HB3697

LRB104 12197 RTM 22302 b

104TH GENERAL ASSEMBLY

State of Illinois

2025 and 2026

HB3697

Introduced 2/18/2025, by Rep. Kelly M. Cassidy

SYNOPSIS AS INTRODUCED:

See Index

Amends the Community Emergency Services and Support Act. Modifies legislative findings. Provides that appropriate mobile response services must, among other things, subject to the care decisions of the individual receiving care, coordinate transportation for any individual experiencing a mental or behavioral health emergency to the least restrictive setting feasible (rather than provide transportation for any individual experiencing a mental or behavioral health emergency). Provides that adequate mobile mental health relief provider training includes, among other things, training in recognizing and working with people with neurodivergent and developmental disability diagnoses and in the techniques available to help stabilize and connect them to further services and training in the involuntary commitment process, in identification of situations that meet the standards for involuntary commitment, and in cultural competencies and social biases to guard against any group being disproportionately subjected to the involuntary commitment process or the use of the process not warranted under the legal standard for involuntary commitment. Provides that mobile mental health relief providers may only participate in the involuntary commitment process to the extent permitted under the Mental Health and Developmental Disabilities Code. Requires the system for gathering information developed by the Statewide Advisory Committee to determine the number of instances of mobile mental health relief providers initiating petitions for involuntary commitment. Provides that the exemption from civil liability for emergency care provided in the Good Samaritan Act applies to anyone providing care under the Act. Provides that each 9-1-1 public safety answering point and emergency service dispatched through a 9-1-1 public safety answering point 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 July 1, 2027 (rather than July 1, 2025). Adds definitions and modifies existing definitions. Effective immediately.

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A BILL FOR

AN ACT concerning local government.

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

Section 5. The Community Emergency Services and Support Act is amended by changing Sections 5, 15, 25, 30, 40, 55, and 65 as follows:

(50 ILCS 754/5)

Sec. 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 mobile mental health relief providers. 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.

The General Assembly also recognizes the history of vulnerable populations being subject to unwarranted involuntary commitment or other human rights violations instead of receiving necessary care during acute crises which may contribute to an understandable apprehension of behavioral health services among individuals who have historically been subject to these practices. The General Assembly intends for the Mobile Mental Health Relief Providers regulated by this Act to assist with crises that do not rise to the level of involuntary commitment. However, the General Assembly also recognizes that Mobile Mental Health Relief Providers may, during the course of assisting with a crisis, encounter individuals who present an imminent threat of injury to themselves or others unless they receive assistance through the involuntary commitment process. This Act intends to balance concerns about misuse of the involuntary commitment process with the need for emergency care for individuals whose crisis presents an imminent threat of injury.

(Source: P.A. 102-580, eff. 1-1-22; 103-105, eff. 6-27-23.)

(50 ILCS 754/15)

Sec. 15. Definitions. As used in this Act:

"Chemical restraint" means any drug used for discipline or convenience and not required to treat medical symptoms.

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

"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.

"Mobile mental health relief provider" means a 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. "Mobile mental health relief provider" does not include a Paramedic (EMT-P) or EMT, as those terms are 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.

"Physical health" means a health condition that the

medical community treats as distinct from mental or behavioral health care.

"Physical restraint" means any manual method or physical or mechanical device, material, or equipment attached or adjacent to an individual's body that the individual cannot easily remove and restricts freedom of movement or normal access to one's body. "Physical restraint" does not include a seat belt if it is used during transportation of an individual and the individual has access to the mechanism that releases the seat belt.

"Public safety answering point" or "PSAP" means the primary answering location of an emergency call that meets the appropriate standards of service and is responsible for receiving and processing those calls and events according to a specified operational policy ~~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.

(Source: P.A. 102-580, eff. 1-1-22; 103-105, eff. 6-27-23.)

(50 ILCS 754/25)

Sec. 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) whenever possible, ensure that individuals experiencing mental or behavioral health crises are diverted from hospitalization or incarceration 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, coordinate ~~provide~~ transportation for any individual experiencing a mental or behavioral health emergency to the least restrictive setting feasible. ~~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 mobile mental health relief provider training. Mobile mental health relief providers 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; ~~.~~

(4) training in recognizing and working with people with neurodivergent and developmental disability diagnoses and in the techniques available to help stabilize and connect them to further services; and

(5) training in the involuntary commitment process, in identification of situations that meet the standards for involuntary commitment, and in cultural competencies and social biases to guard against any group being disproportionately subjected to the involuntary commitment process or the use of the process not warranted under the legal standard for involuntary commitment.

(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 mobile mental health relief providers must have certain credentials and licensing, and to what extent the mobile mental health relief providers 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. Mobile mental health relief providers 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. Mobile mental health relief providers 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 mobile mental health relief providers, 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 mobile mental health relief provider 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.

(Source: P.A. 102-580, eff. 1-1-22; 103-105, eff. 6-27-23.)

(50 ILCS 754/30)

Sec. 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 mobile mental health relief providers 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. Mobile mental health relief providers 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 mobile mental health relief providers, 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 mobile mental health relief providers 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) Mobile mental health relief provider involvement in involuntary commitment. <u>Mobile mental health relief providers</u>

may participate in the involuntary commitment process only to the extent permitted under the Mental Health and Developmental Disabilities Code. The Division of Behavioral Health shall, in consultation with each Regional Advisory Committee, as appropriate, monitor the use of involuntary commitment under this Act and provide systemic recommendations to improve outcomes for those subject to commitment. ~~In order to maintain the appropriate care relationship, mobile mental health relief providers 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 mobile mental health relief providers are not permitted to provide under this Section; (ii) providing witness statements; and (iii) fulfilling reporting requirements the mobile mental health relief providers may have under their professional ethical obligations or laws of this State. This prohibition shall not interfere with any mobile mental health relief provider's ability to provide physical or mental health care.~~

(c) Use of law enforcement for transportation. In any area where mobile mental health relief providers are available for dispatch, unless requested by mobile mental health relief providers, 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 (i) no alternative is available; (ii) the

individual requests transportation from law enforcement and law enforcement mutually agrees to provide transportation; or (iii) the Mental Health and Developmental Disabilities Code requires law enforcement to provide transportation.

(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.

(e) This Section is operative beginning on the date the 3 conditions in Section 65 are met or July 1, 2025, whichever is earlier.

(Source: P.A. 102-580, eff. 1-1-22; 103-105, eff. 6-27-23; 103-645, eff. 7-1-24.)

(50 ILCS 754/40)

Sec. 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, which may include, but are not limited to ~~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; and ~~.~~

(6) the number of instances of mobile mental health relief providers initiating petitions for involuntary commitment, broken down by county and contracting entity employing the petitioning mobile mental health relief providers and the aggregate demographic data of the individuals subject to those petitions.

(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.

(f) The Statewide Advisory Committee shall continue to meet until this Act has been fully implemented, as determined by the Division of Mental Health, and mobile mental health relief providers are available in all parts of Illinois. The Division of Mental Health may reconvene the Statewide Advisory Committee at its discretion after full implementation of this Act.

(Source: P.A. 102-580, eff. 1-1-22; 103-105, eff. 6-27-23.)

(50 ILCS 754/55)

Sec. 55. Immunity.

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

(b) Persons, agencies, governmental bodies, private organizations, governmental organizations, or institutions that in good faith provide emergency or nonemergency behavioral health services during a Department of Human Services-approved training course, in the normal course of conducting their duties, or in an emergency, may not be held civilly liable or liable for civil damages as a result of any acts or omissions in providing those services unless the acts or omissions constitute willful and wanton misconduct. This

immunity from civil liability extends to the administration, sponsorship, authorization, support, finance, education, or supervision of emergency behavioral health crisis services personnel who are certified, licensed, or authorized under this Act, including persons participating in a Department of Human Services-approved training program.

(c) The exemption from civil liability for emergency care provided in the Good Samaritan Act applies to anyone providing care under this Act.

(Source: P.A. 102-580, eff. 1-1-22; revised 7-29-24.)

(50 ILCS 754/65)

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

(a) 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 July 1, 2027 ~~2025~~:

(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.

(b) To achieve the conditions of subsection (a) by July 1, 2027, the following activities shall be completed:

(1) No later than June 30, 2025, pilot testing of the revised protocols;

(2) No later than June 30, 2026:

(A) assessment and evaluation of the pilots;

(B) revisions, as needed, of protocols and operations based on assessment and evaluation of the pilots;

(C) implementation of revised protocols at pilot sites; and

(D) implementation of revised protocols by PSAPs who are ready to implement, otherwise known as early adopters; and

(3) No later than June 30, 2027, implementation of revised protocols by all remaining PSAPs, including any PSAPs that previously cited financial barriers to updating systems.

(Source: P.A. 102-580, eff. 1-1-22; 102-1109, eff. 12-21-22; 103-105, eff. 6-27-23; 103-645, eff. 7-1-24.)

Section 99. Effective date. This Act takes effect upon becoming law.

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