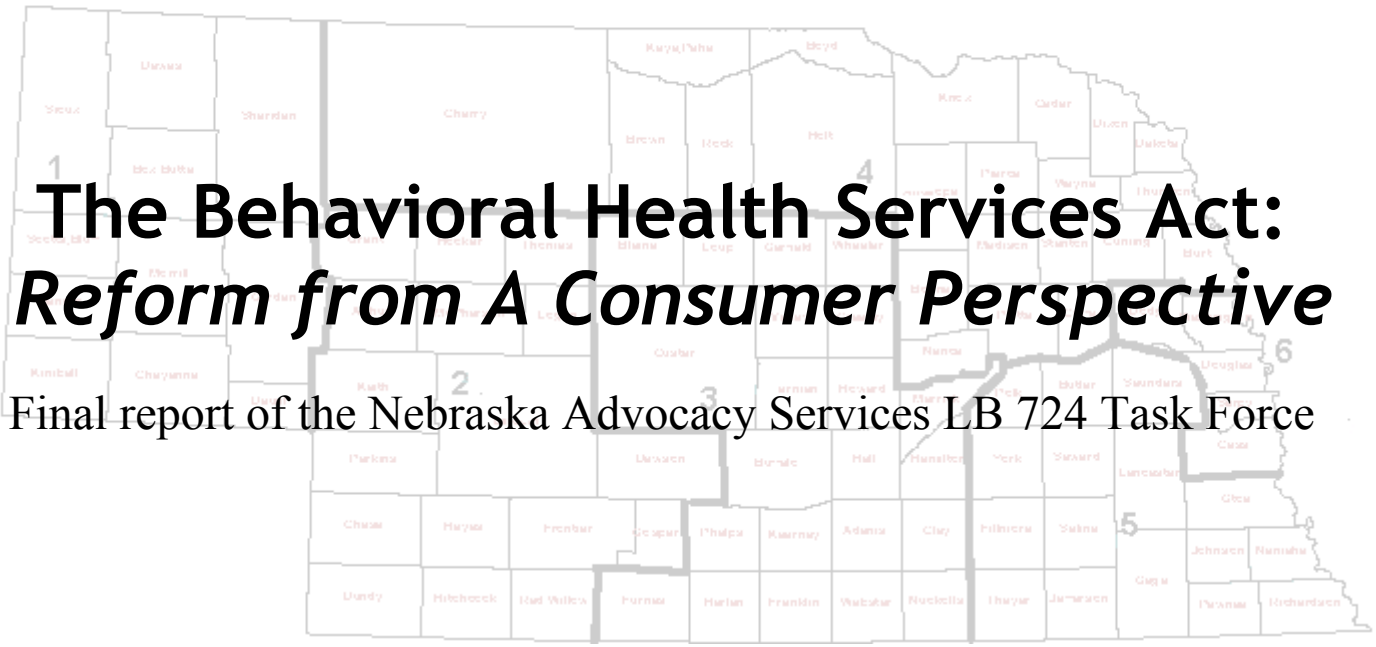

The Behavioral Health Services Act:
Reform from A Consumer Perspective

Final report of the Nebraska Advocacy Services LB 724 Task Force

Nebraska Advocacy Services

Table of Contents

INTRODUCTION

Task Force Purpose and Overview

The NAS LB 724 Task Force was established to solicit comments and input from interested mental health consumers and mental health advocates regarding the Behavioral Health Services Act of 2003. Since September 2003, Nebraska Advocacy Services organized, facilitated, and convened the three meetings of the task force.

The voices of consumers are critically important to any planning or reform of the mental health care system since their experiences highlight important principles upon which a reformed public behavioral health system should stand; consumer and advocate input can shed light on other successful and innovative approaches that could be incorporated into system reform; and consumers themselves will be most directly affected by any reform of the behavioral healthcare system.

Gaining a contextual understanding of the system from those who have had the most significant contact with that system is one of the key pieces to making any reforms effective. A contextual understanding of not only the principles that should form the foundation of the mental health care system but also the practical implications of past and future system structure and activities, are essential—otherwise any reform will be based on hollow analysis.

The Task Force is supportive of many of the proposed changes in the November 19th draft of the LB 724 implementing legislation. This report recognizes the effort being made by Senator Jensen and Governor Johanns to better Nebraska's behavioral health system. This report serves to add a critical voice to the current debate around implementation of the Behavioral Health Services Act of 2003, as well as offering guidance to the reform effort.

Task Force Participants

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DISCUSSION:

The Public Behavioral health system: Roles, Responsibilities, and Principles

The Current System and Values

The task force began its examination of mental health care system reform by identifying the desired roles, responsibilities and principles that should undergird the current system and contrasting them with the current system's values.

The task force concluded that the current system has significant shortfalls. Specifically, the task force identified the following characteristics of the current system:

1. **Poverty**—consumers and families are often forced to expend much of their personal finances in order to access public mental health services. Many consumers who receive public benefits not only are at or near the poverty level, but also find it difficult to obtain viable employment. Moreover, current eligibility criteria for obtaining income supports and public mental health services prevent consumers from seeking employment out of fear that Medicaid benefits will be lost due to increased income.
2. **Coercion and oppression**—consumers are disempowered and lack fundamental choices about treatment methods and medications, coupled with a system commitment to utilizing seclusion, restraint, and isolation as therapy. Consumers are also disproportionately represented within the decision-making power structure of the behavioral health system. The current lack of community services demonstrates a systemic bias toward treating consumers in institutional settings.
3. **Homelessness**—there is a lack of available housing options for consumers before and after entering the public mental health care system. Homelessness further entrenches the impoverishment and stigma of mental health consumers.
4. **Restrictive access to services**—access to public services is constrained by funding, Medicaid eligibility restrictions, inadequate system capacity, a systemic focus on "fail first" policies, and de-emphasis of preventive services.
5. **Stigma**—in addition to the inherent stigma that attaches to mental illness, the rhetoric surrounding current policy and legislation presumes that people with mental illness are inherently more violent and pose a threat to public safety.

Core Values from the Consumer Perspective

The task force contrasted the weaknesses embedded in the current system with those core values and responsibilities that should be reflected in any reformed behavioral health system. Overall, the task force concluded, a new set of core values must be established which incorporate a heightened recognition of the basic human rights and needs of consumers. The task force noted that an optimal system would include values that embody:

1. A strengths-based, recovery-oriented service approach, emphasizing quality-based, portable, trauma-informed, and peer services.
2. A commitment to person-centered planning that emphasizes personhood and valued social roles for the consumer as inherent system and service outcomes.
3. Provision of real and viable choices for consumers and family members within all aspects of their involvement with the behavioral health system.
4. Increased peer involvement and inclusion within the system hierarchy, operation, planning, evaluation, and service delivery, where consumers are viewed and treated respectfully, as experts.
5. Increased consumer safety within the system; the system and services should not hasten harm or death, e.g. through medications prescribed and institutional practices such as restraint and seclusion.
6. Enhanced awareness and access to consumers' rights, remedies, and advocacy.
7. Incorporation and development of innovative, alternative models and services—sole adherence to a strict medical model results in a diminished opportunity for system flexibility, effectiveness, and consumer recovery. It was suggested that the system should embrace more psychosocial models of treatment.

In addition to re-orienting the values, focus, and philosophy of the current behavioral health system, the task force also felt that an optimal, successful, and meaningful reform must address the following significant policy deficits in the current system:

1. A seamless system with adequate supports for consumers to thrive in the community.
2. Increased and affordable access to services.
3. Recognition of increase in dual diagnosis/co-occurring disorders and need for integrated treatment.
4. Better and timelier transition and individual planning services, including an on-going consumer needs assessment.
5. Better discharge planning, especially concerning individuals' financial planning.
6. Fewer eligibility restrictions.
7. Safe, affordable, and comfortable housing.
8. Meaningful work and transportation methods.

9. Re-entry into employment without loss of Medicaid or public health benefits.

10. Access to and assurance of affordable, quality medications without qualifiers.

11. Limited mental health insurance coverage and disparate insurance treatment of mental and physical health care.

12. Inadequate mental health care treatment for persons incarcerated in prisons and jails.

RECOMMENDATIONS

The task force recognizes that it is unlikely that the Behavioral Health Services Act of 2003 will address all of the issues outlined within this report. Transportation and housing issues, for example, appear beyond the scope of the Act as intended by Senator Jensen and Governor Johanns. However, important issues such as these, as well as many others seemingly tangential to the legislative intent of the Behavioral Health Services Act, cannot be underestimated. Mental illness has an impact on multiple aspects of consumers' and families' lives; thus effective mental healthcare policy will need to be equally comprehensive in nature. The Task Force recognizes that regardless of how well-intentioned the Behavioral Health Services Act is, it should not be seen as a "silver bullet" legislation that will solve all the problems mental health consumers and families face. However, the Task Force believes that the legislation is clearly a step in the right direction, spurring a timely and needed critical discussion of the nature, purpose, and function of Nebraska's behavioral health care system.

The Task Force developed the following recommendations:

1. The quality review teams established in section 71-5003.01 NRS be retained and adequate funding be provided to train and support quality review team members in carrying out their responsibilities.
2. Advisory committees to regional behavioral health authorities must be required and shall report annually to both the regional behavioral health authorities and the Office of Consumer Affairs.
3. Greater integration and collaboration between the general health system and the specialized behavioral health system; general practitioners need more training regarding mental health, especially for young patients. Poor mental health training leads to potential for misdiagnosis, and the price for specialist care is cost-prohibitive.
4. All state and federal funding made available from the closing of the two regional centers must follow individuals transitioned into the community from the regional centers. The legislature must ensure those funds are funneled into community-based services, instead of simply training more psychiatrists in prescribing medications. One beneficial use of those funds would be to fund more services such as peer advocacy programs.
5. Regulations must be improved and informed. Such a solution would examine changing the process by which regulations are written. Current regulations do not provide an incentive for appropriate or alternative treatment methods. The process for writing

regulations must be more transparent, open, welcoming of consumer and family involvement and consumer-friendly.

6. The composition of the Behavioral Health Oversight Commission must include significant representation of consumers and family members. At least one-third, and ideally one-half, of the membership should be consumers and family members.
7. The legislature should stringently resist the temptation to combine or dilute the powers of the Mental Health Planning and Evaluation Council (MHPEC). To ensure effective behavioral health system reform, more attention must be given to evaluation and planning, precisely the purpose of the MHPEC. It is unclear if the federal regulations for the MHPEC and the Mental Health Block Grant allow for the combination suggested in the Behavioral Health Services Act draft.
8. Nebraska's behavioral health system needs strengthened accountability, data gathering, and reporting mechanisms and requirements. The legislature should consider strengthening Consumer Advocacy Teams and Quality Review Team legislative language, in addition to building in more system transparency, data collection, planning, and reporting. An essential component of successful reform is the need to develop goals and outcomes for the system and the methods to measure them.
9. The legislature must also reform the remaining institution(s) after closure as no state has been able to eliminate *all* institution-based services. Leaving people in unreformed institutions is a inconsistent with the intent of the Behavioral Health Services Act.
10. Regional system structures must provide for the inclusion and empowerment of consumers. This would include such things as: consumer staff positions, consumer advisory committees to regional governing boards, increased consumer participation in regional planning and hiring individuals to support greater consumer involvement.

NAS LB 724 TASK FORCE SUGGESTED LEGISLATIVE REVISIONS

LB 724
Rough Draft of Implementing Legislation
for Behavioral Health System Reform
December 19, 2003

Short Title

Section 1. (cf. 71-5001) Sections 1 to X of this act shall be known and may be cited as the Nebraska Behavioral Health Services Act.

Legislative Findings

Sec. 2. (1) The Nebraska legislature finds:

(a) Public and social policy toward people with disabilities will be respectful, fair and recognize the need to assist all that need help.

(b) There is a need to reorient and restructure the behavioral health system in Nebraska. Traditionally, the system has provided consumers of mental health services little control, choice, and meaningful involvement in policymaking and service decisions.

(c) The inherent stigma that attaches to mental illness and consumers of mental health services is a significant barrier to recovery from mental illness, and a system that does not seek meaningful involvement from consumers further entrenches stigma.

(d) There is a well-recognized need to increase consumer involvement and empowerment in the operation, design, planning, administration and evaluation of the behavioral health system. To truly be effective, the system must utilize and value the voice, perspectives, and knowledge of consumers, as consumer experiences can help guide the system in prioritizing and providing the services that are the most effective. Recovery from mental illness can best be understood through the lived experiences of mental health consumers.

(e) The system has developed a reliance on psychiatric institutions as the main locus for treatment as opposed to treating individuals within their communities.

(f) The behavioral health system, in order to provide the most cost-effective services, must strengthen its planning and evaluation of services and delivery. Additionally, the system must incorporate new and innovative services, supports, and approaches to mental health care while recognizing the inherent worth of people with mental illness, the individualized nature of mental illness and recovery, and the importance of providing adequate supports to enable consumers to thrive in their communities.

(g) Treatment services and supports to individuals and their families must be appropriate to needs, accessible and timely, consumer-driven, outcome-oriented, culturally and age-appropriate, built on individual strengths, cost-effective, and reflect best practices.

(h) Research, education, and prevention programs can lower the prevalence of mental illness and substance abuse; reduce the impact and stigma; and lead to earlier intervention and improved treatment.

(i) Services should be provided in the most integrated community setting, suitable to the needs and preferences of the individual and planned in partnership with the individual and/or family.

(j) System elements will be seamless: consumers, families, policymakers, advocates, and qualified providers must unite in a common approach that emphasizes support, education/training, rehabilitation and recovery.
(k) Individuals should receive the services needed based on a person-centered plan and in consideration of any legal restrictions, varying levels of disability, and fair and equitable distribution of system resources.
(l) Behavioral health services shall meet measurable standards of safety, quality and clinical effectiveness at all levels of the mental health and substance abuse systems and shall demonstrate the dedication to excellence through adoption of a program for continuous quality improvement.
(m) Consumers must have:
    a. Meaningful input into the design and planning of the service system
    b. Information about services, how to access them and how to voice complaints
    c. Opportunities for employment within the system
    d. Easy and immediate access to services
    e. Educational, employment or vocational experiences that encourage individual growth, personal responsibility and enjoyment of life
    f. Safe and humane living conditions in communities of their choice
    g. Reduced involvement with the justice system
    h. Services that prevent and resolve crises
    i. Opportunities to participate in community life, to pursue relationships with others and to make choices that enhance their productivity, well-being and quality of life
    j. Access to an orderly, fair and timely system of arbitration or other means of alternative dispute resolution

Purpose

Sec. ~~3~~4. The purposes of the Nebraska Behavioral Health Services Act are to: (1) reorganize statutes relating to the provision of publicly funded services to persons with behavioral health disorders; (2) provide for the organization and administration of the public behavioral health system within the department; (3) rename mental health regions as behavioral health regions; (4) provide for the establishment of regional behavioral health authorities and ongoing activities of regional governing boards; (5) reorganize the State Mental Health Planning and Evaluation Council, the State Alcoholism and Drug Abuse Advisory Committee, and the Nebraska Advisory Commission on Compulsive Gambling into a single State Behavioral Health Advisory Council; (6) change and add provisions relating to development of community-based behavioral health services and funding for behavioral health services; and (7) provide for the closure of two regional centers.

Legislative Intent/Policy

Sec. ~~3~~5. (1) The purpose~~s~~ of the public behavioral health system ~~are~~ is to promote recovery, resilience, wellness, and other quality of life enhancements for persons with behavioral health disorders through ensuring community integration ~~ensure~~: (a) statewide access to behavioral health services; (b) high quality, person-centered behavioral health services; (c) cost-effective behavioral health services include services and supports that individuals voluntarily want and need; and (d) ~~the public safety~~ the protection and treatment of individuals with behavioral health disorders who are considered to be a danger to themselves or others.

(2) Statewide access to behavioral health services includes, but is not limited to: (a) capacity and ~~adequate~~ availability of behavioral health providers, programs, and facilities; and (b) an ~~appropriate~~ array of community-based, integrated services ~~and~~ within a continuum of care sufficient to meet the needs identified in the individual person-centered plans. ~~for persons with behavioral health disorders.~~

(3) High quality behavioral health services includes, but is not limited to: (a) services that reflect best practices and emphasize prevention, early intervention, recovery, and integration with primary health care services; (b) ~~appropriate~~, integrated, person-centered, strengths-based, and recovery-oriented treatment planning and ~~beneficial~~ ~~treatment~~ outcomes~~,~~ (c) peer support, consumer-delivered services~~,~~ ~~and~~ case management for consumers, and service coordination; (d) appropriate regulation of behavioral health providers, programs, and facilities; and (e) provision of technical assistance, resources, and supports to enable meaningful and significant constructive participation of consumers ~~consumer involvement~~ as a priority in all aspects of service planning, treatment, administration, ~~and~~ delivery, and evaluation.

(4) Cost-effective behavioral health services includes, but is not limited to: (a) person-centered, strengths-based, integrated, and recovery-oriented services that are efficiently managed and supported with appropriate funding, planning, and information; ~~and~~ (b) funding that follows the consumer and supports his or her plan of treatment, and (c) services and supports that people voluntarily want and need.

Definitions

Sec. ~~4~~ 5. (cf. 71-5002) For purposes of the Nebraska Behavioral Health Services Act:

(1) Administrator means the administrator of the division of behavioral health services within the department;

(2) Behavioral health disorder means mental illness or alcoholism, drug abuse, or other addictive disorder;

(3) Mental illness means a serious mental disorder or serious emotional disturbance as determined by a licensed mental health professional

(4) Serious mental disorder means the condition of a person age eighteen and over, who currently or at any time during the past year, have or have had a diagnosable mental, behavioral, or emotional disorder of sufficient duration that has resulted in functional impairment which substantially interferes with or limits one or more major life activities.

(5) Serious emotional disturbance means a mental, behavioral, or emotional disorder of sufficient duration that results in functional impairment that substantially interferes with or limits one or more major life activities in an individual up to eighteen years of age.

(6) Functional impairment means difficulties that substantially interfere with or limit role functioning in one or more major life activities, including basic living skills (e.g., eating, bathing, dressing); instrumental living skills (e.g., maintaining a household, managing money, getting around in the community, attending to medical care and treatment); and functioning in social, family, and vocational/educational/volunteer contexts.

(~~3~~7) Behavioral health region means a behavioral health region established in section 6 of this act;

(~~4~~8) Behavioral health services means strengths-based, recovery-oriented, person-centered planning, integrated services and supports ~~provided~~ for the prevention, diagnosis, early intervention, community integration and treatment of behavioral health disorders ~~and the recovery of persons affected by such disorders~~;

(~~5~~9) Community-based behavioral health services or community-based services means inpatient or outpatient behavioral health services that are not provided at a regional center;

(10) "Person-centered planning" means a process for planning and supporting the individual receiving services that builds upon the individual's capacity to engage in activities that promote community integration and that honors the individual's preferences, choices, and abilities. The person-centered planning process involves families, friends, and professionals.

(11) "Support plan" means a written plan that specifies the personal support services or any other supports that are to be developed with and provided for a recipient.

(12) "Treatment plan" means a written plan that specifies the goal-oriented treatment or training services, including rehabilitation or habilitation services, that are to be developed with and provided for a recipient.

(~~6~~13) Department means the Department of Health and Human Services;

(~~7~~14) Director means the Director of Health and Human Services;

(~~8~~15) Division means the administrative division for behavioral health services within the department;

(~~9~~16) Nebraska Health and Human Services System means the Department of Health and Human Services, the Department of Health and Human Services Regulation and Licensure, and the Department of Health and Human Services Finance and Support;

(~~10~~17) Policy Cabinet means the Policy Cabinet of the Nebraska Health and Human Services System established in section 81-3009;

(~~11~~18) Public behavioral health system means the statewide array of behavioral health services provided by the public or private sector and supported in whole or in part with funding received and administered by the Nebraska Health and Human Services System, including behavioral health services provided under the medical assistance program established in section 68-1018;

(~~12~~19) Regional administrator means the administrator of a regional behavioral health authority appointed pursuant to section 7 of this act;

(~~13~~20) Regional behavioral health authority means a regional behavioral health authority established pursuant to section 7 of this act; and

(~~14~~21) Regional center means one of the state hospitals for the mentally ill designated in section 83-305.

(~~15~~22) Regional governing board means the governing board of a regional behavioral health authority as provided in section 7 of this act.

(23) Community support services means an array of services delivered by community-based, mobile individuals or multi-disciplinary teams of professionals, consumers and trained others. Services address the individualized mental health needs of the client and are directed towards adults, children, adolescents, and families and will vary with respect to hours, type, and intensity of services, depending on the changing needs of the individuals.

(24) "Peer support service" means individual or group interactions conducted by persons receiving services, persons who have received services, or their families or significant others, for the purpose of providing emotional support and understanding, sharing experiences in coping with problems, mentoring, housing, supported education, supported employment, and developing a network of people that provides on-going support both inside and outside the formal mental health service system.

State Leadership

Sec. ~~5~~6. (cf. 71-5003) (1) The director shall establish and maintain a separate administrative division for behavioral health services within the department. The division shall establish and maintain a separate budget and shall separately account for all revenues and expenditures.

(2) The administrator of the division, after a national search, shall be appointed by the Governor and confirmed by a majority of members of the Legislature. The director shall appoint a clinical officer and a program administrator for consumer affairs for the division. The program administrator for consumer affairs shall be a self-disclosed recipient or former recipient of mental health services who shall possess detailed knowledge of consumer-controlled and -directed mental health programs, mental health service delivery systems, and consumer and family advocacy issues. The clinical officer shall be a board-certified psychiatrist. The administrator shall report to the director and shall be responsible for administration and management of the division. The clinical officer and the program administrator for consumer affairs shall report to the administrator.

(3) The administrator, in consultation with consumers and consumer advocates, shall establish and maintain an Office of Consumer Affairs within the division, which shall be directed by the program administrator for consumer affairs. The purpose and mission of the Office of Consumer Affairs will be to coordinate and support the meaningful and significant involvement of consumers in the planning, implementation, evaluation, and delivery of mental health services in Nebraska. The primary responsibilities of the Office of Consumer Affairs shall include, but not limited to:

(a) Policy and regulation development: The program administrator of the Office of Consumer Affairs shall participate in formal and informal policy discussions among state mental health officials; serve on departmental, division and other task forces, committees, or panels; provide comment on proposed regulations and rule changes. The program administrator shall also facilitate and support the involvement and inclusion of other current or former mental health service recipients in the aforementioned activities.

(b) Program planning: The Office of Consumer Affairs shall assist the department in developing plans regarding service planning, assessment, and consumers' needs. The office shall also advise the department on innovative, alternative services commensurate with the local need.

(c) Evaluation and monitoring: The Office of Consumer Affairs shall work with the department on developing evaluation methods for the effectiveness, quality, and efficacy of services provided and service delivery; the Office of Consumer Affairs shall provide the department with system and program objectives so as to create research- and outcome-based evaluation tools. The Office of Consumer Affairs shall collaborate with the department in collecting statistical and anecdotal evidence.

(d) Training: The Office of Consumer Affairs shall develop and initiate training and technical assistance regarding recovery and consumer issues and perspectives. The Office of Consumer Affairs shall provide training and technical assistance including, but not limited to:

   a. Consumers
   b. Families

c. Service providers
d. State and local mental health officials
e. Legislators
f. Law enforcement, and
g. Mental health commitment boards

(e) Finance and contract management: The program administrator for the Office of Consumer Affairs shall manage any finances and subcontracts pursuant to the duties and responsibilities of the Office of Consumer Affairs.

(f) Addressing complaints and grievances: The Office of Consumer Affairs shall assist the department and quality review teams as established in 71-5008 in identifying and addressing consumer complaints and grievances including, but not limited to:

a. System functionality and efficacy
b. Policies
c. Regulations
d. Service provision, and
e. Quality of services

(g) Research and educational activities:

(4) The Office of Consumer Affairs shall develop a plan in consultation with the Mental Health Planning and Evaluation Council and the State Alcoholism And Drug Abuse Advisory Committee, for including consumers in service provision statewide, and for developing consumer-provided services in mental health and substance abuse. The Office of Consumer Affairs shall submit an annual report to the Health And Human Services Systems Policy Cabinet and the health and human services committee of the legislature identifying the number of self-identified persons living with mental illness working as direct providers of mental health services, supports, and treatments. The report shall also describe consumer-oriented work force development efforts and other activities performed to increase consumer involvement and consumer-provided services in the Nebraska behavioral health services system.

(4-5) The division shall act as the chief behavioral health authority for the State of Nebraska and shall direct the administration and coordination of the public behavioral health system, including but not limited to: (a) administration and management of the division, regional centers, and ~~any~~ all other facilities and programs operated by the division; (b) integration and coordination of the public behavioral health system; (c) comprehensive statewide planning for the development of community-based behavioral health services in each behavioral health region; (d) coordination and oversight of regional behavioral health authorities, including approval of regional budgets and audits of regional behavioral health authorities; (e) development and management of data and information systems; (f) prioritization and approval of all expenditures of funds received and administered by the division, including the establishment of rates to be paid and payment processes for behavioral health services and fees to be paid by consumers of such services; (g) coordination with the Department of Health and Human Services Regulation and Licensure in the licensure and regulation of behavioral health facilities, services, professions and occupations, including recovery-based competencies; (h) audits of behavioral health programs and services; ~~and~~ (i) promotion of activities in research and education, to improve the quality of behavioral health services, the recruitment and retention of behavioral health professionals including consumer providers, the availability of traditional and consumer-

run behavioral health programs and services,~~.~~ ~~and~~ (j) provision of support and technical assistance to increase and enhance consumer involvement in their own lives as well as the design, planning, delivery, and evaluation of services, research and education.
(5) The department shall adopt and promulgate rules and regulations to carry out the Nebraska Behavioral Health Services Act. The process for adopting and promulgating rules and regulations shall incorporate broad-based consumer involvement including technical assistance and resources.

Regional Governance

Sec. ~~6~~7. (cf. 71-5002(6))

There shall be six behavioral health regions, consisting of the following counties:

(1) Region 1 shall consist of Sioux, Dawes, Box Butte, Sheridan, Scotts Bluff, Morrill, Garden, Banner, Kimball, Cheyenne, and Deuel counties;

(2) Region 2 shall consist of Grant, Hooker, Thomas, Arthur, McPherson, Logan, Keith, Lincoln, Perkins, Chase, Hayes, Frontier, Dawson, Gosper, Dundy, Hitchcock, and Red Willow counties;

(3) Region 3 shall consist of Blaine, Loup, Garfield, Wheeler, Custer, Valley, Greeley, Sherman, Howard, Buffalo, Hall, Phelps, Kearney, Adams, Clay, Furnas, Harlan, Hamilton, Merrick, Franklin, Webster, and Nuckolls counties;

(4) Region 4 shall consist of Cherry, Keya Paha, Boyd, Brown, Rock, Holt, Knox, Cedar, Dixon, Dakota, Thurston, Wayne, Pierce, Antelope, Boone, Nance, Madison, Stanton, Cuming, Burt, Colfax, and Platte counties;

(5) Region 5 shall consist of Polk, Butler, Saunders, Seward, Lancaster, Otoe, Fillmore, Saline, Thayer, Jefferson, Gage, Johnson, Nemaha, Pawnee, York, and Richardson counties; and

(6) Region 6 shall consist of Dodge, Washington, Douglas, Sarpy, and Cass counties.

Sec. ~~7~~8. (cf. 71-5004 et seq.) (1) A regional behavioral health authority shall be established in each behavioral health region by counties acting under provisions of the Interlocal Cooperation Act. Each regional behavioral health authority shall be governed by a board consisting of one county board member from each county in the region. Board members shall receive training provided by the Office of Consumer Affairs, shall be appointed for staggered terms of three years and shall serve until their successors are appointed ~~and qualified~~. Board members shall serve without compensation, but shall be reimbursed for their actual and necessary expenses as provided in sections 81-1174 to 81-1177.

(2) The regional governing board shall appoint a regional administrator who shall be responsible for the administration and management of the regional behavioral health authority. The regional behavioral health authority shall initiate, encourage, ~~and~~ facilitate and support the involvement of consumers in all aspects of service planning, ~~and~~ delivery and evaluation within the region. ~~and~~ Each regional governing board shall establish an advisory committee, consisting of no less than sixty percent consumer membership to provide advice on service availability, accessibility, appropriateness, quality and acceptability in addition to providing advice on the planning, organization, contracting, provision, evaluation and fiscal analysis of behavioral health services in the region. The advisory committee shall prioritize and recommend to the regional governing board the types of programs needed to fill identified gaps in services in the region. The advisory committee shall meet bi-monthly and members shall be reimbursed for actual and necessary expenses incurred in carrying out their duties. The advisory committee shall file an

annual report with the governing board, the administrator for behavioral health services, the Mental Health Planning and Evaluation Council and the health and human services committee of the legislature. The Office of Consumer Affairs shall coordinate such activities with, and provide technical assistance to, ~~the office of consumer affairs within the division~~ the advisory committee for each regional governing board. A regional behavioral health authority may establish and utilize such task forces, subcommittees, or other committees as it deems necessary and appropriate to carry out its duties under this section.

(3) Each regional behavioral health authority shall direct the administration and coordination of the public behavioral health system within the behavioral health region pursuant to rules and regulations adopted and promulgated by the department, including but not limited to: (a) administration and management of the regional behavioral health authority; (b) integration and coordination of the public behavioral health system within the behavioral health region and the Statewide Behavioral Health Implementation Plan as outlined in Section 12 of this act; (c) comprehensive planning for the development of strengths-based, person-centered, recovery-oriented ~~community-based~~ behavioral health services within the region's communities; (d) submission of an annual budget and a proposed plan for the funding and administration of behavioral health services for approval by the division on or before July 1 of each year; (e) submission of annual reports and other reports as required by the division; (f) initiation of contracts with private behavioral health service agencies and professionals for the provision of behavioral health services; (g) coordination with the division in conducting audits of behavioral health programs and services.

(4) Each county in a behavioral health region shall contribute financial support for the operation of the behavioral health authority in the region pursuant to a formula established by the department in rules and regulations. Such formula shall require contribution by counties in an amount equal to one dollar for every three dollars of General Funds. At least forty percent of such amount shall consist of local and county tax revenues and such amount shall be at least equal to that contributed by such counties in fiscal year 2002-2003. Any General Funds transferred from regional centers for the provision of community-based behavioral health services after the effective date of this act shall not be considered in determining such amount under this section.

(5) No regional behavioral health authority shall provide behavioral health services funded in whole or in part with funds received and administered by the division under the Nebraska Behavioral Health Services Act unless: (a) there are no qualified and willing providers to provide such services; (b) the regional behavioral health authority receives written authorization from the administrator to provide such services and enters into a contract with the division to provide such services; and (c) the regional behavioral health authority complies with all applicable rules and regulations adopted and promulgated by the department relating to the provision of such services by such authority, including but not limited to rules and regulations establishing definitions of conflicts of interest for regional behavioral health authorities and procedures in case such conflicts arise.

Community-Based Services and Regional Centers

Sec. ~~8~~9. (1) The division shall promote and coordinate the development and ongoing provision of an array of community-based and integrated services within a continuum of care sufficient to meet the needs identified in the individual person-centered plans developed for persons with behavioral health disorders ~~appropriate array of community-based behavioral health~~

~~services and continuum of care in each behavioral health region, with the purpose of~~ to enhance the well-being, resiliency, recovery and quality of life as well as to ensure the protection of individuals with behavioral health disorders who are considered to be a danger to themselves or others ~~protecting the public safety~~ and ~~reducing~~ reduce the necessity and demand for acute and secure regional center services.

(2) Except as otherwise provided in this section, the division shall cease operation of the Norfolk Regional Center on or before June 30, 2005, and shall cease operation of the Hastings Regional Center on or before December 31, 2005. No regional center shall cease operation unless appropriate community-based services or other regional center services are available for every person receiving services at such regional center and no further admissions or readmissions to such regional center are required due to the availability of such services.

(3) The division shall develop, on or before July 1, 2004, a comprehensive and detailed plan to: (a) identify persons currently receiving regional center services for whom community-based services would be appropriate; (b) fund the development and ongoing provision of community-based services for such persons in each behavioral health region; (c) transition such persons from regional centers to appropriate community-based services; (d) reduce new admissions and readmissions to regional centers through the provision of community-based services; and (e) provide for the public safety the ~~public safety~~ protection of individuals with behavioral health disorders who are considered to be a danger to themselves or others. Such plan shall be included as part of the behavioral health implementation plan required under section 12 of this act.

(4) The division shall require service providers to develop, assess, and maintain Person-Centered Individualized Written Plans of Services, including but not limited to:

(a) The responsible mental health service provider for each recipient shall ensure that a person-centered planning process is used to develop a written individual plan of services in partnership with the recipient. A preliminary plan shall be developed within 7 days of the commencement of services or, if an individual is hospitalized for less than 7 days, before discharge or release. The individual plan of services shall consist of a treatment plan, a support plan, or both. A treatment plan shall establish meaningful and measurable goals with the recipient. The individual plan of services shall address, as either desired or required by the recipient, the recipient's need for food, shelter, clothing, health care, residential services, employment opportunities, educational opportunities, legal services, income supports, transportation, and recreation. The plan shall be kept current and shall be modified when indicated. The individual in charge of implementing the plan of services shall be designated in the plan.

(b) If a recipient is not satisfied with his or her individual plan of services, the recipient, the person authorized by the recipient to make decisions regarding the individual plan of services, the guardian of the recipient, or the parent of a minor recipient may make a request for review to the designated individual in charge of implementing the plan. The review shall be completed within 30 days and shall be carried out in a manner approved by the appropriate governing body.

(c) An individual chosen or required by the recipient may be excluded from participation in the planning process only if inclusion of that individual would constitute a substantial risk of physical or emotional harm to the recipient or substantial disruption of the planning process. Justification for an individual's exclusion shall be documented in the case record. The individual may utilize the grievance process to contest such a decision.

Accessibility, Availability, Appropriateness, Acceptability and Evaluation Of Services

Sec.10 (1) Regional behavioral health authority shall require that all services provided be accessible, available, appropriate and acceptable to the persons served.

(2) Minimum criteria for accessibility of services shall include but not be limited to:

(a) Evening and/or weekend hours to meet the needs of persons receiving services;

(b) Compliance with relevant federal and state regulations, including "section 504" of the "Rehabilitation Act of 1973" (29 U.S.C. Section 794 et seq.); and

(c) Geographical access to services for persons served.

(3) Minimum criteria for availability of services shall include, but not be limited to:

(a) Availability of services for persons regardless of ability to pay for such services;

(4) Coordinating discharge planning and behavioral health services for persons leaving state-operated or private psychiatric inpatient settings.

(5) Assuring continuity of care for persons discharged from psychiatric inpatient settings through the provision of necessary services as determined by the regional behavioral health authority in consultation with the person served. Such necessary services shall be provided upon discharge whenever possible and no later than two weeks post discharge if it has been concluded that these services are required within two weeks;

(6) Providing assistance, as appropriate according to the person's needs, at no additional cost to persons served, to persons requesting or receiving services, and their families or significant others, who speak a language other than standard English as a primary means of communication, or who have a communication disorder, such as deafness or hearing impairment. Such assistance shall include availability of appropriate communication devices, including telecommunication devices for the deaf (TDD), according to 29 U.S.C. 794, 45 CFR part 84 et seq. Other assistance to be provided according to the needs of persons served shall apply to all forms of communication and shall include:

(a) Interpreters fluent in the first vernacular language of the person served, and with demonstrated ability and/or certification;

(b) Services provided by a professional who is able to communicate in the same vernacular language as the person served; and

(c) Referral to a service that provides interpreters.

(5) Providing culturally sensitive and responsive treatment planning and service delivery; and

(6) Addressing behavioral health service needs within the region as described in the regional behavioral health plan.

(7) Minimum criteria for acceptability of services shall include, but not be limited to:

(a) Sensitivity to ethnic and cultural differences among people;

(b) Promoting freedom of choice for the person receiving services; and

(c) Requiring the recipient's informed consent for receipt of service.

(8) Provision that no person served shall be denied access to any service based on their refusal to accept any other service.

(9) Minimum criteria for appropriateness of services shall include, but not be limited to:

(a) Provision of services in the most integrated setting;

(b) Delivery of service in the person's natural environment;

(c) Continuity of relationships;

(d) Needs of the person receiving services identified through the person-centered planning process; and

(e) Culturological assessment.

(10) Minimum criteria for appropriateness of services for persons with a severe mental disorder or serious emotional disturbance shall also include assessment of needs and advocacy with other systems or organizations to meet those needs if the regional behavioral health authority does not provide such services. Such needs and advocacy shall include, but are not limited to:

(a) Behavioral health service needs;

(b) Housing;

(c) Employment and/or educational status;

(d) Health;

(e) Income;

(f) Recreation;

(g) Cultural characteristics;

(h) Spiritual needs; and

(i) Family.

(11) The regional behavioral health authority shall review annually the effectiveness of its efforts to ensure accessibility, availability, appropriateness, and acceptability of services. This review shall be incorporated in service evaluation and quality assurance activities.

Sec. 11 Service evaluation

(1) Each regional behavioral health authority shall have an evaluation plan that covers a two year period and that describes the specific methodologies to be used by the regional behavioral health authority to carry out the goals of service evaluation activities.

(2) Service evaluation activities shall:

(a) Include analysis of the following components:

(1) Annual summary of service evaluation activities;

(2) Needs assessment;

(3) Patterns of use;

(4) Feedback from persons served, their families and significant others;

(5) Community acceptance data; and

(6) Outcome evaluation.

(b) Include separate analyses for minority groups when those minorities are significantly represented in the region;

(c) Interrelate with quality assurance activities. Results of service evaluation studies shall be shared with quality assurance staff and service recipients. Information from quality assurance mechanisms shall be used by service evaluation staff in planning which areas shall be the focus of subsequent evaluations; and

(d) Be conducted in such a manner to ensure that confidentiality is maintained.

(3) The regional behavioral health authority annual summary of service evaluation activities shall:

(a) Include a description of the methodology used for each of the evaluation activities, the general findings or results of these activities, and a description of how these findings or results have been or will be used for service or administrative planning;

(b) Be made available to:

(1) The staff of the regional behavioral health authority;

(2) Persons served, their families and significant others, and the general public;

(3) Organizations with which the regional behavioral health authority has affiliation agreements;

(4) Local county commissioners in the region; and

(5) The Office of Consumer Affairs and the division.

(4) Each regional behavioral health authority shall obtain a needs assessment of service recipients in the region.

(a) The regional behavioral health authority shall review the results of the needs assessment annually and integrate the findings into the regional behavioral health authority service plan and other planning efforts.

(b)The needs assessment conducted by the regional behavioral health authority shall:

(1) Coordinate the design and implementation with the regional advisory committee, the Office of Consumer Affairs, and the division;

(2) Ensure the participation of persons served, their families and significant others in the design of the needs assessment;

(3) Integrate the findings into the regional behavioral health authority service plan and other planning efforts.

(4) Make available the data and results of the needs assessment to the regional advisory committee, the Office of Consumer Affairs, the Mental Health Planning and Evaluation Council, and the division.

(5) Conduct the needs assessment by using one or more of the following general methods, one of which shall include input from persons receiving services and/or their families:

(a) Client-oriented techniques, which refers to any standardized qualitative or quantitative assessment of expressed or observed needs existent among groups of persons receiving services within a specified time period;

(b) Community forum, which means a method of securing public participation such as a town meeting in which community members are brought together to respond to formulated questions regarding community needs for mental health services, and of the priorities to be placed on these needs;

(c) Community survey, which means a survey by questionnaire or interview of a representative sample of the general population of a geographic area. Responses are sought to questions regarding past and present needs for mental health services, degree of mental health or impairment, predilection to use public mental health services, and related matters;

(d) Demographic analysis, which refers to the collection, analysis and interpretation of demographic data, including U.S. census data and other publicly available information, to infer the various levels of need for mental health services within a given geographic area;

(e) Key informant techniques, which refers to any survey, by questionnaire, interview, or joint meeting, of significant members of the community, who represent human service organizations, persons served including ethnic, minority, and cultural groups to determine perceived needs for mental health services;

(f) Rates under treatment techniques, which refers to any collection, analysis, and interpretation of data describing persons who have received mental health

services (public and/or private), and the services received, within a specified time period for a given geographic area;

(g) Research or evaluation results from mental health sources or other systems that affect mental health; and

(h) Any other technique that secures needs assessment information in an efficient and methodologically sound manner.

(5) Each regional behavioral health authority shall determine the numbers and types of persons using services in the region.

(a) For purposes of this determination, the regional behavioral health authority shall collect and analyze patterns of use data:

(1) Pertaining to clinical and demographic characteristics of persons served and the amounts and types of services delivered;

(2) Aggregated for characteristics of persons served such as age, sex, race, and for such populations of persons served as are appropriate to the purpose of the regional behavioral health authority; and

(3) Regarding information on the source of client referral.

(b) Each regional behavioral health authority shall assess the levels of accessibility, availability, appropriateness and acceptability of its services annually through patterns of use information that:

(1) Is analyzed in terms of needs identified from the needs assessment process and demographic characteristics of the service area;

(2) Includes attention to cultural and ethnic needs, i.e., an examination of the kinds and levels of specific services that are received by each ethnic or cultural group; and

(3) Includes trends in the income level and employment status of persons served to determine the number of persons who may benefit from employment, vocational and adult educational services.

(c) If services are not utilized as expected by population groups represented by the demographic characteristics of the region, analysis shall be conducted to determine the cause.

(6) Each regional behavioral health authority shall obtain feedback from persons served and their families regarding services received, the manner in which these services were delivered, and whether the services met their needs. Such feedback shall be routinely collected, analyzed and used for service improvements within the regional behavioral health authority.

(a) Feedback from persons served and their families shall be obtained using at least one of the following mechanisms, and shall ensure that at least one of the mechanisms used involves direct participation of persons served and their families:

(1) A satisfaction questionnaire;

(2) A series of telephone or face-to-face interviews with persons served or their families;

(3) A suggestion box made available especially for collecting feedback from persons served or their families;

(4) Meetings with advocacy or self-help groups;

(5) An ombudsman on the staff of the regional behavioral health authority;

(6) A telephone call-in line designated for use by persons served or their families; or

(7) Any other mechanism that secures feedback from persons served and their families in an efficacious manner.

(b) The mechanisms used to obtain feedback shall be made available to all persons served and their families or shall ensure, as much as is practicable, that an accurate representation of opinions is obtained.

(c) The mechanisms used shall ensure that the persons served and their families may remain anonymous and/or have their responses remain confidential.

(7) Each regional behavioral health authority may obtain feedback from police, human services, schools, children's service agencies, area agencies on aging, community mental health providers, mental retardation/developmental disabilities providers, and other systems that interact with the regional behavioral health authority regarding the levels of acceptance and perceived quality and effectiveness of services provided by the regional behavioral health authority, including but not limited to the following requirements:

(a) Special efforts shall be made to identify problems that might exist in coordination of services, particularly for persons with severe mental disability or serious emotional disturbance and for special needs groups; and

(b) Community acceptance surveys or interviews shall be conducted in coordination with the community behavioral health providers so as not to duplicate efforts in the region.

(8) Each regional behavioral health authority shall assess the impact of services on the lives of persons served.

(a) Agencies shall use both quantitative and qualitative techniques to measure:

(1) Progress toward meeting individual treatment goals, which are based on the needs, strengths, and preferences of the person being served;

(2) Level of improvement in functioning or community integration of the person served; and

(3) Level of improvement in feelings of well-being or quality of life from the perspective of the person being served.

(b) Each regional behavioral health authority shall establish baseline data on key client outcome indicators as a way of measuring progress toward meeting outcome goals.

(c) Each regional behavioral health authority shall use the results of quality assurance mechanisms to determine the services to be evaluated.

(d) When evaluating the outcomes of its services, agencies shall assess both the short-term and long-term impacts, as appropriate, on the lives of persons served. Outcome measures shall be based upon what persons served and their families report as being important to them in their lives.

(9) Results of outcome evaluation shall be used, as appropriate, in revisions of the regional behavioral health authority service plan, and in management and policy decisions.

(10) The regional behavioral health authority may choose different services with which to evaluate client and service outcomes from year to year.

Community and Peer Services

Sec. 12 Consumer-operated services shall (1) Be planned, developed, administered, delivered, and evaluated by persons, a majority of whom are receiving or have received inpatient mental health services or other mental health services of significant intensity and duration;

(2) Be responsive to the needs of persons served and be based on local needs as identified by the individuals providing the service;

(3) Adhere to all applicable local, state, and federal laws, particularly those designed to assure safety of facilities;

(4) Promote coordination among similar providers and agencies to maximize the rehabilitation opportunities for persons served; and
(5) Ensure that the service plan is consistent with the principles of a community support system and promotes peer support outside the mental health service system.
(6) The department shall waive all or any portion of the certification standards that would prevent or significantly impede the development and operation of a consumer-operated service.

Sec. 13 Community Support Program: (1) Community support program (CSP) provides an array of services delivered by community based, mobile individuals or multidisciplinary teams of professionals and trained others. Services address the individualized mental health needs of the client. They are directed towards adults, children, adolescents and families and will vary with respect to hours, type and intensity of services, depending on the changing needs of each individual. The purpose/intent of CSP services is to provide specific, measurable, and individualized services to each person served. CSP services should be focused on the individual's ability to succeed in the community; to identify and access needed services; and to show improvement in school, work and family and integration and contributions within the community.
(2) Activities of the CSP service shall consist of one or more of the following:
(a) Ongoing assessment of needs;
(b) Assistance in achieving personal independence in managing basic needs as identified by the individual and/or parent or guardian;
(c) Facilitation of further development of daily living skills, if identified by the individual and/or parent or guardian;
(d) Coordination of the Person-Centered Individualized Written Service Plan, including:
(1) Assistance with accessing natural support systems in the community; and
(2) Linkages to formal community services/systems;
(3) Symptom monitoring;
(4) Coordination and/or assistance in crisis management and stabilization as needed;
(5) Advocacy and outreach;
(6) As appropriate to the care provided to individuals, and when appropriate, to the family, education and training specific to the individual's assessed needs, abilities and readiness to learn;
(7) Mental health interventions that address symptoms, behaviors, thought processes, etc., that assist an individual in eliminating barriers to seeking or maintaining education and employment; and
(8) Activities that increase the individual's capacity to positively impact his/her own environment.
(3) The methods of CSP service delivery shall consist of:
(a) Service delivery to the person served and/or any other individual who will assist in the person's mental health treatment.
(b) Service delivery may be face-to-face, by telephone, and/or by video conferencing; and
(c) Service delivery may be to individuals or groups.
(d) CSP services are not site specific. However, they must be provided in locations that meet the needs of the persons served.

Sec. 14 (1) Peer support services shall (a)Ensure consultation with persons providing peer support service to identify a departmental staff person to serve as an advisor, help gain access to educational information, or participate in planning as requested by the peer support service; (b) Promote coordination among similar providers and agencies within the region to maximize the opportunities for peer support; and (c) Ensure that the service plan is consistent with the principles of a community support system and other approaches identified by persons served to maximize supports outside the behavioral health service system.
(2) Peer support services may be provided in the home of a person served as part of an effort to enhance a person's support network and to enhance their ability to live in the most integrated community setting.
(3) The regional mental health authority shall facilitate the establishment of peer support.

Sec. 15 (1) Peer specialists shall provide peer support services; serve as a consumer advocate; provide consumer information and peer support for consumers in emergency, outpatient or inpatient settings. Peer specialists perform a wide range of tasks to assist consumers in regaining control over their own lives and over their own recovery process. The peer specialists will role model competency in recovery and ongoing coping skills.
(2) The peer specialists will:
(a) Assist consumers in articulating personal goals for recovery.
(b) Assist consumer in determining the objectives the consumer needs to take in order to reach his or her recovery goals.
(3) The peer specialists will document the following on the Person-Centered Individualized Written Service Plan by:
(a) Assisting consumers in determining "problems."
(b) Assisting consumers in identifying recovery goals.
(c) Assisting consumers in setting objectives.
(d) Determining interventions based on consumers recovery/life goals.
(e) Observing progress consumers make toward meeting objectives.
(f) Understanding and utilizing specific interventions necessary to assist consumers in meeting their recovery goals.
(3) Utilizing their specific training, the peer specialists will:
(a) Lead as well as teach consumers how to facilitate Recovery Dialogues by using Focus Conversation and Workshop methods.
(b) Assist consumers in setting up and sustaining self-help (mutual support) groups.
(c) Assist consumers in creating a Wellness Recovery Action Plan (WRAP).
(d) Utilize and teach problem solving techniques with individuals and groups.
(e) Teach consumers how to identify and combat negative self-talk.
(f) Teach consumers how to identify and overcome fears.
(g) Support the vocational choices consumers make and assist them in overcoming job-related anxiety.
(h) Assist consumers in building social skills in the community that will enhance job acquisition and tenure.
(i) Assist non-consumer staff in identifying program environments that are conducive to recovery; lend their unique insight into mental illness and what makes recovery possible.
(j) Attend treatment team meetings to promote consumer's use of self-directed recovery tools.

(4) Utilizing their unique recovery experience, the peer specialists will:

(a) Teach and role model the value of every individual's recovery experience.

(b) Assist the consumer in obtaining decent and affordable housing of his or her choice in the most integrated, independent, and least intrusive or restrictive environment.

(c) Model effective coping techniques and self-help strategies.

(5) The peer specialists will maintain a working knowledge of current trends and developments in the mental health field by reading books, journals and other relevant material.

(a) Continue to develop and share recovery-oriented material with other peer specialists.

(b) Attend continuing education programs, relevant seminars, meetings, and in-service trainings whenever offered.

(6) The peer specialists will serve as a recovery agent by:

(a) Providing and advocating for effective recovery based services.

(b) Assisting consumers in obtaining services that suit that individual's recovery needs.

(c) Informing consumers about community and natural supports and how to utilize these in the recovery process.

(d) Assisting consumers in developing empowerment skills through self-advocacy and stigma-busting.

Funding

Sec. ~~9~~16. (1) The division shall coordinate the management of all funds appropriated by the Legislature or otherwise received by the Nebraska Health and Human Services System from any other public or private source and designated by the Policy Cabinet for the provision of behavioral health services.

(2) Such funds shall be efficiently and effectively integrated and managed ~~in the best interests of consumers~~ to maximize recovery, resilience, wellness, community integration and quality of life enhancements for persons with behavioral health disorders ~~of behavioral health services~~, ~~to ensure~~ by ensuring: (a) an array of community-based services ~~and~~ within a continuum of care sufficient to meet the needs identified in the person-centered individualized written service plans ~~an appropriate array of community-based behavioral health services for consumers~~ in each behavioral health region; (b) development of consumer-run, peer support, and peer specialist services and (c) the ~~appropriate~~ allocation of ~~such~~ sufficient funds in a manner consistent with the ~~consumer's~~ needs identified in the person-centered individualized written service plan.

Advocacy

Sec. ~~10~~17. (1)~~Combine~~ Retain the State Mental Health Planning and Evaluation Council~~,~~ as currently required in section 71-5008 NRS and PL-102-321and the State Alcoholism and Drug Abuse Advisory Committee as currently required in section XXXXXXXX NRS. ~~, and the Nebraska Advisory Commission on Compulsive Gambling~~ The chairperson of each entity noted above shall be appointed to the Behavioral Health Oversight Commission of the legislature as established in this act. The executive committees established for these organizations shall meet together on a quarterly basis as a single, statewide behavioral health system ~~into one statewide~~ advocacy and advisory organization to the department of health and human services regarding the integration of behavioral health services, including an examination of and recommendations for services and supports to address the needs of individuals diagnosed with co-occurring mental

health and substance abuse disorders. ~~that meets federal requirements. , with three subcommittees. Retain provisions relating to the Compulsive Gamblers Assistance Fund~~; and (2) Each quality review team must be required to submit an annual report to the director of the division of behavioral health and the health and human services committee of the legislature detailing the results of the requirements in subsection 3 of 71-5003.01 NRS. On or before September 1 of each year, the director of the behavioral health system shall issue an annual report in response to the findings and recommendations contained in the quality review team annual reports including specific recommendations in response to the findings, recommendations, and concerns identified in the quality review team annual reports. The director shall submit the report to the health and human services committee of the legislature and the Mental Health Planning and Evaluation Council.

Transition/Legislative Oversight

Sec. ~~11~~18. (1) The Behavioral Health Oversight Commission of the Legislature is established. The commission shall consist of no more than fifteen persons appointed by the chairperson of the Health and Human Services Committee of the Legislature and confirmed by a majority vote of members of the committee. No less than one-third of the membership must be current or former recipient of mental health services, or family members of consumers; other ~~M~~members of the commission shall possess a demonstrated interest and commitment and specialized knowledge and expertise relating to the provision of behavioral health services in the State of Nebraska and shall be broadly representative of all behavioral health regions. Members shall be reimbursed from the Nebraska Health Care Cash Fund for their actual and necessary expenses as provided in sections 81-1174 to 81-1177.

(2) The commission, under the direction of the Health and Human Services Committee of the Legislature, shall oversee and support implementation of the plan submitted by the division under section 12 of this act and shall administer such funds as appropriated by the Legislature from the Nebraska Health Care Cash Fund and approved by the committee.

(3) The commission and this section shall terminate on December 31, 2006.

Planning Activities

Sec. ~~12~~19. The division shall submit annually a five-year behavioral health implementation plan to the Governor and the Legislature on or before ~~July~~ October 1, 2004. The plan shall be consistent with provisions of the Nebraska Behavioral Health Services Act, and shall provide a detailed description of completed and proposed activities and outcomes by the division over a ~~three~~ five-year period to implement the act. The plan shall be reviewed by the Health and Human Services Committee of the Legislature and by the Behavioral Health Oversight Commission of the Legislature established under section 11 of this act. The division shall immediately advise the committee and the commission of any changes to the plan, and shall report at least monthly to the committee and the commission as to its implementation.

Research Activities

Sec. 20. (1) When a regional behavioral health authority conducts, participates in, or is the site of research activity with individuals characterized as human subjects, this research activity shall comply with the following requirements:

(a) Any information that can be used to identify an individual shall be kept strictly confidential, unless consent to release this information is given by the subject. Provisions shall be made for the secure storage and timely disposal of confidential information. Client names and other identifying information shall be destroyed as soon as this information is no longer needed for completion of the research.

(b) Participants in research activity shall be fully informed prior to the start of research activity of the considerations listed in paragraphs (A)(7)(a) to (A)(7)(i) of this rule. In all cases, participants shall be orally informed at the beginning of the research activity that they are being asked to participate in research and that they are free to refuse or withdraw at any time without penalty.

(c) The consent of each subject is to be obtained in writing for all research except:

(1) Research involving the collection or study of existing data that are publicly available or if the information is made available to the investigator in such a manner that subjects cannot be identified, directly or through identifiers linked to the subject; or

(2) Paper and pencil questionnaires involving the solicitation of non-threatening information.

(3) Consent shall be obtained from the parent or guardian for individuals under eighteen years of age and individuals for whom a legal guardian has been assigned because they are deemed incompetent to consent. If the multi-disciplinary review committee finds that there is more than "minimal risk" for individuals under eighteen years of age, consent is to be obtained from both parents unless one parent is deceased, unknown, incompetent, not reasonably available or when only one parent has legal responsibility for the care and custody of the child. Consent by a parent or guardian shall be accompanied by the voluntary participation of the research subject, if at all possible.

(4) An overt refusal to participate by either the adult or child subject or the parent or guardian is to be taken as final.

(5) If the research involves a regional mental health authority, the regional mental health authority director shall also provide consent.

(6) The written consent from a research subject shall be obtained on a consent form and kept for the duration of the research activity. The consent form shall indicate the purpose and use of the information that is being collected, potential risks and benefits, and shall make clear to the individual that withdrawal from participation is possible at any time without penalty. Any known discomforts, side effects, or particularly beneficial alternatives to participation shall be explained. The consent form shall use simple and non-coercive language and shall include the following basic elements:

(a) A statement that the study involves research, an explanation of the purposes of the research and the expected duration of the subject's participation, a description of the procedures to be followed, and identification of any procedures which are experimental;

(b) A statement concerning all other data sources that will be consulted concerning the subject, including other persons, records, or other service system records;

(c) A description of any foreseeable side effects, risks or discomforts to the subject;

(d) A description of any benefits to the subject or to others that may reasonably be expected from the research;

(e) A disclosure of appropriate alternative procedures or courses of treatment, if any, that may be advantageous to the subject;

(f) A statement describing the extent to which confidentiality of records identifying the subject will be maintained;

(g) For research involving more than minimal risk, an explanation as to whether any compensation is available, and an explanation as to whether any medical treatments are available if injury occurs and, if so, what they consist of, or where further information may be obtained;

(h) An explanation of whom to contact for answers to pertinent questions about the research and research subject's rights, and whom to contact in the event of a research-related injury to the subject; and

(i) A statement that participation is voluntary, that refusal to participate will involve no penalty or loss of benefits to which the subject is otherwise entitled, and that the subject may discontinue participation at any time without penalty or loss of benefits to which the subject is otherwise entitled.

(2) An entity that conducts research activity shall ensure research attention to the needs and characteristics of minority groups, including the requirements that:

(a) Research shall be conducted in a manner that provides minority individuals with the opportunity of being selected for research at least in proportion to their representation in the population being studied.

(b) All research that includes minority representation shall include, at a minimum, a qualitative examination of potential differences in findings for minority groups. Data analysis conducted as part of research shall include tests of differences in findings and interactions pertaining to membership in minority groups.

(3) All research activity shall be reviewed and approved by a multi-disciplinary review committee.

(a) A majority of the committee shall not be directly associated with the research activity under consideration. This committee shall be composed of at least five members, including:

(1) Representatives of minority populations in numbers proportional to their representation in the service population being studied, and a member who represents the client rights perspective; and

(2) Individuals who are appropriately experienced in programmatic aspects of the research and individuals with methodological expertise that is relevant to the research.

(3) The research committee may be either a permanent or an ad hoc committee, a committee of the department or regional mental health authority, or an officially constituted research committee of an academic institution with which one or more of the department staff or researchers are affiliated.

(4) Prior to the initiation of any research activity, the research committee shall conduct a detailed review and determine authorization. The review shall consider compliance with the standards set forth in this rule for confidentiality and written informed consent, and adherence to all applicable state and federal laws and regulations. The committee shall review the following factors and consider them in determining authorization:

(a) Adequacy of the research design and compliance with methodological standards;

(b) Relevance to existing scientific theory;

(c) Potential to yield new knowledge;
(d) Generalizability of findings;
(e) Qualifications of the individuals conducting the research activity;
(f) Benefits and risks to the individuals involved, the regional mental health authority and the department;
(g) Possible disruptive effects on normal routine operations of services or agencies; and
(h) Costs to the division or regional mental health authority.