Northwest MHTTC Advisory Board Meeting Summary
December 2, 2022

Land Acknowledgement

Question posed by Christina Clayton, Northwest MHTTC: What are folks seeing and hearing regarding land acknowledgments? How do we avoid just "checking a box?"

1. Eric Boyer, Alaska Mental Health Trust Authority: Generally speaking, land acknowledgments are verry common in Alaska; however, there needs to be action associated with the words we say. That is especially important in Alaska due to its very rural setting. Ensuring the equity of support and resources to all Alaska tribes is vital to continuity of care.
2. Cody Chipp, Alaska Behavioral Health Association: Agrees that most people in Alaska do land acknowledgments.
3. David Dickinson, Regional Administrator, Region 10: Different Native people and different tribes will have different opinions on this. When we talk about justice for our Tribal nations, it must include more than just words. Our land acknowledgments must include an intent to fully meet Tribal treaty agreements, and an intent to give the land back to the Tribes. We should be having an honest conversation about land acknowledgements with our Tribal partners. If they want us to use a land acknowledgment, we should. If they request that we do not use a land acknowledgment, we should stop.
4. Bryan Hartzler, Northwest ATTC: At the recent Northwest ATTC Advisory Board meeting, the group talked openly about the importance of doing something more than just a perfunctory announcement at the beginning of the meeting. We should be discussing our work with Tribal communities throughout the meeting if we include a land acknowledgment at the beginning of it. In our roles, we cannot give land back, but we can work towards reducing disparities for Native communities.
5. Lucilla Mendoza, Washington State Health Care Authority: Some Tribal representatives do appreciate land acknowledgments, and some do not. What is included in the land acknowledgement is very important. The Washington Health Care Authority does include land acknowledgments, but other state agencies have opted not to.

Changes to Northwest MHTTC Advisory Board

1. Jerry Jenkins has transitioned off the board.
2. Cody Chipp from the Alaska Behavioral Health Association is re-joining the board.
3. Jess Angel, a certified trauma support specialist and licensed PeerZone facilitator from Alaska is joining the board.

SAMHSA / Regional Updates

1. David Dickinson, Regional Administrator, Region 10:
    a. The 988 line went completely offline yesterday, December 1. It is back online with a temporary fix this morning.
    b. David recently attended an in-person meeting with families who have lost people to the opioid epidemic. He will continue to collaborate with these families in advocacy work to end the epidemic.
    c. David also attended the launch of the Native and Strong Lifeline event. We should aim to replicate this model in other states in Region 10 and eventually across the nation.
    d. SMAHSA continues to provide support to families impacted by mass shootings on a 24/7 basis through 988 and the Disaster Distress Helpline.
        i. SAMHSA's Disaster Distress Helpline can be reached at 1-800-985-5990 or use the ASL now link at https://www.samhsa.gov/find-help/disaster-distress-helpline.
    e. With the recent mid-term elections, there will be changes in administration at the governor level in some of our states which will result in some additional changes as the appointee level. These changes in political leaders will likely result in SAMHSA budget changes.
2. Cody Chipp, Alaska Behavioral Health Association: Alaska has seen a huge reorganization of staff - especially leadership - in its behavioral health field. Many people are leaving the field altogether.
3. Lucilla Mendoza, Washington State Health Care Authority: The Native and Strong Lifeline launched last month in Washington State.
    a. Access the Lifeline by calling 988 and pressing option four.
    b. If someone calls the Lifeline from another state, they are not turned away.
    c. People who are not Native but are from a different community of color have occasionally called the Native and Strong Lifeline because they wanted to talk with someone from a culture other than the dominant white culture.
    d. The Lifeline is fully staffed by Native counselors, most of whom are from Washington, but some who live in other states.
    e. Due to the main 988 line being down, the Lifeline is not currently receiving any forwarded calls. This will hopefully be resolved soon.
    f. Lucilla's top priority is to make sure Native people know this is a resource they can access.
    g. She and her team are working with a communications partner to develop a culturally specific marketing campaign for the Lifeline.
    h. The Washington Indian Behavioral Health Hub is another resource for Native folks. It helps Tribal members navigate the complex health systems in

Washington State. The Hub currently has only one staff member; Lucilla is hoping to expand this resource soon.

Northwest MHTTC Updates

We have published our Year 4 Summary and our Area of Focus Document.

Year 5 Training Plan

1. Northwest MHTTC conducted a large needs assessment in our region. The top ranked training topics from that assessment will drive our training plan for Year 5.
2. Tier Three planned activity: ACT Team Implementation Project in Idaho
3. Tier Two planned activities:
    a. Learning communities on SMI essentials of care, crisis workforce, equity
    b. Collaborative project with Native communities in Region 10
    c. Nursing collaborative: teams working with early psychosis
4. Tier One planned activities:
    a. Flipbooks on CBTp and ACT
    b. Newsletters
    c. Website
    d. Resource library
    e. Webinars
    f. Podcasts
    g. Conference presentations
    h. Online courses
        i. Collaboration with Regions One and Nine on prioritizing racial equity in the workplace
        ii. CBT course
5. Training topics already covered in Year 5:
    a. NAMI Seattle
    b. Intersectionality of the Transitioning Veteran
    c. Suicide prevention with the Idaho Department of Health and Welfare
    d. Overdose prevention
    e. Mental Health institute: Social Justice & Inclusion, Co-Occurring Disorders, Intellectual & Developmental Disabilities
    f. Learning community for SMI Essentials of Care
6. If any advisory board members have ideas for other topics we should be addressing, please reach out to Lydia and Christina.
7. We continue to use webinars as a lead-in for learning communities.
    a. Crisis workforce resilience with Kira Mauseth
        i. Eric Boyer, Alaska Mental Health Trust Authority: interested in collaborating with Northwest MHTTC on additional workforce resilience trainings.

   b. Anti-racist work in therapeutic environments and in the workplace with Sherronda Jamerson
   c. Addressing trauma, stress and safety with Rebekah Demirel
8. Native Communities Collaboration Session in November
   a. We collaborated with the National American Indian & Alaska Native MHTTC to host this follow-up session with Tribal community members following our Native Listening Sessions this past summer.
   b. We now have a few ideas for specific projects and are considering which ones to pursue.
   c. Discussion: Does anyone have thoughts on what sort of training or project targeting Native communities would be useful for us to host?
      i. Eric Boyer, Alaska Mental Health Trust Authority: Crisis stabilization specifically for tribes. How do we adapt crisis stabilization to a region that is remote and has numerous diverse tribes?
      ii. Maria Monroe-DeVita, Northwest MHTTC: The MHTTC Network has a working group focused on early psychosis needs in rural areas. It could be beneficial to start a national working group focused on crisis stabilization needs in Tribes across the country.
      iii. Lucilla Mendoza, Washington State Health Care Authority: Lucilla recently visited a Tribe in Arizona that had their own crisis team. It would be great to bring that model to Washington.

State-Specific Advisory Board Meetings

Northwest MHTTC is thinking about how we can be responsive to each of the states in Region 10. We are considering having some state-specific meetings in the new year in lieu of a Regional Advisory Board Meeting.

988 and Our Crisis Workforce

Discussion: How else might we support the crisis workforce and outreach teams?

1. Cherryl Ramirez, Association of Oregon Community Mental Health Programs:
   a. We need to spend time and effort on bolstering mobile crisis response teams. Oregon needs to increase the number of clinicians, especially licensed, masters-level clinicians.
   b. Oregon is trying to implement the Crisis Now model, an enhanced mobile crisis response model in order to be eligible for specific federal grants. This model will bolster mobile crisis teams, pairing a behavioral health specialist with an EMT rather than with law enforcement.
   c. Oregon is also trying to pass a telcom tax again with the help of NAMI. Also hoping to get funding for more crisis stabilization centers.
   d. Oregon is trying to build up housing and residential treatment facilities in the communities for forensics and post-crisis patients.

   e. Cherryl is looking for a curriculum for a mobile crisis response academy.
      i. The Oregon Health Authority has applied for a grant through SAMHSA. If they get that grant, they will be able to write a curriculum including response protocol for a variety of populations (Intellectual & Developmental Disabilities, Substance Use Disorder, C-Occurring Disorders, children, families, culturally specific).
2. Adam Panitch, Idaho Department of Health & Welfare: It would be helpful to have support on how to link Certified Community Behavioral Health Clinics with mobile crisis support. There will likely be a need for this in the future.

Kira Mauseth & Eric Bruns on Gun & Other Violence

1. Following the shooting at Ingraham High School in Seattle, the UW SMART Center and Northwest MHTTC School Mental Health team pulled together a group of providers, legislators and representatives from the Department of Education to discuss how to provide support in a coordinated way for the students and families.
2. In situations like this school shooting, there may or may not be a crisis plan in place. If there is a plan in place, it may not address behavioral health concerns (which was the case for Ingraham High School).
3. The team established a group of trained disaster mental health professionals to provide crisis response for anyone in the Ingraham community who was interested. This included three 10-hour days of availability one weekend and one 4-hour day of availability the next weekend.
4. Lessons learned from providing these crisis response services:
   a. It is essential to include a behavioral health component in the post-disaster communications plan. This plan must include the PTA in order to effectively get the information out to the school community.
   b. The community was reactive to this situation. Hopefully, if this happens again, we can be proactive.
   c. Being responsive to school crises requires identifying a central person or team for responses and information to flow through.
   d. It is important to identify which kinds of things need to be immediately provided and what can wait. Also identify which groups of people (students, parents, staff, teachers, etc.) need which types of resources. Different groups will have different needs.
5. As a result of this process, we now have a Washington State Collaborative Coordinated Response Coalition that has a plan in place for responding to future similar crises.
6. Everyone should ensure that this type of response planning is taking place at your workplace.

Conclusion

Farewell, GPRA evaluation. Next advisory board meeting will be in March 2023.