorazepam, are commonly used in the treatment of acute agitation. Lorazepam is available orally, intramuscularly, and intravenously and is often administered with haloperidol.

d) Psychotherapy

Psychotherapy is a highly effective treatment for mental disorders, offering invaluable support and relief for individuals experiencing various psychological challenges. Evidence-based practices underscore the efficacy of psychotherapy, with the top three being Cognitive Behavioral Therapy (CBT), Dialectical Behavior Therapy (DBT), and Acceptance and Commitment Therapy (ACT).

Cognitive Behavioral Therapy (CBT): CBT helps individuals identify and modify negative thought patterns and behaviors contributing to their mental disorders. Its proven effectiveness in treating conditions like depression, anxiety, and PTSD highlights its adaptability and success in promoting lasting positive change.

Dialectical Behavior Therapy (DBT): DBT, originally designed for borderline personality disorder, has demonstrated success in addressing a wide range of conditions. By emphasizing emotional regulation, interpersonal effectiveness, distress tolerance, and mindfulness, DBT equips individuals with invaluable skills to manage their mental health.

Acceptance and Commitment Therapy (ACT): ACT encourages individuals to accept their thoughts and feelings rather than struggling against them, fostering psychological flexibility. It has been particularly effective in managing conditions like anxiety, depression, and chronic pain, promoting meaningful and values-driven lives.

These evidence-based psychotherapies, grounded in rigorous research, affirm the utility of psychotherapy in treating mental disorders. They offer hope, guidance, and lasting solutions, empowering individuals to achieve improved mental well-being and lead fulfilling lives.

e) Other Treatments

In addition to psychotherapy and medication, several alternative and complementary treatments can be considered for severe mental health disorders. It's important to note that the effectiveness of these treatments can vary, and they should be used in conjunction with, rather than as a replacement for, evidence-based psychotherapy and medication. Always consult with a mental health professional before pursuing alternative treatments. Some alternatives include:

- Electroconvulsive Therapy (ECT): ECT is a medical procedure in which electrical currents are passed through the brain to induce controlled seizures. It is often used for severe depression, bipolar disorder, and some other mood disorders when other treatments have not been effective.
- Mindfulness and Meditation: Mindfulness-based interventions, such as Mindfulness-Based Stress Reduction (MBSR) and Mindfulness-Based Cognitive Therapy (MBCT), can complement traditional treatment. They help individuals manage stress, reduce symptoms of anxiety and depression, and enhance overall well-being.
- Transcranial Magnetic Stimulation (TMS): TMS involves the use of magnetic fields to stimulate specific areas of the brain. It is used primarily for treatment-resistant depression and has shown promise in clinical studies.

Support Groups and Peer Support: Connecting with others who have similar experiences can offer valuable emotional support and coping strategies. Many organizations offer support groups for various mental health conditions.

3. Involuntary Medication

For discussion of Nebraska law as it relates to involuntary medication see Section **Error! Reference source not found.**.

Involuntary medication, often necessitated in cases where patients pose a severe danger to themselves or others due to their mental health condition, raises complex legal, ethical, and medical concerns. Maintaining adherence to medication is an essential but challenging course in the treatment for major psychiatric disorders and nonadherence can lead to exacerbation of illness, reduced treatment effectiveness or leave the patient less responsive to subsequent treatment.

Non-compliance with, or refusal of prescribed medications can often be attributed to a variety of factors. It can stem from a lack of insight into their illness, which impairs their ability to understand the necessity of treatment. This lack of insight can be a hallmark of certain mental health disorders, further complicating the decision-making process. Furthermore, concerns related to side effects and adverse reactions can deter patients from adhering to their prescribed medication regimens. Fear of unpleasant physical or psychological effects may lead individuals to resist taking medication, even when it is medically deemed necessary. Crucially, this situation intersects with competence, due process, informed consent and the concept of patient autonomy. Involuntary medication, by its nature, infringes upon a

patient's autonomy and right to make medical decisions about their own body. Board ordered administration of involuntary medications includes the expected clinical deterioration or dangerous behavioral without such medication. Balancing the immediate need for safety and the preservation of life with an individual's right to self-determination is a complex ethical dilemma faced by healthcare providers, mental health boards, families, and society as a whole.

4. Substance Dependence

The MHCA uses the phrase "substance dependent" and defines it for the purpose of civil commitment proceedings as follows:

> 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.[306]

Although versions of the DSM prior to DSM-5 (2013) used the terms "dependence" and "abuse" in their definitions of disorders related to substance use, the DSM-5-TR uses the term "substance use disorder." As with definitions of mental disorders, Neb. Rev. Stat. §71-913 defines "substance dependent" with terminology that may or may not be consistent with DSM-5-TR terminology. Substance use disorders are an area where the goal of the DSM-5-TR as a mechanism for diagnosis and treatment is evident. The DSM-5-TR summarizes substance-related disorders as follows:

> All drugs that are taken in excess have in common the ability to directly activate the brain reward systems, which are involved in the reinforcement of behaviors and establishment of memories. Instead of achieving reward system activation through adaptive behaviors, these substances produce such an intense activation of the reward system that normal activities may be neglected.[307]

The DSM-5-TR makes a distinction in substance-related disorders between substance use disorders and substance-induced disorders. Substance-induced disorders refers to individuals who present with symptoms caused the physiological effects of an external substance on the central nervous system and includes typical intoxicants.[308] For example, an individual presents disoriented, unsteady on their feet, and with slurred speech after drinking alcohol. An essential feature of a substance use disorder is that the individual continues to use the substance despite significant substance-related problems.[309] For example, an individual continues to drink alcohol daily after being diagnosed with liver failure. The

[306] Neb. Rev. Stat. § 71-913.
[307] Diagnostic and Statistical Manual of Mental Disorders (Fifth Ed. Text Revision) at 543 (2022).
[308] Id at 544.
[309] Id.

diagnosis of a substance use disorder is based on the consistent, compulsive, behaviors of the individual related to use of the substance.[310] Mental health board members should question the individual and the clinician about substance use to determine whether its compulsory and impacting their activities of daily living.

5. Substance Use Disorders

The DSM-5-TR section Substance-Related and Addictive Disorders outlines criteria sets for substance use disorder, substance intoxication, substance withdrawal, and substance/medication-induced mental disorders. The substance-related disorders encompass 10 separate classes of drugs: alcohol; caffeine; cannabis; hallucinogens; inhalants; opioids; sedatives, hypnotics, or anxiolytics; stimulants (amphetamine-type substances, cocaine, and other stimulants); tobacco; and other (or unknown) substances.[311] Aside from caffeine, each of these substances are "controlled substances, illegal drugs, or alcohol" as stated in Neb. Rev. Stat.§ 71-913.

The DSM-5-TR outlines 11 diagnostic criteria grouped in the categories of impaired control, social impairment, risky use, and pharmacological criteria. Each of these can be reviewed in depth in the DSM-5-TR. Some key points are as follows:

- Impaired control: manifests in a variety of ways including cravings, an inability to cut down or regulate use, and the individual expending significant time obtaining the substance, using the substance, and/or recovering from the effects of the substance. Current craving is often used as a treatment outcome measure because it may be a signal of impending relapse.[312]
- Social impairment: refers to a failure to fulfill major role obligations in a variety of settings and withdrawal from family activities and hobbies to use the substance. The individual persists in using the substance despite having persistent or recurrent social or interpersonal problems because of the substance use.[313]
- Risky use: involves recurrent substance use in situations in which it is physically hazardous or despite physical or psychological problems related to the substance. Risky use refers to the individual's failure to abstain from using the substance despite the difficulty it is causing not to the problems caused by the use.[314]
- Pharmacological criteria: mostly refers to the individual's tolerance level to the substance and experience of withdrawal. Neither tolerance nor withdrawal is necessary for a diagnosis of a substance use disorder.
    - Tolerance: is signaled by requiring a markedly increased dose of the substance to

[310] Id.
[311] *Id* at 543.
[312] *Id* at 544-546.
[313] *Id* at 546.
[314] *Id*.

achieve the desired effect or a markedly reduced effect when the usual dose is consumed. Tolerance can be difficult to distinguish from individual sensitivity to the effects of particular substances. Laboratory testing can be helpful to identify if an individual has high amounts of a substance in their system without evidence of the usual effects of the particular substance.

- Withdrawal: is characterized by the development of problematic behavioral change that is due to the cessation of, or reduction in, heavy or prolonged substance use. The behavioral change is such that is causes clinically significant distress or impairment in social, work, or other important areas of functioning.[315]

Substance use disorders are common in individuals with other mental health disorders, and there are several terms to describe this including "co-occurring disorders." An individual with a mental health disorder and a co-occurring substance use disorder can be challenging to treat because the substance use disorder can exacerbate the symptoms of the mental disorder and withdrawal from the substance can cause significant distress to the individual. While some medications can cause symptoms of tolerance and withdrawal as part of medical treatment, prescribed medications are not counted when diagnosing substance use disorder. However, the appearance of normal tolerance and withdrawal during the course of medical treatment has historically caused misdiagnosis of an "addiction."[316] Individuals may experience withdrawal symptoms while tapering or stopping medications. This varies from person to person and depends on the type of medication, its half-life, how long the medication has been used.

It is important for mental health board members to recognize that temporary states associated with substance use may or may not meet the definitions of "mental illness" or "substance dependence" in the MHCA. Dangerousness to self or others remains the essential criterion for commitment. Dangerousness does not require prediction for future actions, only that there is some risk he/she will act in a way that causes harm of some sort, to a sufficient degree that a particular intervention, including commitment, is justified.

6. Substance-Induced Disorders

The category of substance-induced disorders includes substance intoxication, substance withdrawal, and substance/medication-induced mental disorders. Mental health board members may encounter these situations so a basic understanding is necessary.

[315] *Id* at 548.
[316] *Id* at 547.

a) Substance Intoxication

The key feature of substance intoxication is that the effect of the substance ingested by the individual is reversible.[317] Substance intoxication is a transient condition that generally causes impairment of perception, wakefulness, attention, thinking, judgment, psychomotor behavior, and interpersonal behavior. The impairments and individual experiences can vary between short-term and chronic substance intoxications. Substance intoxication may often accompany a substance use disorder. If persistent substance-related problems exist, a substance use disorder is the preferred diagnosis.

b) Substance/Medication-Induced Mental Disorders

"Substance/medication-induced mental disorders are potentially severe, usually temporary, but sometimes persisting central nervous system syndromes that develop in the context of the effects of substances of abuse, medications, and some toxins,"[318] In general, more sedating drugs can produce prominent and clinically significant depressive disorders during intoxication, and anxiety symptoms can occur during withdrawal. Stimulating substances (e.g., amphetamines and cocaine) are more likely to be associated with substance-induced psychotic disorders and anxiety disorders, with substance-induced depressive episodes observed during withdrawal. For a diagnosis of substance/medication-induced disorder there must be evidence that the symptoms are not caused by an independent mental disorder.[319]

7. Treatment Options

Treatment for substance use disorders is a complex and multifaceted process that typically involves a combination of medical, psychological, and social interventions. The specific approach to treatment can vary based on the individual's unique needs, the type and severity of the substance use disorder, and available resources. Here are some key aspects of SUD treatment, including how relapse is handled and potential barriers to treatment:

- Assessment and Diagnosis:
  The first step in treating SUDs is often a comprehensive assessment by a healthcare provider or addiction specialist. This assessment helps determine the severity of the disorder, any co-occurring mental health conditions, and the individual's readiness for treatment.

- Detoxification (Detox):
  For individuals with severe physical dependence on substances, detoxification may be the initial step. This involves safely managing withdrawal symptoms under medical supervision. Detox alone is not sufficient for long-term recovery but can be a crucial first step.

- Behavioral Therapy:

[317] *Id* at 548.
[318] *Id* at 550.
[319] *Id* at 551.

Evidence-based behavioral therapies, such as cognitive-behavioral therapy (CBT), contingency management, and motivational interviewing, are commonly used in SUD treatment. These therapies help individuals identify and change destructive patterns of behavior, set goals, and develop coping strategies.

- Medication-Assisted Treatment (MAT):
  For some substances, medications like methadone, buprenorphine, naltrexone, and acamprosate can be prescribed to reduce cravings and withdrawal symptoms. It is not the substitution of one drug for another. MAT is the use of medications in combination with counseling and behavioral therapies.

- Support Groups and Peer Support:
  Self-help groups like Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) provide valuable peer support and a structured program for maintaining abstinence.

- Relapse Prevention:
  Relapse is a common part of the recovery process. Treatment programs often emphasize relapse prevention strategies, helping individuals identify triggers and develop skills to avoid or manage high-risk situations.

Potential barriers to successfully treatment outcomes include, stigma, access to services, financial barriers, co-occurring mental illness, and social influences. Addressing these barriers requires a comprehensive approach that includes reducing stigma, expanding access to treatment, providing education and outreach, and offering ongoing support to individuals in recovery. Recognizing that relapse is a potential part of the recovery process and not a failure is also essential for improving long-term outcomes.

D. Dangerousness Due to Mental Illness or Substance Dependence

1. Harm to Others

It is important to recognize that most persons with a mental disorder are not violent and dangerous; however, certain types of symptoms, a combination of substance use and mental illness, and other factors may increase an individual's risk for violent behavior.

> While perpetrating violence is relatively uncommon among those with serious mental illness, when it does occur, in many cases it is intertwined with other issues such as co-occurring substance use,

adverse childhood experiences, and environmental factors.[320]

When considering mental health symptoms, there are several symptoms associated with psychosis that can raise the risk of an individual engaging in harmful behaviors towards others. One of those symptoms is command hallucinations (i.e., when an auditory hallucination instructs a person to act in a harmful way). Persecutory delusions are another type of mental health symptom that is associated with increased risk of violence. Persecutory delusions are fixed false beliefs in which the person thinks they are being harmed or harassed by an individual, group, or organization.[321]

Mania, particularly the heightened energy and impulsivity associated with such an episode, has also been associated with an increased risk for aggression.[322] Impulsivity as symptom of bipolar disorder, other mental illness, or substance use disorder reduces an individual's regular behavioral controls, which would typically aid an individual in regulating their behavior.[323]

Aside from specific symptoms increasing violence risk, substance use is correlated with increases in violent behavior in the general population and in individuals with mental illness. Substance use may be associated with violent behavior for several reasons, including disinhibited and impulsive behavior associated with intoxication, exacerbation of mental health symptoms associated with violence risk (e.g., paranoia), and problems with social safety nets that serve as a protective factor for violence (e.g., disruption in housing, supportive relationships).[324] Some studies have found that individuals with co-occurring substance use disorders and mental disorders were significantly more likely to engage violent behaviors than those with only a mental disorders or the general population.[325]

a) Factors Associated with Risk of Violence

When individuals with mental illness exhibit violent behavior, such behavior is often related to contextual or background factors that are associated with similar violent behavior exhibited by the general population. "Factors that predict violent in general…also predict violence in individuals with mental illness."[326] In addition to certain types of mental health symptoms and substance use, research has identified other factors associated with increased risk for violence.[327] These factors include:

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[320]DeAngelis, T. (2022, July 11). Mental illness and violence: Debunking myths, addressing realities. Monitor on Psychology, 52(3). https://www.apa.org/monitor/2021/04/ce-mental-illness (quoting Eric Elbogen, PhD, professor of psychiatry and behavioral science at Duke University School of Medicine).
[321] DeAngelis, *supra* note 320.
[322] *Id; See also* Peterson, J. K., Skeem, J., Kennealy, P., Bray, B., & Zvonkovic, A. (2014). How often and how consistently do symptoms directly precede criminal behavior among offenders with mental illness? Law and Human Behavior, 38(5), 439–449.
[323] Appelbaum & Gutheil. (2007). Clinical Handbook of Psychiatry and the Law, 4th ed.
[324] *Id*.
[325] Van Dorn, R., Volavka, J. & Johnson, N. Mental disorder and violence: is there a relationship beyond substance use?. Social Psychiatry & Psychiatric Epidemiology, 47, 487–503 (2012).
[326] DeAngelis, *supra* note 320.
[327] Appelbaum, *supra* note 323.

- **Past violence**

  Individuals who engaged in violent behavior early in life are more likely to engage in violence as an adult compared to someone who never exhibited violence. In addition, violent behavior exhibited across developmental stages suggest a more pervasive pattern of violence.[328]
- **Age**

  Violent behavior peaks in the teens to early 20s and tends to decline with age, with a significant decrease in violent behavior after age 40.[329]
- **Gender**

  Males are more likely than women to exhibit violent behavior towards others.[330]
- **Certain Personality Traits/Disorders**

  Antisocial Personality Disorder and psychopathic personality traits are shown to increase the risk of violence.[331] Such personality traits include callousness towards others, lacking empathy for others, emotional and behavioral impulsivity, hostility, and a disregard of the rights of others. Also, important to monitor are attitudes promoting violence towards individuals or groups.[332]
- **History of trauma/adverse childhood experiences**

  Evidence suggests that traumatic experiences and adverse childhood experiences can disrupt normal development, model antisocial and violent behavior, and thwart learning of adaptive problem-solving skills.[333]
- **Psychosocial Factors**

  Unstable education/employment, unstable relationships (e.g., highly conflictual, frequent contact with peer group who engages in antisocial behavior), and residing in areas with high exposure to violence are all associated risk factors for violence.

Many of these factors identified above are static (i.e., unchangeable). Equally important to consider are dynamic (i.e., changeable) factors that can increase or decrease risk. Such factors include both internal characteristics or states of the individual, as well as external factors related to supports systems, treatment parameters, restricted contact with/access to likely potential victims and other external constraints. Evaluation of a person's unique circumstances associated with prior violent behavior will be important to consider.

- **Insight into factors associated with violent behavior**

  This may relate to insight into mental health symptoms or substance use problems and

[328] Douglas, K.S, Hart, S.D, Webster, C.D., Belfrage, H., Guy, L.S., & Wilson, C.M. (2014). Historical-Clinical-Risk Management-20, Version 3 (HCR-20V3): Development and Overview, International Journal of Forensic Mental Health, 13:2, 93-108.
[329] Appelbaum, *supra* note 323.
[330] *Id*.
[331] Skeem, J., Kennealy, P., Monahan, J., Peterson, J., & Appelbaum, P. (2016). Psychosis Uncommonly and Inconsistently Precedes Violence Among High-Risk Individuals. Clinical Psychological Science, 4(1), 40–49.
[332] Douglas, *supra* note 327.
[333] *Id*; Appelbaum, *supra* note 323.

need for treatment or recognition of triggers/high risk situations for violent behaviors.[334] For example, if an individual lacks awareness that his/her belief that the government is trying to kill them is a persecutory delusion, he/she may continue to engage in behaviors that are dangerous as he/she perceives it necessary to protect themselves.

- **Violent thought content**

  Ideas about perpetrating violence on others, particularly when persistent, specific, and feasible raise the risk of violence. The thought content could be related to mental health symptoms (e.g., command hallucinations or delusions) or unrelated to mental health symptoms.
- **Current/recent symptoms of mental illness**

  As noted above, particular attention should be paid to hallucinations, delusions, or ideas with hostile, violent, and angry themes, as well as impulsivity (behavioral or affective), agitation, suicidal ideas and behavior, and other manic symptoms.
- **Access to weapons**
- **Engagement in and response to treatment**

  Individuals who are engaged in and responding well to treatment designed to ameliorate problems that are raising the risk for violence (e.g., taking medicines to address hallucinations, delusions, or mood instability; abstaining from substance use) are mitigating the factors that increase violence risk.[335]
- **Living situation**

  Stable or unstable living situations can impact an individual's engagement in treatment, limit or provide access to de-stabilizers or high-risk items (e.g., substance use, weapons), and promote/model prosocial or antisocial behaviors.
- **Support systems**

  Similar to the impact of an individual's living situation, an individual's support system can promote engagement in safe, healthy lifestyles (e.g., treatment, recovery, adaptive problem solving) or the alternative. Lack of access to any meaningful social supports can also be a risk for individuals who have mental health or substance use concerns.[336])
  "Also important is developing treatments that address family dynamics in relation to a patient's violence, in part because research suggests that about 1 in 5 family members of people with serious mental illness is the target of such violence each year."[337]

Assessment of violence risk is not an exact science. Clinicians consider the complex interplay of various internal (i.e., things about an individual) and external (i.e., thing about the individual's environment) factors when assessing violence risk and making treatment recommendations. Such evaluations consider

[334] Douglas, *supra* note 327.
[335] Swanson, J. W., Van Dorn, R. A., Swartz, M. S., Smith, A., Elbogen, E. B., & Monahan, J. (2008). Alternative pathways to violence in persons with schizophrenia: The role of childhood antisocial behavior problems. Law and Human Behavior, 32(3), 228–240.
[336] Douglas, *supra* note 327.
[337] *Id* (quoting Lisa B. Dixon, MD, MPH, of the Columbia University Department of Psychiatry).

an individual's past and present functioning, including frequency, severity, imminence, and likelihood of violent behaviors. "Each patient needs to be assessed individually to identify factors that seem causally related to acts of violence that have occurred in the past, and to focus on intervening with those factors to reduce future risk," says Appelbaum.[338]

At present, violence risk assessment can be assessed using actuarial instruments, which calculate a person's risk for future violence based on a statistical analysis of empirically based risk factors, or through structured professional judgment (also referred to as structured clinical judgment) instruments, which include evaluations of static (i.e., unchangeable) and dynamic (i.e., changeable) factors that research has shown to be associated with a heightened risk of violence. While both sources of risk assessment are valid, structured professional judgment is often preferred because it allows the use of clinical judgment to evaluate the seriousness of risk factors and provides for integration of dynamic risk factors into risk formulation and decision making. For instance, a recent event such as a major loss or grievance against an identified target or discontinuation of psychotropic medication for an individual with long history of persecutory delusions may be particularly relevant in making decisions about violence risk but would not be considered by actuarial instruments. Structured professional judgment instruments also allow for consideration of factors that may mitigate violence risk and can be used to make valuable recommendations that can be used in treatment, supervision, and monitoring.

2. Self-Harm

Persons with mental illness are at increased risk of non-suicidal self-injury, which is defined as "behaviors intended to harm one's own body, typically without the intent to die."[339] "One study showed approximately 11.3% of those with psychotic disorders (e.g., schizophrenia, schizoaffective disorder) have engaged in self-harm compared to 6.4% of the general population."[340]

The American Self-Harm Information Clearinghouse 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."[341] 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, swallowing nonfood items, etc. The most common forms of self-harm are cutting, burning, and head banging. [342]

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

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[338] DeAngelis, *supra* 323.
[339] Emilee Green, *Mental Illness and Violence: Is there a Link?*, Ill. Crim. Just. Info. Authority, May 4, 2020, https://icjia.illinois.gov/researchhub/articles/mental-illness-and-violence-is-there-a-link.
[340] *Id.*
Elizabeth A. Osuch et al.,*The Motivations for Self-Injury in Psychiatric Inpatients*, 62 Psychiatry334 (1999).
[341] Sarah Meedel, Self-Injury Created by Various Methods, for Various Reasons, Mar. 1, 2002, https://www.unothegateway.com/self-injury-created-by-various-methods-for-various-reasons/.
[342] Sarah Meedel, Self-Injury Created by Various Methods, for Various Reasons, Mar. 1, 2002, https://www.unothegateway.com/self-injury-created-by-various-methods-for-various-reasons/.

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.
- 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 defined as "no words feeling"), is common in people who self-harm.

There are many myths associated with self-harming behavior[343], including:

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.

Myth: "People who self-injure are crazy and should be locked up."
Truth: "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."[344]

[343]Kathleen Young, *Common Myths About Self-Injury*, Feb. 28, 2010, https://drkathleenyoung.wordpress.com/2010/02/28/common-myths-about-self-injury/ (providing a list of common myths about self-injury as compiled by the American Self-Harm Information Clearinghouse).
[344] *Id* (quoting Tracy Alderman, *The Scarred Soul,* New Haringer Publications (1997)).

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.

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

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. Misdiagnosis is common, however, and so mental health board members should inquire about the diagnostic criteria of BPD and what symptoms the individual experiences.

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.

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.[345]

3. Suicide

According to the DHHS Nebraska Statewide Suicide Prevention Plan, the 2020 rate for suicides in Nebraska was slightly higher than the national average, with 283 deaths by suicide.[346] Nebraska's suicide rate is 14.9 per 100,000 people, and Nebraska ranks 28th in the nation.[347] Suicide is the 2nd leading cause

[345] *Id.*
[346] Nebraska 2022-2025 Statewide Suicide Prevention Plan at 5 (citing the 2020 Nebraska State Epidemiological Profile (Nebraska Dept. of Health and Human Svc.).
[347] *Id.*

of death for Nebraskans aged 25- to 34-years old.[348] Every 32 hours a Nebraskan loses their life to suicide.[349]

a) Terminology

For a discussion about suicide, it is important to establish a basic understanding of the clinical terminology used. The following are common terms used in the discussion of suicide:

- **Suicidal ideation**: Thoughts about killing oneself; these thoughts may include a plan.
- **Suicide attempt**: Self-injurious behavior that is intended to kill oneself but is nonfatal.
- **Suicide**: Self-injurious behavior that is intended to kill oneself and is fatal.
- **Suicide threat**: Thoughts of engaging in self-injurious behavior that are verbalized and intended to lead others to think that one wants to die, despite no intention of dying (eg, "If you leave me, I will kill myself").
- **Suicide gesture**: Self-injurious behavior that is intended to lead others to think that one wants to die, despite no intention of dying.
- **Non-suicidal self-injurious thoughts**: Thoughts of engaging in self-injurious behavior characterized by the deliberate destruction of body tissue in the absence of any intent to die and for purposes that are not socially sanctioned.
- **Non-suicidal self-injury**: Self-injurious behavior characterized by the deliberate destruction of body tissue in the absence of any intent to die and for purposes that are not socially sanctioned.

Self-injurious behavior that is accompanied by any intent to die is classified as a suicide attempt, which is consistent with the practice of most clinicians and researchers, as well as recommendations from the United States Centers for Disease Control and Prevention. This approach deliberately errs on the side of safety by categorizing ambivalent behaviors as suicidal.

b) Risk Factors

The subsections below describe factors that are associated with an increased risk of suicide. Identifying modifiable factors, as well as protective factors (see 'Protective factors' below), can guide treatment.

- History of previous suicide attempts: It is estimated that there are 10 to 40 nonfatal suicide attempts for every completed suicide, and a prior history of attempted suicide is the strongest single factor predictive of suicide. Research show that one of every 100 suicide attempt survivors will die by suicide within one year of their index attempt, a risk approximately 100 times that of the general population. Following a suicide attempt, the risk for completed suicide is greatest in patients with schizophrenia, major depression, and bipolar disorder.
- Mental disorders: Having a mental disorder is a strong predictor of suicide. More than 90 percent of patients who attempt suicide have a mental disorder, and 95 percent of patients who

[348] *Id*.
[349] *Id*.

complete suicide have a diagnosed mental disorder.

- Severity of mental disorder is associated with risk of suicide. The mental disorders most commonly associated with suicide include depression, bipolar disorder, alcoholism or other substance abuse, schizophrenia, personality disorders, anxiety disorders including panic disorder, posttraumatic stress disorders, and delirium. Among patients with depression, a history of suicide attempts correlated most strongly with feelings of worthlessness. Concurrent personality disorder was also strongly correlated with suicide attempts in depressed patients. Patients who have multiple psychiatric comorbidities appear to be at higher risk than those with uncomplicated depression or an anxiety disorder.
- Recent Psychiatric Hospitalization: Suicide may be concentrated in the days and weeks following psychiatric inpatient hospitalization. In one systematic review, 41 percent of those who completed suicide had been psychiatric inpatients within the previous year, and as many as 9 percent of suicides occurred within one day of discharge from psychiatric inpatient care. This last figure may have been inflated by including some patients who completed suicide during their inpatient stays.
- Anxiety disorders: more than double the risk of suicide attempts, and a combination of depression and anxiety greatly increases the risk. Symptoms of psychosis (delusions, command auditory hallucinations, paranoia) may increase the risk regardless of the specific diagnosis.
- Hopelessness: Across mental disorders, hopelessness is associated with suicidal ideation and behavior. A meta-analysis of 166 longitudinal studies found that hopelessness was associated with an increased risk of suicidal ideation, attempt, and death.
- Relationship Status: The risk of suicide increases in patients who live alone, have lost a loved one, or have experienced a failed relationship within one year. The anniversary of a significant relationship loss is also a time of increased risk. Among those widowed, the risk of suicide is highest in the first week after bereavement, decreasing rapidly in the first months thereafter, but remaining elevated throughout the first year following the loss. Suicide occurs more often in people who are not married than those who are married. Researchers hypothesized that marriage increases social integration and meaning within one's life.
- Socioeconomic Status: Sociopolitical, cultural, and economic forces can lead to increased suicide rates in populations. Violence and political coercion are associated with increased rates of suicide, as are economic downturns, unemployment, and economic strain. Suicide may be greater in patients who serve in unskilled occupations than skilled occupations. Homelessness, particularly in those with psychiatric disorders, increases the risk of suicide.
- Sexual Orientation: The risk of suicidal ideation and behavior is increased in sexual minorities. As an example, a meta-analysis of 46 studies found that the proportion of individuals who attempted suicide in the last 12 months was approximately two to three times greater for those who are bisexual, gay or lesbian, compared with heterosexual persons. In addition, lifetime suicide attempts were roughly four times greater in sexual minorities than heterosexuals. LGBTQ (Lesbian, Gay, Bisexual, Transgender, Queer, and Questioning) youth are at significantly increased risk for suicide.

  - The Trevor Project's 2022 National Survey on LGBTQ youth[350] found that LGBTQ youth are four times as likely to attempt suicide than their peers. The survey also indicated that 45% of the LGBTQ youth who participate seriously considered attempting suicide in the past year, with youth of color reporting higher rates than their white peers. The survey also found that 14% of LGBTQ youth attempted suicide in the preceding year. The survey also found that LGBTQ youth who felt high social support from their family reported attempting suicide at less than half the rate as those who felt they received low or moderate social support.

- Military service: In the United States, the rate of suicide in military veterans exceeds that of the general population. Military veterans made up 13.7% of suicides among U.S. adults in 2019, with veterans ages 55-74 accounting for 38.6% of veteran suicide deaths.[351] In 2021, the suicide rate among active-duty troops was 24.3 per 100,000, for reserve members it was 21.2 per 100,000, and for National Guard members it was 26.4 per 100,000.[352] The most common method of suicide was by firearm.[353]
  - Military service of a family member can also be a risk factor. In 2020, the rate of suicide for military spouses was 13 per 100,000.[354]
- Medical illnesses: Suicide risk increases with medical illness, including asthma, cancer, chronic obstructive pulmonary disease, coronary artery disease, diabetes mellitus, spine disorders (e.g., disc disorders), stroke, recent surgery, and chronic or terminal disease. Neurologic disorders also have increased risk for suicide.
- Chronic pain: Chronic pain is prevalent in people who die by suicide. Risk factors for suicidal ideation and behavior in those with chronic pain include multiple pain conditions, severe pain, more frequent episodes of intermittent pain (e.g., migraines), longer duration of pain (e.g., >3 months), and sleep onset insomnia. Psychological processes relevant to suicidality in patients with chronic pain include helplessness and hopelessness about the pain, a desire to escape the pain, and problem-solving deficits.
- Traumatic brain injury (TBI): Research has shown that the incidence rate ratio of suicide was approximately two times greater in patients with TBI than individuals without TBI, regardless of TBI severity. The risk of suicide was greatest within the first six months of TBI, and the risk remained elevated for at least seven years compared with the control population. In addition, the risk of suicide was greater in patients with two or more likely distinct TBI events, compared to patients with one TBI. Patients with post-TBI psychiatric disorder and patients with post-TBI nonfatal deliberate self-harm were at greater risk of suicide than were patients with TBI alone.
- Childhood adversity: The risk of suicide attempts is two to four times greater in adults who

[350] 2022 National Survey on LGBTQ Youth Mental Health, The Trevor Project (2022), https://www.thetrevorproject.org/survey-2022/.
[351] U.S. Dept. of Veteran Affairs, *2021 National Veteran Suicide Prevention Annual Report,* Sept. 2021. Firearm was the leading method for suicide among male veterans, 69.2%, in 2019.
[352] U.S. Dept. of Defense, *Department of Defense Annual Report on Suicide in the Military Calendar Year 2021*, at 4.
[353] *Id*. In 2021, 70% of service members who died by suicide used a firearm.
[354] *Id.*

suffered childhood abuse or other adverse childhood experiences which includes physical neglect, physical abuse, sexual abuse, and emotional abuse.

- Family history and genetics: The risk of suicide increases in patients with a family history of suicide. As an example, a national registry study found that if one sibling died by suicide, the risk of remaining siblings doing so was increased both among females and males.
- Firearms: Suicide in the United States most often involves firearms. Among all suicides in the United States in 2021, firearms were used by 26,328 decedents out of the 48,183 suicides.[355]
    - As part of a safety plan (an example Safety Plan can be found in Appendix III.M.) for individuals who reside in homes with firearms and are at increased risk of suicidal behavior (e.g., those with current suicidal ideation or depressive disorders, or a prior history of suicide attempt), we recommend either removing the firearms or restricting access by storing firearms locked, unloaded, and separate from ammunition.
    - Evidence supports that limiting access to guns reduces suicide rates. Restricting access to firearms may help decrease suicides because suicidal ideation is often transient, suicidal behavior is frequently impulsive, and firearms are more lethal than other suicide methods such as poisoning (overdoses).
    - In addition, multiple studies have found that laws and regulations that restrict access to guns are associated with decreases in firearm suicides, without increases in suicide by alternative methods. Thus, restricting access to firearms appears to decrease firearm suicides and overall suicides.
- Rural residence: Between 2000 and 2020, suicide rates have increased 46% in non-metro areas compared to 27.3% in metro areas.[356] A factor to this higher rate is reduced access to mental health care in rural locations due to provider shortages.[357]
- Media reporting: Media reports of suicide deaths may be associated with a subsequent increase in suicides in the general population. Highly publicized suicides, even if completed by someone unknown to the patient, can increase the risk of emulation, resulting in "clusters" of suicides as seen on college campuses. After reports of celebrity suicides, the risk of suicide for the general population increased by 13 percent in some studies. In addition, media reports of celebrity suicides that included the method (e.g. hanging) were associated with a 30 percent increase in suicides by the same method. Some experts recommend that medial reports of suicide should follow existing guidelines for responsible reporting, which includes avoiding sensationalism and the method used.

c) Protective Factors

[355] Centers for Disease Control and Prevention, *Suicide and Self-Harm Injury*, https://www.cdc.gov/nchs/fastats/suicide.htm.
[356] Center for Disease Control and Prevention, *Suicide in Rural America*, Apr. 21, 2023, https://www.cdc.gov/ruralhealth/Suicide.html.
[357] Over 60% of rural Americans live in designated mental health provider shortage areas. Dawn. A. Morales et. Al, *A Call to Action to Address Rural Mental Health Disparities,* Nat'l Libr. of Med., May 4, 2020.

Social support and family connectedness are protective against suicide. While family discord increases the risk of suicide. As an example, a study of nationally representative samples found that after controlling for several potential confounding factors, social support was associated with a decreased risk of suicide in the United States. Pregnancy decreases the risk of suicide, as does parenthood, particularly for mothers. Religiosity and participating in religious activities are associated with a lower risk of suicide.

d) Signs of Crisis

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. 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 range from buying a gun to suddenly putting one's affairs in order.
- **Other warning signs**: 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 to note 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

e) Risk Assessment

The purpose of a suicide risk assessment is to review risk and protective factors with a focus on identifying modifiable targets for intervention. Clinicians may worry that asking about suicide will initiate suicidal thoughts or actions, but there are no data to support this concern. By contrast, many patients appreciate the opportunity to discuss suicidal thoughts, and may not verbalize these issues without being prompted. A review of 13 studies reported that none found a significant increase in suicidal ideation among participants asked about suicidal thoughts. The observation that patients who subsequently complete suicide have often recently visited primary care clinicians has been interpreted as reflecting help-seeking behavior. However, clinicians may be unaware of their patient's intent. As an example, in one study of depressed suicide victims, 59% who were treated in a psychiatric setting had communicated their intent compared with only 19% cared for in a medical setting. While patients may be reluctant to communicate their intent to attempt suicide, patients with suicidal ideation will generally tell their clinicians about such thoughts when asked.

The evaluation of a patient who may be suicidal includes an assessment of ideation, method, plan, and intent. Several standardized scales have been proposed to evaluate suicide risk, but none is associated with a high predictive value. Depression rating scales are commonly used, but these are better measures of depression severity than suicide risk. Examples of assessments and screeners include: Patient Health Questionnaire–Nine Item (PHQ-9), Beck Hopelessness Scale, Beck Depression Scale, Suicide Probability Scale, and Columbia Suicide Screener. Standard practice in suicide evaluation includes a clinical interview and suicide screener.

(1) Suicidal Ideation and Behavior

The first step in evaluating suicide risk is to determine the presence of suicidal ideation (i.e., suicidal thoughts), including their content and duration. The questioning should determine whether the patient has active or passive suicidal ideation:

- Active suicidal ideation: Thoughts of taking action to kill oneself. As an example, "I want to kill myself" or "I want to end my life and die."
- Passive suicidal ideation: The wish or hope that death will overtake oneself. As an example, "I would be better off dead," "My family would be better off if I was dead," or "I hope I go to sleep and never wake up."

If suicidal ideation is present, the clinician should ask if the thoughts are new, about changes in what may be chronic thoughts (e.g., increased intensity or frequency), and if or how the patient has been controlling these thoughts. Other inquiries include the patient's expectations about death (including thoughts of reuniting with lost significant others), thoughts of evoking punishment of others, the need to escape a painful physical or psychological situation, or thoughts of harming others first before harming him or herself.

The presence of a suicide plan and the degree of intent to kill oneself can be elicited by asking about the following:

- Has a specific plan been formulated or implemented, including a specific method, place, and time? What is the anticipated outcome of the plan?
- Are the means of attempting suicide available or readily accessible? Does the patient know how to use these means?
- What is the lethality of the plan? What is the patient's conception of lethality versus the objective lethality? What is the likelihood of rescue?
- Have any preparations been made (e.g., gathering pills, changing wills, suicide notes) or how close has the patient come to completing the plan? Has the patient practiced the suicidal act or has an actual attempt already been made?
- What is the strength of the intent to carry out suicidal thoughts and plans?
- Is there a history of impulsive behaviors or substance use that might increase impulsivity? What is the ability to control impulsivity?
- What is the accessibility of support systems and recent stressors that may threaten the patient's ability to cope with difficulties and ability to participate in treatment planning?
- History: Clinicians should ask about a past history of suicidal ideation and behavior and family history of suicide.
- In addition, observe whether the patient is disconnected, disengaged, or shows a lack of rapport during the clinical interview, because these clinical signs are associated with an increased risk of suicide.

(2) Contracting for Safety

As part of assessing suicidal ideation, as well as supporting the patient's ability to avoid suicidal behavior, clinicians often ask if the patient can "contract for safety" or agree to a "no harm contract." The phrases imply that patients can promise clinicians that they will try not to harm themselves when they have suicidal thoughts and will seek help if necessary. The terms are not defined or used consistently, and clinicians generally do not receive formal training in suicide prevention contracts. Despite their wide use, there is little evidence that such contracts actually reduce suicide. Contracting for safety may thus provide a false sense of security. Better tools include: open dialogue between patients and clinicians to establish a therapeutic alliance, as well as ongoing assessments of suicide risk over time.

For clinicians who want to further evaluate suicidal ideation and behavior in patients with mental disorders or past histories of suicide attempts, we suggest complementing the clinical assessment with the structured, interviewer-administered Columbia-Suicide Severity Rating Scale. This scale is the preferred instrument (the "gold standard") for assessing suicidality in clinical trials that fall under the authority of the United States Food and Drug Administration. A structured instrument can enable the interviewer to clarify ambiguous or contradictory responses; however, these instruments are labor intensive and seldom used in routine clinical practice. Rather, they are generally reserved for specialized evaluation, treatment, or research settings.

f) Treatment

(1) Psychotherapy

After a suicide attempt, psychotherapy may prevent subsequent attempts. In a study including cognitive-behavioral therapy (CBT), problem solving therapy, dialectical behavior therapy (DBT), and psychodynamic psychotherapy, suicide deaths occurred in fewer individuals who received psychotherapy than standard care (1.6 versus 2.2 percent). All-cause mortality was also lower in individuals who received psychotherapy than standard care (6.9 versus 9.6 percent). Self-harm includes both non-suicidal self-injury and suicide attempts, which differ in multiple ways, including frequency; non-suicidal self-injury may occur daily, whereas suicide attempts occur less frequently. Multiple studies indicate that CBT can specifically reduce suicide attempts; however, CBT does not seem to reduce suicide. Studies comparing DBT with usual care in individuals with an episode of self-harm found that the frequency of self-harm decreased more with DBT.

(2) Medication

Pharmacotherapy for psychiatric disorders in suicidal individuals may be inadequate with doses below the therapeutic minimum. Psychologic autopsy studies have found that among all individuals who complete suicide, only 8 to 17 percent received any psychiatric medications; among depressed suicide victims, only 6 to 14 percent were adequately treated.

Currently, there are three pharmacologic agents with FDA indication to reduce suicide risk: lithium, clozapine, and ketamine. There is robust evidence that lithium decreases suicide risk in individuals with major depressive disorder and bipolar disorders. Although it is not known how lithium reduces the risk of suicide, lithium can prevent recurrence of mood episodes and may also reduce aggression or impulsivity. One study found that the risk of completed and attempted suicides was 80% lower in patients treated with lithium in comparison to those who were not. It is hypothesized that lithium mitigates suicide behavior by reducing impulsivity, a common characteristic of many who attempt suicide. Despite the possibility that lithium toxicity and overdose can damage organs and may be lethal, mental health board members may frequently hear about the use of lithium in the context of treatment plan discussions.

g) Monitoring and Follow-Up

Individuals at risk of suicide should be followed regularly, as warranted by the level of risk, bearing in mind that level of risk fluctuates (particularly if the individual's situation changes). As part of monitoring previously suicidal individuals, the clinician should determine if there have been changes, especially a reemergence of precipitating events, adverse life circumstances, or mental disorders. Following acute management of suicidal ideation and behavior, clinicians should assure that individuals are actively engaged in ongoing care for any mental disorders and that they receive maintenance treatment to prevent recurrent episodes of unipolar depression, bipolar disorder, anxiety disorders, psychotic disorders, and substance use disorders.

Mental health board members should be cognizant that the risk of suicide is increased in the days and initial weeks following discharge from psychiatric hospitalization, particularly if individuals perceive that they have lost a therapeutic support system, including contact with a mental health professional. The risk is particularly high in the first week after discharge, and more than one-third of all suicides in the first year following hospital discharge occur in the first month. Scheduling the first follow-up visit soon

after a psychiatric hospitalization may reduce suicide rates. An observational study found that implementing a policy to follow-up individuals within seven days of discharge was associated with a decreased rate of suicide during the three months after discharge (from 2.5 to 2.0 suicides per 10,000 discharged individuals).

Individuals are also at high risk for nonadherence to pharmacotherapy soon after discharge, and thus have a consequent increased risk of suicide. By contrast, those who continue care in the community and who maintain pharmacotherapy are at lower risk. In addition, an observational study found that assertive community outreach to individuals who are nonadherent with medications or appointments was associated with decreased suicide rates. Nonadherence may be due to adverse effects, lack of symptom relief, not understanding the purpose of medications, or failure to appreciate the consequences.

4. Neglect

Neglect means the failure to care for oneself properly and can be the result of brain injury, dementia, or mental illness. Sever neglect would be an inability to care for oneself and subsequently endangering one's life due to an untreated mental health condition. A person may neglect oneself due to mental illness if, for instance, they flee housing due to auditory hallucinations. A common clinical scenario in the setting of psychiatric emergencies is that a person with a mental disorder is not at risk for suicide or violence but nevertheless is at risk of harm to self because of their inability to care for themselves. This inability is related to their mental disorder and can manifest in a variety of ways in which aspects of the mental disorder impairs an individual's judgment to the extent that they are vulnerable and susceptible to personal injury and/or death. The MHCA states, "evidence of inability to provide for his or her basic human needs, including food, clothing, shelter, essential medical care, or personal safety"[358] is grounds for civil commitment of an individual who is mentally ill or substance dependent. A person is not in danger due to self-neglect if that person can survive safely with the help of responsible family or social supports to help provide for the person's basic needs.

5. Risk and Aggressive Behavior Assessments

E. Dangerous Sex Offenders

The DSM-5-TR uses the phrase "paraphilic disorders" to describe disorders involving "intense and persistent sexual interest other than sexual interest in genital stimulation or preparatory fondling with an observably normal, physically mature, consenting human partners."[359] This section will focus on those disorders that are common to individuals committed under the Sex Offender Commitment Act (SOCA), which means that the behavior exhibited by the individual must be illegal. See Section II.C. for a legal overview of SOCA. It is not necessary that an individual have a diagnosis of a paraphilic disorder for

[358] Neb. Rev. Stat. 71-908.

[359] Diagnostic and Statistical Manual of Mental Disorders (Fifth Ed. Text Revision) at 779 (2022).

SOCA purposes. This section is intended to provide the clinical perspective on how sex offenders are diagnosed (if applicable) and treated, and how clinicians determine an individual's risk of re-offending.

1. Sex Offenses and Mental Illness

While many sexual offenders are diagnosed with one or more mental disorders,[360] the most frequently observed disorders in this general population are personality disorders, paraphilic disorders, and substance use disorders.[361] The role of mental disorders in sexual offending is unclear.[362] However, it has been suggested that mental disorders do not appear to be a criminogenic factor relevant to recidivism in most cases.[363] Moreover, sex offenders as a group "bring their own unique characteristics and circumstances to diagnostic scrutiny" that are often delineated very ambiguously or not at all by the DSM.[364] While the most common diagnoses among civilly committed sex offenders includes paraphilic disorders and antisocial personality disorder,[365] an understanding of the other common diagnostic categories and disorders is needed.

A basic overview of the following mental disorders, taken from the most recent version of the Diagnostic and Statistical Manual of Mental Disorders ("DSM-5-TR"),[366] and behaviors in the context of sexual offenders is provided for a better understanding of sexual offenders.

a) Personality Disorder

A 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."[367] Personality disorders is a broad category of several disorders; however, antisocial personality disorder is most commonly diagnosed personality disorder amongst civilly committed sex offenders.[368]

b) Antisocial Personality Disorder

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[360] R. Eher et al., *The prevalence of mental disorders in incarcerated contact sexual offenders*, 139 Acta Psychiatrica Scandinavica (Issue 6) 572 (2019).
[361] *Id*.
[362] Brad D. Booth & Sanji Gulati, *Mental Illness and Sexual Offending*, 37 Psychiatric Clinics N. Am. (2014).
[363] James Bonta et al., *The Prediction of Risk for Mentally Disordered Offenders: A Quantitative Synthesis*, Pub. Safety Can. (2013). *See also* Drew A. Kingston et al., *The Relationship Between Mental Disorder and Recidivism in Sexual Offenders*, 14 Int'l J. of Mental Health 20 (Feb. 2015).
[364] Richard Rogers & Daniel Shuman, Fundamentals of Forensic Practice: Mental Health and Criminal Law (Sprincer Science+Business Media, Inc. 2005).
[365] Holly A. Miller et al., *Sexually Violent Predator Evaluations: Empirical Evidence, Strategies for Professionals, and Research Directions,* 29 Law & Human Behavior 29 (Feb. 2005). *See also* Jill S. Levenson, *Sexual Predator Civil Commitment: A Comparison of Selected and Released Offenders*, 48(6) Int'l J. of Offender Therapy and Comparative Criminology 638 (2004).
[366] Diagnostic and Statistical Manual of Mental Disorders (Fifth Ed. Text Revision) (2022).
[367] *Id* at 733.
[368] Levenson, *supra* note 363.

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."[369] 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.

c) Paraphilias

Paraphilias refer to "any intense and persistent sexual interest other than sexual interest in genital stimulation or preparatory fondling with phenotypically normal, physically mature, consenting human partners."[370] It should be noted that "a paraphilia is a necessary but not a sufficient condition for having a paraphilic disorder, and a paraphilia by itself does not necessarily justify or require clinical intervention."[371] For a diagnosis of paraphilic disorder, the interest should occur for at least 6 months.

d) Exhibitionism

Exhibitionism involves recurrent and intense sexual arousal from the exposure of one's genitals to an unsuspecting person, as manifested by urges or behaviors.[372] 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.

e) Voyeurism

Voyeurism involves the act of observing unsuspecting individuals, who are naked, in the process of disrobing, or engaging in sexual activity.[373] 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.

f) Pedophilic Disorder

Pedophilic Disorder involves "recurrent, intense sexually arousing fantasies, sexual urges, or behaviors involving sexual activity with a prepubescent child or children (generally age 13 or younger)."[374] To qualify for a diagnosis, these concerns must last at least 6 months in duration, and the individual experiencing the fantasies, urges, or behaviors must be at least 16 years old and at least 5 years older than the child.

The DSM-5-TR specifies that an individual in late adolescence involved in an ongoing relationship with a 12- or 13-year-old should not be diagnosed with pedophilic disorder. Individuals with pedophilic disorder generally report an attraction to children of a particular age range. Those with pedophilic

[369] *Id* at 748.
[370] *Id* at 779.
[371] *Id* at 780.
[372] *Id* at 783.
[373] *Id* at 780-781.
[374] *Id* at 793.

disorder may be attracted to males, females, or both sexes, and some individuals with pedophilic disorder also express attraction to adults. The course of the disorder is usually chronic, especially in those attracted to males. The recidivism rate for persons with an attraction to males is roughly twice that for those who are attracted to females. The DSM-5-TR notes that pedophilic disorder is often associated with co-occurring antisocial personality disorder; substance use disorders; depressive, bipolar, and anxiety disorders; and other paraphilic disorders.

g) Sexual Sadism

Sexual sadism involves acts in which the individual derives sexual excitement from the psychological or physical suffering (including humiliation) of the non-consenting person.[375] 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.

2. Risk of Re-offending

Sex offense recidivism is generally treated with great concern due to the potential harm to others, which can lead to hesitation to discharge individuals. However, the rate of re-offense in Nebraska in 2013 was 2.6% within two years of release.[376] The re-offense rate is about 5% nationally within three years of release.[377] Of course, this data must be taken with the understanding that sex offenses often go unreported.[378] Mental health board members should be aware of the risk for re-offending but also understand the risk factors. It is important for mental health board members to ask the experts about what factors were present and how the individual's risk was assessed.

Similar to a violence risk assessment, assessment of risk of sex offense re-offending is not an exact science. Clinicians who assess and treat individuals with sexual behavior problems use actuarial instruments (e.g., Static-99R[379] and STABLE-2007[380]), which calculate a person's risk for future violence based on a statistical analysis of evidence-based risk factors that research has shown to be associated with a heightened risk of sexual re-offending. Factors related to sex offender recidivism in Nebraska can be divided into offender and victim characteristics and type of offense.

- Offender Characteristics: offenders were at greater risk of reoffending if they were male or

[375] *Id* at 790-791.
[376] University of Nebraska, Nebraska Sex Offender Registry Study: Final Report, Consortium for Crime and Just. Research (2013)..
[377] Roger Przybylski, Recidivism of Adult Sexual Offenders, SOMAPI Research Brief (July 2015). It is worth noting that recidivism rates look at recidivism within different time periods. The longer the time period studied, the more the recidivism rate increases (from about 5% after 3 years to about 24% after 15 years). *Id* at 4.
[378] *Id*. There is a long history or research indicating sexual offenses are underreported and that the likelihood of a sexual offense being reported reduces with the victim's age. Additionally, not all reported offenses result in prosecution or arrest.
[379] A sex offender risk assessment tool used to assess male sex offenders based on static (unchanging) risk factors that predict the potential for re-offending. State Authorized Risk Assessment Tools for Sex Offenders, Risk Assessment Instruments, https://saratso.org/index.cfm?pid=1360.
[380] An evidence-based assessment tool used to measure dynamic (changing) risk factors which are empirically related to the risk of re-offending. *Id*.

diagnosed with a personality disorder.[381]

- Victim characteristics: if the victim was a relative or acquaintance of the offender, age 11 or younger, then the rate of re-offense was significantly higher.[382]
    - Sex of victim: If the offender's victims were male and female, the risk of reoffending is substantially higher.[383]
- Offense type:
    - The typical sex offender in Nebraska is a white male over the age of 26 with a female victim that is an acquaintance, age 12 to 17. The most common offense is fondling.
    - A 2004 study of child molestation (including, fondling) recidivism found the recidivism rate ranged from 23% within 5 years to 35.4% within 15 years.[384]
    - The same 2004 study found rapists had a recidivism rate ranging from 14% after 5 years and 24% after 15 years.[385]
    - Exhibitionists are understudied in the field, but a 2006 study found exhibitionists re-offended at a rate of 23.6% within 13.2 years based on a new sexual charge or conviction.[386]

Sex offender treatment generally involves group treatment in which the offenders work to identify their risk factors including warning signs and triggers for offense behaviors. Cognitive distortions, including blaming victims, denial, and justifying sexual offending behavior are also targeted in psychotherapy. In addition, treatment focuses on development of healthy, prosocial coping skills for managing sexually deviant urges and behaviors. Sex offender treatment should also focus on identifying other areas of concern related to the offending behaviors such as substance abuse, social and relationship skills, distress tolerance, cognitive distortions, mental health difficulties, and any other factor that creates instability in an individual's life and elevates their specific risks.

[381] University of Nebraska, Nebraska Sex Offender Registry Study: Final Report, Consortium for Crime and Just. Research at 3 (2013), https://www.unomaha.edu/college-of-public-affairs-and-community-service/nebraska-center-for-justice-research/documents/ne-sex-offender-recidivism-final-report.pdf.
[382] *Id.*
[383] *Id.*
[384] Roger Przybylski, Recidivism of Adult Sexual Offenders, SOMAPI Research Brief at 3 (July 2015), https://smart.ojp.gov/sites/g/files/xyckuh231/files/media/document/recidivismofadultsexualoffenders.pdf.
[385] *Id* at 2.
[386] *Id* at 4.

GLOSSARY

Activities of Daily Living

Activities that allow individuals to live successfully in non-institutional settings. 206 NAC § 1-002.01.

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

(MHCA) The administrator or other chief administrative officer of a treatment facility or his or her designee. Neb. Rev. Stat. § 71-904 (MHCA) & 71-1203 (SOCA).

Advance health care directive

An individual instruction under the Health Care Surrogacy Act (Neb. Rev. Stat. §), a declaration executed in accordance with the Rights of the Terminally Ill Act, or power of attorney for health care. Neb. Rev. Stat. § 30-603.

Adult with Severe and Persistent Mental Illness

An individual, aged 19 or older, with a diagnosis of a major mental illness who is at risk of institutionalization with significant limitations pursuant to 206 NAC § 1-002.02.

Affect

A technical term used by mental health professionals describing a pattern of observable behaviors that is the expression of a subjectively experienced feeling state (emotion). Disturbances in affect include:

Blunted: significant reduction in the intensity of emotional expression.

Flat: absence or near absence of any sign of affective expression.

Inappropriate: discordance between affective expression and the content of speech or ideation.

Labile: abnormal variability in affect with repeated, rapid, and abrupt shifts in affective expression.

Restricted or constricted: mild reduction in the range and intensity of emotional expression. DSM-V (2013) at 817.

Agent

A natural person designated in a power of attorney (*See* the Uniform Power of Attorney Act, Neb. Rev. Stat. § 30-3401 to 30-3432) to make decisions on behalf of the natural person granting the power, i.e., the principal.

See **Attorney in Fact** (power of attorney for health care, Neb. Rev. Stat. § 30-3402).

Alcohol Use Disorder

A problematic patter of alcohol use leading to clinically significant impairment or distress. DSM-V (2013) at 490.

ASAM/American Society of Addiction Medicine Criteria

The most current edition of the American Society of Addiction Medicine Criteria as published by the American Society of Addiction Medicine.

Attorney in fact

An adult, a person 19 years of age or older, properly designated and authorized pursuant to Neb. Rev. Stat. § 30-3401 to 30-3432 to make health care decisions for a principal pursuant to a power of attorney for health care and shall include a successor attorney in fact. Neb. Rev. Stat. § 30-3402(3).

See **Agent** (Uniform Power of Attorney Act, Neb. Rev. Stat. § 30-4002)

Behavioral Health Disorder

Mental illness or alcoholism, drug abuse, problem gambling, or other addictive disorder. Neb. Rev. Stat. § 71-804.

Behavioral Health Region

A Regional Behavioral Health Authority established pursuant to Neb. Rev. Stat. § 71-807.

Behavioral Health Services

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. Neb. Rev. Stat. § 71-804.

Burden of Proof

Generally, the standard that a party seeking to prove a fact must satisfy in order to prevail.

Capacity (Advance Mental Health Care Directives Act)

Having both (1) the ability to understand and appreciate the nature and consequences of mental health care decisions, including the benefits and risks of each, and alternatives to any proposed mental health treatment, and to reach an informed decision, and (2) the ability to communicate in any manner such mental health care decision. Neb. Rev. Stat. § 30-4404(3)(a).

See **Incapacitated Person** (Nebraska Probate Code/Guardianship), **Incapable** (Advance Mental Health Care Directive Act), **Incapacity** (Uniform Power of Attorney Act)

Civil Protective Custody (CPC)

When an individual is taken into custody by city police, county sheriffs, officers of the Nebraska State Patrol, and any other such law enforcement officer with power to arrest for traffic violations because they are intoxicated and in the judgment of the officer dangerous to himself, herself, or others, or who is other- wise incapacitated, from any public or quasi-public property pursuant to Neb. Rev. Stat. § 53-1,121.

Clear and convincing evidence

Evidence that produces a firm belief or conviction about the fact to be proved.[387]

Clinical assessment

An examination of a person's current mental health status, employing interview and/or standardized testing, performed by a qualified mental health professional.

Clinical interview

A component of clinical assessment involving a direct, interactive inquiry into an individual's feelings, perceptions, inclinations, and personal history.

Community-based Behavioral Health Services or Community-based Services

[387] *See* Fales v. Norine, 263 Neb. 932, 644 N.W.2d 513 (2002), In re Estate of Mecello, 262 Neb. 493, 633 N.W.2d 892 (2001).

Behavioral health services that are not provided at a regional center. Neb. Rev. Stat. § 71-804.

Conservator

Any person appointed to protect a protected person and may include the Public Guardian. Neb. Rev. Stat. § 30-2601(9).

Co-Occurring Disorders (COD)

Coexistence of both a mental illness and a substance use disorder. 206 NAC § 1-002.06.[388]

Crisis Center

A crisis center is designed to provide custody, screening, emergency mental health evaluation, and crisis intervention to individuals, age 18 and older, who are detained under Nebraska civil commitment statutes within Region 5.[389]

Crisis Response Services

Services provided by the Behavioral Health Division of DHHS to provide services designed to use natural supports and resources to resolve an immediate mental health or substance use crisis in the least restrictive environment by creating a plan with the individual to resolve the crisis.[390]

Crisis Stabilization Services

Services provided by the Behavioral Health Division of DHHS to provide immediate, short-term, individualized, crisis-oriented treatment and recovery needed to stabilize acute symptoms of mental illness. 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.[391]

Dangerous Sex Offender (Sex Offender Commitment Act)

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 their criminal behavior, or 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 their criminal behavior. Neb. Rev. Stat. § 83-174.01.

De Novo

A de novo review means to review anew or afresh; a review where a court weighs the facts of a case and interprets laws and regulations without deference to the previous court's conclusions.

Delusion

A false belief based on incorrect inference about external reality that is firmly held despite what almost everyone else believes and despite what constitutes incontrovertible and obvious proof or evidence to the contrary. DSM-V (2013) at 819.

DSM-V

The Diagnostic and Statistical Manual of Mental Disorders Fifth Edition published by the American Psychiatric Association.[392]

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[388] See SAMHSA's website for more information at https://www.samhsa.gov/find-help/disorders.
[389] Lancaster Mental Health Crisis Center, https://www.lancaster.ne.gov/368/Mental-Health-Crisis-Center.
[390] Service definition from Nebraska Continuum of Care Manual for Mental Health and Substance Use Disorders at 17.
[391] Service definition from Nebraska Continuum of Care Manual for Mental Health and Substance Use Disorders at 21.
[392] https://dsm.psychiatryonline.org/doi/book/10.1176/appi.books.9780890425787

Dysphoria (dysphoric mood)

A condition in which a person experiences intense feelings of depression, discontent, and in some cases indifference to the world around them. DSM-V (2013) at 821.

Developmental Disability (DD)

A group of conditions due to an impairment in physical, learning, language or behavior areas that begin during the developmental period, may impact day-to-day functioning, and usually last throughout a person's lifetime.[393]

Developmental Disability Court-Ordered Commitment Act, the definition is set forth at Neb. Rev. Stat. § 71-1107.

The Developmental Disabilities Services Act, the definition is set forth at Neb. Rev. Stat. § 83-1205.

Developmental Disabilities Court-Ordered Commitment Act, the definition is set forth at Neb. Rev. Stat. § 71-1107.

DHHS/the Department

The Department of Health and Human Services. Neb. Rev. Stat. § 71-804.

Director: the Director of the Division of Behavioral Health. Neb. Rev. Stat. § 71-804.

Division: the Division of Behavioral Health. Neb. Rev. Stat. § 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 Neb. Rev. Stat. § 71-908 or subdivision (1) of Neb. Rev. Stat. § 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

[393] CDC Developmental Disabilities (2022), https://www.cdc.gov/ncbddd/developmentaldisabilities/facts.

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. Neb. Rev. Stat. § 71-919.

Fact finder (finder of fact)

In a civil proceeding, the party (e.g., judge, jury, mental health board) who decides if facts have been proven.

Firearm-related disability

(MHCA) A person is not permitted to (1) purchase, possess, ship, transport, or receive a firearm under either state or federal law, (2) obtain a certificate to purchase, lease, rent, or receive transfer of a handgun under Neb. Rev. Stat. § 69-2404, or (3) obtain a permit to carry a concealed handgun under the Concealed Handgun Permit Act (Neb. Rev. Stat. § 69-2427).

Functional Impairment

Serious limitations an individual has which substantially interfere with or limit functioning in major life activities, as determined through an assessment by qualified personnel pursuant to Title 206 NAC 2-000.

Guardian

Person(s) appointed by the court to make personal decisions for a ward, a person determined to be an incapacitated person or protected person.

Guardian ad litem

1. Generally, a guardian ad litem is an attorney appointed by a court to advocate for the best interests of the minor or incapacitated adult, to provide legal counsel to the minor or incapacitated adult, to provide information to the court about the subject of the action, and to make recommendations for disposition.
2. (Neb. Probate Code) An attorney appointed by the court in a guardianship, conservatorship, or other protective proceeding pursuant to Neb. Rev. Stat. § 30-4201 to 30-4210 to represent the interests of a person who has been alleged to be incapacitated, ward, person to be protected, or minor.
3. (Juvenile Code) An attorney appointed to act as a parent and as legal counsel for a child subject to the jurisdiction of the juvenile court pursuant to Neb. Rev. Stat. § 43-246.01.

Hallucination

A perception-like experience with the clarity and impact of a true perception but without external stimulation of the relevant sensory organ. Hallucinations should be distinguished from illusions, in which an actual external stimulus is misperceived or misinterpreted.

Auditory: a hallucination involving the perception of sound, most commonly of voice.

Somatic: a hallucination involving the perception of physical experience localized within the body (e.g., a feeling of electricity).

Tactile: a hallucination involving the perception of being touched or of something being under one's skin.

Visual: a hallucination involving sight, which may consist of formed images, such as of people, or unformed images, such as flashes of light. DSM-V (2013) at 822-4.

Hearsay

a statement, including an oral or written assertion or nonverbal conduct if it is intended to be an assertion, other than one made by the declarant while testifying during the hearing, which is offered into evidence to prove the truth of the matter asserted. Neb. Rev. Stat. § 27-801.

Health care

Any treatment, procedure, or intervention to diagnose, cure, care for, or treat the effects of disease, injury, and degenerative conditions, including mental health care. Neb. Rev. Stat. § 30-3402(4).

HIPAA (Health Insurance Portability and Accountability Act)

A federal law that requires the creation of national standards to protect sensitive patient health information from being disclosed.

Hypomania

An abnormality of mood resembling mania but of lesser intensity. *See also* **Mania**. DSM-V (2013) at 824.

Incapacitated person (guardianship)

Any person who is impaired by reason of mental illness, mental deficiency, physical illness or disability, chronic use of drugs, chronic intoxication, or other cause (except minority) to the extent that the person lacks sufficient understanding or capacity to make or communicate responsible decisions concerning himself or herself. Neb. Rev. Stat. § 30-2601(1).

See **Capacity** (Advance Mental Health Care Directives Act), **Incapable** (Power of Attorney for Health Care), **Incapacity** (Uniform Power of Attorney Act)

Incapable (Power of Attorney for Health Care)

The inability to understand and appreciate the nature and consequences of health care decisions, including the benefits of, risks of, and alternatives to any proposed health care or the inability to communicate in any manner an informed health care decision. Neb. Rev. Stat. § 30-3402(7).

See **Capacity** (Advance Mental Health Care Directives Act), **Incapacity** (Uniform Power of Attorney Act), **Incapacitated person** (guardianship)

Incapacity (Uniform Power of Attorney Act)

An inability of an individual to manage property or property affairs effectively because the individual has (a) an impairment in the ability to receive and evaluate information or to make or communicate responsible decisions even with the use of technological assistance for reasons such as mental illness, mental deficiency, physical illness or disability, chronic use of drugs, chronic intoxication, or lack of discretion in managing benefits received from public funds, or (b) is missing, detained (including incarcerated in a penal system), or outside of the United States and unable to return. Neb. Rev. Stat. § 30-4002(6).

See **Capacity** (Advance Mental Health Care Directives Act), **Incapable** (Power of Attorney for Health Care), **Incapacitated person** (guardianship)

Incompetency

A term used to describe a deficit in mental capacity. Legally, it is a threshold that may be defined differently, depending on the statutory context and jurisdiction. Clinically, it encompasses the full continuum of functional and decisional incapacities.

Independent mental health professional

A psychiatrist or psychologist with expertise in treating persons with developmental disabilities who has not previously been involved in the treatment of the subject in a significant way. Neb. Rev. Stat. § 71-1108.

Intellectual disability

Significantly subaverage general intellectual functioning which is associated with significant impairments in adaptive functioning manifested before the age of twenty-two years. Significant subaverage general

intellectual functioning shall refer to a score of seventy or below on a properly administered and valid intelligence quotient test. Neb. Rev. Stat. § 71-1108.01.

Intensive Outpatient Services

Services that provide group-based, non-residential, intensive, structured interventions consisting primarily of counseling and psychoeducation about substance related and co-occurring mental health problems.[394]

Least restrictive alternative

1. Constitutional requirement that federal or state government, when curtailing a person's fundamental rights, do so in ways that serve a legitimate governmental purpose and least infringe upon their rights.
2. (Mental Health Commitment Act) For a civil commitment there must be a finding by the mental health board that no other treatment alternatives are 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 to others or the subject described in Neb. Rev. Stat. § 71-908. Neb. Rev. Stat. § 71-921(1).
3. (Developmental Disability Court-Ordered Custody Act) A placement and services provided in a manner no more restrictive of a subject's liberty and no more intrusive than necessary to provide appropriate treatment and protect society. Neb. Rev. Stat. § 71-1109.

Mania

A mental state of elevated, expansive, or irritable mood and persistently increased level of activity or energy. DSM-V (2013) at 824.

Medical Assistance Program

The medical assistance program is established, which shall also be known as Medicaid. Neb. Rev. Stat. § 68-903.

Medicaid

1. The medical assistance program established by the State of Nebraska. Neb. Rev. Stat. § 68-903
2. The federal medical assistance program established in 1972 as Title XIX of the Social Security Act.[395]

Medicare

A federal entitlement program that subsidizes medical services for persons who are age 65 or older and retired, and some recipients of social security disability benefits.

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

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[394] Service definition from Nebraska Continuum of Care Manual for Mental Health and Substance Use Disorders at 175.
[395] Medicaid and CHIP Payment and Access Commission publishes a Reference Guide to Federal Medicaid Statute and Regulations that can be found online at https://www.macpac.gov/reference-materials/reference-guide-to-federal-medicaid-statute-and-regulations/

A board created under Neb. Rev. Stat. § 71-915.

Mental health professional

1. Generally, a person who holds himself or herself out as a person qualifies to engage in mental health practice or a person who offers or renders mental health practice services. *See* Neb. Rev. Stat. § 30-2116 et seq.
2. (Mental Health Commitment Act) 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. Neb. Rev. Stat. § 71-906.

Mentally Ill

1. Generally, a troubling and/or disabling emotional, intellectual, or behavioral condition subject to psychiatric and/or psychological assessment and treatment.
2. (Mental Health Commitment Act) 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. Neb. Rev. Stat. § 71-907.

Mood

A pervasive and sustained emotion that colors the perception of the world. In contrast to affect, which refers to more fluctuating changed in emotional "weather," mood refers to a pervasive and sustained emotional "climate." Types of mood include:

Dysphoric: an unpleasant mood, such as sadness, anxiety, or irritability.

Elevated: an exaggerated feeling of well-being, or euphoria or elation.

Euthymic: a mood within the "normal" range, which implies the absence of depressed or elevated mood.

Expansive: lack of restraint in expressing one's feelings, frequently with an over-valuation of one's significance or importance. DSM-V (2013) at 824-5.

Opioid Treatment Program

The program that provided medical and social services along with outpatient substance use disorder treatment to individuals with severe opioid use disorder.[396]

Outpatient Treatment

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. Neb. Rev. Stat. § 71-909 (Mental Health Commitment Act) & 71-1203(3) (Sex Offender Commitment Act).

Outpatient Individual Therapy

Therapy for the treatment of substance related disorders geared towards enabling the individual to gain insight, reduce maladaptive behaviors related to the disorder, and restore normalized functioning and appropriate interpersonal and social relationships.[397]

[396] Service definition from Nebraska Continuum of Care Manual for Mental Health and Substance Use Disorders at 223.
[397] Service definition from Nebraska Continuum of Care Manual for Mental Health and Substance Use Disorders at 173.

Outpatient Group Therapy

Therapy for the treatment of substance related disorders through scheduled therapeutic visits between the therapist and the individual in the context of a group setting.[398]

Paranoid ideation

Ideation, of less than delusional proportions, involving suspiciousness or the belief that one is being harasses, persecuted, or unfairly treated. DSM-V (2013) at 826.

Paraphilia

1. A condition characterized by abnormal sexual desires.
2. A term denoting "any intense and persistent sexual interest other than sexual interest in genital stimulation or preparatory fondling with phenotypically normal, physical mature, consenting human partners." DSM-V (2013) at 685.

Peace Officer or Law Enforcement Officer

(Mental Health Commitment Act) A sheriff, a jailer, a marshal, a police officer, or an officer of the Nebraska State Patrol. Neb. Rev. Stat. § 71-910.

Personality Disorder

Disorders characterized by impairments in personality functioning and pathological personality traits. DSM-V (2013) at 761.

Personality Functioning

Cognitive models of self and others that shape patterns of emotional and affiliative engagement. DSM-V at 826.

Personality Trait

A tendency to behave, feel, perceive, and think in relatively consistent ways across time and across situations in which the trait may be manifest. DSM-V (2013) at 826.

Person-Centered Care

Services and supports designed around the needs, preferences, and strengths of an individual.

Preponderance of evidence

Evidence which is of greater weight or more convincing than the evidence which is offered in opposition to it; that is, evidence which as a whole shows that the fact sought to be proved is more probable than not.

Power of attorney

(Uniform Power of Attorney Act) A writing or other record that grants authority to an agent to act in the place of the principal, whether or not the term power of attorney is used. Neb. Rev. Stat. § 30-4002(8).

(Power of Attorney for Health Care) a power of attorney executed in accordance with Neb. Rev. Stat. §§ 30-3401 to 30-3432 which authorizes a designated attorney in fact to make health care decisions for the principal when the principal is incapable. Neb. Rev. Stat. § 30-3402(11).

Principal

An adult, someone nineteen years of age or older, who while competent grants authority to an agent to make decisions on their behalf via a power of attorney.

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[398] Service definition from Nebraska Continuum of Care Manual for Mental Health and Substance Use Disorders at 169.

See (Power of Attorney for Health Care) Neb. Rev. Stat. § 30-3402(12), (Uniform Power of Attorney Act) Neb. Rev. Stat. § 30-4002(10).

Psychomotor Agitation

Excessive motor activity associated with a feeling of inner tension. The activity is usually nonproductive and repetitious and consists of behaviors such as pacing, fidgeting, wringing of the hands, pulling of clothes, and inability to sit still. DSM-V (2013) at 827.

Public behavioral health system

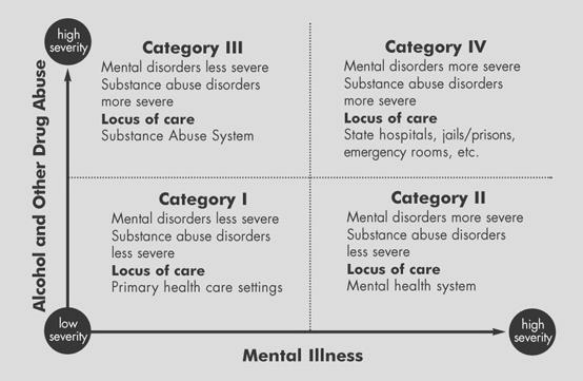
The statewide array of behavioral health services for children and adults provided by the public sector or private sector and supported in whole or in part with funding received and administered by DHHS, including behavioral health services provided under the Medical Assistance Program. Neb. Rev. Stat. § 71-804.

Public Guardian, Office of the

The office established by the Public Guardianship Act, Neb. Rev. Stat. § 30-4104 to 30-4118, to serve as the guardian or conservator for an incapacitated or protected person when no other alternative is available.

Quadrants of Care

Quadrants of Care is a conceptual framework that classifies settings within which clients with Co-Occurring Disorders (COD) are treated. The four quadrants are based on relative symptom severity, rather than by diagnosis (see image to the right).



Recovery

A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential. 206 NAC § 2-000.

Regional Behavioral Health Authority

The regional administrative entity responsible for each behavioral health region. 206 NAC § 1-002.18.

Regional Center

A state hospital for the mentally ill as designated in Neb. Rev. Stat. § 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.

Rehabilitation

Services to promote recovery, full community integration and improved quality of life for persons who have been diagnosed with any mental health, substance use, or co-occurring condition that seriously impairs their ability to lead meaningful lives. 206 NAC § 2-000.

Relapse

1. A deterioration in someone's state of health after a period of improvement.
2. The return to active substance use in a person with a diagnosed substance use disorder.

Remission

The absence of distress or impairment due to a substance use or mental disorder.

Representative Payee

An individual or agency that handles financial matters for an incapacitated person, but only with respect to a specific set of transactions, such as Social Security or Veterans benefits.

Risk Analysis

A comprehensive evaluation of a person's potential for future dangerous behavior towards others, including recommendations to minimize the likelihood of harm to others in the least restrictive alternative. Neb. Rev. Stat. § 71-1112.

Serious mental illness

A phrase used by SAMHSA meaning a diagnosable mental, behavior, or emotional disorder that causes serious functional impairment that substantially interferes with or limits one or more major life activities.

Severe chronic cognitive impairment

Clinically significant difficulties in the ability to remember, think, perceive, apply sound judgment, and adequately use deductive reasoning not attributable to a mental illness. Neb. Rev. Stat. § 71-1113.

Severe Emotional Disturbance (SED)

Severe emotional disturbance diagnosable mental disorder in children and adolescents that is persistent and results in functional impairment in two or more life domains.

Sex Offender

1. Generally, a person who commits a crime involving a sexual act, the definition of which will depend on jurisdiction.
2. (Sex Offender Registration Act) Someone to whom the Sex Offender Registration Act applies pursuant to Neb. Rev. Stat. § 29-4003.

See **Dangerous Sex Offender**.

Subject

1. (Mental Health Commitment Act) Any person concerning whom a certificate or petition has been filed under the Nebraska Mental Health Commitment Act who is at least eighteen years of age or an emancipated minor. Neb. Rev. Stat. § 71-912.
2. (Sex Offender Commitment Act) Any person concerning whom (a) a certificate has been filed under Neb. Rev. Stat. § 71-1204, (b) a certificate has been filed under Neb. Rev. Stat. § 71-919 and such person is held pursuant to subdivision (2)(b) of Neb. Rev. Stat. § 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. Neb. Rev. Stat. § 71-1203(4).
3. (Developmental Disability Commitment Act) a person who is named in a petition filed under the Developmental Disabilities Court-Ordered Custody Act. Neb. Rev. Stat. § 71-1114.

Substance Dependent

(Mental Health Commitment Act) 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. Neb. Rev. Stat. § 71-913.

Substance/Medication-Induced Disorders

Substance/Medication-induced mental disorders are potentially severe, usually temporary, but sometimes persisting central nervous system syndromes that develop in the context of the effects of substances of abuse, medications, or several toxins. DSM-V at 487.

Substance use disorders

A phrase by SAMHSA that means when the recurrent use of alcohol and/or drugs causes clinically significant impairment, including health problems, disability, and failure to meet major responsibilities at work, school, or home.

Surrogate

A natural person who is authorized under the Health Care Surrogacy Act, Neb. Rev. Stat. § 30-604, to make a health care decision on behalf of an individual when a guardian or an agent under a power of attorney for health care has not been appointed or otherwise designated for such individual. Neb. Rev. Stat. § 30-603.

Psychomotor Agitation

Excessive motor activity associated with a feeling of inner tension. The activity is usually nonproductive and repetitious and consists of behaviors such as pacing, fidgeting, wringing of the hands, pulling of clothes, and inability to sit still. DSM-V at 827.

Threat of harm to others

(Developmental Disability Commitment Act) A 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; or, by the use of an explosive, having damaged or destroyed property, put another person at risk of harm, or injured another person. Neb. Rev. Stat. § 71-1115.

Trauma-Informed Services

Services that are informed about, and sensitive to, trauma-related issues present in survivors; but they need not be specifically designed to treat symptoms or syndromes related to sexual or physical abuse or other trauma. Trauma-informed services are designed to include a basic understanding of how trauma impacts the life of an individual seeking services. 206 NAC 1-002.20.

Treatment

1. (Developmental Disability Commitment Act) Support and services which will assist a subject to acquire the skills and behaviors needed to function in society so that the subject does not pose a threat of harm to others and is able to cope with his or her personal needs and the demands of his or her environment. Neb. Rev. Stat. § 71-1116.

Treatment Facility

1. (Mental Health Commitment Act) A facility which is licensed to provide services for persons who are mentally ill or substance dependent, or both. Neb. Rev. Stat. § 71-914.
2. (Sex Offender Commitment Act) A facility which provides services for persons who are dangerous sex offenders. Neb. Rev. Stat. § 71-1203(5).

Ward

A person for whom a guardian has been appointed. Neb. Rev. Stat. § 30-2601(4).

Withdrawal

A syndrome that occurs when blood or tissue concentrations of a substance decline in an individual who had maintained prolonged heavy use of the substance. DSM-V at 484.

APPENDIX I: NEBRASKA STATUTES & REGULATIONS

A. Mental Health Commitment Act, Index
Neb. Rev. Stat. §§ 71-901 to 71-963

You can find the current MHCA online at https://nebraskalegislature.gov/laws/browse-chapters.php?chapter=71.

71-901. Act, how cited.

71-902. Declaration of purpose.

71-903. Definitions, where found.

71-904. Administrator, defined.

71-904.01. Firearm-related disability, defined.

71-905. Mental health board, defined.

71-906. Mental health professional, defined.

71-907. Mentally ill, defined.

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

71-909. Outpatient treatment, defined.

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

71-911. Regional center, defined.

71-912. Subject, defined.

71-913. Substance dependent, defined.

71-914. Treatment facility, defined.

71-915. Mental health boards; created; powers; duties; compensation.

71-916. Mental health board; training; department; duties.

71-917. Clerk of the district court; duties relating to mental health board.

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

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

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

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

71-922. Mental health board proceedings; commencement; custody; conditions; dismissal; when.

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

71-924. Hearing; mental health board; duties.

71-925. Burden of proof; mental health board; hearing; orders authorized; conditions; rehearing.

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

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

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

71-929. Mental health board; execution of warrants; costs; procedure.

71-930. Treatment order of mental health board; appeal; final order of district court; appeal.

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

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

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

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

71-935. Mental health board; review hearing; order discharge or change treatment disposition; when.

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

71-937. Mental health board; notice of release; hearing.

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

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

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

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

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

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

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

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

71-946. Appointment of counsel; procedure.

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

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

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

71-950. Continuances; liberally granted.

71-951. Mental health board hearings; closed to public; exception; where conducted.

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

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

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

71-955. Hearings; rules of evidence applicable.

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

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

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

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

71-960. Subject; waive rights; manner.

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

71-962. Violations; penalty.

71-963. Firearm-related disabilities; petition to remove; mental health board; review hearing; evidence; decision; appeal; petition granted; effect.

B. Nebraska Evidence Rules, Index
Neb. Rev. Stat. §§ 27-101 to 27-1301

The full rules can be found online at: https://nebraskalegislature.gov/laws/browse-chapters.php?chapter=27

27-101. Rule 101. Scope.

27-102. Rule 102. Purpose and construction.

27-103. Rule 103. Rulings on evidence; effect of erroneous ruling; objection; offer of proof; record of offer and ruling; hearing of jury; plain error.

27-104. Rule 104. Preliminary questions; questions of admissibility, generally; relevancy conditioned on fact; hearing of jury; testimony by accused; weight and credibility.

27-105. Rule 105. Limited admissibility.

27-106. Rule 106. Remainder of or related writings or recorded statements; action of judge.

27-201. Rule 201. Judicial notice of adjudicative facts; kinds of facts; when discretionary; when mandatory; opportunity to be heard; time of taking notice; instructing jury.

27-301. Rule 301. Presumptions in general.

27-302. Rule 302. Applicability of federal law in civil cases.

27-303. Rule 303. Presumptions in criminal cases; scope; submission to jury; instruction to jury.

27-401. Rule 401. Relevant evidence, defined.

27-402. Rule 402. Relevant evidence admissible; exceptions; irrelevant evidence inadmissible.

27-403. Rule 403. Exclusion of relevant evidence; reasons.

27-404. Rule 404. Character evidence; not admissible to prove conduct; exceptions; evidence of other crimes, wrongs, or acts; standard of proof; sexual assault; provisions applicable.

27-405. Rule 405. Method of proving character; reputation or opinion; specific instances of conduct.

27-406. Rule 406. Habit; routine practice; admissibility; method of proof.

27-407. Rule 407. Subsequent remedial measures.

27-408. Rule 408. Compromise and offers to compromise.

27-409. Rule 409. Payment of medical and similar expenses.

27-410. Rule 410. Guilty plea; nolo contendere; offered plea; withdrawn plea; inadmissible; exceptions.

27-411. Rule 411. Liability insurance.

27-412. Sex offense cases; relevance of alleged victim's past sexual behavior or alleged sexual predisposition; evidence of victim's consent; when not admissible.

27-413. Offense of sexual assault, defined.

27-414. Criminal use; evidence of similar crimes in sexual assault cases.

27-415. Civil case; evidence of crimes in sexual assault cases.

27-501. Rule 501. Privileges recognized only as provided.

27-502. Omitted.

27-503. Rule 503. Lawyer-client privilege; definitions; general rule of privilege; who may claim privilege; exceptions to the privilege.

27-504. Rule 504. Physician-patient privilege; professional counselor-client privilege; definitions; general rule of privilege; who may claim privilege; exceptions to the privilege.

27-505. Rule 505. Husband-wife privilege; general rule of privilege; definitions; waiver; criminal cases; exceptions to the privilege.

27-506. Rule 506. Communications to clergyman; definitions; general rule of privilege; who may claim privilege.

27-507. Rule 507. Political vote; privilege.

27-508. Rule 508. Trade secrets; privilege; protective measures.

27-509. Rule 509. Secrets of state and other official information; general rule of privilege; who may claim privilege; procedure; effect of sustaining claim.

27-510. Rule 510. Identity of informer; rule of privilege; who may claim; exceptions; informer appearing as a witness; procedure; orders; legality of obtaining evidence.

27-511. Rule 511. Waiver of privilege by voluntary disclosure.

27-512. Rule 512. Privileged matter disclosed under compulsion or without opportunity to claim privilege.

27-513. Rule 513. Comment on or inference from claim of privilege improper; jury instruction.

27-601. Rule 601. General rule of competency.

27-602. Rule 602. Lack of personal knowledge; witness may not testify; evidence.

27-603. Rule 603. Oath or affirmation.

27-604. Rule 604. Interpreters.

27-605. Rule 605. Competency of judge as witness.

27-606. Rule 606. Competency of juror as witness; at the trial; inquiry into the validity of verdict or indictment.

27-607. Rule 607. Who may impeach.

27-608. Rule 608. Evidence of character and conduct of witness; opinion and reputation evidence of character; specific instances of conduct; privilege against self-incrimination.

27-609. Rule 609. Impeachment by evidence of conviction of crime; general rule; time limit; effect of pardon, annulment, or equivalent procedure; juvenile adjudications; pendency of appeal.

27-610. Rule 610. Religious beliefs or opinions.

27-611. Rule 611. Mode and order of interrogation and presentation; control by judge; scope of cross-examination; leading questions.

27-612. Rule 612. Writing used to refresh memory; rights of adverse party; matters unrelated; preservation for appeal; orders.

27-613. Rule 613. Prior statements of witnesses; examining witness concerning prior statement; extrinsic evidence of prior inconsistent statement by witness.

27-614. Rule 614. Calling and interrogation of witnesses by judge; objections.

27-615. Rule 615. Exclusion of witnesses; exceptions.

27-701. Rule 701. Opinion testimony by lay witnesses; when.

27-702. Rule 702. Testimony by experts; when.

27-703. Rule 703. Bases of opinion testimony by experts; when revealed; admissibility.

27-704. Rule 704. Opinion on ultimate issue.

27-705. Rule 705. Disclosure of facts or data underlying expert opinion.

27-706. Rule 706. Judge appointed experts; procedure; compensation; disclosure of appointment; parties may call experts of own selection.

27-707. Eyewitness identification and memory; expert witness; admissibility of testimony.

27-801. Rule 801. Definitions; statement, declarant, hearsay; statements which are not hearsay.

27-802. Rule 802. Hearsay rule.

27-803. Rule 803. Hearsay exceptions; enumerated; availability of declarant immaterial.

27-804. Rule 804. Hearsay exceptions; enumerated; declarant unavailable; unavailability, defined.

27-805. Rule 805. Hearsay within hearsay.

27-806. Rule 806. Attacking and supporting credibility of declarant; opportunity to explain; examine declarant.

27-901. Rule 901. Requirement of authentication or identification; general provision; illustrations and examples; enumerated.

27-902. Rule 902. Self-authentication; when.

27-903. Rule 903. Subscribing witness testimony; when necessary.

27-1001. Rule 1001. Definitions; writings and recordings, photographs, original, and duplicate.

27-1002. Rule 1002. Requirement of original; exception.

27-1003. Rule 1003. Admissibility of duplicate; when.

27-1004. Rule 1004. Admissibility of other evidence of contents; when.

27-1005. Rule 1005. Public records; contents, how proved.

27-1006. Rule 1006. Voluminous writings, recordings, or photographs; summaries; availability; orders.

27-1007. Rule 1007. Contents of writings, recordings, or photographs; how proved.

27-1008. Rule 1008. Functions of judge and jury.

27-1101. Rule 1101. Applicability of rules; courts; proceedings generally; rules inapplicable; grand jury, miscellaneous proceedings; rules applicable in part.

27-1102. Rule 1102. Act, when effective.

27-1103. Rule 1103. Act, how cited.

27-1201. Unanticipated outcome of medical care; civil action; health care provider or employee; use of certain statements and conduct; limitations.

27-1301. Evidence of visual depiction of sexually explicit conduct; restrictions on care, custody, and control; Supreme Court; duties.

C. Developmental Disabilities Court-Ordered Custody, Index
Neb. Rev. Stat. §§ 71-1101 to 71-1134

You can find the following statutes online at https://nebraskalegislature.gov/laws/browse-chapters.php?chapter=71.

71-1101. Act, how cited.

71-1102. Public policy.

71-1103. Purpose of act.

71-1104. Definitions, where found.

71-1105. Court, defined.

71-1106. Department, defined.

71-1107. Developmental disability, defined.

71-1108. Independent mental health professional, defined.

71-1108.01. Intellectual disability, defined.

71-1109. Least restrictive alternative, defined.

71-1110. Transferred to section 71-1108.01.

71-1111. Petitioner, defined.

71-1112. Risk analysis, defined.

71-1113. Repealed. Laws 2017, LB333, § 14.

71-1114. Subject, defined.

71-1115. Threat of harm to others, defined.

71-1116. Treatment, defined.

71-1117. Petition; where filed; contents; evidentiary rules; applicability.

71-1118. Subject; rights.

71-1119. Emergency custody; application; court order; evaluation by department.

71-1120. Emergency custody order; expedited hearing.

71-1121. Petition and summons; service.

71-1122. Petition; hearing; procedure; representation by legal counsel.

71-1123. Subject; response to petition.

71-1124. Burden of proof; court findings; dispositional hearing; when required.

71-1125. Departmental plan; contents.

71-1126. Dispositional hearing; considerations; court order.

71-1127. Court-ordered custody and treatment; annual review hearings; procedure.

71-1128. Review hearing; when authorized; notice.

71-1129. Jurisdiction of court.

71-1130. Findings under act; effect.

71-1131. Costs; payment; public defender; appointment.

71-1132. Treatment needs of subject; rights of subject or subject's guardian.

71-1133. Juvenile; when subject to act.

71-1134. Reports.

D. Sex Offender Commitment Act, Index
Neb. Rev. Stat. §§ 71-1201 to 71-1226

You can find the current SOCA statutes online at https://nebraskalegislature.gov/laws/browse-chapters.php?chapter=71.

71-1220. Regional center or treatment facility; administrator; discharge of involuntary patient; notice.

71-1221. Mental health board; notice of release; hearing.

71-1222. Mental health board; person released from treatment; compliance with conditions of release; conduct hearing; make determination.

71-1223. Escape from treatment facility or program; notification required; contents; warrant; execution; peace officer; powers.

71-1224. Rights of subjects.

71-1225. Mental health board hearings; closed to public; exception; where conducted.

71-1226. Hearings; rules of evidence applicable.

E. Behavioral Health Services Regulations, Index

The Division of Behavioral Health's Title 202 Regulations can be found online at: https://dhhs.ne.gov/Pages/Title-202.aspx

TITLE 202. Operations within Facilities and Community-Based Services for Persons with Mental Illness or Developmental Disabilities

Chapter 1. Determining Ability to Pay for Supports and Services Funded by the Nebraska Department of Health and Human Services

The Division of Behavioral Health's Title 206 Regulations can be found online at: https://dhhs.ne.gov/Pages/Title-206.aspx

TITLE 206. Behavioral Health Services

Chapter 1. Scope and Definitions

Chapter 2. Administration

Chapter 3. Contracting Requirements for Regional Behavioral Health Authorities

Chapter 4. Requirements for Providers Contracting with Regional Behavioral Health Authorities

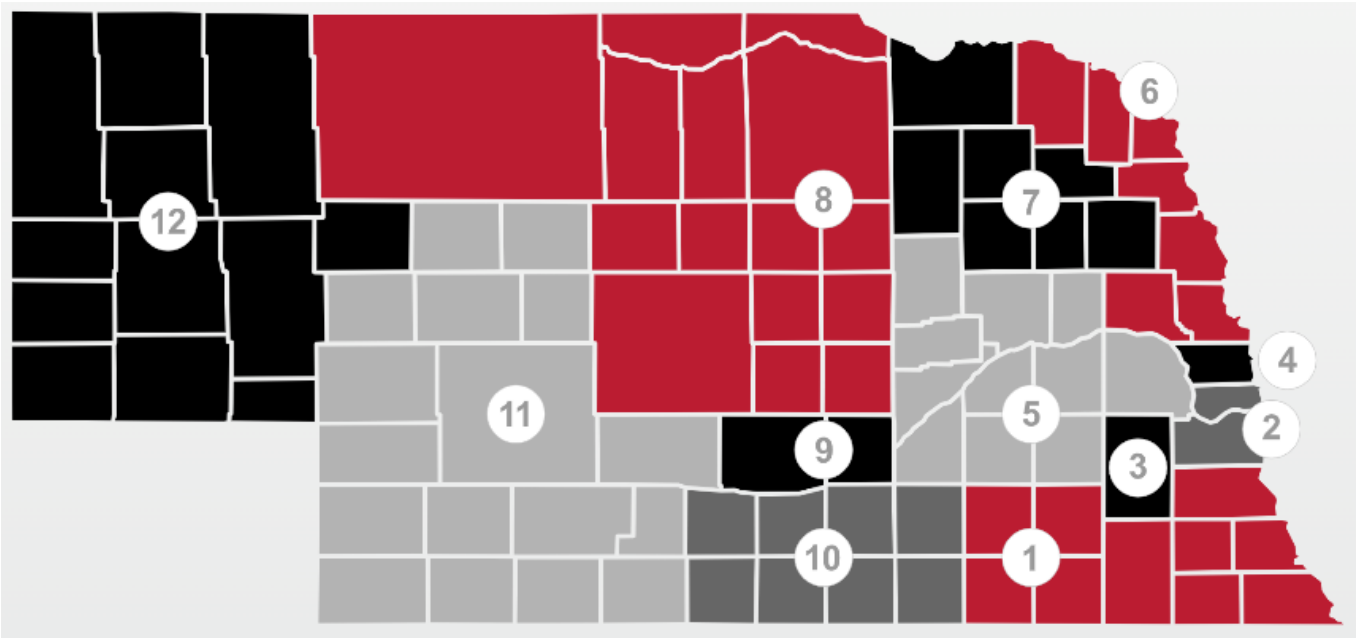
Chapter 5. Consumer Eligibility

Chapter 6. Mental Health Board Training

Chapter 7. Peer Support

APPENDIX II: MAPS

A. Map of Nebraska Judicial Districts



The above map is current as of 6/2022. Click on the map to visit the Nebraska Judicial Branch website. The map reflects District Court Judicial Districts and Probation Districts. The composition of Judicial Districts 1, 2, and 10 differ between District and County Courts.

List of Counties by Judicial District:

(District links will take you to webpage with county contact information)

District 1:
- Fillmore
- Gage
- Jefferson
- Johnson
- Nemaha
- Otoe
- Pawnee
- Richardson
- Saline
- Thayer

District 2:
- Cass
- Sarpy

District 3:
- Lancaster

District 4:
- Douglas

District 5:
- Boone
- Butler
- Colfax
- Hamilton
- Merrick
- Nance
- Platte
- Polk
- Saunders
- Seward
- York

District 6:
- Burt
- Cedar
- Dakota
- Dixon
- Dodge
- Thurston
- Washington

District 7:
- Antelope
- Cuming
- Knox
- Madison
- Pierce
- Stanton
- Wayne

District 8:
- Blaine
- Boyd
- Brown
- Cherry
- Custer
- Garfield
- Greeley
- Holt
- Howard
- Keya Paha
- Loup
- Rock
- Sherman
- Valley
- Wheeler

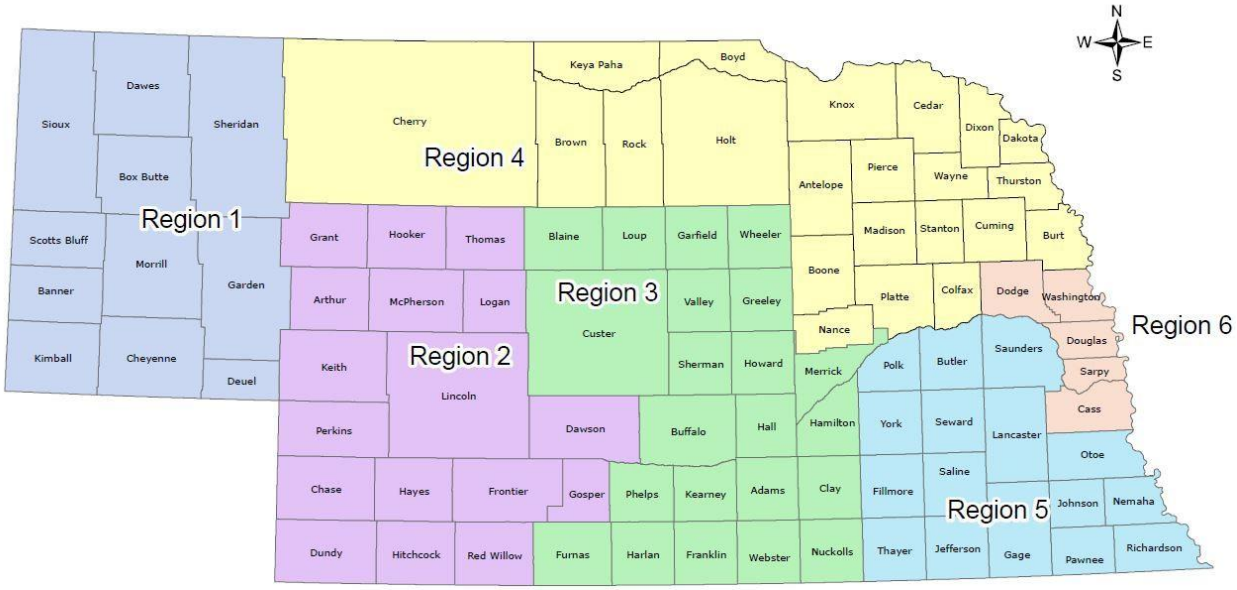
District 9:
- Buffalo
- Hall

District 10:
- Adams
- Clay
- Franklin
- Harlan
- Kearney
- Nuckolls
- Phelps
- Webster

District 11:
- Arthur
- Chase
- Dawson
- Dundy
- Frontier
- Furnas
- Gosper
- Hayes
- Hitchcock
- Hooker
- Keith
- Lincoln
- Logan
- McPherson
- Perkins
- Red Willow
- Thomas

District 12:
- Banner
- Box Butte
- Cheyenne
- Dawes
- Deuel
- Garden
- Grant
- Kimball
- Morrill
- Scotts Bluff
- Sheridan
- Sioux

B. Map of Nebraska Behavioral Health Regions



Mental Health Regions Contact Information:

	Phone Number	**Website**
Region 1	(308) 635-3173	www.region1bhs.net/
Region 2	(308) 534-0440	www.r2hs.com
Region 3	(308) 237-5113	www.Region3.net
Region 4	(402) 370-3100	www.region4bhs.org
Region 5	(402) 441-4343	www.region5systems.net
Region 6	(402) 444-6573	www.regionsix.com

List of Counties by Behavioral Health Regions

Region 1:

- Banner
- Box Butte
- Cheyenne
- Deuel
- Dawes
- Garden
- Kimball
- Morrill
- Scotts Bluff
- Sheridan
- Sioux

Region 2:

- Arthur
- Chase
- Dawson
- Dundy
- Frontier
- Gosper
- Grant
- Hayes
- Hitchcock
- Hooker
- Keith
- Lincoln
- Logan
- McPherson
- Perkins
- Red Willow
- Thomas

Region 3:

- Adams
- Blaine
- Buffalo
- Clay
- Custer
- Franklin
- Furnas
- Garfield
- Greeley
- Hall
- Hamilton
- Harlan
- Howard
- Kearney
- Loup
- Merrick
- Nuckolls
- Phelps
- Sherman
- Valley
- Webster
- Wheeler

Region 4:

- Antelope
- Boone
- Boyd
- Brown
- Burt
- Cedar
- Cherry
- Colfax
- Cuming
- Dakota
- Dixon
- Holt
- Keya Paha
- Knox
- Madison
- Nance
- Pierce
- Platte
- Rock
- Stanton
- Thurston
- Wayne

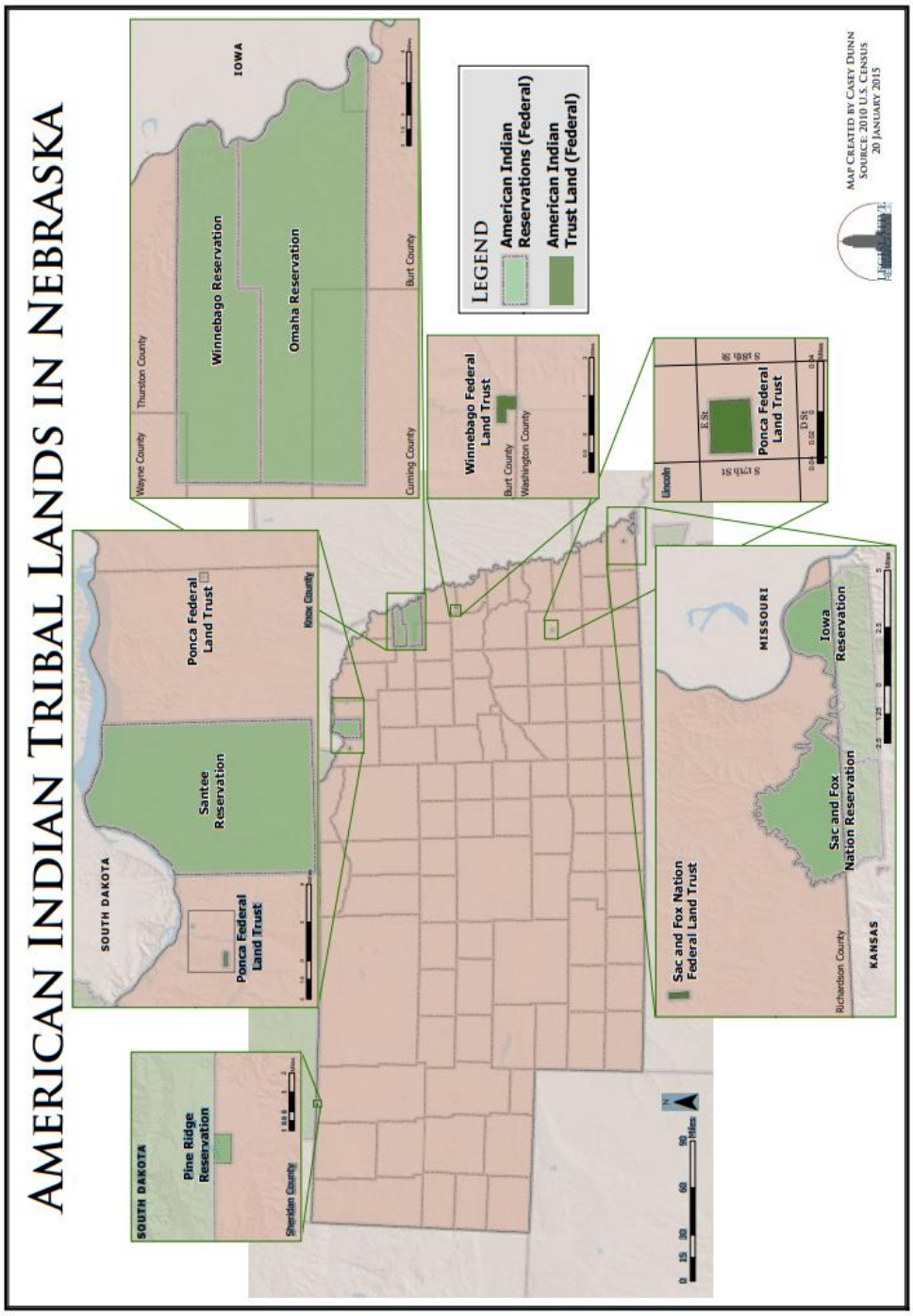
Region 5:

- Butler
- Fillmore
- Gage
- Jefferson
- Johnson
- Lancaster
- Nemaha
- Otoe
- Pawnee
- Polk
- Richardson
- Saline
- Saunders
- Seward
- Thayer
- York

Region 6:

- Cass
- Dodge
- Douglas
- Sarpy
- Washington

C. Map of Native American Reservations in Nebraska



APPENDIX III: FORMS

A. Power of Attorney

This form is available online at https://supremecourt.nebraska.gov/sites/default/files/DC-6-12-fillin.pdf

Nebraska Power of Attorney

DESIGNATION OF AGENT

I _____ (*your name*) name the following person as my agent (individual with power of attorney):

Agent: _____

Address: _____

Telephone Number: _____

DESIGNATION OF SUCCESSOR AGENT(S) (*OPTIONAL*)

If my agent is unable or unwilling to act for me, I name as my successor agent:

Name of Successor Agent: _____

Address: _____

Telephone Number: _____

If my successor agent is unable or unwilling to act for me, I name as my second successor agent (*OPTIONAL*):

Name of Second Successor Agent: _____

Address: _____

Telephone Number: _____

RELEASE OF INFORMATION

I agree to, authorize, and allow full release of information, by any governmental agency, business, creditor, or third party who may have information pertaining to my assets or income, to my agent named on this form.

GRANT OF GENERAL AUTHORITY

I grant my agent and any successor agent general authority to act for me with respect to the following subjects (as defined in the Nebraska Uniform Power of Attorney Act):

(*CHECK* ☐ *Yes* ***or*** ☐ *No* ***AND*** *initial for each of the subjects that follow. These subjects represent those you may want to include in the agent's general authority. If you wish to grant general authority over all of the subjects you may check* ☐ *Yes for "All Preceding Subjects" AND initial that line instead of checking each subject.*)

Power of Attorney, DC 6:12 PSC, Rev. 07/19 § 30-4041 Page 1 of 4

Check one: Initials:

☐ Yes ☐ No _____ Real Property

☐ Yes ☐ No _____ Tangible Personal Property

☐ Yes ☐ No _____ Stocks and Bonds

☐ Yes ☐ No _____ Commodities and Options

☐ Yes ☐ No _____ Banks and Other Financial Institutions

☐ Yes ☐ No _____ Operation of Entity or Business

☐ Yes ☐ No _____ Insurance and Annuities

☐ Yes ☐ No _____ Estates, Trusts, and Other Beneficial Interests

☐ Yes ☐ No _____ Claims and Litigation

☐ Yes ☐ No _____ Personal and Family Maintenance

☐ Yes ☐ No _____ Benefits from Governmental Programs or Civil or Military Service

☐ Yes ☐ No _____ Retirement Plans

☐ Yes ☐ No _____ Taxes

☐ Yes ☐ No _____ All Preceding Subjects (includes all items listed above)

GRANT OF SPECIFIC AUTHORITY (*OPTIONAL*)

My agent **MAY** do any of the following specific acts for me IF I have CHECKED the specific authority listed below:

(*CAUTION: Granting any of the following will give your agent the authority to take actions that could significantly reduce your property or change how your property is distributed at your death.* ***CHECK YES AND INTIAL ONLY the specific authority you WANT to give your agent. NOTE: If you do not mark yes and initial the authority, the authority is not granted.***)

Check one: Initials:

☐ Yes ☐ No _____ Create, amend, revoke, or terminate an inter vivos trust

☐ Yes ☐ No _____ Make a gift, subject to the limitations of the Nebraska Uniform Power of Attorney Act and any special instructions in this power of attorney

☐ Yes ☐ No _____ Create or change rights of survivorship

☐ Yes ☐ No _____ Create or change a beneficiary designation

☐ Yes ☐ No _____ Delegate to another person to exercise the authority granted under this power of attorney

☐ Yes ☐ No _____ Waive the principal's right to be a beneficiary of a joint and survivor annuity, including a survivor benefit under a retirement plan

☐ Yes ☐ No _____ Exercise fiduciary powers that the principal has authority to delegate

☐ Yes ☐ No _____ Renounce or disclaim an interest in property, including a power of appointment.

LIMITATION ON AGENT'S AUTHORITY

If I did not check the "Power of Personal and Family Maintenance" or the "All Preceding Subjects" in the Grant of General Authority above, my agent MAY NOT use my property to benefit themselves or anyone they support except for those items listed below in the Special Instructions.

SPECIAL INSTRUCTIONS (*OPTIONAL*)

You may give special instructions in the following space:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

NOMINATION OF [CONSERVATOR OR GUARDIAN] (*OPTIONAL*)

If it becomes necessary for a court to appoint a conservator of my estate, I nominate the following person(s) for appointment:

Name of nominee for conservator of my estate: _____

Address: _____

Telephone Number: _____

If it becomes necessary for a court to appoint a guardian of my person, I nominate the following person(s) for appointment:

Name of nominee for guardian of my person: _____

Address: _____

Telephone Number: _____

RELIANCE ON THIS POWER OF ATTORNEY

Any person, including my agent, may rely upon the validity of this power of attorney or a copy of it unless that person knows it has terminated or is invalid.

EFFECTIVE DATE: This power of attorney is effective immediately unless I have stated otherwise in the special Instructions.

TERMINATION: I understand this power of attorney ends immediately upon my death.

SIGNATURE AND ACKNOWLEDGMENT

(CAUTION: This document MUST be signed IN THE PRESENCE of a notary to comply with the Nebraska Uniform Power of Attorney Act)

_____ _____

Your Signature Date

_____

Your Name Printed

_____

_____

Your Address

_____

Your Telephone Number

NOTARY

State of Nebraska)
) ss.
[County] of _____)

This document was acknowledged before me on _____
(Date)

by _____.
(Name of Principal)

_____ (Seal, if any)
Signature of Notary

My commission expires: _____

B. Power of Attorney for Health Care

This form is available online at https://supremecourt.nebraska.gov/sites/default/files/DC-6-13-fillin16.pdf

Nebraska Power of Attorney

Health Care

POWER OF ATTORNEY FOR HEALTH CARE

I, _____(your name) name the following person as my attorney in fact for health care:

Name: _____

Address: _____

Phone Number: _____

SUCCESSOR TO POWER OF ATTORNEY FOR HEALTH CARE

If my agent (above) is unwilling or unable to act, I appoint the following person as my successor power of attorney for health care:

Name: _____

Address: _____

Phone number: _____

By initialing the below, I acknowledge that I have read and understand each statement and the consequences of executing a power of attorney for health care.

____ I authorize my attorney in fact for health care appointed by this document to make health care decisions for me when I am determined to be incapable of making my own health care decisions

____ I direct that my attorney in fact for health care comply with the following instructions or limitations:

_____

_____

_____

_____

Power of Attorney, DC 6:13 PSC, Rev. 03/16 § 30-3408

Page 1 of 3

____ I direct that my attorney in fact for health care comply with the following instructions on life-sustaining treatment: (*optional*)
limitations:

_____
_____
_____
_____

____ I direct that my attorney in fact for health care comply with the following instructions on artificially administered nutrition and hydration: (*optional*)

_____
_____
_____
_____

____ **I have read this power of attorney for health care. I understand that it allows another person to make life and death decisions for me if I am incapable of making such decisions. I also understand that I can revoke this power of attorney for health care at any time by notifying my attorney in fact for health care, my physician, or the facility in which I am a patient or resident. I also understand that I can require in this power of attorney for health care that the fact of my incapacity in the future be confirmed by a second physician.**

____ **I have read the above warning which accompanies this document and understand the consequences of executing a power of attorney for health care.**

_____ _____

Signature of person making designation *Date*

Do not sign this form until you are in the presence of either the two witnesses or a notary.

DECLARATION OF WITNESSES

We declare that the individual signing this power of attorney for health care is personally known to us, has signed or acknowledged his or her signature on this power of attorney for health care in our presence, and appears to be of sound mind and not under duress or undue influence. Furthermore, neither of us, nor the principal's attending physician, is the person appointed as attorney in fact for health care by this document.

Witnessed By:

_____ _____

(Signature of Witness/Date) (Printed Name of Witness)

_____ _____

(Signature of Witness/Date) (Printed Name of Witness)

OR

NOTARY

State of Nebraska)
) ss.
[County] of _____)

This document was acknowledged before me on _____
(Date)

by _____.
(Name of Principal)

_____ (Seal, if any)
Signature of Notary

My commission expires: _____

C. Advance Mental Health Care Directive

Statutory form provided by Neb. Rev. Stat. § 30-4415 (reformatted).

ADVANCE MENTAL HEALTH CARE DIRECTIVE

I _____, being an adult nineteen years of age or older and of sound mind, freely and voluntarily make this directive for mental health care to be followed if it is determined that my ability to receive and evaluate information effectively or communicate decisions is impaired to such an extent that I lack the capacity to refuse or consent to mental health care. "Mental health care" includes, but is not limited to, treatment of mental illness with psychotropic medication, admission to and retention in a treatment facility for a period up to 21 days, or electroconvulsive therapy.

I understand that I may become incapable of giving or withholding informed consent for mental health care due to the symptoms of a diagnosed mental disorder. These symptoms may include, but not be limited to:

_____

PSYCHOTROPIC MEDICATIONS

If I become incapable of giving or withholding informed consent for mental health care, my wishes regarding psychotropic medications, including classes of medications if appropriate, are as follows (check one or both of the following, if applicable):

☐ I consent to the administration of the following medications:

_____

☐ I do not consent to the administration of the following medications:

_____

Conditions or limitations, if any:

_____

ADMISSION TO AND RETENTION IN FACILITY

If I become incapable of giving or withholding informed consent for mental health care, my wishes regarding admission to and retention in a health care facility for mental health care are as follows (check one of the following, if applicable):

☐ I consent to being admitted to a treatment facility for mental health care.

☐ I do not consent to being admitted to a treatment facility for mental health care.

This directive cannot, by law, provide consent to retain me in a treatment facility for more than 21 days.

Conditions or limitations, if any:

_____

ELECTROCONVULSIVE THERAPY

If I become incapable of giving or withholding informed consent for mental health care, my wishes regarding electroconvulsive therapy are as follows (check one of the following, if applicable):

☐ I consent to the administration of electroconvulsive therapy.

☐ I do not consent to the administration of electroconvulsive therapy.

Conditions or limitations, if any:

_____

DESIGNATION OF IRREVOCABILITY DURING INCAPACITY

If I become incapable of giving or withholding informed consent for mental health care, my advance mental health care directive remains irrevocable during such period of incapacity:

☐ Yes

☐ No

If yes, the directive is irrevocable during such period of incapacity with regard to:

☐ Admission and retention in a treatment facility for mental health care for up to 21 days;

☐ Psychotropic medication as follows: _____;

☐ Electroconvulsive therapy; or

☐ All of the above.

If there is anything in this document that you do not understand, you should ask a lawyer to explain it to you. This directive will not be valid unless it is signed in the presence of a notary public or signed by two qualified witnesses who are either personally known to you or verify your identity and who are present when you sign or acknowledge your signature.

SELECTION OF PHYSICIAN (OPTIONAL)

If it becomes necessary to determine if I have become incapable of giving or withholding informed consent for mental health care, I choose _____ of _____ (address of licensed physician) to be one of the two licensed physicians who will determine whether I am incapable. If that licensed physician is unavailable, that physician's designee shall serve as one of the two licensed physicians who will determine whether I am incapable.

ADDITIONAL REFERENCES OR INSTRUCTIONS

_____

Conditions or limitations, if any:

_____

This document will continue in effect until you revoke it as described below or until a date you designate in this document. If you wish to have this document terminate on a certain date, please indicate:

_____
(Date of expiration of directive)

_____
(Signature of Principal)

_____
(Printed Name of Principal)

_____
(Date signed)

THIS DOCUMENT MUST BE SIGNED IN THE PRESENCE OF WITNESSES OR SIGNED IN THE PRESENCE OF A NOTARY PUBLIC. COMPLETE THE APPROPRIATE PORTION WHICH FOLLOWS:

AFFIRMATION OF WITNESSES

We affirm that the principal is personally known to us or the principal presented identification, that the principal signed this advance mental health care directive in our presence or, if the principal was unable to sign the directive, the principal's designated representative signed the directive in our presence, that the principal did not appear to be incapacitated or under duress or undue influence, and that neither of us is:

(a) The principal's attending physician or a member of the principal's mental health treatment team;

(b) The principal's spouse, parent, child, grandchild, sibling, presumptive heir, or known devisee at the time of the witnessing;

(c) In a romantic or dating relationship with the principal;

(d) The attorney in fact of the principal or a person designated to make mental health care decisions for the principal; or

(e) The owner, operator, employee, or relative of an owner or operator of a treatment facility at which the principal is receiving care.

Witnessed By:

_____
(Signature of Witness)

_____
(Printed Name of Witness)

_____
(Date)

_____
(Signature of Witness)

_____
(Printed Name of Witness)

_____
(Date)

OR COMPLETE THE FOLLOWING PORTION IF THIS DOCUMENT IS SIGNED IN THE PRESENCE OF A NOTARY PUBLIC

State of Nebraska,)
) ss.
County of _____)

On this _____ day of _____, 20____, before me, _____, a notary public in and for _____ County, personally came _____, personally to me known to be the identical person whose name is affixed to the above advance mental health care directive as principal, and I declare that such person appears in sound mind and not under duress or undue influence, that such person acknowledges the execution of the same to be such person's voluntary act and deed, and that I am not the attorney in fact of the principal designated by any power of attorney for health care.

Witness my hand and notarial seal at _____ in such county the day and year last above written.

_____

Seal Signature of Notary Public

NOTICE TO PERSON MAKING AN ADVANCE MENTAL HEALTH CARE DIRECTIVE

This is an important legal document. It creates an advance mental health care directive. Before signing this document, you should know these important facts:

This document allows you to make decisions in advance about mental health care, including administration of psychotropic medication, short-term (up to 21 days) admission to a treatment facility, and use of electroconvulsive therapy. The instructions that you include in this advance mental health care directive will be followed only if you are incapable of making treatment decisions. Otherwise, you will be considered capable to give or withhold consent for the treatments.

If you have an attorney in fact appointed under a power of attorney for health care, your attorney in fact has a duty to act consistent with your desires as stated in this document or, if your desires are not stated or otherwise made known to the attorney in fact, to act in a manner consistent with what your attorney in fact in good faith believes to be in your best interest. The person has the right to withdraw from acting as your attorney in fact at any time.

You have the right to revoke this document in whole or in part at any time you have been determined to be capable of giving or withholding informed consent for mental health care. A revocation is effective when it is communicated to your attending health care professional in writing and is signed by you. The revocation may be in a form similar to the following:

REVOCATION

I, _____, knowingly and voluntarily revoke my advance mental health care directive as indicated (check one of the following):

□ I revoke my entire directive.

□ I revoke the following portion or portions of my directive: _____

_____

_____ _____

(Date) (Signature of Principal)

_____

(Printed Name of Principal)

EVALUATION BY HEALTH CARE PROFESSIONAL (OPTIONAL)

I, _____, have evaluated the principal and determined that the principal is capable of giving or withholding informed consent for mental health care.

_____ _____

(Signature of health care professional) (Date)

_____

(Printed Name of health care professional)

D. Emergency Admittance Pursuant to Certificate of a Peace Officer

The following form is available online at https://dhhs.ne.gov/Pages/Mental-Health-Commitment.aspx

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 & Address of Subject Taken into Custody)

_____

on the _____ day of _____, 20_____.
(Month)

I have personally observed this subject or I have been informed by _____
(Name of a Witness)

of _____,
(Address of 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, a Mental Health Emergency Assessment Form, identified as Attachment A which is attached hereto and incorporated herein by reference.

I am therefore causing this person to be admitted to your facility.

Date: _____ Signed: _____ Badge #_____
(Signature of Peace Officer)

_____ (_____) _____
(Name & Address of Law Enforcement Agency) (Phone Number)

_____
(County)

This certificate or a copy thereof must be forwarded immediately to the County Attorney. (Neb. Rev. Stat. §71-919)

ATTACHMENT A

Mental Health Emergency Assessment

(Supplemental Document to Emergency Admittance pursuant to Certificate of a Peace Officer)

DATE: TIME: THERAPIST'S NAME:

CLIENT NAME: LOCATION:

DOB: AGE: GENDER:

MARITAL STATUS: SSN:

ADDRESS: CITY/STATE/ZIP

PHONE #: EMPLOYMENT STATUS:

EMERGENCY CONTACT PERSON: RELATIONSHIP:

PHONE #: SOCIAL SUPPORTS:

OUTPATIENT THERAPIST: PHONE #:

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: _____

Date: _____ _____

Signature (LMHP, NP, PhD, MD)

(Attach this form to EPC Certificate)

E. Mental Health Professional Certificate

This form is available online at https://dhhs.ne.gov/Pages/Mental-Health-Commitment.aspx

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 at _____ (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:_____

F. Mental Health Board Order—Inpatient Treatment

This sample order is available online at https://dhhs.ne.gov/Pages/Mental-Health-Commitment.aspx

BEFORE THE MENTAL HEALTH BOARD OF THE _____ JUDICIAL DISTRICT OF _____ COUNTY, NEBRASKA

IN THE INTEREST OF	)	
	)	CASE NO. _____
_____,	)	
	)	ORDER
Alleged to be a Mentally Ill and Dangerous Person.	)	(Inpatient Treatment)
	)	

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 Neb. Rev. Stat. § 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

G. Mental Health Board Order—Outpatient Treatment

This sample order is available online at https://dhhs.ne.gov/Pages/Mental-Health-Commitment.aspx

BEFORE THE MENTAL HEALTH BOARD OF THE _____ JUDICIAL DISTRICT OF _____ COUNTY, NEBRASKA

IN THE INTEREST OF	)	
	)	CASE NO. _____
_____,	)	
	)	ORDER
Alleged to be a Mentally Ill and Dangerous Person.	)	(Outpatient Treatment)
	)	

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 Neb. Rev. Stat. § 71-908.

Having considered all treatment alternatives, the Board orders the subject placed in the custody of _____ (name and address) 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 Neb. Rev. Stat. § 71-933, said outpatient treatment facility shall report to the board and the county attorney if 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

H. Warrant of Admission

This document is available online at https://dhhs.ne.gov/Pages/Mental-Health-Commitment.aspx

BEFORE THE MENTAL HEALTH BOARD OF THE _____ JUDICIAL DISTRICT OF _____ COUNTY, NEBRASKA

IN THE INTEREST OF	)	
	)	CASE NO. _____
_____,	)	
	)	WARRANT OF ADMISSION
Alleged to be a Mentally Ill and Dangerous Person.	)	(Inpatient Treatment)
	)	

To: Administrator/Director of _____, an inpatient treatment facility located at_____(address).

At a proper hearing before the Mental Health Board of the _____ Judicial District on the _____ day of _____, 20_____, _____(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 _____, 20_____.

_____
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_____.

I. Warrant to Take Custody of Outpatient Subject Pending Rehearing

This document is available online at https://dhhs.ne.gov/Pages/Mental-Health-Commitment.aspx

BEFORE THE MENTAL HEALTH BOARD OF THE _____ JUDICIAL DISTRICT OF _____ COUNTY, NEBRASKA

IN THE INTEREST OF	)	
	)	CASE NO. _____
_____,	)	
	)	WARRANT TO TAKE CUSTODY OF OUTPATIENT
Alleged to be a Mentally Ill and Dangerous	)	SUBJECT PENDING REHEARING
Person.	)	(Neb. Rev. Stat. § 71-934)

TO: Law enforcement officer of _____
(Law Enforcement Agency)

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 Neb. Rev. Stat. § 71-933(c), which matter is set for further hearing at _____ (location) on the _____ day of _____, 20_____, at _____ a.m./p.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 Neb. Rev. Stat. §§ 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:_____

J. Warrant for Arrest

This document is available online at https://dhhs.ne.gov/Pages/Mental-Health-Commitment.aspx

BEFORE THE MENTAL HEALTH BOARD OF THE _____ JUDICIAL DISTRICT OF _____ COUNTY, NEBRASKA

IN THE INTEREST OF _____, Alleged to be a Mentally Ill and Dangerous Person.	)))))))	CASE NO. _____ WARRANT OF ARREST

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 County of _____	)) ss.)	

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___.

_____ County Sheriff

By: _____
Deputy

Fees: Services & Return _____
Warrant _____
Mileage _____
Total _____

K. Provider Treatment Plan Recommendation to Mental Health Board

This document is available online at https://dhhs.ne.gov/Pages/Mental-Health-Commitment.aspx

PROVIDER TREATMENT PLAN RECOMMENDATIONS
(Inpatient or Outpatient Provider)

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

☐ Recommendations are set forth below.

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.

L. Notice of Release

NOTICE OF RELEASE
(Neb. Rev. Stat. § 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.

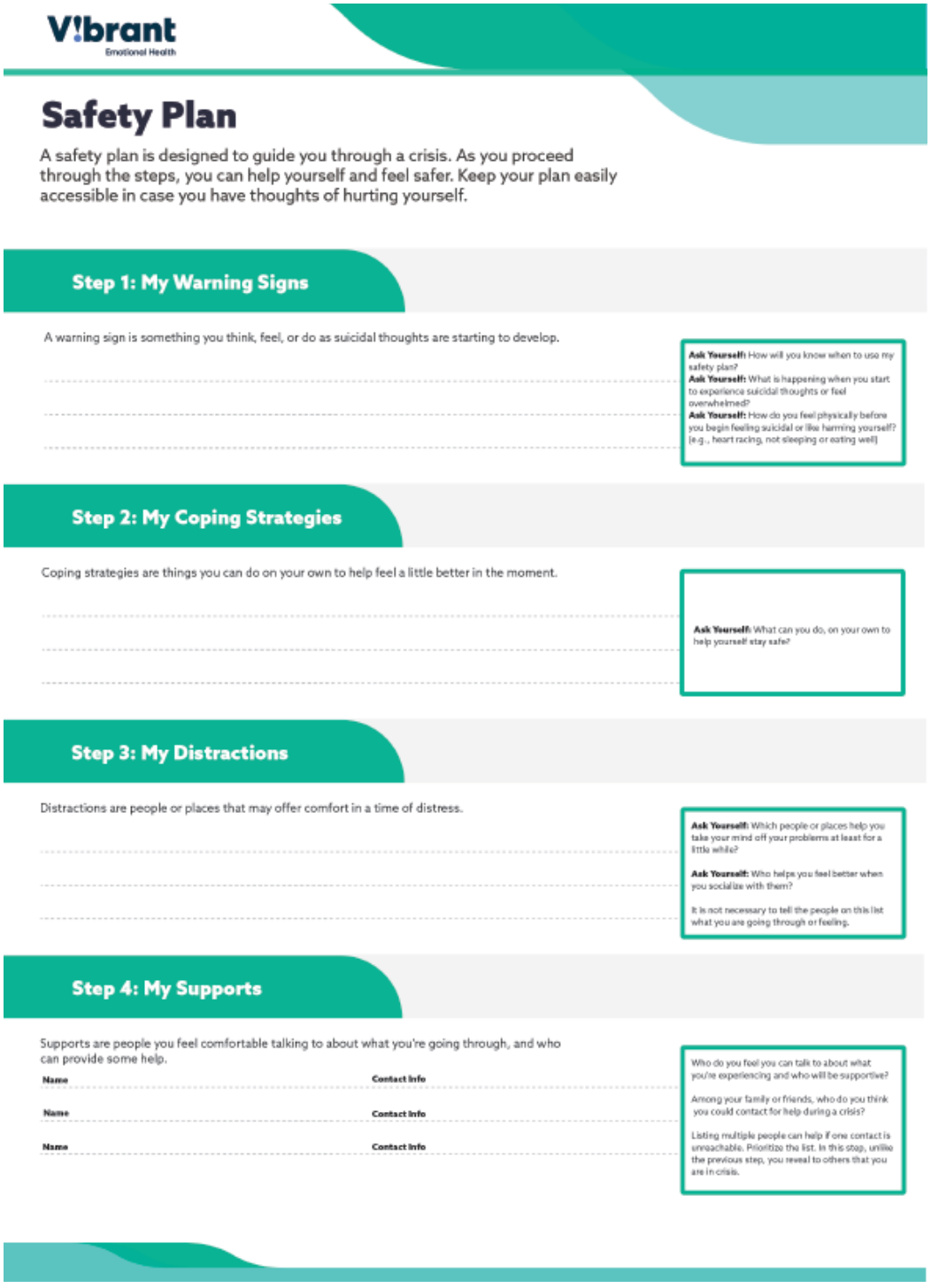
The above-named person has been under our care for treatment of _____. We are releasing this person from our treatment facility.

Dated: _____

_____
Administrator or Program Director

M. Safety Plan

The following is an example of a safety plan template used for suicide safety planning.



Vibrant Emotional Health

Safety Plan

A safety plan is designed to guide you through a crisis. As you proceed through the steps, you can help yourself and feel safer. Keep your plan easily accessible in case you have thoughts of hurting yourself.

Step 1: My Warning Signs

A warning sign is something you think, feel, or do as suicidal thoughts are starting to develop.

Ask Yourself: How will you know when to use my safety plan?
Ask Yourself: What is happening when you start to experience suicidal thoughts or feel overwhelmed?
Ask Yourself: How do you feel physically before you begin feeling suicidal or like harming yourself? (e.g., heart racing, not sleeping or eating well)

Step 2: My Coping Strategies

Coping strategies are things you can do on your own to help feel a little better in the moment.

Ask Yourself: What can you do, on your own to help yourself stay safe?

Step 3: My Distractions

Distractions are people or places that may offer comfort in a time of distress.

Ask Yourself: Which people or places help you take your mind off your problems at least for a little while?

Ask Yourself: Who helps you feel better when you socialize with them?

It is not necessary to tell the people on this list what you are going through or feeling.

Step 4: My Supports

Supports are people you feel comfortable talking to about what you're going through, and who can provide some help.

Name **Contact Info**

Name **Contact Info**

Name **Contact Info**

Who do you feel you can talk to about what you're experiencing and who will be supportive?

Among your family or friends, who do you think you could contact for help during a crisis?

Listing multiple people can help if one contact is unreachable. Prioritize the list. In this step, unlike the previous step, you reveal to others that you are in crisis.

Vibrant Emotional Health

Step 5: Professional Supports

Professional contacts are people who can provide professional care and support.

Name _____ **Contact Info** _____

Name _____ **Contact Info** _____

Name _____ **Phone Number** _____

Ask Yourself: Who are the mental health professionals you feel belong on your safety plan?

List other contacts, such as urgent care, mobile crisis team, mental health clinic, or a crisis center.

Step 6: My Safe Environment

Making your environment safer will help to lower or delay the risk of you acting on suicidal thoughts. Are there elements of your plan and/or other dangerous items in your environment that you can disable, secure, remove or otherwise make more difficult to access?

_____

_____

_____

Do you own a firearm, such as a gun or rifle?

What other items do you have access to and may use to attempt to kill or harm yourself?

What would make it harder for you to access and use these items?

Emergency contacts

National:
988 Suicide & Crisis Lifeline: **Call or Text** 988
Chat https://988lifeline.org/chat/

Safety Plan Template 2008 created by Barbara Stanley and Gregory K. Brown.
You can contact the authors at bhs2@columbia.edu or gregbrow@mail.med.upenn.edu.

APPENDIX IV: Reference Tools

A. Questions to ask the Mental Health Professional

1. Questions for a Mental Health Commitment Hearing

- What are your credentials? What training and experience do you have?
- What is your experience with the individual?
    - Are you basing your opinion on your experience?
    - Has the individual been diagnosed with a mental disorder or substance use disorder?
        - What assessment tools were used to arrive at the diagnosis?
            - Face-to-face interview?
            - Record review?
            - Psychological testing?
            - Medical consult?
            - Family interview?
        - Are there any medical conditions that can worsen the mental disorder and/or substance use disorder symptoms?
        - If the individual has a substance use disorder, is the person medically and psychiatrically stable enough to participate in primary substance use disorder treatment?
        - Does the individual have a crisis plan?
    - Have you reviewed the individual's medical history?
        - What, if any, is the individual's treatment history?
            - Was the individual in mental health or substance use disorder services at the time the case was filed?
        - What treatments have been successful historically?
        - Has the individual been in recovery before?
- Is the individual a danger to others? Are they a danger to their self?
    - How did you arrive at this opinion?
- What levels of care have you considered when preparing your report?
    - What is the least restrictive level of care where the individual can be safe and receive treatment?
    - What barriers exist to community-based treatment?
    - What solutions or resources could be used to overcome those barriers?
    - Are all the mental health professionals involved in the assessment of the individual in agreement with the current treatment recommendations?
    - What arrangements have been made for the recommended treatment?
        - Outpatient appointments?
        - Tours of facilities?
        - AA or NA group locations?
        - Transportation arrangements?
        - Access to medication?

2. Questions for a Sex Offender Hearing

- What are your credentials? What training and experience do you have?
- What is your experience with the individual?
    - Are you basing your opinion on your experience?
    - Has the individual been diagnosed with a mental disorder or substance use disorder?
- What assessment tools, if any, were used as part of your evaluation?
- Has the individual undergone a risk assessment?
    - What were the results?
- How is the individual progressing in treatment?
    - What are their highest treatment needs?
    - What progress would you like to see in treatment to consider this individual for a lower level of care?
- In your opinion, what is the least restrictive level of care where the individual can be safe and receive treatment?
- If the individual is in OUTPATIENT treatment:
    - Has the individual missed any of the following scheduled appointments?
        - Outpatient sex offender treatment
        - Substance abuse treatment
        - Meetings with a parole/probation officer
        - Medical appointments
    - How does missing an appointment, if they missed any, impact the individual's risk of reoffending?
    - What are the current topics of the Sex Offender treatment?
        - Are the areas of high need as identified per the most recent risk assessment being targeted in treatment?
        - How is the individual progressing in treatment?
        - Does the individual bring their own treatment needs / concerns with them to scheduled sessions?
        - Based on current treatment progress, what areas does the individual still need to work in order to help mitigate their risk to reoffend?
- If there is a request to discharge the individual from inpatient treatment:
    - When was the individual's most recent risk assessment completed?
        - What assessment tools were used to arrive at the decision?
            - Face-to-face interview?
            - Record review?
            - Psychological testing?
            - Medical consult?
            - Family interview?
        - What did the results of the risk assessment suggest?
            - If particular / high needs areas have been identified, has the outpatient treatment provider been made aware of these areas?
            - What is currently being done to target these areas while the individual is in inpatient treatment?
            - What might increase the individual's level of risk in the community?

        - Does the individual experience any medical conditions that with deterioration may increase the individual's risk of recidivism?
        - Was substance use determined to be a risk factor for this individual?
            - What is the individual's substance use treatment plan should they be released to / remain in the community?
            - What concerns may arise should the individual not be compliant with substance use treatment?
    - Is the recommendation to release the individual based on your opinion?

B. Questions to Ask the Individual at the Hearing

- What is your diagnosis/diagnoses?
    - What medications are you taking?
        - Why do you take medication(s)?
        - Can you take your medication(s) on your own?
        - Do you have side effects from your medication(s)?
    - What current treatment are you receiving and with whom?
        - Do you feel the treatment is helping?
        - When was the last time you saw a mental health professional? Who did you see?
        - What mental health programs have you attended in the past? Did they help?
- Have you recently been in recovery? What helped while you were in recovery?
- Do you recommend the recommended treatment plan?
    - Do you have a crisis plan?
    - Do you believe you can follow the treatment plan?
    - What would stop you from following the plan?

C. Mental Health Board Determination Process Quick Reference

DETERMINATION # 1: IS THE PERSON MENTALLY ILL?

1. Diagnosis, symptoms, behaviors (most current version DSM).
2. Does the person have:
    a. A psychiatric disorder? (Note: dementia and organic disorders are not psychiatric)
    b. Does the disorder cause severe or substantial impairment of their thought processes, senses, mood balance, memory or ability to reason?
        i. What are the reported symptoms and behaviors?
    c. Does their impairment interfere with their ability to meet the demands of living? (e.g., working, maintaining hygiene, maintaining shelter)
        i. Are there other explanations for their situation? (e.g., medical conditions, job loss, cannot afford medications)
    d. Does their impairment interfere with the safety or well-being of others?

DETERMINATION # 2: IS THE PERSON DANGEROUS - NOT ONLY WHETHER DANGEROUSNESS IS *PRESENT*, BUT ALSO *TO WHAT EXTENT* RISK OF VIOLENCE OR DANGEROUSNESS TOWARD SELF OR OTHERS EXISTS?

Areas of dangerousness include: suicide threat (verbal), suicide attempt, homicidal threat (verbal) homicide attempt, threat to harm others (verbal or nonverbal), destruction of property, inability to provide the basic needs of food, clothing, shelter, safety, medical care.

CONSIDER THESE FOUR FACTORS IN DETERMINING DANGEROUSNESS:

1. Magnitude of danger – what is the level of danger presented?

Examples: threat to harm people is more dangerous than threat to harm property; threat of physical harm to others is more serious than psychological threats; use of a weapon escalates risk of danger; choice of weapon must be considered.

2. Likelihood of dangerousness – what is the probability of occurrence of violence?

Example - Best predictor is history but you must consider 8 demographics that correlate to increased risk of violence: Age, Gender, Social Class, IQ, Education, Employment, Residence, Substance use.

3. **Imminence of danger – how soon might danger occur?**
Statute says the risk must be within the "near future." What is your Board's working definition of "imminent"?

Right now, or within 24 hours is common timeframe. The sooner violence may occur equates to higher risk of danger due to minimal chances to mitigate.

4. **Frequency – is there a history of past violence? Is there a pattern that has been set and may reoccur?**

DETERMINATION #3: WHAT IS THE LEVEL OF RISK?

- **Is the Risk Factor static or dynamic?**

  Examples: Change risk by taking away a weapon or access to a weapon; psychosis is altered by enforcing medication compliance. In the later, the presence of mental illness is static, but the risks are changeable and can be mitigated.

- **What is the acuteness and psychosis of the illness?**

  Examples: Delusions more dangerous than hallucinations; hallucinations more dangerous if they are of command type; delusions with command hallucinations have heightened risk of dangerousness.

- **What is the level of risk due to severity and occurrence? (Low potential to extreme potential)** – Consider:

  1. Low potential for dangerousness - no indicated suicidal or homicidal thoughts or impulses; no history of suicidal or homicidal ideation; no indication of distress**.**
     - ✓ Unlikely to result in harm, injury, property destruction, no life-threatening incidences. Even if imminent – magnitude is lower.

  2. Moderate potential – significant current suicidal or homicidal ideation without intent or conscious plan and without history; current distress may be present without active ideation but history of suicidal/homicidal behavioral exits; past binge use of substances resulting in aggression towards others or self without recent episodes; some evidence of self-neglect and compromise in ability to care for self.
     - ✓ Greater magnitude, not as imminent, consequences like to result in harm, injury, or property destruction but without life threatening consequences.

  3. Extreme potential – current suicidal or homicidal behavior or intentions with a plan and means to carry out plan; with a history of serious past attempts; or presence of command hallucinations or delusions which threaten to override impulse control; repeated episodes of violence towards self/others or behaviors resulting in likely harm to self/others which under the influence of substances; extreme inability to care for self or monitor the environment with deterioration in physical condition or injury related to these deficits.

- ✓ Acute level, high magnitude, imminent risk with consequences to include loss of life, limb, and/or major property destruction.

- **What is the risk level of aggressive behavior?** Where are they on the spectrum? (Mild to serious danger)

  a) VERBAL AGGRESSION **(MILD)**
     - Makes loud noises, shouts angrily.
     - Yells mild personal insults, e.g. "You're stupid!".
     - Curses viciously, uses foul language in anger, makes moderate threats to others or self; or
     - Makes clear threats of violence toward others or self, i.e.," I'm going to kill you!" or requests help to control self.

  b) PHYSICAL AGGRESSION AGAINST OBJECTS
     - Slams door, scatters clothing, makes a mess.
     - Throws objects down, kicks furniture without breaking it, marks the wall.
     - Breaks objects, smashes windows; or
     - Sets fires, throws objects dangerously.

  c) PHYSICAL AGGRESSION AGAINST SELF
     - Hits or scratches skin, hits self on arms or body, pinches self, pulls hair (with no or minor injury).
     - Bangs head, hits fist into object, throws self onto floor or into objects (hurts self without serious injury).
     - Small cuts or bruises, minor burns; or
     - Mutilates self, makes deep cuts, bites that bleed, internal injury, fractures, loss of consciousness, loss of teeth.

  d) PHYSICAL AGGRESSION AGAINST OTHERS **(SERIOUS)**
     - Makes threatening gestures, swings at people, grabs at clothes.
     - Strikes, kicks, pushes, pulls hair (without injury).
     - Attacks others causing mild/moderate physical injury (bruises, sprains, welts); or
     - Attacks others causing severe physical injury (broken bones, deep lacerations, internal injury).

- **What is the danger and risk to self?**

  - **SUICIDE? Apply Magnitude, Likelihood, Imminence, Frequency Factors**
    1. Suicidal Ideation – thoughts of ending one's own life.
       a) Passive – thoughts without a plan

b) Active – thoughts with a plan

2. Suicidal Gesture – self inflicted harm done without a realistic expectation of death; possible an attention-getting plea.
3. Suicidal Attempt – self-inflicted harm with clear expectation of death
4. Signed contract for safety or no self-harm? (May decrease imminence).
5. Danger signs: statements of hopelessness, helplessness, worthlessness, preoccupation with death and talk of suicide?
6. Predictor – history of attempts or family member/friend who completed suicide?

- **NEGLECT? Is the inability to care for self a result of mental illness?**
  1. What is the level of impairment? Consider the following:
     a. Appearance: Do they have clothing necessary for the environment?
     b. Hygiene: Do they refuse to groom or bathe?
     c. Shelter: Do their symptoms make maintaining shelter difficult?
     d. Medical needs: Do they have an existing medical condition that requires maintenance or medication?
     e. Decision-making:
        i. Do they understand their situation?
        ii. Can they appreciate the consequences of decisions?

DETERMINATION # 4: WHAT LEVELS OF CARE ARE BEING CONSIDERED AND ARE THEY THE LEAST RESTRICTIVE FOR SAFETY AND EFFECTIVE TREATMENT? IF DANGEROUSENSS IS NOT MET, WHAT TREATMENT IS RECOMMENDED? CAN/IS RISK MITGATED BY THE LEVEL OF CARE RECOMMENDED?

Information Required to Determine Commitment: If there is not enough information about the risk factors for dangerousness present, members must discover any elements by questioning the person, the mental health professional, and any legal representatives.

Board members must understand:

1. The precipitating event that brought the petition

2. The person's behavior

3. The history as an aid in determining dangerousness

A LABEL OF DANGEROUS OR VIOLENT APPLIED TO A PERSON SHOULD NOT BE ACCEPTED AT FACE VALUE BUT MUST REST ON THE INCIDENT AND BEHAVIORS

Board members must ascertain:

1. WHAT: EVENTS, BEHAVIOR, DIAGNOSIS, PRESENCE/ABSENCE OF mi OR SUBSTANCE USE

2. WHERE: CIRCUMSTANCES AND PLACE

3. WHY: ATTEMPT TO DETERMINE WHAT TRIGGERED VIOLENCE (RETALIATION FOR IMAGINED OR REAL EVENT), MOTIVATION BEHIND BEHAVIOR

4. HOW: DETERMINE IF THERE IS A PATTERN – PAST BEHAVIOR ASSESSED AS TO PATTERN AND FUTURE STATE

D. List of Common Medications

List taken from the National Alliance on Mental Illness (NAMI) website. Links direct to NAMI webpages.

TYPES OF MEDICATIONS

- Acamprosate (Campral)
- Alprazolam (Xanax)
- Amphetamine (Adderall)
- Aripiprazole (Abilify)
- Asenapine (Saphris)
- Atomoxetine (Strattera)
- Brexanolone (Zulresso)
- Brexpiprazole (Rexulti)
- Buprenorphine (Sublocade)
- Buprenorphine/Naloxone (Suboxone)
- Bupropion (Wellbutrin)
- Buspirone
- Carbamazepine (Tegretol)
- Cariprazine (Vraylar)
- Citalopram (Celexa)
- Clonazepam (Klonopin)
- Clonidine (Kapvay and Catapres)
- Clozapine (Clozaril and Versacloz)
- Desvenlafaxine (Pristiq)
- Deutetrabenazine (Austedo)
- Dexmedetomidine (IGALMI)
- Dextromethorphan and Bupropion (Auvelity)
- Diazepam (Valium)
- Disulfiram
- Duloxetine (Cymbalta)
- Escitalopram (Lexapro)
- Esketamine (Spravato)
- Fluoxetine (Prozac)
- Fluphenazine
- Fluvoxamine (Luvox)
- Guanfacine (Intuniv)
- Haloperidol (Haldol)
- Hydroxyzine (Vistaril)
- Iloperidone (Fanapt)
- Lamotrigine (Lamictal)
- Levomilnacipran (Fetzima)
- Lithium
- Lofexidine (Lucemyra)
- Lorazepam (Ativan)
- Loxapine (Adasuve)
- Lumateperone (Caplyta)
- Lurasidone (Latuda)
- Methadone
- Methylphenidate or Dexmethylphenidate (Concerta, Ritalin and others)
- Mirtazapine (Remeron)
- Naloxone (Narcan)
- Naltrexone (Vivitrol)
- Olanzapine (Zyprexa)
- Olanzapine/Samidorphan (Lybalvi)
- Oxcarbazepine
- Paliperidone (Invega)
- Paroxetine (Paxil)
- Phenelzine (Nardil)
- Pimavanserin (Nuplazid)
- Quetiapine (Seroquel)
- Risperidone (Risperdal)
- Sertraline (Zoloft)
- Topiramate (Topamax)
- Tranylcypromine (Parnate)
- Valbenazine (Ingrezza)
- Valproate (Depakote)
- Venlafaxine (Effexor)
- Vilazodone (Viibryd)
- Viloxazine (Qelbree)
- Vortioxetine (Trintellix)
- Ziprasidone (Geodon)