ATTENDEES

Tim Manley, Brinnon Fire; Andy Pernsteiner, JSCO; Tim McKern, Quilcene Fire; Jim Novelli, DBH; Steven Eckles, DBH/JSCO Navigator; Tammy Ridgway, EJFR; Sheriff Nole, JCSO; Stacie Huibregtse, JeffCom 911; Kent Smith, JHC-ED; Laurie Tinker, EMS Council; Gabbie Caudill, Believe In Recovery; David Carlbom, JeffCo EMS; Lori Fleming, CHIP/BHC; Jolene Kron, SBH-ASO.

CASE STUDY – OBSERVATIONS & INSIGHTS

First impressions re: Case Study situation where individual ultimately was determined to be in seizure status and had pulmonary edema:

- Law Enforcement: If the person hadn't committed a crime, Law Enforcement wouldn't chase them unless they are a danger to themselves or others. Would go to original scene and try to sort out additional info. Would be assessing if this person could be taken into custody if something criminal was happening.
- Navigator: Looking to see what is happening with the individual, what do they need right up front. He would follow to ensure the individual stays safe and isn't hurting themselves.
- DBH: Need collateral information, would want to engage/keep an eye on person. Would look to law enforcement to share what he learns. Navigator goal is to keep the individual safe.
- Summary: Split the team to get more info and watch to keep the person safe.

Second stage – post ketamine administration – discussion: is this assault (paramedic restraining someone against their will)

- Tinker: Would like to see more documentation for options of with sudden aggressiveness and agitation – to better understand why this option of last resort was employed.
- Navigator: Would like to have more information before shooting up with ketamine.
- EMS: Half an hour is a long time if a scrappy human is aggressive with herself (breaking her own bones as she was punching/kicking the shed) and posing a threat if you consider the need for team safety.
- Law Enforcement: the relevant RCW states:
  "Whenever used by any person to prevent a mentally ill mentally incompetent or mentally disabled person from committing a dangerous act to any person, or an enforcing necessary restraint for the protection, or restoration to the health of the person during such period only, as is necessary to obtain legal authority."
- Tinker: If ketamine is going to be used, there needs to be significant documentation as to "why".

Guesses as to what was wrong with patient?

- Diabetic? Urinary tract infection? meth psychosis? Novice CBD reaction?
- Gabbie noted there are things that present as behavioral health/SUD – that clearly aren't.

ORGANIZATION OVERVIEWS

Believe In Recovery: Slides on pp 5-9 in Meeting Packet

Gabbie Caudill presented an overview of Believe In Recovery
(Of note was the discussion around the role BiR is playing in crisis service provision.)

Jefferson County Sheriff's Office: Slides on pp 11-14 in Meeting Packet
Joe Nole overviewed this law enforcement agency

FLOWCHART REVIEW

(Refer to Behavioral Health Patient Assessment Flow Chart v2 this group reviewed; and the subsequently updated Flow Chart posted in June 2022, along with the adopted EMS Behavioral Health Response Protocol.)

- Add mobile crisis outreach team language to where it says DCR – and add Navigator under the "collaborative approach".
- Also address under "requesting resources" what to do if it isn't "safe to remain". We discussed finding solutions from the resources people can access – the mobile access outreach team (MCOT), REAL team, others.
- We discussed that suicide/homicidal ideation fits under "gravely disabled".

TRAINING - IDEAS

- At the May 3rd event Carlbom's goal is to get Deputies, PT police and EMS providers to get to know each other. Want to get the Port Townsend Navigator engaged as well.
- Brainstorm what makes sense with Tammy Ridgway, Chiefs Manly and McKern, and team.

Next Meeting Scheduled for Tuesday, September 27th, 3-4:30pm

A save the date was sent out from Lori's JCPH email for Tuesday, September 27th – 3pm