MAINE PUBLIC UTILITIES COMMISSION

REPORT ON PROTOCOLS AND PROCEDURES NECESSARY TO ENSURE THE DELIVERY OF CRISIS RESPONSE SERVICES PURSUANT TO RESOLVES 2021, CHAPTER 29

Presented to the
Joint Standing Committee on
Energy, Utilities and Technology
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EXECUTIVE SUMMARY

In 2020, the Federal Communication Commission (FCC) adopted rules that established 988 as the National Suicide Prevention Lifeline and Veterans Crisis Line, which, like 911, will be accessed by either dialing or texting the nationwide three-digit phone number.[1] In response, nationwide stakeholders in the public safety and crisis response groups are exploring options to provide alternate support and referral of individuals in crisis.

On June 8, 2021, Resolve, To Facilitate the Inclusion of Crisis Response Services in Emergency Services Offered through the E-9-1-1 System (The Resolve),[2] was signed into law. The Resolve requires the Public Utilities Commission's (Commission) Emergency Services Communication Bureau (ESCB) to submit a report to the Joint Standing Committee on Energy, Utilities and Technology outlining protocols and procedures necessary to ensure the delivery of crisis response services under the State's E-9-1-1 system including any recommendations and proposed legislation necessary to implement such protocols and procedures by February 1, 2022.

On July 28, 2021, the Commission issued a Request for Proposals (RFP) to engage expert 911 consulting services to research, review, and provide a report to the Legislature on protocols and procedures necessary to ensure the delivery of crisis response services under Maine's 911 system. In partnership with the Commission, Mission Critical Partners, LLC conducted a combination of in-state and out-of-state exploratory research and outreach to identify recommendations supporting this need.

In-state research included interviews with subject matter experts, seven focus group discussions, eight Public Safety Answering Points (PSAPs), and four Dispatch Only Centers virtual visits. A custom survey was also developed and delivered to 168 email addresses that encompassed representatives from each PSAP, each Dispatch Only Center, and law enforcement, fire, and emergency medical services (EMS) providers. Out-of-state research included review of articles, public policies, and procedures, and 12 interviews with agencies and organizations outside of Maine with related pilot and established crisis response services programs. A complete list of research participants can be found in Appendix A.

It is clear from discussions that all stakeholders, from both public safety and crisis services, have a high level of concern, passion, and dedication to providing the highest level of service to the public. They recognize that change is needed; however, want it to be well thought out and done safely. Throughout the stakeholder conversations and engagement efforts, concerns were identified and included liability, staffing, funding, screening criteria and capabilities, crisis caller location, and communication and information sharing. The interviews with out-of-state stakeholders who have initiated similar efforts also addressed these areas and impressed the need for relationship building and early engagement by diverse resources and response groups. No national standards or best practices have been formally developed that address a specific behavioral health response and dispatch screening. As a result, a set of recommendations were identified.

[1] https://www.federalregister.gov/documents/2020/09/16/2020-16908/implementation-of-the-national-suicide-hotline-improvement-act-of-2018.
[2] Resolves 2021, Chapter 29.

The following is a summary of the full recommendations, which can be found in their entirety in Section V.

1. Implement a companion mental health protocol that integrates into the Emergency Medical Dispatch (EMD) protocol system that Maine uses today.[3]

Protocols are scripted guidelines that are used by all PSAPs and many Dispatch Only Centers in Maine to provide a consistent level of service for those in need. There are several items to consider as a part of this recommendation:

- Procure a commercially available standardized emergency mental health dispatch (EMHD) protocol that incorporates into Maine's existing system and does not require additional recertification requirements or call review. This approach will help shorten the transition and proficiency period for telecommunicators and reduce risk exposure for all agencies involved in crisis response. It will provide a standardized set of screening criteria to support the safe transfer of callers to higher levels of care.

- Integrate the EMHD requirement into the EMD statute by amending 32 MRS §85-A. Integrating EMHD into the existing EMD protocol system used today would allow for consistent integration of 911 and crisis response services statewide.

- Modify 25 MRS §2927 to allow E-9-1-1 surcharge monies to fund EMHD training and related software, resulting in alignment of costs for EMHD certification and protocol implementation using current funding rules.

2. Conduct a rolling implementation of the EMHD protocol to train all existing telecommunicators and require standardized statewide training of new PSAP and Dispatch Only Center staff in EMHD and other crisis response related skills.

A change of this magnitude requires careful planning and coordination as it involves the safety of individuals in need. As such, a phased approach to implementation is recommended, including:

- **Develop a rolling implementation schedule**.

  Procurement, training, and implementation of the EMHD certification and accompanying protocol can be accomplished using a rolling implementation. It is anticipated that this can be completed in three years, including one year for developing administrative rules and policies, budget planning and procurement, and two years for implementation.

[3] Since the field of EMHD is so new, Priority Dispatch, the EMD and EFD provider in Maine, is the only known vendor. It is unclear how the procurement rules will apply if this recommendation is adopted.

- **Utilize lessons learned from past implementations.**

  This approach considers lessons learned from past EMD and Emergency Fire Dispatch (EFD) protocol implementations and allows for proper change management applications. It will also help outline deliberate and mindful changes to each part of the behavioral health ecosystem.

3. Establish Multi-Disciplinary Committee and EMHD Protocol Coordinator

- A cross section of stakeholders, in collaboration with a statewide EMHD Protocol Coordinator, will be needed throughout the entirety of this initiative. This will help ensure proper communication and implementation across Maine's public safety and behavioral health ecosystems and will include the development of metrics to understand and drive improvements as the field of EMDH matures.

Addressing these recommendations will add another mandated protocol, which, based on current funding rules, may be interpreted as an unfunded mandate. However, if not pursued by PSAPs and required of Dispatch Only Centers that voluntarily provide EMD, gaps in services may be created. The total implementation and training cost across the entire implementation timeline are projected to be $163,900 for the protocol. Under the current funding regulations, Dispatch Only Centers would bear the implementation and training costs. Although subject to negotiation with the vendor, a per seat licensing fee of $500 and a $222 per person training fee have been quoted by the current protocol provider. In addition, adding an EMHD Protocol Coordinator to the MEMS staff would add an annual salary of approximately $100,000 funded through the E-9-1-1 surcharge. Total first-year costs are approximately $263,900.

Beyond the first year, the $500 per seat licensing fee would increase the annual protocol provider expense by approximately $64,000. Assuming the ESCB conducts six training courses of 15 telecommunicators each per year, the annual training costs would increase approximately by $19,980, not including any ancillary expenses. The total annual recurring costs are estimated at $183,980, which includes the funding for the EMHD Protocol Coordinator.

Today, telecommunicators in Maine do not possess the training, skills and abilities to confidently and accurately screen calls and determine which may be better served by crisis line responses rather than traditional police, fire, or EMS resources. It is essential that these gaps are addressed, so those calling for assistance to 911, directly to a Dispatch Only Center or a crisis line in the State, are afforded a level of care that aligns with their needs. Implementing these recommendations will fill that gap and put Maine on a path to providing services for alternate support and referral of individuals in crisis.

I. INTRODUCTION

During the First Special Session of the 130th Legislature, the Legislature enacted Resolves 2021, chapter 29[4] (The Resolve). The Resolve states:

> **Sec. 1. Emergency Services Communication Bureau; report. Resolved:** That, in consultation with the Department of Public Safety, the E-9-1-1 Council, established in the Maine Revised Statutes, Title 5, section 12004-I, subsection 74-A, crisis response services providers and other stakeholders, the Public Utilities Commission, Emergency Services Communication Bureau shall research and review protocols and procedures necessary to ensure the delivery of crisis response services under the State's E-9-1-1 system. On or before February 1, 2022, the Emergency Services Communication Bureau shall submit a report to the Joint Standing Committee on Energy, Utilities and Technology outlining protocols and procedures necessary to ensure the delivery of crisis response services under the State's E-9-1-1 system and including any recommendations, including proposed legislation, necessary to implement such protocols and procedures. The report under this section may also include measures for the training of dispatch staff in the provision of crisis response services. After reviewing the report, the joint standing committee may report out related legislation to the 130th Legislature.
>
> As used in this section, "crisis response services" means services offered to individuals experiencing mental health emergencies, emergencies relating to substance use disorder or other emergencies for which fire, emergency medical or police services are determined not to be required.

The Commission provides this report to the Legislature pursuant to the Resolve.

II. BACKGROUND

In 2020, the FCC adopted rules that established 988 as the National Suicide Prevention Lifeline and Veterans Crisis Line, which, like 911, will be accessed by either dialing or texting the nationwide three-digit phone number.[5] In addition to connecting citizens experiencing a mental health event with suicide prevention and mental health crisis counselors, it is envisioned that crisis response services available via 988 will also provide support to those experiencing substance abuse, housing insecurity and other social challenges.[6]

In Maine, and nationwide, stakeholders across the spectrum from public safety to crisis response groups are exploring options to provide alternate support and referral of individuals in crisis. This work requires a focus on those in crisis, training and procedures

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[4] Resolve, To Facilitate the Inclusion of Crisis Response Services in Emergency Services Offered through the E-9-1-1 System (LD 1306). Resolves 2021, chapter 29

[5] https://www.federalregister.gov/documents/2020/09/16/2020-16908/implementation-of-the-national-suicide-hotline-improvement-act-of-2018.

[6] For clarity, when referring to Maine Crisis Line or other crisis line services, it is inclusive of 988 which is planned to be operational in Maine in July 2022, as +
well as across the country to replace crisis lines.

for public safety and behavioral health, and the safety of responders. Currently, there is a lack of data and common performance metrics available from existing programs upon which to make recommendations.

Maine has 24 PSAPs and approximately 35 Dispatch Only Centers. Maine's PSAPs are emergency communications centers that receive 911 calls[7] and, as appropriate, directly dispatch emergency response services or transfer calls to other public safety agencies for dispatch.[8] Dispatch Only Centers are emergency communications centers that do not receive 911 calls directly, have calls transferred to them from the PSAPs, and only perform dispatch functions. All PSAPs are equipped to receive text-to-911 requests for assistance and use the same call taking protocols.[9] Training and support for 911 are provided by the ESCB. Under current law, the 911 surcharge pays for the protocol software, the printed materials (i.e., card sets), 911 equipment and maintenance at PSAPs (not Dispatch Only Centers) and the training of call takers.[10]

The Maine Department of Health and Human Services (DHHS), Office of Behavioral Health (OBH) provides access to health and prevention services to residents experiencing mental health crises, substance abuse, housing, and behavioral health issues via the Maine Crisis Line. This is a contracted service provided by The Opportunity Alliance (TOA). TOA is a single point, confidential, toll-free 10-digit number that provides callers with a crisis assessment and either resolves the situation on the phone or provides referrals to local assets as necessary. The TOA also provides assistance to non-English speakers as well as the deaf or hard of hearing community.

The FCC's 988 rulemaking presents several opportunities for both Maine's 911 and OBH systems to build upon the level of service currently provided. It will also help address the public's evolving expectations for 911 services and enhance the standard of care, including additional screening of calls to assess the need for mental and behavioral health services that do not require traditional police, fire, or EMS response.

Today, no national standards or best practices have been formally developed that address behavioral health response and dispatch screening. Numerous other state and local entities are working to address this issue. Just as when standardized dispatch protocols for medical and fire calls were first developed, no official national standards have been issued to the public safety community on how to appropriately respond to individuals experiencing a behavioral health event. Currently, there are no standards for delivery or provisions for the licensing of PSAPs to provide EMHD screening. These gaps must be addressed to ensure that those calling 911, a Dispatch Only Center or a crisis line for assistance are afforded a level of care that aligns with their needs.

The statewide application of EMD and EFD is a standard protocol that prioritizes call types and the configuration of resources (police, fire and medical) to be dispatched to calls

[7] Title 25, Section 2921, subsection 17, https://legislature.maine.gov/legis/statutes/25/title25sec2921.html
[8] Title 25, Section 2921, https://legislature.maine.gov/legis/statutes/25/title25sec2921.html
[9] Currently, emergency medical dispatch (EMD) and emergency fire dispatch (EFD) protocols are required in Maine. Emergency dispatch protocols provide structured standardized call taking processes to assess a caller's condition, gather scene information, provide instruction to callers, and provide an appropriate response to the emergency based on the answers to the questions.
[10] https://www.fcc.gov/consumers/guides/what-you-need-know-about-text-911

for service—including those determined to be psychiatric in nature. A limited number of jurisdictions, including the City of Augusta and Penobscot County, leverage mental health resources outside of the PSAP or Dispatch Only Center. No PSAPs or Dispatch Only Centers have full-time embedded mental health professionals. Currently, if needed, behavioral health resources are requested by public safety personnel already on the scene or are "self-dispatched" because of the monitoring of radio activity. Due to a lack of funding and available resources, these programs find it difficult to hire mental health professionals. However, in one case, three jurisdictions have coordinated and shared a single crisis response provider.[11]

PSAPs, and Dispatch Only Centers that voluntarily offer EMD or EFD, are required to regularly review individual calls where the protocols are used (referred to as quality assurance programs). The review process is funded by the PSAPs or Dispatch Only Centers. This regular review of calls helps ensure that the protocols are being followed correctly. As call review requirements are set by the MEMS for EMD and the ESCB for EFD, similar call review requirements for 911 and crisis response services integration will be necessary.

The data collected and reviewed focused on assessing how 911 may better integrate with crisis response services (including 988 once implemented) and resulted in a set of recommendations that will allow telecommunicators to engage alternative response services rather than relying on traditional police, fire and/or EMS response.

III. STAKEHOLDER PROCESS

On July 28, 2021, the Commission issued a Request for Proposals (RFP) to engage expert 911 consulting services to research, review, and provide a report to the Legislature on protocols and procedures necessary to ensure the delivery of crisis response services under Maine's 911 system. In partnership with the Commission, Mission Critical Partners, LLC conducted a combination of in-state and out-of-state exploratory research and outreach.

In-state research included interviews with subject matter experts, focus groups, virtual PSAP visits and a survey, while out-of-state research was conducted through interviews.

The participation of all stakeholders is greatly appreciated. The concern, empathy, and dedication to providing the highest level of service to the public were clearly evident. Public safety stakeholders take service of the public to heart and when outcomes are not positive, it is not uncommon for them to take it personally, contributing to increased stress. Knowing that change is needed, and in many ways the current system is not serving the public the way it should, the question is how do we do it safely. As such, it is important to approach this initiative in a collaborative, inclusive and thoughtful manner.

[11] Coordination of this effort was first discussed during the virtual PSAP tour and includes Cumberland, Falmouth and Yarmouth Police Departments.

A. Interviews and Focus Groups

Select stakeholders[12] and staff, identified below, with subject-matter specific responsibilities from each member agency were invited to participate in in-person interviews and focus groups. Between October 29 and November 12, 2021, three interviews and seven focus groups were conducted virtually using the Zoom platform. A slide presentation guided the interviews and focus group discussions.

Interview participants included Representative Victoria Morales; Sam Hurley, Director, Maine Emergency Medical Services (MEMS); Brodie Hinckley, Director, Department of Public Safety Consolidated Emergency Communications Bureau; Dr. Jessica Pollard, Director, OBH, and Commission staff. Focus group participants included PSAP leadership; Dispatch Only Center leadership; PSAP and Dispatch Only Center training personnel; law enforcement personnel; the 911 Advisory Council; crisis and community response service providers, and fire and EMS personnel. (Appendix A)

Each session was led by a facilitator from Mission Critical Partners who worked through a series of exercises with the intent of identifying themes and trends that could be balanced against the statistical data and used to develop practical and realistic recommendations. Sign language interpreter services were provided during the 911 Advisory Council and crisis and community response service provider focus groups. Follow-up sessions were conducted as necessary with stakeholders to clarify data.

During these sessions, stakeholders discussed:

- How calls for crisis response services are currently handled within their segment of the response.

- Issues identified by stakeholders related to integrating the delivery of crisis response services such as Maine's Crisis Line and 988 into Maine's 911 system, with consideration of liability, screening criteria, staffing, training, funding, quality assurance, dispatch response time, technology, information sharing and effectiveness of crisis response services.

- What stakeholders envision as a successfully integrated 911 and crisis services response program and how their segments may contribute to success.

- Lessoned learned from previous statewide legislation that can be leveraged when developing proposed legislation for integrating the delivery of crisis response services with Maine's 911 system.

- Funding available in the E-9-1-1 fund to cover costs associated with the adoption and implementation of call screening protocols that integrate with existing EMD protocols and related requirements, with attention to precedent for expending funds to support PSAPs and not Dispatch Only Centers.

[12] For clarity, the term stakeholder is synonymous with any of the stakeholder process methods for gathering information and conducting research, including interviews, focus groups, or the survey.

B. Virtual PSAP Tours

In coordination with the Commission, Mission Critical Partners conducted virtual tours of eight PSAPs and four Dispatch Only Centers between November 8 and November 12, 2021. Agencies were selected based on agency size,[13] geographical location, call type statistics, existing or pilot alternative response dispatch programs and level of community engagement and outreach programs.

Using a video conferencing platform and a virtual tour preparation guide, each agency provided a live narrated tour of its communications facility, including the operations floor, administrative offices, and other adjacencies such as training and available workspace as applicable. A standardized questionnaire (Appendix B) solicited responses to questions regarding applications, programs, protocols and workflows currently in use.

PSAP participants included the Department of Public Safety Central Maine Regional Communication Center (DPS CMRCC); Department of Public Safety Houlton Regional Communications Center (DPS Houlton RCC); Hancock County RCC; Lewiston Auburn 911; Oxford RCC; Penobscot RCC; Portland RCC and Waldo RCC. Dispatch Only Center participants included Waterville Police Department; Kittery Police Department; Augusta Police Department and Falmouth Police Department.

C. Survey

Leveraging the information gleaned from interviews, focus groups and virtual tours, a custom survey was developed (Appendix C) and delivered to 168 email addresses that encompassed each PSAP, each Dispatch Only Center, and law enforcement, fire, and EMS providers.[14] The survey, published on November 17, 2021, allowed 15 days for completion with two reminders sent to recipients on November 29 and December 1, 2021.

Of the 168 survey invitations sent, 18 agencies completed the survey, a participation rate of 10.71 percent. Responses were received from Cumberland County RCC;[15] DPS CMRCC; DPS Houlton RCC; East Millinocket Police Department; Fairfield Police Department; Fryeburg Police Department; Hancock County RCC; Islesboro DPS; Kennebunk Police Department; Lincoln County 911; Lincoln County Sheriff's Office; Lisbon Police Department; Maine DPS-Consolidated Emergency Communications Bureau; Saco Police Department; Sagadahoc County Sheriff's Office; Somerset RCC;[16] Southwest Harbor Police Department and York County Sheriff's Office. Of the responding agencies, ten serve rural jurisdictions; two are a mix of rural and suburban jurisdictions; three are a mix of rural, suburban, and metropolitan jurisdictions; one is a suburban jurisdiction; one is a city, and one is a statewide agency.

[13] Agency size is defined in the National 911 Program's *Next Generation 911 Cost Estimate, A Report to Congress* https://www.911.gov/project_nextgeneration911coststudy.html
[14] One hundred sixty-eight (168) total email addresses were provided that met these categories.
[15] Cumberland County RCC did not provide demographic data.
[16] Two agency responses were submitted; survey results combined as a single response.

D. Out-of-State Exploratory Research and Outreach

Between December 15 and December 19, 2021, interviews were conducted with 12 agencies and organizations outside of Maine with related pilot and established crisis response services programs. These agencies and organizations spanned local, regional, and state levels of government in both the public and private sectors. Interviewees were selected based on a set of criteria: inclusion in the National Association of State Mental Health Program Directors' *Strategies for the Delivery of Behavioral Health Crisis Services in Rural and Frontier Areas of the U.S.* report,[17] Tribal Nations, rural and urban demographic similarities, length of time the program has existed, integration of nurse navigation,[18] use of in-house or outsourcing of mobile crisis response team resources and integration of emergency protocols for screening.

The interviews were all conducted virtually using the Zoom platform or a conference bridge. A standardized questionnaire (Appendix D) was used to guide the interview discussions. Discussion topics included the type of program implemented; how the program originated; if formal agreements, protocols or legislation were required; the timeframe required for program implementation and if the program integrates with 911, and if so how. Additionally, questions were asked about the processes in place for managing liability exposure and mitigation; if metrics are captured; program costs and how any costs are funded. The last questions focused on the public education efforts undertaken; if the program is successful; how staffing shortages in mental/behavioral health resources are being addressed and the lessons learned.

Interview participants included the cities of Aurora, Colorado; Austin and Houston, Texas; Baltimore, Maryland; Charleston, South Carolina; Fairbanks, Alaska; Missoula, Montana and Newport News, Virginia, as well as the District of Columbia Office of Unified Communications; the State of Oklahoma; the Portland Street Response, Portland, Oregon, and the Vera Institute of Justice,[19] New York and D.C.

IV. STAKEHOLDER DISCUSSIONS

The meetings were intended to facilitate an open and informal discussion among the stakeholders. Mission Critical Partners cited verbal and written comments but did not capture every statement made by stakeholders nor did it attribute comments to a specific person.

[17] https://www.nri-inc.org/media/1679/2020paper10.pdf
[18] Nurse navigation, also known as the Emergency Communication Nurse System (ECNS), is a set of call screening criteria by which telecommunicators can transfer a caller to a nurse to receive medical advice or referrals. This may eliminate the need for a patient to be transported by EMS to a medical facility. See https://www.emergencydispatch.org/what-we-do/emergency-priority-dispatch-system/nurse-triage-protocol from the International Academies of Emergency Dispatch (IAED) for additional information.
[19] https://www.vera.org/about

A. In-State Discussions

1. Liability

Addressing mental health in the 911 call taking sequence is a relatively new notion. Industry standards have not been established and best practices are in their infancy; this was identified as a part of the stakeholder discussions. A nearly unanimous concern from PSAPs, law enforcement, fire and EMS personnel is increased liability and risk exposure when evaluating the appropriate response to mental health calls if a mental health clinician is added into the response chain.

Today a majority of PSAPs and Dispatch Only Centers dispatch calls to only police, fire, or EMS resources. Feedback indicated the lack of proper tools to support uniform and consistent treatment of mental health requests for service. Stakeholders expressed the need for uniform statewide mental health training for entry-level and in-service personnel. Very few, if any, of the State's telecommunicators have received behavioral health training that matches or exceeds that of Maine Crisis Line and National Suicide Prevention Lifeline personnel. While Maine has statewide standards for mandatory minimum telecommunicator training,[20] the training for "person in (psychiatric) crisis" for PSAPs is in its infancy and therefore lacks full adoption across the nation. Maine is no exception. Telecommunicators receiving required basic entry-level Emergency Telecommunicator (ETC) certification offered through the International Academies of Emergency Dispatch (IAED)[21] do not currently have the training or the tools to confidently screen callers to determine if their situation is better served by a traditional public safety response, transfer to the Maine Crisis Line, or a co-response.

Concerns were expressed regarding the risk assumed in referring or transferring 911 callers to resources such as crisis hotlines in lieu of dispatching a traditional resource such as police, fire, or EMS. The scenario of a 911 call taker screening a caller's "eligibility" as a transfer to the Maine Crisis Line, or a like resource, and having the same caller "loop back" from that resource to 911 for a dispatch of traditional resources results in transferring the caller several times, possibly dropping the call, and having the caller get frustrated, lose confidence in the system, and disconnect. This scenario was expressed several times by stakeholders, leaving PSAP staff to wonder if this call sequence will increase organizational risk exposure rather than mitigate it.

An additional concern brought forth during the virtual PSAP tours conducted by Mission Critical Partners was the risk of "dispatcher abandonment."[22] A section of the ETC training curriculum includes dispatcher abandonment, which has created a common perception that not dispatching a traditional resource to a caller could be considered abandonment. This concern will require clarifying policy or legislation if 911 is to integrate

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[20] https://www.maine.gov/maine911/psap-training/training

[21] Provided by IAED. See https://www.emergencydispatch.org/what-we-do/courses-and-training?tab=etc-tab for additional information.

[22] *Principles of Emergency Medical Dispatch, Fifth Edition*, states that "Abandonment is the unilateral termination of a patient-caregiver relationship by the caregiver where an adequate replacement for that caregiver has not been provided *and* when this action results in some preventable harm. The most common form of abandonment in EMS today is what plaintiffs' attorneys now call dispatch abandonment—the failure to provide Pre-Arrival Instructions when possible and appropriate."

effectively with the Maine Crisis Line and establish a mental and behavioral health diversion protocol.

Many stakeholders expressed concern regarding scene safety and are uncomfortable allocating unarmed resources to even low risk requests for services. The idea that a subject with uncertain or unstable behavior can spontaneously turn violent was discussed in every stakeholder session, leaving most people with the thought that a solo clinician response with no field responder is undesirable.

Lastly, lack of quality assurance and improvement are a concern, increasing risk and possibly introducing liability. The current scripted EMD call taking protocol system[23] has a standardized process and long-established quality assurance and improvement program with a scoring mechanism for auditing calls and providing feedback to telecommunicators. Stakeholders questioned how "non-standard" calls that are not integrated with the existing call taking protocols would be reviewed by the quality assurance team and measured against unknown criteria.

2. Staffing

Stakeholders provided input regarding the lack of telecommunicators, emphasizing that adding new protocols will tax an already overburdened PSAP. The lack of staffing in PSAPs is a nationwide crisis that affects PSAPs of all sizes, challenging the ability to execute even the most basic critical functions.

Field personnel, especially in small and rural agencies, expressed the inability to hire police officers, which often translates to minimum staffing levels in patrol or one patrol person on duty. During periods of short shift staffing, oftentimes there are no local clinician resources available as well, leaving the de facto solo response a law enforcement resource. Adding complexity to this situation is extended response and call-handling times. Law enforcement responders assigned to a mental health call often have extended response times due to a rural location that can take up to one hour to reach. This can tie up the 911 call taker or crisis line personnel who may need to stay on the line with the caller until a first responder arrives. The response time, coupled with the complexity of how to address and/or resolve mental health calls can take hours, particularly if the police officer transports the subject to a healthcare facility or jail. It was reported that when these situations arise, it leaves only one, or no resource, to send on other calls and requires the agency to rely on adjoining jurisdictions, through mutual aid, to handle pending calls for service.

Agencies in Maine and across the country recognize the need to prioritize calls more strategically due to low staffing and make difficult decisions about calls that must wait due to limited field responders. Managing repeat calls from or about the same individual is an example of how the relationship between telecommunicators and field responders is impacted. The call taker can spend several minutes trying to understand the need or what the person is doing that requires a response—e.g., breaking the law, having a behavioral health event or just "acting out." In any of these scenarios, it is common for law enforcement to respond to multiple calls per shift for the same subject, as was shared by participants in multiple PSAP tours and at least one focus group. Legally, there may be no reason to

[23] https://legislature.maine.gov/legis/bills/bills_123rd/chapters/PUBLIC42.asp

detain this person as they may not be violating the law or demonstrating a threat to themselves or the public. Rather, the subject's behavior is just disturbing or a nuisance. In these cases, field responders must respond, thereby making them unavailable for higher priority calls.

Multiple agencies expressed interest in having a mental health diversion program; yet hiring qualified mental health clinicians has been problematic. In one case in Maine, three agencies are attempting to hire a single clinician and share this resource, which is deemed better than not having a clinician at all.[24]

The City of Augusta has a mental health clinician that is notified of calls for service and co-responds with police. The City of Portland has a Behavioral Health Unit with two full-time behavioral staff who respond with police (this has been in place for twenty years). Crisis line stakeholders are appreciative of the support they receive from law enforcement when they request on-scene assistance for their safety and have good relationships with them. Funding for the City of Augusta's clinician is through the State, but this arrangement only applies to Augusta and is not applicable to all agencies that have clinicians; thus, funding must come from a community or county general fund.

3. Funding

Under the current funding model, the Commission provides funding for PSAPs only through the E-9-1-1 Fund; all expenses incurred by Dispatch Only Centers are the responsibility of the respective locality. The Commission provides the same initial basic Emergency Telecommunicator Course certification for telecommunicators working for a Dispatch Only Center as for telecommunicators working for a PSAP; however, the cost of additional classes such as EMD and EFD are borne by the Dispatch Only Center.

During multiple focus group sessions and virtual PSAP tours conducted by Mission Critical Partners, stakeholders asked questions regarding funding for new programs. It was frequently stated that these would be mandatory costs imposed on the municipality without reimbursement and would, therefore, be an unfunded mandate. While new program initial training costs are often funded, the PSAPs noted associated ongoing costs that become their responsibility, such as the salary of telecommunicators attending class, overtime costs to backfill a shift if necessary, and costs to integrate new technology or software such as dispatch protocols into existing technology (e.g., computer-aided dispatch system).

Utilizing 911 surcharge fees to fund any type of 988 effort has been deemed "911 fee diversion" by the FCC and must therefore be avoided. The FCC defines 911 fee diversion as "the obligation or expenditure of such fee or charge for a purpose or function other than the purposes and functions designated in the final rules issued under paragraph (3) of section 6(f) of the Wireless Communications and Public Safety Act of 1999, as added by this Act, as purposes and functions for which the obligation or expenditure of such a fee or charge is acceptable."[25] To fund 988, the Legislature must create a separate fee if so

[24] The program was mentioned by the Falmouth Police Department during a virtual PSAP tour and includes Cumberland, Falmouth and Yarmouth Police Departments.
[25] 911 Fee Diversion. FCC-21-80. (2021).

desired, as Virginia did.[26] Any programs that are to be funded by 911 surcharge fees must have nexus to 911 and legal authorization to spend on such activities.

4. Screening Criteria and Capabilities

Standardized call processing systems have algorithms and well-designed protocols that guide telecommunicators through questions. Based on a caller's answers to these questions a recommendation for the next step in the care continuum is made. This process helps to diminish the concern of dispatch abandonment.

While the current EMD protocol system is such a system, it has only one option or chief complaint for mental and behavioral health related concerns. When selected, there are limited, general scripted questions regarding what constitutes a behavioral health event and what chief complaint should be selected for the call for service. However, there is no protocol support for determining an individual's need for other services available through the Maine Crisis Line such as substance abuse, housing, food and heating insecurities, and, therefore, the experience of the call taker must be relied on. The majority of agencies interviewed noted that most crisis services calls screened through the existing tools are not an emergency, and little information is provided regarding an individual's current state as it relates to any diagnosis they may have had (e.g., an individual has been diagnosed as bi-polar, is armed with a baseball bat and is currently threatening occupants in a residence).

The dispatch of field responders for behavioral health event calls for service varies across Maine. Most departments stated that a majority of the calls are low-level or non-emergent—the calls do not require the assistance of other entities (e.g., fire/EMS or behavioral health clinicians). Some Maine police departments have contracts with mental health clinicians who are dispatched or self-initiate to a call or are requested by on-scene personnel. Generally, this relationship between a patrol responder and a clinician is categorized as a co-response, which allows law enforcement to secure the scene and leave, allowing the clinician to address the individual without the need for uniformed personnel, whose presence, at times, may aggravate a situation. In an emergent situation, police, fire/EMS and clinician services may all be dispatched: law enforcement for scene safety, fire/EMS for any life (medical) safety intervention, and the clinician for mental health services.

Screening tools used in the field by mental health crisis responders determine the risk of a potentially suicidal subject, allowing clinicians to determine the level of care needed or required. Generally, this screening is administered by trained personnel who have behavioral health backgrounds and by suicide hot lines across the nation to determine the caller's degree of acuity. Maine Crisis Line personnel use the Columbia Suicide Severity Rating Scale,[27] allowing them to keep subjects on the phone to get to a resolution or request assistance from government or public safety resources.

Stakeholders also noted the current and predicted challenges in processing calls from people with communication challenges. This challenge is primarily in 911 call processing, where face-to-face communication is not an option, where the reliance is on

[26] https://talk.crisisnow.com/virginia-is-first-state-to-pass-988-service-fee-legislation/
[27] https://zerosuicide.edc.org/resources/resource-database/columbia-suicide-severity-rating-scale-c-ssrs

voice or text. This results in concerns of inequity across varying groups that may have challenges accessing care. PSAP stakeholders interviewed had very specific questions about their relationship with the Maine Crisis Line, including how caller eligibility for transfer to the crisis line will be determined; if telecommunicators need to stay on the phone listening to the conversation in case something happens that warrants a 911 response; if the crisis line will always be available for transfers; how resources in Maine will reach crisis line staff; if a call re-enters 911 from a crisis line transfer, is it automatically a 911 response and if there will be other resource entities to transfer callers to (e.g., housing insecurity resources).

Maine's PSAPs currently provide or have connectivity to voice-carry-over (VCO), hearing-carry-over (HCO), Video Relay Services (VRS), full TTY[28] service, Text-to-911 and foreign speaker interpretation services. In November 2021, the FCC expanded its rulemaking to require all telecommunication and interconnected VoIP[29] carriers to support Short Message Service (SMS) text messaging to 988. This optimizes direct access to 988 for groups that prefer text over a voice call. However, if text is used to access a PSAP in Maine, which is determined to be eligible for 988 services, the PSAP will have no choice but to remain in contact with the texter (caller) as there is currently no mechanism to transfer Text-to-911 calls. As with PSAPs, Telecommunications Relay Services (TRS) will also be available to 988, as well as a separate TTY number and an online chat portal. Users that communicate via Internet Protocol (IP) Relay, IP-captioned telephone services, will also have access to 988 upon implementation.[30]

Members of the 988-stakeholder group being coordinated by OBH's Dr. Pollard, expressed concern about access for the deaf as some cannot sign, hear on the phone or read/write. Some people may need special interpreters in lieu of using technology to communicate. In addition, cultural communication issues will exist (e.g., non-English speakers). In these situations, PSAP-to-crisis line transfers will be a critical procedure. There is concern regarding people calling the Maine Crisis Line directly and how the Maine Crisis Line will pass important information to 911, so it is not lost. It is currently not possible to transfer text calls from either 911 to the Maine Crisis Line or vice versa. This is important as deaf and hard-of-hearing persons text more often than they use a TTY. PSAPs and Maine Crisis Line personnel discussed the amount of time spent screening calls. Even callers without communication challenges experience frustration with the number of questions asked, hindering the efforts of staff to help. "Just send someone" is the prevailing request, rather than thoughtfully going through scripted questions to determine the appropriate response. These situations can result in callers hanging up, and potentially redialing, or calling other jurisdictions that cannot help because they have the wrong resource.

5. Crisis Caller Location

During interviews, stakeholders reported that if a caller accesses one of the various mental health crises hot lines and the location of the client is unknown to the caller or cannot be easily identified, challenges in determining their location exist. The Maine Crisis

[28] Teletypewriter
[29] Voice over internet protocol
[30] Federal Register: Implementation of the National Suicide Hotline Improvement Act of 2018

Line does not have the same location technology (e.g., automatic location identification [ALI][31] integrated GIS mapping, or advanced location systems such as RapidSOS)[32] as a PSAP. When these situations occur, Maine Crisis Line personnel contact the local 911 center for assistance in locating a caller. This may require asking the caller to hang up and dial 911, which increases the risk that the caller may not call 911 or may reach a different PSAP that has not spoken to the Maine Crisis Line.

6. Communications and Information Sharing

Multiple stakeholders reported issues with the public's awareness of and access to "N11"[33] and the multiple services that are accessible. In addition to 911, there are various three-digit access numbers such as 211, 311, 611 and others that may be available to callers. The options are expanding to include the upcoming rollout of 988 as the National Suicide Prevention Lifeline and Veterans Crisis Line, which will be accessed by either dialing or texting.[34] Stakeholders believe it is important to improve public education regarding the roles, capabilities, and appropriate time to contact these programs and how not to use 911 as a default when particular numbers are either unknown or do not provide the level of service one would expect. OBH is planning a public education campaign to assist with the 988 rollout. Public access to N11 numbers is compounded with stakeholder concerns about their knowledge of the capabilities of these other programs and how to properly assist a caller by referring them to the right service.

There is a disconnect between agencies on what information can be collected and shared, and with whom and when it can be shared, especially considering the Health Insurance Portability and Accountability Act (HIPAA) requirements and how they apply to 911, law enforcement and EMS when mental health calls are received. "Dispatch agencies provide an important function in patient care. In most cases, dispatch agencies are free to do their jobs with minimal worries imposed by HIPAA. HIPAA permits all communications necessary to treat a patient—from call intake to initial dispatch to on-scene coordination to the communication of medical information to the hospital."[35] Conversely, information held by the Maine Crisis Line or other mental health providers/clinicians about a subject experiencing a mental health event can be shared with 911 for the purpose of mitigating a public safety incident.

[31] The automatic display at the PSAP of the caller's telephone number, the address/location of the telephone, and supplementary emergency services information of the location from which a call originates. https://cdn.ymaws.com/www.nena.org/resource/resmgr/standards/nena-adm-000.24-2021_final_2.pdf

[32] RapidSOS provides a service to connect people, their devices, and their families directly to first responders in emergencies. See http://www.rapidsos.com for additional information.

[33] N11 codes are used to provide three-digit dialing access to special services. In the U.S., the FCC administers N11 codes. The FCC recognizes 211, 311, 511, 711, 811 and 911 as nationally assigned, but has not disturbed other traditional uses. https://nationalnanpa.com/number_resource_info/n11_codes.html

[34] https://suicidepreventionlifeline.org/; https://www.fcc.gov/suicide-prevention-hotline

[35] Wolfberg, Wirth, & Staffelback. "HIPAA: The Intersection of Patient Privacy with Emergency Dispatch". (nd). Retrieved from https://naemsp.org/NAEMSP/media/NAEMSP-Documents/Annual%20Meeting/MDC%20references-multi-year/MDC-OTHER-REF-21-Legal-opinion-EMS-patient-communications.pdf?fbclid=IwAR1mo5HXN7XTkovET0WV4mTpa8ZK6VpGKK6fGcUKPB2FIlQybpVoO7jdcDI

7. General Comments

Stakeholders agreed that there is no collective or uniform approach in how behavioral health and other social issues situations are addressed by the PSAPs and Dispatch Only Centers, or by public safety responders. Public safety responders also noted that there is a lack of uniformity in field responses and limited mental health or alternative destinations to transport clients to when they are experiencing a behavioral health event. This lack of uniform direction results in disparate outcomes, including local self-initiated programs; how those programs are configured; training for telecommunicators and field personnel and public expectations of service delivery.

Stakeholders envision mostly law enforcement or law enforcement and EMS responding to 911 calls for individuals experiencing a behavioral health event. For situations where an individual may also have a need for medical attention (e.g., they have attempted to harm themselves or have a simultaneous underlying medical issue), law enforcement assures that the scene is safe and EMS cares for the individual in crisis. In a small number of jurisdictions throughout Maine, mental health clinicians respond when requested by law enforcement to help mitigate the individual's crisis.

Of the survey responses received by Mission Critical Partners, two PSAPs and two law enforcement agencies believe, to varying degrees, that an alternative mode of crisis response such as transferring calls to the Maine Crisis Line should not be implemented. Those respondents expressed that law enforcement is the only way to ensure that the individual experiencing a crisis event does not further harm themselves, a member of the public safety team, or the public.

Almost all stakeholders expressed frustration with the varying operating hours for mental health services. In most areas, except for Maine Crisis Line access, in-house services are offered during normal business hours. The frustration derives from those periods which fall after normal business hours, on weekends and on holidays, where service providers are closed and the only default is a "blue paper" protective custody hold[36] if the circumstances warrant, admission to a local hospital or a referral to services when they open.

B. Out-of-State Discussions

1. Alternate Perspective on Liability

Alternative views regarding liability were discovered during the out-of-state program research. An interesting view was presented by Fairbanks, Alaska, which also has geographic challenges such as vast rural areas and extended response times by responders and crisis services. This stakeholder said that they are obligated to provide the best care possible to the caller. In the case of 911 receiving a call of a person experiencing a behavioral health event, the best resource is a behavioral health provider. This stakeholder used a poison control center as a comparison for providing the best-in-class care. Today, PSAPs do not take issue or have a liability concern when transferring a 911

[36] Blue paper - *State Of Maine "Blue Paper" Application For Emergency Involuntary Admission To A Psychiatric Hospital* – MH-100 March 2021 Revision

caller to a poison control center for services that can specifically address the issue and provide the appropriate recommendation for treatment. The perspective is that the PSAP is at greater risk trying to help individuals experiencing a crisis event rather than transferring them to resources that possess education and skills beyond that of the telecommunicator.

To address concerns about mobile crisis team safety, the Fairbanks PSAP and crisis services members worked together to provide technology that integrates with the agency's computer-aided dispatch system, as well as develop mutually agreeable policies and procedures. The crisis team has the Freedom application loaded on its cellular phone and/or an agency-provided iPad. The crisis team uses this application when they are in the field as part of a co-response or independent of police or EMS. The iPad has locator software and an emergency button that a member of the crisis team can activate if needed. Two neighboring agencies that use the same computer-aided dispatch system also receive these alerts. Staff can write notes in the application, which supports policies and procedures that further safeguard crisis team safety, including the requirement for the PSAP to check on deployed crisis team staff every thirty minutes, unless the crisis team documents its "okay" status in the application. Because they are connected to the computer-aided dispatch system, the PSAP can easily copy calls when a co-response is required, or a crisis team requires assistance. Crisis teams share information about available services that can help the PSAP and crisis line, such as creating a Smart911 profile,[37] so the PSAP has access to information.

A further discussion involved the transfer of calls to a higher level of care which is embedded in the IAED's EMD protocols. The Omega determinant[38] allows local medical directors who oversee the EMD system to approve the transfer of low acuity or low priority call classifications (e.g., Overdose/Ingestion/Poisoning). Based on the person's signs and symptoms, low acuity calls can be transferred to subject-matter expert call centers that can apply the most relevant and accurate level of care. For example, in an ingestion case, a poison control center. Applied correctly, shifting the liability to the higher level of care relieves the telecommunicator of liability, and in most low acuity (i.e., Omega) cases, omits a traditional police or EMS response. Before this course of action is assumed, appropriate legal counsel should be consulted

Another issue raised relates to callers with disabilities or other challenges. There have been calls from advocacy groups for the disabled for equal access to mental health crisis resources through N11 numbers, and now 988, as some out-of-state organizations do not have the technology to assist callers on TTYs or the ability to receive text messages.

Some groups mentioned the laws pertaining to underaged or minor mental health clients and how managing these situations can be vastly different from those of emancipated adults. Often, underaged runaways who have co-diagnosis (e.g., mental health condition and a social disorder such as substance abuse) must be treated not only confidentially, but may also need to be placed into protective custody due to the lack of parental consent or any other professional resource. A situation such as this takes time to

[37] https://www.smart911.com/

[38] In the textbook *Principles of Emergency Dispatch (6 ed.)* from the IAED an Omega determinant is defined as "a response level outlined in the protocol for special referral and response, such as forwarding the call to a poison control center, nurse advise, or ombudsman program."

process and manage and may be best handled by a mental health professional rather than law enforcement.

2. Relationship Building

A consistent theme from the out-of-state stakeholders was an emphasis on ensuring the right stakeholders are involved at the beginning of any program implementation and ensuring efforts are made to keep stakeholders involved to build trust. Members typically include individuals from the community, first responder partners, 911 personnel and service providers. A program begun in 2013 in Austin, Texas has developed strong relationships over time. Community health providers; the EMS agency; EMS transport providers; 911 at the city police department; relevant secondary PSAPs; receiving facilities; and academic and policy partners regularly meet to enhance and evolve services. Established teams suggest the inclusion of business owners and residents of frequently serviced areas within the jurisdiction to build awareness of the services available, along with education on what is needed and the appropriate response (e.g., when does the individual need crisis support or what circumstances determine a need for law enforcement, fire and/or EMS response to augment a crisis response).

Prioritizing crisis response training that yields results that align with the caller's desired response, where appropriate, is necessary to build trust to ensure utilization of services by citizens.

3. Early Adopter Alternative Resource and Response Initiatives

Public safety reform advocates nationwide have long advocated for more community outreach programs and public education to reach communities suffering from a wide variety of mental health conditions and social issues. Except for 988, official national guidance has not been issued or widely socialized to the public safety community on how to appropriately respond to individuals experiencing a mental health event.

The lack of national guidance and the lack of awareness of publications such as the "National Guidelines for Behavioral Health Crisis Care – Best Practice Toolkit" published by the Substance Abuse and Mental Health Services Administration in February 2020;[39] "The Essential Elements of PMHC (Police Mental Health Collaboration) Programs" published by the Bureau of Justice Administration[40] and the National Emergency Number Association's

[39] The best practices toolkit provides an illustration of 911 to crisis call centers integration, including a graphic that shows a law enforcement triage tree. This triage tree represents a relationship between PSAPs, crisis calls centers, and field response. https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf

[40] The Bureau of Justice Administration offers their guidelines in creating effective Mental Health Programs. In the "The Essential Elements of PMHC (Police Mental Health Collaboration) Programs", Call taker and Dispatcher Protocols are cited, suggesting entities developing new programs "provide (911) personnel with specific guidance on how to record information in the dispatch database about calls in which mental illness may be a factor." https://bja.ojp.gov/program/pmhc/learning/essential-elements-pmhc-programs/1-collaborative-planning-and-implementation

Suicide Prevention Standard published in 2013[41] has prompted jurisdictions across the country to develop individual programs. Program components include criteria-based or protocol-driven dispatch decisions (either commercial or internally developed protocols); mixed-use crisis response teams, comprised of medical providers, mental health clinicians, fire and EMS personnel, and law enforcement officers; co-response/no-response telephone or telemedicine care; contracts with non-governmental mental healthcare providers; PSAP- or other public safety facility-based crisis counselors; PSAP nurse practitioners who can prescribe pharmaceuticals; enhanced crisis care call centers and seven- and ten-digit crisis suicide prevention/mental health counseling phone numbers.

A common theme presented by the creators of the local initiatives was the importance of education and outreach to the target population, the entire community and first responders. They also voiced an intent to move forward despite the ambiguity on how their initiatives will integrate with the 988 program.

Los Angeles County, California, was one of the first to develop call classifications for mental health situations, primarily due to the vast amount of mental health cases incarcerated in its jail. Los Angeles County's Behavioral Health Crisis Triage tool assigns levels of patient acuity from Risk Level I – Caller needs support/services – not immediate risk to Level 4 – Immediate Threat to public safety – crime. This matrix is one of the first tools used in both a PSAP and in the field that assesses mental health acuity.[42] The development of this tool was a collaboration of several expert groups. This matrix has been the basis of triage programs across the nation, which then develop the same or similar programs that fit their community needs.

Broome County, New York, created a flow chart that includes all stakeholders in the public safety call continuum.[43] In 2018, approximately 3 percent of all mental health-related calls to 911 resulted in transfers to a local crisis hotline. There have been no adverse outcomes and 87 percent of calls have successfully been de-escalated, resulting in stabilization of the subject experiencing a behavioral health event.[44]

In the absence of formal national guidance based on historical data, national trade organizations such as the Association of Public-Safety Communications Officials International and the National Emergency Number Association and jurisdictions across the country have begun to develop their own policies and alternate response capabilities. In September 2021, the Association of Public-Safety Communications Officials published its "Crisis Intervention Techniques and Call Handling Procedures for Public Safety

[41] The National Emergency Number Association is in the process of updating the 2013 standard with STA-001.2-2021 NENA Suicide/Crisis Line Interoperability Standard. The updated version provides guidance for PSAPs on working with a variety of crisis lines, including the Lifeline/988. The standard will include explanations of crisis line coverage, crisis line procedures for establishing imminent risk/exigent circumstances, crisis line procedures when calling PSAPs for intervention/rescue, and general procedures for PSAPs for crisis line-initiated intervention/rescue, along with information about follow-up between PSAPs and crisis centers, and relevant information about HIPAA, privacy and legal issues.

[42] Crisis Now – led by the National Association of State Mental Health Program Directors (NASMHPD) https://crisisnow.com/wp-content/uploads/2020/02/CrisisNow-BusinessCase.pdf

[43] IACP Webinar Supporting Document - 911 Distressed Caller Diversion Program in Broome County, New York (theiacp.org)

[44] Ibid.

Telecommunicators" document.[45] In December 2021, the National Emergency Number Association began a 911/988 workgroup to provide call and information sharing solutions to PSAPs and 988 call centers.

There are similarities and vast differences among the pilot programs that were identified and evaluated; many of these programs are based on the Crisis Assistance Helping Out On The Streets (CAHOOTS), first introduced in 1989 in the City of Eugene, Oregon, in collaboration with the White Bird Clinic. CAHOOTS is a mobile crisis intervention program whose teams are staffed by a crisis intervention counselor and a medical provider, either an emergency medical technician (EMT) or a nurse. It is important that programs be tailored to the communities they serve. For example, the majority of CAHOOTS calls in Eugene is for unhoused people, and Maine may have a different issue. Different states have people with different needs; programs should be adjusted accordingly.

4. Communications and Information Sharing

Information sharing was cited as paramount to the success of the various early adopter alternative response initiatives that have been established. Information is a valuable commodity when handling diverse populations and navigating the myriad of mental health events that these populations may experience. In a vast majority of communities, data and information about individuals seeking mental health treatment and care are not shared with the public safety community at large. This break in information sharing causes the flow of data to become unidirectional, ending with the mental health care community. To be successful, response initiatives must close this circuit, exchanging data where necessary to assist 911 in integrating with mental health services.

To communicate this information, early adopters have instituted a variety of methods to capture and share data compliant with HIPAA and personally identifiable information (PII)[46] requirements. One example is a spreadsheet that maintains patient demographics and outcome data, resources used, and cost savings for everyone encountered. The spreadsheet, shared only with response team members, has specific user security rights so that unauthorized individuals cannot access the file. A downfall to this method, however, is that data must be entered manually; a delay in data entry can render the spreadsheet less effective during an individual's mental health event. Information about specific response addresses or individuals can also be entered into an agency's computer-aided dispatch system where this information is accessible to anyone authorized to access the system. Another manner of maintaining and sharing documentation is using iCarol Crisis Helpline Referral software,[47] which is currently used by the Maine Crisis Line. Crisis response team members have limited access to the software to document response efforts when responding to individuals experiencing a mental health event. Despite the use of these various systems, each system is disparate, and there is no standard method or software for sharing information with the PSAP.

[45] APCO ANS 1.120.1-2021 Crisis Intervention Techniques and Call Handling Procedures for PSTs. https://www.apcointl.org/~documents/standard/11201-2021-cit-and-call-handling?layout=default

[46] Any representation of information that permits the identity of an individual to whom the information applies to be reasonably inferred by either direct or indirect means. https://www.dol.gov/general/ppii

[47] https://www.icarol.com/crisis-center-software/?gclid=CjwKCAiA-9uNBhBTEiwAN3IlNI1o4-Daz9eE-dsediUcOjpk5hqIlc2d8nSRs1BP3j9xnliGnIT2khoCh4IQAvD_BwE

No universal metrics exist, leaving early adopters to create their own. In 2019, CAHOOTS responded to 24,000 calls for assistance. That same year CAHOOTS reported that about 35 percent of calls were for transportation, 15 percent of which was transportation to shelters.[48] Currently, CAHOOTS has about thirty-six workers that respond to about twenty calls a day; the staff work twelve-hour shifts. In most cases, existing and pilot programs have not established metrics and are not yet capturing response data or patient information. Metrics are used to drive improvement and help agencies and jurisdictions to focus responders and resources on the most important factors.

In Seattle, Washington, nearly 49 percent of 911 calls were determined not to need police response.[49] Seattle also cited that an alternative, non-sworn response could have been appropriate for up to 49 percent of Seattle Police Department calls, or about 685,000 dispatch responses between 2017 and 2019. Those calls, which accounted for over 23,000 service hours, involved incidents such as a person down or welfare checks, which are regarded as low risk.

An existing, self-developed program in the District of Columbia Office of Unified Communications uses a criteria-based protocol model to evaluate an average of 50 mental health related calls to the 911 center daily. Of these calls, an average of two are found to be appropriate for diversion to the Department of Behavioral Health. This is an average of 4 percent of calls being evaluated that are found to be appropriate for diversion to mental health resources instead of a traditional response.

Another program in Baltimore, Maryland, uses IAED protocols as a foundation to evaluate calls for potential diversion to a mental health crisis resource instead of dispatching police and/or EMS. In a four-month period beginning in June 2021, 438 calls were sent to the diversion program for evaluation. Of these 438 calls, 93 (21 percent) did not require police or EMS response.[50]

Clear and concise metrics allow for the continuous improvement of services provided to citizens.

V. DETAILED RECOMMENDATIONS

The recommendations for protocols, procedures, and policies necessary to ensure delivery of crisis response services through Maine's 911 system, reinforce existing ESCB and MEMS rules and provide a pathway to improved service levels for Maine's citizens. The recommendations suggest actions to be taken to reduce risk to all individuals from the point of entry into the emergency response system through short- and/or long-term care as they relate to communication and information sharing between 911 and crisis response services. The recommendations are intended to set expectations and performance metrics to promote continual improvement by measuring success. The

[48] https://www.ems1.com/public-health/articles/as-its-popularity-grows-eugene-ores-cahoots-launches-crisis-response-course-SpmLt7YR3ZSKyeVp/?utm_source=EMS1&utm_campaign=f2a5a0a0f1-EMAIL_CAMPAIGN_2021_12_13_09_18&utm_medium=email&utm_term=0_13aebf8568-f2a5a0a0f1-89757244

[49] National Institute for Criminal Justice Reform (NICJR), July 2021 - Police Aren't Needed for 49% of 911 Calls: Seattle Report | The Crime Report

[50] Baltimore: 911 diversion program is reducing police response to mental crises (police1.com) – October 2021

recommendations are based on current and proposed nationwide efforts and established best practices, the current state of PSAP operations, as well as the vision of the State's emergency services stakeholders (police, fire and EMS) to improve the delivery of crisis response services.

A. Develop Rules and Statewide Policies and Procedures for Adoption by the PSAPs and Dispatch Only Centers

As the State's 911 system integrates with crisis response services, standardized statewide policies and procedures are needed to address screening and transferring of mental health calls for service. Rulemaking similar to what was established for EFD will be required.[51]

Policies and procedures reduce the potential for unexpected outcomes related to improper call handling and reduce the associated liability. A cross section of stakeholders will need to be engaged to develop a comprehensive set of policies and procedures that reduce risk exposure for all agencies involved in crisis response. This committee should include the OBH Director, ESCB Director, MEMS Director (or medical director of MEMS) and law enforcement, EMS and dispatch (municipal, county, state) personnel.

This multi-disciplinary committee can help determine the appropriate amendments to existing or new procedures for communicating and integrating each component of delivering crisis response when received by PSAPs or Dispatch Only Centers, including:

- The receipt, acknowledgment, and transfer of behavioral health crisis response calls
- Identification of the appropriate agency to receive calls
- Safe transfer of a caller to higher levels of behavioral health care to include safeguards (such as obtaining phone number and location prior to hand-off) in the event of a disconnect
- Assessment of scene safety, and responsibilities of PSAPs and agencies providing service; primary and backup policies for transferring or conferencing the disabled communities to the Maine Crisis Line via voice, text, TTY or other technologies
- Accommodations such as interpreters to ensure universal access to services, who is responsible for providing such service and when it is utilized, financial responsibility when calls are relayed or transferred.

The output of this committee could lead or contribute to statewide rulemaking that addresses alternative response options and provides for the safe transfer of callers to higher levels of care.

Not transferring a caller to an appropriate level of psychiatric care (if one exists and/or is available) increases telecommunicator risk by defaulting to the existing standard (e.g., a police/fire dispatch). These same call diversion policies and practices can free call taker time on task and potentially address feedback from several field response agencies

[51] https://www.maine.gov/maine911/sites/maine.gov.maine911/files/inline-files/Chapter5%20EFD%20Rule%203-2020.docx

that law enforcement, fire, EMS, hospital, PSAP/Dispatch Only Center and mental health clinicians are short-staffed in Maine.

B. Explore Procurement of a Commercially Available Standardized EMHD Protocol that Incorporates into the Existing System to Determine Need for Crisis Response Services

Professionally developed protocols allow telecommunicators to interact with the caller to determine a chief complaint. This determination allows the most appropriate level of care to be assigned. The State should explore procuring and implementing a commercially available standardized EMHD protocol. EMHD protocol use should be required in PSAPs and any Dispatch Only Centers statewide that voluntarily elect to adopt them. Ideally, any Dispatch Only Center that provides EMD would be required to also provide EMHD ensuring no gap in services occurs.

As determined through the stakeholder process (Section III), the State's current EMD and EFD provider, Priority Dispatch Corporation (PDC), provides the only known commercially available EMHD protocol. If the PDC's LifeBridges Flex-Protocol is adopted, it can be added to the existing EMD protocol set.

While other providers may choose to develop an EMHD protocol in the future, moving forward with the current PDC offering would allow Maine to:

- Address behavioral health event requests for service sooner and with less operational disruption;
- Address key concerns expressed by stakeholders regarding the lack of training and guidance to determine the appropriate response to behavioral health events;
- Shorten what otherwise would be a lengthy procurement and implementation timeline that would delay providing these valuable services to the community; and
- Facilitate a seamless integration into the State's existing EMD system to provide telecommunicators the ease of using a system they are already familiar with.

Currently, the default response for an individual experiencing a behavioral health event is either a law enforcement or law enforcement and EMS response. The EMHD protocol does not provide a medical or psychological diagnosis of the caller's condition but rather determines the appropriate chief complaint so that the call taker can ask the right questions. Each protocol has a send point where calls can be transferred to crisis response services after screening out risk factors for imminent life safety concerns.

The LifeBridges Flex-Protocol is an add-on to the existing ProQA software that allows behavioral health event calls to be processed in accordance with the EMHD protocol while allowing for ease of call processing and appropriate determination of needed crisis response services.

The LifeBridges Flex-Protocol can be delivered to PSAPs and Dispatch Only Centers in three ways: PDF version for centers unable to adopt software solutions; standalone software version for non-IAED protocol users; and an add-on version integrated

into the ProQA software platform (proprietary IAED software currently used by Maine PSAPs).

C. Require Standardized Statewide Training of Existing and New PSAP and Dispatch Only Center Staff in EMHD and Other Crisis Response Related Skills

Training of PSAP and Dispatch Only Center staff would address the universally acknowledged stakeholders' positions that under current conditions, telecommunicators do not have enough training to undertake a more active role in offering crisis response services. This is especially true given the potential to provide resolution to callers experiencing a mental health event by transferring the caller to the Maine Crisis Line. To adequately prioritize and process calls for behavioral health events, telecommunicators must receive additional training.

To adequately address the increased need for telecommunicator training, it is imperative that training specific to behavioral health related requests for service is adopted. This training will help a telecommunicator determine if the call requires a behavioral health, social needs, or substance abuse related response. The national trend towards reducing law enforcement and EMS response to individuals experiencing a mental health event is intended to provide the best outcome for the caller requesting services and minimize unnecessary impacts to first responders.

A three-day course, which includes hands-on application, provides the foundation for basic training. For PSAPs and Dispatch Only Centers that choose to be EMD and EMHD Centers, the recommended training includes the three-day EMHD certification course that incorporates behavioral health scenarios similar to Crisis Intervention Team (CIT) training. EMHD certification will not increase current bi-annual recertification hour requirements for IAED as the continuing dispatch education (CDE) hours used for IAED EMD recertification can also be submitted to the 911 Training Institute for EMHD recertification. There will be an increase in the number of days of mandatory training to accommodate EMHD training for new hires, but the number of CDE hours required bi-annually will not change.

Including the recommended EMHD training within the State-mandated initial telecommunicator training provided by the Commission ensures that all future call takers and dispatchers receive the same level of training to provide the same level of service to all callers. If EMHD training is not part of a telecommunicator's initial training, it should be completed in alignment with EMD certification requirements for new hires. A call taker without certification in a required protocol faces the loss of liability protection if handling calls through the protocol system and exposes the agency to risk. Requiring specific training for callers experiencing a behavioral health event will provide callers with more adequate care.[52]

To date, there is no EMHD-specific quality assurance certification course. IAED and the 911 Training Institute have elected to include quality assurance of EMHD-specific calls for service under the existing EMD quality assurance certification. PSAP and Dispatch Only

[52] Marshall, J., Ashwood, D., Fox, A., Soukup, J. "Measuring the Impact of Training on Emergency Dispatcher Management of General Mental Crisis Calls and Suicide Calls." (2020). Annals of Emergency Dispatch & Response, Volume 8(1), pages 16-19.

Center personnel who conduct quality assurance audits and provide feedback to staff must attend the three-day certification course, however.

D. Develop Formal Agreements and Legislation

1. Incorporate EMHD Protocol Usage into EMD Legislation

Incorporating the EMHD protocol into PSAP and Dispatch Only Centers that are currently EMD centers will provide telecommunicators tools needed to address behavioral health requests for assistance and close the continuity and accountability gap that exists across all stakeholder groups. It also addresses the gap of fledgling programs with home-grown screening criteria that are currently in place and serving their communities.

In 2007 and 2015, the State enacted legislation that required EMD and EFD[53] at all PSAPs. Dispatch Only Centers could voluntarily elect to provide EMD or EFD. Requiring EMHD protocol usage and adding this requirement to EMD statute (32 MRS §85-A) as part of EMD services will allow for consistent integration of 911 and crisis response services statewide. A modification to 25 MRS §2927 will also be required to allow E-9-1-1 surcharge monies to fund EMHD related training and protocol software.[54]

Because the recommended EMHD protocol approach is like the application of existing EMD and EFD protocols, the amendment would align with existing requirements and increase the rate of adoption by the public safety community. This step will address concerns regarding liability, as it would include the authorization and implementation of screening criteria in the form of call taking protocols and procedures that allow for the transfer of 911 behavioral health crisis calls to a non-traditional resource such as a mental health crisis line with medical direction.

2. Affirm Statewide Agreements Between PSAPs, Dispatch Only Centers, and OBH

The agreements that manage the relationships between the Commission, PSAPs, Dispatch Only Centers and OBH are adequate.[55] While the agreements are adequate, if new standards are approved,[56] the agreements should be reviewed and updated as required.

3. Incorporate a Quality Assurance Requirement for EMHD-related Calls into Legislation

A commitment to quality assurance is an essential component of reducing risk and liability when using a system for call screening and diversion for crisis response services. Currently, quality assurance is a required component of the EMD and EFD systems. Because the EMHD protocol is included within EMD, EMHD-related calls will be included in the overall number of calls reviewed during the quality assurance process.[57] In alignment

[53] Maine Revised Statute (MRS) Title 32 Section 85-A
[54] https://legislature.maine.gov/legis/statutes/25/title25sec2927.html
[55] https://legislature.maine.gov/legis/statutes/25/title25ch352sec0.html
[56] For example, STA-001.2-2021 NENA Suicide/Crisis Line Interoperability Standard
[57] EMHD Centers may choose to review EMHD calls separately at their discretion, but this is not a requirement of the IAED quality assurance process.

with the location of the existing EMD requirements, the oversight of the quality assurance requirement for EMHD-related calls should be the responsibility of Maine EMS.

E. Conduct a Rolling Implementation of the EMHD Certification and LifeBridges Flex-Protocol to Train all Existing Telecommunicators

Procurement, training, and implementation of the EMHD certification and accompanying LifeBridges Flex-Protocol can be accomplished in a rolling implementation with a completion goal of two years following one year to develop administrative rules and policies, budget planning and procurement. This best practice approach considers lessons learned from EMD and EFD implementations, the number of telecommunicators to be trained, the length of proposed courses, scheduling, and time for agencies to budget costs that are not covered in alignment with current funding rules (e.g., backfilling staff to attend training).

A minimum of twenty-five classes would be necessary to accommodate the State's 450 telecommunicators. Protocol implementation and certification courses can be divided into phases, allowing for a rolling program implementation (e.g., as one agency completes protocol implementation and certification of all telecommunicators, said agency goes live with the EMHD protocol). A phased approach to the software installation and telecommunicator certification process provides the least amount of disruption to each PSAP and provides ample time for ancillary costs such as overtime to backfill schedule vacancies caused by this training to be allocated. A phased approach to project implementation allows the protocols to be implemented regionally to maximize PDC and 911 Training Institute resources

Spreading implementation over multiple calendar years allows for proper change management applications and deliberate and mindful change to each part of the behavioral health ecosystem. This allows stakeholders ample time to meet and confer on important topics that will become the over-arching governance for an integrated crisis response network. A two-to-three-year implementation period allows the National Emergency Number Association's 911/988 workgroup to provide call and information sharing solutions to PSAPs and 988 call centers.

F. Costs and Funding Sources

1. Align Costs for EMHD Certification and LifeBridges Flex-Protocol Implementation with Current Funding Rules

As the only currently available commercial solution and as the State's current EMD and EFD provider, PDC provided the following implementation and training cost options for the State's 24 PSAPs. Projected implementation costs are based on the anticipated reoccurring cost per license for the LifeBridges Flex-Protocol, a total of $64,000 per year ($500 per seat license cost spread over 128 PSAP seats statewide). Projected training costs were provided for three training models: self-study, remote courses, and onsite courses. Since the EMHD three-day certification course involves scenario-based roleplay exercises, the onsite training model is recommended at the cost of $99,900 (450 telecommunicators at $222 per person). The total implementation and training cost across

the entire implementation timeline are projected to be $163,900. These prices are projections only based on existing client data and are subject to change by either PDC, the 911 Training Institute, or both.

No additional costs will be incurred by each PSAP to integrate the LifeBridges Flex-Protocol with a PSAP's computer-aided dispatch system. While the software can stand alone, existing ProQA integration provides added benefits for telecommunicators and law enforcement, fire, and EMS personnel. Since the LifeBridges Flex-Protocol is an expansion of the existing EMD protocol and accompanying ProQA software, no additional costs will be incurred for CAD integration.

In total, first-year costs are estimated at $263,900, including the cost of an EMHD coordinator, as discussed below. Beyond the first year, the $500 per seat licensing fee would increase the annual protocol provider expense by approximately $64,000. Assuming the ESCB trains 90 new telecommunicators each year, the annual training costs would increase approximately by $19,980, not including any ancillary expenses. The total annual recurring costs are estimated at $183,980, which also includes the funding for the EMHD Protocol Coordinator.

2. Provide Ongoing Funding for EMHD Certification and LifeBridges Flex-Protocol Implementation Using Existing Statewide Funding Model

In the current cost estimate provided by PDC and the 911 Training Institute, the initial training for the Dispatch Only Center telecommunicators would not be covered as an allowable cost by the Commission from the E9-1-1 Fund. To ensure that all telecommunicators statewide are trained to the same level, Dispatch Only Centers that provide EMD services must plan and budget for the protocol implementation and course costs for telecommunicators. As these costs are the responsibility of the respective locality, the implementation time may vary and could span longer than the projected two-year implementation phase. Beyond the initial protocol implementation period, Dispatch Only Centers are also expected to cover their costs, as is the case using the current statewide funding model.

Should a Dispatch Only Center that provides EMD services choose not to become an EMHD Center, a service delivery gap to that locality may exist. As noted previously, stakeholders are not in favor of an unfunded state mandate, and as a result this situation could arise. However, to avoid the service delivery gap associated with not becoming an EMHD Center, all Dispatch Only Centers that have elected to provide EMD should also be required to become EMHD Centers.

3. Create an EMHD Protocol Coordinator Position

Given the extensive role that EMD and EFD and the EMHD protocol will play in the public safety telecommunications landscape statewide, it is expected that the existing MEMS will not have adequate resources to coordinate multi-disciplinary committee collaboration, training and protocol implementation and rulemaking of the EMHD protocol. The addition of an EMHD Protocol Coordinator position, at an approximate annual salary of $100,000 funded by the E9-1-1 Fund, would benefit the Maine EMS Office in managing this new program.

G. Require Tracking of Behavioral Health Event Calls and Submission of Statistical Data to the ESCB and MEMS

Operational decisions in the public safety realm rely on data and metrics captured from various sources such as the computer-aided dispatch system, call handling equipment, and quality assurance reviews. These data or metric points allow agency management to track processes over time to determine if the current course of action is the correct course or if current policies and procedures need to be adjusted to achieve a new result. Disparate computer-aided dispatch systems will make capturing statistical data difficult.

Because EMHD is included as a protocol within EMD, it is recommended that MEMS, in collaboration with the ESCB, the OBH and the multi-disciplinary committee, develop rules for collecting statistical data, how often the data is submitted to the Commission and how it is submitted. Data points and metrics to be tracked and evaluated include calls evaluated for crisis diversion; calls diverted; calls handled by crisis resource; calls that require law enforcement or EMS response; additional calls for same location/subject and the number of instances where a subject experiencing a behavioral health event is transported to the emergency room.

H. Other Considerations

1. Implement Change Management Practices

To achieve success, it is essential that risks associated with transformational change and the impacts on staff and the community are understood as the recommendations are implemented. Programmatic change of this magnitude warrants a change management approach that includes tracking, quality assurance and identification of knowledge gaps. Use of change management tools can help measure stakeholders' understanding and level of acceptance with a project of this nature. Stakeholders assist in developing an effective communications plan and help assess the degree of risk to optimal outcomes of this effort.

Recognizing that saving lives is a common goal, change management will promote optimal outcomes to this key initiative, namely effective integration of 911 and 988. This will require engaging change management assessments early in the project to address understanding of the current state with the future state. To address the gap between the two in terms of understanding the stakeholder perspective of the need for change may require a plan. Assessments will address what will change and who will be impacted, with an objective to address optimal project outcomes. This will occur by measuring the expected speed of adaption, degree of proficiency and sustained utilization of the tools by users.

Where implementations are involved, a change management methodology to map the impact to stakeholders helps project leadership remain aware of adoption and utilization risk as to the project timeline advances. The health of project outcomes is scored by evaluating qualitative traits such as governance, direction, resistance, engagement, utilization, and adoption through tools that measure and track project health quantitatively. The results feed updates to the communications and training plans to continuously implement lessons learned and track targeted optimal outcomes.

2. Identify Technology Needs

As the solutions for coordinated response evolve, it is important to keep the pulse on technology and opportunities for integration. The State should monitor and seek understanding of technology solutions that help improve emergency response and coordination and integration between 911 and 988/behavioral health agencies. Some technologies worth exploring include computer-aided dispatch-to-computer-aided dispatch interfaces, RapidSOS integration and use of video platforms.

Although not available today, implementation of a computer-aided dispatch-to-computer-aided dispatch type interface that allows for data flow and information sharing between 911 and 988 could potentially be an integral part of the overall solution. Such an interface would permit computer-aided dispatch incidents received in a PSAP or Dispatch Only Center to be transmitted and received by crisis response services and vice versa. Updates to the incident can be transmitted, and any co- or independent crisis resource can be monitored for safety.

Computer-aided dispatch-to-computer-aided dispatch of disparate system interfaces enable uniform and standardized event tracking. Integrated systems will facilitate an authority's view of incidents in real time, archive the data in their records management system and exchange the data, promoting access to outcome data. Absent standardization of systems, it will be difficult to gather outcome data as recommended. There would be significant costs that are not identified in this report; until one or more vendors are engaged to discuss what such a solution would look like in both practical and technical terms, these costs are unknown and cannot be estimated.

Utilization of a citizen-emergency response data platform such as RapidSOS provides citizen-supplied critical emergency data to PSAPs and Dispatch Only Centers from devices, sensors and profiles and delivers near-precise location data via a centralized platform. An individual's medical data profile allows for voluntary personal disclosure of medical conditions that may prove useful to 911, crisis response services and first responder personnel. Use of this interface could eliminate the need for statewide database development and administration, lowering the cost and time impact to the overall implementation of services to the constituents of Maine.[58]

Video platforms also provide the opportunity for interactive discussion between crisis response agencies and PSAPs. These interactions can improve the level of service to those in need and reduce telecommunicator time-on-task.

3. Alternate Facility and Transport Considerations

Legislation and policy should be considered to address the transport of clients with behavioral conditions to alternate receiving facilities (those other than hospital emergency

[58] RapidSOS is currently in use statewide as an integrated component of the GeoComm mapping solution; the RapidSOS Portal with jurisdiction view is not utilized by the majority of PSAPs. PSAPs and Dispatch Only Centers not currently using this product can request access, at no cost to the jurisdiction, directly from RapidSOS. Based on the RapidSOS funding model, Maine Crisis Line can also request access to RapidSOS at no cost; however, due to limited privacy agreements with Apple and Google, RapidSOS can only provide query services (not jurisdiction view). This is limited until new privacy agreements are reached with Apple and Google.

rooms). Several options have emerged in recent years that were specifically designed to decrease emergency room congestion and jail incarcerations. Alternate facilities in other jurisdictions have found success in funding and creating detoxication centers or sobering centers,[59] 23-hour stabilization centers,[60] direct law enforcement drop-offs,[61] psychiatric emergency centers and dedicated rehabilitation centers. The consistent vision in these models is for these resources to be available twenty-four hours a day, seven days a week and located regionally throughout a state.

Changes in legislation that allow medical transport (ambulance) providers to bring individuals to these alternative destinations were a consideration mentioned by stakeholders. Benefits of alternative transport could reduce hospital turnaround times after patient transfer, making these resources available for dispatch to other emergencies (ambulance patient offload delay)[62], as well the possibility of reducing "boarding" time in the emergency room for crisis patients who have dual or multiple diagnoses, including mental health conditions, and the related need for law enforcement officers to remain with patients for extended periods of time if they are involved in psychiatric committals. In these cases, patients screened by field personnel could be routed to the most appropriate resource, rather than continuing to default to local hospital emergency rooms that are already overwhelmed, understaffed, or have limited bed availability.

VI. CONCLUSION

Pursuant to the Resolve, this report provides certain information sought by the Legislature related to facilitating the inclusion of crisis response services in emergency services offered through Maine's E-9-1-1 system. The question of how 911 will integrate with Maine's crisis services is a policy decision for the Legislature.

Telecommunicators in Maine currently do not possess the training, skills, and abilities to confidently and accurately screen calls and determine which calls may be better served by crisis line responses rather than traditional police, fire, or EMS resources. It is essential that these gaps are addressed to ensure that those calling for assistance to 911, directly to a Dispatch Only Center, or a crisis line in the State are afforded a level of care that aligns with their needs.

[59] City of Houston, TX

[60] 23-hour crisis stabilization service provides immediate care and an always-available entryway to behavioral health services, a Crisis Residential/short term stabilization service to provide care when an individual needs additional intervention to resolve the crisis beyond the 23-hour stabilization service, and Intensive Case Management to connect clients with appropriate services to improve continuity of treatment. Core-Elements-One-Pagers_23-Hour-Stabilization.pdf (alaskamentalhealthtrust.org)

[61] Value Options – Phoenix AZ – allows immediate law enforcement drop at a psychiatric emergency facility diverting transport to a medical emergency room for medical clearance. Crisis Now - Transforming Crisis Services

[62] APOD is the occurrence of a patient remaining on the ambulance gurney and/or the emergency department has not assumed responsibility for patient care beyond the Local Emergency Medical Services Agency approved APOD standard. APOT-Methodology_Guidance-2016.pdf (ca.gov)

APPENDIX A – INTERVIEW AND FOCUS GROUP PARTICIPANTS[63]

The October 29, 2021, project initiation and stakeholder interview was attended by Brodie Hinckley; Sam Hurley; Representative Victoria Morales; Dr. Jessica Pollard; Commission staff Maria Jacques, Cory Golob and Amie Greenham, and Mission Critical Partners representatives Bonnie Maney, Jim Potteiger and Jaime Young.

The November 2, 2021, PSAP leadership and telecommunicator focus group was attended by Roger Beaupre; Mike Carter, Jr.; Melinda Fairbrother-Dyer; Andrew Dziegielewski; JoAnne Fisk; Martin Fournier; Tim Hall; Greg Hamilton; Brodie Hinckley; Geff Inman; Michael Labbe; Paul LeClair; Joshua Lilley; Bob Martin; Jessica Milliken; Sonia Moeller; Deb Plummer; Michael Smith; Andrea Taatjes and Joe Thornton. Commission staff Maria Jacques, Cory Golob and Amie Greenham were in attendance with Mission Critical Partners representatives Bonnie Maney and Jim Potteiger.

The November 2, 2021, Dispatch Only Center leadership and telecommunicator focus group was attended by B Bailey; Brianna Dana-Mann; Aaron Farrell; Chris Fox; Levi Gould; John Kilbride; Carol Kloth; Glenn Moshier; Robert Richter and Shawn Willey. Commission staff Maria Jacques, Cory Golob and Amie Greenham were in attendance with Mission Critical Partners representatives Bonnie Maney, Jason Malloy, Jim Potteiger and Jaime Young.

The November 3, 2021, 911 Advisory Council focus group was attended by Stephan Bunker; Kevin Chabot; Greg Desjardin; William Gillespie; Sam Hurley; Michael Johnson; Brodie Hinckley; Steven Mallory; Terry Morrell and Nancy Winter. Commission staff Maria Jacques, Cory Golob and Amie Greenham were in attendance with Mission Critical Partners representatives Bonnie Maney, Molly Falls, Jason Malloy, Jim Potteiger and Jaime Young. Margaret Haberman and Julia Schafer served as American Sign Language interpreters.

The November 3, 2021, crisis and community response service provider (988) focus group was attended by Aaron Burke; Nikki Busmanis; Erik Eisele; Kristine Gile; Brodie Hinckley; Joel Leak; Jessica LeBlanc; Tracy Mallwitz; Brianne Masselli; Cindy McPherson; Melanie Miller; Derek Morin; Jamilyn Murphy-Hughes; Sheila Nelson; Danielle Parent-Sweetser; Brooke Pochee-Smith; Regina Rooney; Bear Shea; Sarah Sherman; Benjamin Strick; Kiley Wilkens and Jessica Wood. Commission staff Maria Jacques, Cory Golob and Amie Greenham were in attendance with Mission Critical Partners representatives Bonnie Maney, Molly Falls, Jason Malloy, Jim Potteiger and Jaime Young. Margaret Haberman and Julia Schafer served as American Sign Language interpreters.

The November 3, 2021, PSAP and Dispatch Only Center trainers focus group was attended by Brodie Hinckley, Ralston Means and Phil Viola. Commission staff Maria Jacques, Cory Golob and Amie Greenham were in attendance with Mission Critical Partners representatives Bonnie Maney, Jason Malloy and Kyra Pulliam.

[63] During the focus group meetings, some attendees did not provide full first and last name identification and were not included due to incomplete information.

The November 4, 2021, law enforcement representatives focus group was attended by Colleen Adams; Stanley Bell; Andrew Booth; Todd Brackett; Jack Clements; John Cote; Ryan Frost; William Gagne; Brodie Hinckley; Carol Kloth; Sean Lally; Bob MacKenzie; Ryan McGee; Joel Merry; Tony Milligan; Jared Mills; Danny Mitchell; Jason Moffitt; Patrick Polky; P Powers; Robert Richter; Eric Samson; Kevin Schofield; Scott Stewart and a representative from the Maine Association of Police. Commission staff Maria Jacques, Cory Golob and Amie Greenham were in attendance with Mission Critical Partners representatives Bonnie Maney, Jack Dougherty, Jason Malloy and Jaime Young.

The November 12, 2021, fire and EMS leadership representatives focus group was attended by Melissa Adams; Robert Chase; Sam Hurley; Michael Rickard; Dr. Matthew Sholl; Joe Thornton; Michael Thurlow; Chris Whytock and Kate Zimmerman. Commission staff Maria Jacques, Cory Golob and Amie Greenham were in attendance with Mission Critical Partners representatives Bonnie Maney, Jason Malloy and Jim Potteiger.

On November 15, 2021, Mission Critical Partners representatives Bonnie Maney, Molly Falls, Jason Malloy, Jim Potteiger, Kyra Pulliam and Jaime Young met with Jim Marshall, 911 Training Institute,[64] and Brain Dale and Ivan Whitaker, PDC, to understand current innovative efforts underway toward the pursuit of an integrated best practice approach to serving the public's mental health crises. This included learning more about Mr. Marshall's pioneering solution for Emergency Mental Health Dispatching the LifeBridges Flex-Protocol, its integration with existing EMD protocols, and telecommunicator resiliency training.

On November 19, 2021, Commission staff Maria Jacques and Mission Critical Partners representatives Bonnie Maney and Jason Malloy met with Dr. Jessica Pollard.

[64] https://www.911training.net/

APPENDIX B – VIRTUAL PSAP TOUR QUESTIONS

1. What functions does your center support?
    a. Call taking, dispatch or both?
2. What disciplines does your center support?
    a. Fire, Police, EMS and/or Other?
3. How many positions are in your center?
4. What is the normal staffing level?
5. What CAD *[computer-aided dispatch]* system does your center use?
6. What version of ProQA is being used?
7. What version of protocol cards is being used?
8. Are there any other questions asked at Case Entry other than the scripted questions?
9. Is there any agency-specific programming on Protocols?
    a. Card 23 (Overdose)
    b. Card 25 (Psychiatric/Suicide Attempt)
    c. Card 32 (Unknown Problem)
10. Are field units with an incident put through the SEND protocol to reach a determinant for on-scene patients?
    a. Do direct requests from the field or public for behavioral emergencies get processed through a protocol?
        i. If yes, EMD or internal script?
11. Are you aware of the upcoming national 988 rollout?
12. Does your center participate in the transfer of calls to crisis centers or local mental health resources?
    a. If yes:
        i. Whom do you transfer to?
        ii. What is the process/protocol?
        iii. Do you feel additional protocols are needed?
        iv. Is it time/day limited?
        v. Is the resource always available or are they sometimes not able to assist?
        vi. Is this transfer “warm” or do you just disconnect?
        vii. What is the impact of this re-direction on your center?
        viii. Did your staff receive any training to facilitate/implement this program?
        ix. Describe.
13. Does your PSAP receive calls from crisis centers or local mental health resources?
    a. If yes:
        i. Is there a protocol to process them?
        ii. How are they handled?
14. Does your center support any existing or pilot programs and initiatives with the dispatch of any of the following?

a. PORT – Post Overdose Response Team
b. CPT – Community Paramedicine Team
c. Telemedicine
d. Center-based Nurse Triage
e. Community Outreach Teams
f. Community Integration Team – team with resources familiar to the community served such as clergy, translator, or local leader
g. Other
    i. If yes:
        1. Describe the program(s)
        2. Are they helpful?
        3. Do Fire or Police co-respond?

15. What, if any, concerns do you have about how your center handles mental health crisis calls?
16. What can we, as an industry or your agency specifically, do better to handle crisis calls?

APPENDIX C – SURVEY QUESTIONS

1. What crisis response initiatives do you currently have underway in your jurisdiction?
2. How many calls from crisis centers/social service entities have you received in the past year?
3. Do you transfer calls to the Maine Crisis Line that do not require a law enforcement, fire, or EMS response?
4. What are the current protocols used to screen callers and/or to transfer callers to crisis response services?
5. What training is provided to personnel to process/respond to individuals experiencing a crisis?
6. How often do you provide crisis response training to your employees?
7. What call processing metrics do you feel are required to measure performance when processing a call requiring mental health support or a caller in crisis?
8. What prerequisites would need to be in place to be confident to transfer responsibility for initial care for an individual in crisis to alternative crisis response services (e.g., Maine Crisis Line/988, field mental health clinicians, etc.)?
9. What changes to legislation, call-taking protocols, policies/procedures, etc. do you feel are necessary to provide safe delivery of crisis response services to individuals in crisis through Maine's 911 system?

APPENDIX D – OUT-OF-STATE EXPLORATORY RESEARCH QUESTIONNAIRE

Out-of-state exploratory research questions included the following:

1. What form of a program do you have or are implementing? (i.e., co-response, either/or, resource/clinician in the center, nurse navigation, PSAP transfer, telemedicine, community response, other)
    a. Is it a pilot or a full program?
2. What was the genus/origins of your program – is it adopted from an existing program, a local pilot or extension of an existing program?
3. What concerns were presented most often when considering implementing crisis services/response call diversion (top 5 then #1 of those 5)?
    a. How did/are you addressing the top concern?
4. Were formal agreements developed?
5. Was local/state legislation necessary to implement crisis response protocols and procedures?
6. Realistically how long did it take to implement (concept to go-live)?
7. Does the program integrate with 911?
    a. If so, how does it integrate?
    b. If not, are there plans to do so?
8. Are there plans on integrating with 988 when it goes live in July 2022?
9. How are calls for crisis services/response handled differently in the PSAP(s) under this program?
    a. Did you change your 911 call answering announcement (if talking to a PSAP director)?
10. What have you found that works to help telecommunicators determine when or under what circumstances they will be explicitly directed to dispatch crisis response services?
11. Are any protocols or procedures incorporated into existing protocols, such as emergency medical dispatch (EMD), or are they screened via ad-lib questioning, lived experience, etc.?
12. If new protocols were necessary, what was the process for developing or obtaining them?
13. How is outcome data maintained/shared between public safety and public health officials to maintain an effective communications loop?
    a. How are HIPAA and privacy rights addressed?
14. Are there any existing technology applications that are helping staff to process and/or track crisis services and quality of life of related calls?
15. What training is provided for 911 staff to prepare them for screening/triaging crisis response related calls?
    a. What training are you going to need (e.g., classroom, scenarios)?

    b. What related continuing education training do telecommunicators receive (e.g., CIT or equivalent, de-escalation) and is it mandated?
    c. What training do you think crisis response services should have?
16. How do your policies, procedures or protocols address potential liability issues, including health, wellness and safety of telecommunicators, field personnel, crisis staff and the community?
17. What role do quality assurance and quality improvement serve in your pilot/program?
    a. What are the plans for revising, expanding, improving the program?
18. What metrics do you see being measured at the PSAP that will contribute to the overall success of a new, comprehensive crisis response program?
    a. Impacts to 911, law, fire, EMS, community, hospitals – any metrics yet?
19. How are you funding this initiative?
    a. What costs did you incur to support crisis response integration?
    b. What costs were borne by the PSAPs to support crisis response integration?
20. What public education efforts have been engaged?
    a. What are the community integration resources that are available to promote crisis response/988 integration?
21. Do you consider your program a successful integrated crisis services response program?
    a. If so, what do you contribute that success to (top 3)?
    b. If not, what will it take to be successful (top 3)?
22. How are you addressing the reported shortage of mental/behavioral health and crisis response professionals?
23. Lessons learned
    a. If you, did it again, what would you do differently?
    b. If you, did it again, what would you do the same?
    c. What advice do you have for others going down this path?