Delegate Card Write Ups

See Me Q. What will you do to reduce stigma?
Research in progress regarding people's narrative of mental health core involvement. Important for people to tell their story and for people to hear.
Build on our work with See Me if resources are available. Deaf awareness across mental health sector.
I feel that in Forth Valley where we have Primary Care mental health nurses in 40/54 GP practices. It's helping to reduce stigma (quick MH assessment within a non-MH environment.
Not be a bystander but highlight & challenge where others use stigmatising language or actions.
Start more conversations with people on how they are – and listen to their answers!
As a senior member of staff in a mental health public body, continue to talk about my own lived experience of mental ill health.
Work with SYP to share my own and other young people's experiences.
Be more open about my experience and share it with others to show that mental health does not define who I am as a whole.
Ensure reduction of stigma is embedded in strategies & implementation plans.
Better info & communication among network plus schools.
Avoid making assumptions & support others to do the same.
Talk in more ordinary language e.g. Call the IMH implementation group "Wellbeing for wee ones".
Encourage staff to talk about stress of work.

Joy at Work Q. What will you do by next Tuesday?
I will explain the meaning of ACE in social; media in BSL – to help deaf people understand the topic better.
Feedback NHS Lanarkshire approach to Scot Gov strategy and making it local.
Talk with ½ local partners to help facilitate mental health & wellbeing in workplace in Scotland.
Circulate Nussbaum, capabilities article through mental health nursing network. (I looked the article up during presentation).
Contact suicide prevention leadership group & ask if it's possible to join. Link project model with See Me.
Meet with my colleagues to look at areas for further training & development within the CMHS in Angus.
Draft my pathway for wee ones.
"Joy at work" – I will introduce this concept to my team with a view to trying out some of the ideas.
Think about ways that today's session can be applied to the new Mental Health Collaborative.

Ask team what matters to them.
Discuss today at our Mental Health First Aiders' Network meeting at work tomorrow.
I will take the ideas from "joy in work" workshop to my team meeting.
Ensure staff (reports) will have been "listened" to in terms of "what would help?"
Do a 1-2-1 with all my staff over the next 3 months and ask "what matters to you?" Get 3 positive comments and 3 things to change from everyone.
Share our experience of a collaborative to improve mental health recovery in Dundee with an NHS/Scottish Government audience.
Think about how to involve employers more in this discussion.
I will be motivating my staff & asking them to come up with improvements in the team.
I am going to make sure to praise, encourage and thank my colleagues for all the work and support.
Suggest bringing good UOS stores to team meetings
Be honest with my boss how I feel about development of my role in the workplace
Give my colleague who's been having a hard time a wee call.
Discuss the introduction of action learning for NQN's.
Assertively manage incivility with team member.
Discuss with team the possibility of concentrating on quality rather than quality.
Arrange a weekly team lunch.
Contact NHS Tayside to learn more about the QI work.
Meet with my team managers – discuss todays presentation with commitments to create a plan or change to achieve joy in work during 2020.
Ask staff at 1:1's what matters to them.
Connect with presenters from Tayside to arrange a sharing event.
Tell colleagues when I think they have done something well – every time.
Ask colleagues – what one thing that could be changed to bring more joy in work.
What's went well this week – ask staff? – Just started in a new team/brand new service.

I will share my experience with at least two people with little or no experience in mental health to promote awareness.
Sharing knowledge from today with partners across various projects Follow up links with contacts meet today.
Shadow the Run Director at a local Park Run to enable the Stornoway Park Run to get up & running.
Consider 'Capabilities' model as a way of assessing resilience rather than constant Risk assessment emphasis.
Share message from today across my partnership.
I will contact the DBI lead to ask about getting this within our own Board (Forth Valley).

Q1. I am from… **Q2. Where do you think we should focus our improvement efforts?**
Q1. Other – Individual - Counsellor Q2. Better communication & networking among organisations rather than against due to competition/funding?
Q1. – Q2. I think we need to shift away from clinical focus on mental health. "Illness like any other" isn't working. More focus on prevention, recovery and ACES. Also return to core values.
Q1. Third Sector & Other – "Peer Support is Fundamental" Q2. Sharing best practice and endeavour to find most efficient and effective way of capturing baseline data, qualitative and/or quantitative. (Some) people do like to see evidence – this ensures we are not reinventing the wheel when ideas unfortunately haven't worked in reality.
Q1. Third Sector Q2. Absolutely loved Michael Smith's presentation. Really appreciated his honesty. – This clearly shows the need for mental health in all policies, approach nationally and locally. We also need a substantial resource shift from illness services to community prevention.
Q1. Service user/Advocate Q2. Increasing education and awareness among professionals so they don't focus on your 'label' and see the bigger picture.
Q1. – Q2. Upstream in bottom-up initiatives at the grassroots. Showcase & incorporate the best into service delivery.
Q1. – Q2. Building healthy communities to have & raise our children. Prevention & early intervention.
Q1. Other Q2. Agree that we need caution in how we established actions from the strategy have been achieved – Surely we need to see how these are effective, impact etc. before we can state these are achieved. Embedding improvement work & strong learning from this (good & bad) is so important.

Q1. Third Sector
Q2. Building on Michael's comments towards a change in dynamic from clinical to community. This needs new & innovative thinking (as well as funding).

- Bringing together clinical & community responses
- Clinicians working in community initiatives
- Value placed on community initiatives

A question was asked about whether we are ready for change. Lots of us have been ready for a long time!

Q1. Other – Business
Q2. I'm surprised at the lack of employer representation here today. How are we going to reach people who won't use the NHS or Third Sector in the earlier stages of poor mental health?

Q.1 Secondary
Q2. Early intervention & prevention

Q1. Other- HSCP Across sectors
Q2. Get Health Boards to recognise IJB's are responsible for local delivery – not HB's
Improvements can only happen if HB's make bold radical choices to change which at this time they do not do. Resources need to go fun active – community.

Q1. Primary care<>Secondary care
Q2. Support structure for families/loved ones bereaved by suicide
Spread distress brief intervention across Scotland
Consider critically the assertive increase clinical approach required for some groups who struggle top access mental health care where needed (for example homelessness and Justice services)

Q1. –
Q2. Prevention- work in schools
Active – sharing of evidence for good practice in addressing suicide & self-harm
Address stigma & discrimination in community, across generation
Increase provision at low level. Intervention in community

Q1. Other – SG
Q2. Measuring experience of service and outcome! And reporting nationally.

Q1. Other -Third sector
Q2. Gaps

- deaf children's mental health services
- Deaf awareness & communication tactics. Language development including BSL
- Prevention to break the links between deafness & dementia, loneliness etc

Q1. Third Sector
Q2. Parity of esteems/value of a social as well as a medical model of mental health.
Investment in and development of peer led links as supports in community settings.
Investment in and explicit value of non-specialist, non-clinical supports in the community where people can get help & be listened to when they need it.

Q1. Third Sector
Q2. Community mental health teams and work-prevention of inpatient admissions.

Q1. Third Sector
Q2. New clinical intervention
DBI approaches to have compassionate staff that listen.
Sharing data
Digital solutions

Q1. Other – Public Sector
Q2. I'd like to see more focus on dissemination & roll out of effective initiatives.

Q1. –
Q2. Short term funding does not help.
Additional funding is welcome but please make it recurrent.

Q1. – Q2. Public awareness of psychologically informed approaches and the impact they can have on public/society e.g. as part of PSE curriculum.

Q How can we make talking about our mental wellbeing easier?
Make central across <u>all</u> partners & council/NHS departments
We are on the right road, but we need to continue to promote messages of recovery, give people with lived experience a platform & encourage those who experience multiple disadvantages - In schools - In H&SC - In Government
Encourage role modelling – politicians (including FM) sports people, celebs, business people (& openly talk about their mental health & wellbeing.
Take the 'mental' out of it and talk about well being with the expectation this will be about the whole person.
Advertising – 'It's okay not to be okay'? Talk about it!?
Change our language - Fantasist..? - Start early – wellbeing for wee ones
Stigma reduction efforts are helpful, but there is still work to be done, particularly around severe mental illness. It is important not t forget the experiences of people who experience inpatient care, who may have detorsion or compulsory treatment in the community.
Awareness and education to stop stigma and discrimination. If the Scottish Government feel that this is a National priority, we need to consider a humanitarian approach and start to look at social research, Dr David Reilly – the WEL approach.
Counselling in schools will not be the whole answer. Introduce online learning package to schools so young people & teachers learn <u>together</u> to use language about thoughts, feelings & behaviour together, and to learn evidence based (probably BT based) coping and change strategies. These are available (e.g. equivalent of Beating the Blues) & could be licenced & rolled out across Scotland.
To lead by example and normalise this. We are all humans. Contribute to a compassionate society.
I think being honest and open in our interactions with everyone.
More first-person account- from professional staff too – woven throughout the day – powerful!
Make it ordinary and make help seeking ordinary – not specialised and not hidden away.
Challenge stigma and discrimination because this will make it easier to talk about mental health without fear of being judged and misunderstood.
(and nationally) Increase Resources to e.g. See Me, so that further actions can be taken across sectors to make a measurable* improvement in attitudes to mental health problems. *E.g. via Social Attitudes Surveys
Normalising the discussion – its ok not to be ok & help to build emotional resilience & intelligence. Building on current See Me & learning. Engaging across equalities & Human rights issues – normalising equality work.
- Schools – education to reduce stigma & discrimination - Community hubs – discuss wellbeing & MH - Supported accommodation for elderly

Normalise emotion – help everyone across all sectors (education/housing/health/third sector etc). To have a basic understanding of emotional regulation (use skill such as deciders) to help m realise the aim at "mental health is everyone business"
Reduce the stigma! EDUCATE that everyone has mental health, and ways to help yourself and others.
At a strategic level we need professionals to educate and particularly to stop talking about mental illness epidemics and start talking about mental health and the rate of lived experience. On a practical level use CHIME – communications, hope, identity, measuring, empowerment – which help recovery and support good mental health. Scottish recovery volunteers have resources and help.

Q1. Do you have an experience of an outstanding improvement in Mental Health Services that you would have liked to have share this morning? **Q2. Could it be scaled for Scotland?**
Q1. IPTAC – Interpersonal Psychotherapy Acute Crisis – 4 services psychological therapy intervention delivered in A&E at RIE, by … liaison nurses. 74 pts completed. 4 services intervention after presenting with self-poisoning/harm, comparison of symptoms at services 1 & 4 shared significantly reduced distress and depressive symptoms. Action 15 m… - increase staff to deliver IPTAC at the RIE (2 full time staff). Q2. -
Q1. Making Recovery Real in Dundee – multi Agency collaboration with 1 real experience at the centre which has resulted in change in number of local services and organisations, particularly around the development of a wide range of peer reviews to improve support, experience and outcomes. For more information contact Scottish Recovery. Q2. -
Q1. Pilot project to increase access to evidence-based intervention (CBT) using a service delivered via live messaging (computer/tablet/phone). This has resulted in twice as many self-referrals as those referred by GPs/Professionals. In an area with low referral rates & rural & remote challenges. Q2. -
Q1. Solihull in Schools Programme. Participation Lead Officer (CAMHS). (Service-user link) CAMHs 20 year anniversary (D&G NHS) – joint organised & facilitated with YP, NHS & 3rd sector – due on 18th Sept 2020 – focus on YPMH & transition. Q2. -
Q1. Link Up community wellbeing & development at Inspiring Scotland. Q2. -
Q1. Work on health for young people to secure care by NHS GGC & development of the Dean Core Pathway & Standards Scotland which are due to launch nationally on 1st April 2020. Work on core leavers & looked after children. Q2.
Q1. No. Q2. -
Q1. Embedding of psychological therapies into H+SC partnership for long term conditions – such as COPD. Q2. -
Q1. Not services but MH support via communities. Work we are doing with refugee communities to build choices & sense of community & solutions to locally identified problems.

Mental Health Foundation Refugee health & strategy policy group Peer Education Project & Stress less programmes in schools. Both building a peer support & building skill to manage emotions. Q2. Yes -all can be scaled. PEP- infrastructure in place to provide to schools at £200 annual license fee with similar for stress less being developed Refugee work – via New Scots strategy.
Q1. Implementation of the Decider Skills in CMHT. Q2. Yes, and would be very good for school children, particularly those affected by ACE's.
Q1. Developing infant mental health service. Increase awareness/education leading now to investment in "wellbeing for wee ones". Q2. Yes. We're strong in 2 Boards & living to perinatal & to C+YP PB.
Q1. Work in Forth Valley between MH services and police to get people straight to MH assessment diverting from A&E. Primary care mental health nurses across Firth valley – reducing mental health patients to GP Decider roll out – benefits. Q2. Yes.
Q1. Often have a sense at these events that as a small board we in Scottish borders rarely have the time to shout about the good work we do as we are busy doing it. I would highlight; - Joint service development - Evaluation & commissioning of third sector MH services Q2. Work to transform MH services Co-production charter for inclusion of people with lived experience in all aspects of MH provision – recruitment, development etc Improving accessibility through self-referral They would all be scalable.
Q1. Moray Wellness Centre and integrated mental health services – Making Recovery Real. Q2. The model could – Yes
Q1. Yes: Delivering 4 sessions of evidenced based psychological therapy at the Emergency Department when someone arrives having made a significant attempt to end their life (so delivering right intervention at the right time) -delivered by mental health nurses (& supervised by clinical Psychologist). Part of a <u>whole system approach</u> – matched care model 0of delivery using 1 theory to understand distress: The Project Model in Scotland. Q2. It is a model to describe WHAT – and absolutely specifically designed to be scaled up for Scotland.
Q1. B… of quality measures across CAMAS and ND services. Q2. Yes! Scotland is big enough to host its own event/programme.
Q1. Moray Mental Health & Wellness centre's approach – reaching people early, connecting listening and valuing livid experience. Q2. Yes.
Q1. Not services but our informative clips in British Sign Language (can a link be distributed via sharing re: papers etc of the event?) Q2. Yes, it is for Scotland. Need to draw attention to communication & language barriers, adjustments to participation etc.
Q1. The importance of peer support and self-care strategies. Delighted to see the shift from clinical to social intervention. I have lived experience of mental ill-health and social intervention saved me. I acknowledge this is not for everyone however.

Q2. 100%! I recognise the importance of 3rd sector please (I work and have worked in NHS for 20 years!) More allocated funding please.
Q1. NHS Grampian. New integrated CAMHS premises increasing clinical capacity and improved experiences of care. Patient reps involved in improvement meetings. Cornhill ligature reduction Redesign of wards Reducing SH incidents Q2. Yes – funding dependant