AN ACT concerning health.

Be it enacted by the People of the State of Illinois, represented in the General Assembly:

Section 1. Short title.

(a) This Act may be cited as the Community Emergency Services and Support Act.

(b) This Act may be referred to as the Stephon Edward Watts Act.

Section 5. Findings. The General Assembly recognizes that the Illinois Department of Human Services Division of Mental Health is preparing to provide mobile mental and behavioral health services to all Illinoisans as part of the federally mandated adoption of the 9-8-8 phone number. The General Assembly also recognizes that many cities and some states have successfully established mobile emergency mental and behavioral health services as part of their emergency response system to support people who need such support and do not present a threat of physical violence to the responders. In light of that experience, the General Assembly finds that in order to promote and protect the health, safety, and welfare of the public, it is necessary and in the public interest to provide emergency response, with or without medical transportation, to individuals requiring mental health or

behavioral health services in a manner that is substantially equivalent to the response already provided to individuals who require emergency physical health care.

Section 10. Applicability; home rule. This Act applies to every unit of local government that provides or coordinates ambulance or similar emergency medical response or transportation services for individuals with emergency medical needs. A home rule unit may not respond to or provide services for a mental or behavioral health emergency, or create a transportation plan or other regulation, relating to the provision of mental or behavioral health services in a manner inconsistent with this Act. This Act is a limitation under subsection (i) of Section 6 of Article VII of the Illinois Constitution on the concurrent exercise by home rule units of powers and functions exercised by the State.

Section 15. Definitions. As used in this Act:

"Division of Mental Health" means the Division of Mental Health of the Department of Human Services.

"Emergency" means an emergent circumstance caused by a health condition, regardless of whether it is perceived as physical, mental, or behavioral in nature, for which an individual may require prompt care, support, or assessment at the individual's location.

"Mental or behavioral health" means any health condition

involving changes in thinking, emotion, or behavior, and that the medical community treats as distinct from physical health care.

"Physical health" means a health condition that the medical community treats as distinct from mental or behavioral health care.

"PSAP" means a Public Safety Answering Point tele-communicator.

"Community services" and "community-based mental or behavioral health services" may include both public and private settings.

"Treatment relationship" means an active association with a mental or behavioral care provider able to respond in an appropriate amount of time to requests for care.

"Responder" is any person engaging with a member of the public to provide the mobile mental and behavioral service established in conjunction with the Division of Mental Health establishing the 9-8-8 emergency number. A responder is not an EMS Paramedic or EMT as defined in the Emergency Medical Services (EMS) Systems Act unless that responding agency has agreed to provide a specialized response in accordance with the Division of Mental Health's services offered through its 9-8-8 number and has met all the requirements to offer that service through that system.

Section 20. Coordination with Division of Mental Health.

Each 9-1-1 PSAP and provider of emergency services dispatched through a 9-1-1 system must coordinate with the mobile mental and behavioral health services established by the Division of Mental Health so that the following State goals and State prohibitions are met whenever a person interacts with one of these entities for the purpose seeking emergency mental and behavioral health care or when one of these entities recognizes the appropriateness of providing mobile mental or behavioral health care to an individual with whom they have engaged. The Division of Mental Health is also directed to provide guidance regarding whether and how these entities should coordinate with mobile mental and behavioral health services when responding to individuals who appear to be in a mental or behavioral health emergency while engaged in conduct alleged to constitute a non-violent misdemeanor.

Section 25. State goals.

(a) 9-1-1 PSAPs, emergency services dispatched through 9-1-1 PSAPs, and the mobile mental and behavioral health service established by the Division of Mental Health must coordinate their services so that the State goals listed in this Section are achieved. Appropriate mobile response service for mental and behavioral health emergencies shall be available regardless of whether the initial contact was with 9-8-8, 9-1-1 or directly with an emergency service dispatched through 9-1-1. Appropriate mobile response services must:

(1) ensure that individuals experiencing mental or behavioral health crises are diverted from hospitalization or incarceration whenever possible, and are instead linked with available appropriate community services;

(2) include the option of on-site care if that type of care is appropriate and does not override the care decisions of the individual receiving care. Providing care in the community, through methods like mobile crisis units, is encouraged. If effective care is provided on site, and if it is consistent with the care decisions of the individual receiving the care, further transportation to other medical providers is not required by this Act;

(3) recommend appropriate referrals for available community services if the individual receiving on-site care is not already in a treatment relationship with a service provider or is unsatisfied with their current service providers. The referrals shall take into consideration waiting lists and copayments, which may present barriers to access; and

(4) subject to the care decisions of the individual receiving care, provide transportation for any individual experiencing a mental or behavioral health emergency. Transportation shall be to the most integrated and least restrictive setting appropriate in the community, such as to the individual's home or chosen location, community crisis respite centers, clinic settings, behavioral health

centers, or the offices of particular medical care providers with existing treatment relationships to the individual seeking care.

(b) Prioritize requests for emergency assistance. 9-1-1 PSAPs, emergency services dispatched through 9-1-1 PSAPs, and the mobile mental and behavioral health service established by the Division of Mental Health must provide guidance for prioritizing calls for assistance and maximum response time in relation to the type of emergency reported.

(c) Provide appropriate response times. From the time of first notification, 9-1-1 PSAPs, emergency services dispatched through 9-1-1 PSAPs, and the mobile mental and behavioral health service established by the Division of Mental Health must provide the response within response time appropriate to the care requirements of the individual with an emergency.

(d) Require appropriate responder training. Responders must have adequate training to address the needs of individuals experiencing a mental or behavioral health emergency. Adequate training at least includes:

(1) training in de-escalation techniques;

(2) knowledge of local community services and supports; and

(3) training in respectful interaction with people experiencing mental or behavioral health crises, including the concepts of stigma and respectful language.

(e) Require minimum team staffing. The Division of Mental

Health, in consultation with the Regional Advisory Committees created in Section 40, shall determine the appropriate credentials for the mental health providers responding to calls, including to what extent the responders must have certain credentials and licensing, and to what extent the responders can be peer support professionals.

(f) Require training from individuals with lived experience. Training shall be provided by individuals with lived experience to the extent available.

(g) Adopt guidelines directing referral to restrictive care settings. Responders must have guidelines to follow when considering whether to refer an individual to more restrictive forms of care, like emergency room or hospital settings.

(h) Specify regional best practices. Responders providing these services must do so consistently with best practices, which include respecting the care choices of the individuals receiving assistance. Regional best practices may be broken down into sub-regions, as appropriate to reflect local resources and conditions. With the agreement of the impacted EMS Regions, providers of emergency response to physical emergencies may participate in another EMS Region for mental and behavioral response, if that participation shall provide a better service to individuals experiencing a mental or behavioral health emergency.

(i) Adopt system for directing care in advance of an emergency. The Division of Mental Health shall select and

publicly identify a system that allows individuals who voluntarily chose to do so to provide confidential advanced care directions to individuals providing services under this Act. No system for providing advanced care direction may be implemented unless the Division of Mental Health approves it as confidential, available to individuals at all economic levels, and non-stigmatizing. The Division of Mental Health may defer this requirement for providing a system for advanced care direction if it determines that no existing systems can currently meet these requirements.

(j) Train dispatching staff. The personnel staffing 9-1-1, 3-1-1, or other emergency response intake systems must be provided with adequate training to assess whether coordinating with 9-8-8 is appropriate.

(k) Establish protocol for emergency responder coordination. The Division of Mental Health shall establish a protocol for responders, law enforcement, and fire and ambulance services to request assistance from each other, and train these groups on the protocol.

(l) Integrate law enforcement. The Division of Mental Health shall provide for law enforcement to request responder assistance whenever law enforcement engages an individual appropriate for services under this Act. If law enforcement would typically request EMS assistance when it encounters an individual with a physical health emergency, law enforcement shall similarly dispatch mental or behavioral health personnel

or medical transportation when it encounters an individual in a mental or behavioral health emergency.

Section 30. State prohibitions. 9-1-1 PSAPs, emergency services dispatched through 9-1-1 PSAPs, and the mobile mental and behavioral health service established by the Division of Mental Health must coordinate their services so that, based on the information provided to them, the following State prohibitions are avoided:

(a) Law enforcement responsibility for providing mental and behavioral health care. In any area where responders are available for dispatch, law enforcement shall not be dispatched to respond to an individual requiring mental or behavioral health care unless that individual is (i) involved in a suspected violation of the criminal laws of this State, or (ii) presents a threat of physical injury to self or others. Responders are not considered available for dispatch under this Section if 9-8-8 reports that it cannot dispatch appropriate service within the maximum response times established by each Regional Advisory Committee under Section 45.

(1) Standing on its own or in combination with each other, the fact that an individual is experiencing a mental or behavioral health emergency, or has a mental health, behavioral health, or other diagnosis, is not sufficient to justify an assessment that the individual is

a threat of physical injury to self or others, or requires a law enforcement response to a request for emergency response or medical transportation.

(2) If, based on its assessment of the threat to public safety, law enforcement would not accompany medical transportation responding to a physical health emergency, unless requested by responders, law enforcement may not accompany emergency response or medical transportation personnel responding to a mental or behavioral health emergency that presents an equivalent level of threat to self or public safety.

(3) Without regard to an assessment of threat to self or threat to public safety, law enforcement may station personnel so that they can rapidly respond to requests for assistance from responders if law enforcement does not interfere with the provision of emergency response or transportation services. To the extent practical, not interfering with services includes remaining sufficiently distant from or out of sight of the individual receiving care so that law enforcement presence is unlikely to escalate the emergency.

(b) Responder involvement in involuntary commitment. In order to maintain the appropriate care relationship, responders shall not in any way assist in the involuntary commitment of an individual beyond (i) reporting to their dispatching entity or to law enforcement that they believe the

situation requires assistance the responders are not permitted to provide under this Section; (ii) providing witness statements; and (iii) fulfilling reporting requirements the responders may have under their professional ethical obligations or laws of this state. This prohibition shall not interfere with any responder's ability to provide physical or mental health care.

(c) Use of law enforcement for transportation. In any area where responders are available for dispatch, unless requested by responders, law enforcement shall not be used to provide transportation to access mental or behavioral health care, or travel between mental or behavioral health care providers, except where no alternative is available.

(d) Reduction of educational institution obligations. The services coordinated under this Act may not be used to replace any service an educational institution is required to provide to a student. It shall not substitute for appropriate special education and related services that schools are required to provide by any law.

Section 35. Non-violent misdemeanors. The Division of Mental Health's Guidance for 9-1-1 PSAPs and emergency services dispatched through 9-1-1 PSAPs for coordinating the response to individuals who appear to be in a mental or behavioral health emergency while engaging in conduct alleged to constitute a non-violent misdemeanor shall promote the

following:

(a) Prioritization of Health Care. To the greatest extent practicable, community-based mental or behavioral health services should be provided before addressing law enforcement objectives.

(b) Diversion from Further Criminal Justice Involvement. To the greatest extent practicable, individuals should be referred to health care services with the potential to reduce the likelihood of further law enforcement engagement.

Section 40. Statewide Advisory Committee.

(a) The Division of Mental Health shall establish a Statewide Advisory Committee to review and make recommendations for aspects of coordinating 9-1-1 and the 9-8-8 mobile mental health response system most appropriately addressed on a State level.

(b) Issues to be addressed by the Statewide Advisory Committee include, but are not limited to, addressing changes necessary in 9-1-1 call taking protocols and scripts used in 9-1-1 PSAPs where those protocols and scripts are based on or otherwise dependent on national providers for their operation.

(c) The Statewide Advisory Committee shall recommend a system for gathering data related to the coordination of the 9-1-1 and 9-8-8 systems for purposes of allowing the parties to make ongoing improvements in that system. As practical, the

system shall attempt to determine issues including, but not limited to:

(1) the volume of calls coordinated between 9-1-1 and 9-8-8;

(2) the volume of referrals from other first responders to 9-8-8;

(3) the volume and type of calls deemed appropriate for referral to 9-8-8 but could not be served by 9-8-8 because of capacity restrictions or other reasons;

(4) the appropriate information to improve coordination between 9-1-1 and 9-8-8; and

(5) the appropriate information to improve the 9-8-8 system, if the information is most appropriately gathered at the 9-1-1 PSAPs.

(d) The Statewide Advisory Committee shall consist of:

(1) the Statewide 9-1-1 Administrator, ex officio;

(2) one representative designated by the Illinois Chapter of National Emergency Number Association (NENA);

(3) one representative designated by the Illinois Chapter of Association of Public Safety Communications Officials (APCO);

(4) one representative of the Division of Mental Health;

(5) one representative of the Illinois Department of Public Health;

(6) one representative of a statewide organization of

EMS responders;

(7) one representative of a statewide organization of fire chiefs;

(8) two representatives of statewide organizations of law enforcement;

(9) two representatives of mental health, behavioral health, or substance abuse providers; and

(10) four representatives of advocacy organizations either led by or consisting primarily of individuals with intellectual or developmental disabilities, individuals with behavioral disabilities, or individuals with lived experience.

(e) The members of the Statewide Advisory Committee, other than the Statewide 9-1-1 Administrator, shall be appointed by the Secretary of Human Services.

Section 45. Regional Advisory Committees.

(a) The Division of Mental Health shall establish Regional Advisory Committees in each EMS Region to advise on regional issues related to emergency response systems for mental and behavioral health. The Secretary of Human Services shall appoint the members of the Regional Advisory Committees. Each Regional Advisory Committee shall consist of:

(1) representatives of the 9-1-1 PSAPs in the region;

(2) representatives of the EMS Medical Directors Committee, as constituted under the Emergency Medical

Services (EMS) Systems Act, or other similar committee serving the medical needs of the jurisdiction;

(3) representatives of law enforcement officials with jurisdiction in the Emergency Medical Services (EMS) Regions;

(4) representatives of both the EMS providers and the unions representing EMS or emergency mental and behavioral health responders, or both; and

(5) advocates from the mental health, behavioral health, intellectual disability, and developmental disability communities.

(b) The majority of advocates on the Emergency Response Equity Committee must either be individuals with a lived experience of a condition commonly regarded as a mental health or behavioral health disability, developmental disability, or intellectual disability, or be from organizations primarily composed of such individuals. The members of the Committee shall also reflect the racial demographics of the jurisdiction served.

(c) Subject to the oversight of the Department of Human Services Division of Mental Health, the EMS Medical Directors Committee is responsible for convening the meetings of the committee. Impacted units of local government may also have representatives on the committee subject to approval by the Division of Mental Health, if this participation is structured in such a way that it does not give undue weight to any of the

groups represented.

Section 50. Regional Advisory Committee responsibilities. Each Regional Advisory Committee is responsible for designing the local protocol to allow its region's 9-1-1 call center and emergency responders to coordinate their activities with 9-8-8 as required by this Act and monitoring current operation to advise on ongoing adjustments to the local protocol. Included in this responsibility, each Regional Advisory Committee must:

(1) negotiate the appropriate amendment of each 9-1-1 PSAP emergency dispatch protocols, in consultation with each 9-1-1 PSAP in the EMS Region and consistent with national certification requirements;

(2) set maximum response times for 9-8-8 to provide service when an in-person response is required, based on type of mental or behavioral health emergency, which, if exceeded, constitute grounds for sending other emergency responders through the 9-1-1 system;

(3) report, geographically by police district if practical, the data collected through the direction provided by the Statewide Advisory Committee in aggregated, non-individualized monthly reports. These reports shall be available to the Regional Advisory Committee members, the Department of Human Service Division of Mental Health, the Administrator of the 9-1-1 Authority, and to the public upon request; and

(4) convene, after the initial regional policies are established, at least every 2 years to consider amendment of the regional policies, if any, and also convene whenever a member of the Committee requests that the Committee consider an amendment.

Section 55. Immunity. The exemptions from civil liability in Section 15.1 of the Emergency Telephone Systems Act apply to any act or omission in the development, design, installation, operation, maintenance, performance, or provision of service directed by this Act.

Section 60. Scope. This Act applies to persons of all ages, both children and adults. This Act does not limit an individual's right to control his or her own medical care. No provision of this Act shall be interpreted in such a way as to limit an individual's right to choose his or her preferred course of care or to reject care. No provision of this Act shall be interpreted to promote or provide justification for the use of restraints when providing mental or behavioral health care.

Section 65. PSAP and emergency service dispatched through a 9-1-1 PSAP; coordination of activities with mobile and behavioral health services. Each 9-1-1 PSAP and emergency service dispatched through a 9-1-1 PSAP must begin

coordinating its activities with the mobile mental and behavioral health services established by the Division of Mental Health once all 3 of the following conditions are met, but not later than January 1, 2023:

(1) the Statewide Committee has negotiated useful protocol and 9-1-1 operator script adjustments with the contracted services providing these tools to 9-1-1 PSAPs operating in Illinois;

(2) the appropriate Regional Advisory Committee has completed design of the specific 9-1-1 PSAP's process for coordinating activities with the mobile mental and behavioral health service; and

(3) the mobile mental and behavioral health service is available in their jurisdiction.