Surrey Minority Ethnic Forum (SMEF) and the Independent Mental Health Network (IMHN) Surrey & NE Hants

The Mental Health impact of Covid-19 on people from BAME groups and barriers to accessing services and support

EXECUTIVE SUMMARY

Surrey Minority Ethnic Forum (SMEF) and the Independent Mental Health Network (IMHN) worked together during 2020 to gain insight into, and understanding of, the impact that Covid-19 has had on the Mental Health of Surrey's BAME communities. This insight gathering work also helped to identify existing barriers that adults from BAME groups experience when accessing the current mental health provision.

A survey was co-designed and distributed to BAME community groups for completion by their members. The survey was completed by almost 200 people in a range of languages and in a range of formats.

A steering group consisting of leaders of BAME community groups was established. The steering group analysed and discussed the result of the survey to provide an understanding of the impact of COVID-19 on the Mental Health of Surrey's BAME communities and the barriers faced in accessing support.

The steering group worked together to make a series of recommendations as to how services and support should adapt to better meet the needs to the community.

SUMMARY OF USER PROFILE

Age range: 22% of the 196 participants were in the age group 18-35 years, 44% were in the age group 36-55 years and 32% were in the age group over 56 years.

Gender: 35% of the respondents identified as male and 58.6% female.

Ethnicity: 52% of respondents were Asian or Asian British (Pakistani, Bangladeshi, Nepalese) and 19% were African.

Employment: 58% of the respondents were in paid work vis-a-vis 37% who were not in paid work.

Family: 43% of the respondents have no children and 47% have between 1-2 children.

MAIN FINDINGS

PRE AND POST COVID-19 MENTAL HEALTH

92% of the responses suggest that mental health prior to the Covid-19 pandemic was excellent, very good or good. Post coronavirus, 80% of the responses suggest having excellent, very good or good health. Therefore, **26.5% have reported a deterioration in their mental health during the Covid-19 pandemic.**

On the question of how covid-19 has affected their mental health, 24% were feeling more anxious and 20% were feeling low in mood.

SUPPORT SERVICES

NHS 111 (online and by phone) is the support service most respondents were aware of (more than 50% response). This is not a surprise due to the national advertising and promotion that this service receives. Samaritans and the Healthy Surrey website had the next level of brand recognition, followed by the Community Connections service.

Most respondents said they would go the **GP** if they needed mental health support (24% of all responses), followed by the NHS (20% of all responses), and then rely upon personal support systems like friends and family, local community groups and faith groups (15%).

Online advertising, social media (59%) and websites (38%) is the preferred advertising medium, followed by advertising through faith groups (36%).

CURRENT STATUS OF MENTAL HEALTH

64% of those surveyed explained that they had been working on their mental health and had been able to maintain or improve it.

The participants indicated that maintaining good mental health was often managed within their home without the use of professional support. 22% of the respondents highlighted finding exercising helpful, 16% talking to others, 13% said faith-based activities are most helpful for them.

Approximately 74% of participants have not had or are not currently accessing any help and support with mental health from organisations or

professionals. The main reason for not accessing mental health support stems out of them feeling that they do not require, or are not eligible for, formal support services.

Support that has been received is mostly in the nature of visiting GP or mental health team, or peer support from family and friends.

Most people that contributed had a preference to get one to one support (24%) and regular peer support group sessions. It is indicated by 23% of responses that more information about mental health support services will help them to understand what help they could get for themselves or their family and friends.

OUR RECOMMENDATIONS

Our insight gathering work and the discussions of the steering group have led to the formation of a set of 20 recommendations which fall under 5 broad areas of work:

1. **Knowledge and understanding of the offer and reducing stigma**
2. **Improving the diversity and quality of services**
3. **Improved identification and support for Carers**
4. **Improved accessibility of communications and resources**
5. **A sustained commitment to co-production with people from BAME groups**

Improved community knowledge of what support is on offer and decreasing the stigma surrounding Mental Health

1. Faith and Community Leaders should be offered support and training to recognise mental ill-health, to tackle stigma and to understand how to support their communities in seeking help.
2. The system should consider the role of Mental Health Navigator volunteers or champions (perhaps linked to the Time to Change Surrey campaign).
3. Navigator support (for example, a guide, training, and other resources) should be developed and made available, clearly laying out the offers

of support in Surrey. BAME specific services within Surrey and also bespoke national BAME mental health support services. Navigator resources and communications should include the 'mental health offer' in its broadest sense, including complimentary therapies and other interventions on offer in the community.

Improve the diversity and quality of support and services that are on offer

4. The system should explore the offer of increased choice and provision of support groups, specifically aimed at people from BAME groups, working with the existing community and faith groups in operation.
5. Providers should consider increasing the diversity of the physical activity opportunities that they offer and review the location that these are held at.
6. The IAPT service should be specifically promoted to BAME communities. Faith and Community Leaders should be given more information about what is on offer from IAPT providers.
7. Digital inclusion outreach projects which are being trialled should include a focus around translation apps and developing a training module to teach those who are digitally excluded how to use them.
8. GPIMHS (General Practice Integrated Mental Health Service) and MHICS (Mental Health Integrated Care Service) models should be expanded to cover the entire county and that this service should be very well advertised to BAME communities through Faith and Community Leaders.
9. Future planning, for peer support groups, focuses on locations that are familiar to, and easily accessible by, people from BAME communities.
10. Health and care professionals should be invited to regularly increase their knowledge and cultural understanding. We would recommend that this work would be best delivered by local Faith and Community Leaders.

Improve the identification of and support for Carers

11. Peer support groups for BAME families/carers providing support to a family member or friend should be set up.
12. The system should set a target for carer assessments done with people from BAME groups and work on a carers communication plan

for people from BAME groups to aid carer self-identification and registration.

Improve the accessibility of communications and resources

13. Healthy Surrey's website content should be made available in the most spoken non-English languages in Surrey such as Nepalese, Bengali, Pakistani and Polish.
14. Communications work should always state that services are confidential.
15. Promotional material for services should highlight the diversity of the mental health professionals working across the system and within specific services.
16. Promotional material and messages should state that services are free or include their cost (for services delivered by partners where small charges occur).
17. The visibility of communications campaigns should be improved by being linked to special functions like Gurkha Cup Football Competition, Nepali (Fete) Mela and Victoria Day Function, Diwali, and Eid Melas.

Make a system commitment towards sustained co-production

18. The Integrated Care System and all its partners should commit to on-going coproduction with BAME groups and communities. We recommend that providers should be asked to lay out their intentions to co-produce services, specifically with people from BAME groups, and should be held to account for doing so.
19. We recommend that this work (along with the BAME Rapid Needs Assessment completed as part of the Community Impact Assessment) be viewed as a starting point to build on. It is clear further exploration and understanding is required.
20. We recommend that SMEF/IMHN conduct a survey with BAME communities at regular points in the year, to get a dynamic view of what is working for people and what is not.

Please see page 20 for the discussion and reflections behind our recommendations.

MAIN REPORT

This document summarises the findings under the following headings with their page numbers.

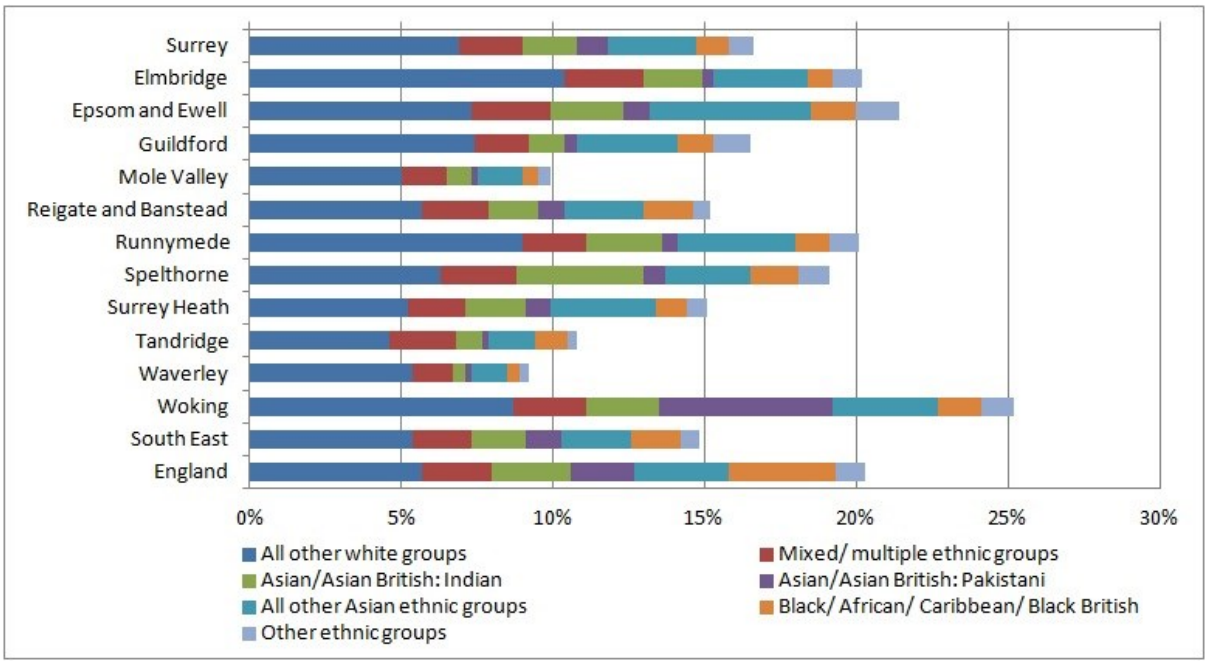
INTRODUCTION

An anonymous online survey was conducted to gain insight into, and understanding of, the impact that Covid-19 has had on the Mental Health of Surrey's BAME communities. The survey also helped to identify existing barriers that adults from BAME groups experience when accessing the current mental health provision. The survey was completed by almost 200 people in a range of languages and in a range of formats.

A steering group consisting of leaders of BAME community groups was established. The steering group analysed and discussed the result of the survey to provide an understanding of the impact of COVID-19 on the Mental Health of Surrey's BAME communities and the barriers faced in accessing support. The steering group worked together to make a series of recommendations as to how services and support should adapt to better meet the needs to the community.

The survey was conducted using Microsoft forms, on paper and by telephone. The results data has been analysed in excel using simple percentages.

SURREY ETHNIC MINORITIES ONS 2011



METHODOLOGY

- A small working group from the Independent Mental Health Network (IMHN) worked on identifying key questions to understand how well supported BAME communities in Surrey were.
- The draft questions were then submitted to a steering group set up by Surrey Minority Ethnic Forum (SMEF). The steering group consisted of representatives of Afro Caribbean, Bangladeshi, Indian, Nepali and Pakistan communities who have the expertise in Mental Health.
- Discussion and refinement sessions were held to ensure that right questions were being asked in a culturally sensitive way. Language translation was decided during these sessions depending on which groups were unable to read English.
- These questions were taken to the Emotional Wellbeing and Mental Health reference group to check they were not a repetition of any existing insight work.
- The questions were then translated into Bengali, Urdu, Nepali by SMEF groups and Polish by IMHN.
- The IMHN entered the questions into an online survey on Microsoft Forms with the five language options.
- SMEF produced the hard copy questionnaire for people who preferred this option.
- SMEF then promoted the survey and managed to get a staggering 200 responses!
- The IMHN entered responses from the hard copy versions into the online form (in the appropriate language).

- The IMHN translated all questionnaires into English and brought the results together in one data set.
- The IMHN produced a summary over-view results sheet to collate results for the steering group to consider.
- The IMHN sent the results data over to SMEF for further analysis.
- The survey was analysed and presented to the SMEF Steering group. The presented report helped finalise the recommendations.

ANALYSIS OF RESULTS (Percentages have been rounded to the nearest whole number)

The questions are divided into different thematic sections.

Section 1: DEFINITION OF MENTAL WELL-BEING

According to the World Health Organization, mental health is defined as "a state of well-being in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community."

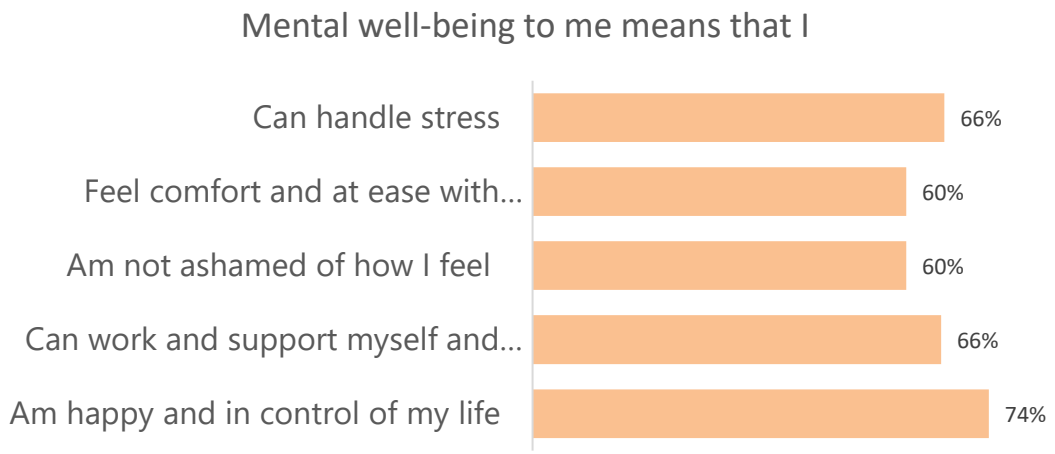
1. **Do you agree with this definition?**

Almost 92% of the sample (n=196) answered in the affirmative that the above statement reflected their understanding of mental wellbeing.

2. **Below are some statements about mental well-being…**

With statements about mental well-being (the respondents were asked to choose all answers that they felt applied to them) 73.5% believed mental well-being related to being happy and in control of their life, 66% cited working and supporting themselves and their family and being able to handle stress. 60% were not ashamed of how they felt and were comfortable and at ease with others.

GRAPH 1: TOP RESPONSES TO WHAT MENTAL HEALTH MEANS TO ME (Question 2)



Section 2: ABOUT YOU

3. **What age are you?**

The most selected age bracket of the respondents (23.47%) was the 36-45 age group. 21% were in the 56-65 age group followed by 20% in the 46-55 years. At both ends of the spectrum, 66 and over and 18 to 25 the percentage was low with 12% and 11% respectively. A small minority left the age group blank.

4. **What is your gender?**

59% of the respondents were females with 35% males. 6% of the respondents chose not to answer the question.

5. **What is your closest ethnic group?**

The results indicated that the highest number of respondents (19%) self-identified as belonging to an African ethnic background. The next highest ranking group were Nepalese (16.33%) followed by Bangladeshis and Pakistanis (15.31% and 13.26% respectively). Indians were in the minority of the people who had responded with only 7.65% followed by Chinese with 3.06%. Other ethnic groups presented in a very small minority.

6. **Do you support or provide care for someone in your family or a friend, who is ill, has an addiction or has a disability?**

77% stated that they did not provide care for a family member or friend, whilst 22% of those questioned felt that they did provide care or support for another person.

7. **If yes: Have you ever had a "Carers assessment"?**

Out of the 22% who answered yes to providing care to their friends and family (question 6), 65% said that they have never had a carers assessment. 28% left the question blank and only a small percentage (8%) had received a carers assessment in the past.

8. **Are you in paid work?**

58% indicated they were currently employed in paid work and 37% were unemployed at the time of the survey. 5% of questionnaire respondents did not answer the question.

9. **Are you a volunteer?**

32% indicated that they were involved in some form of volunteering at the time of the survey. 65% said that they did not currently hold any sort of volunteering role. A small percentage did not respond.

10. **How many adults (18 years and above) live in your house and their ages?**

41% answered that they had just 2 adults in their household, followed by 22% with 3 adults. 13% of the households had 4 adults residing in the property. 3% said there was 6 adults and 2% had 5 adults. 6% did not respond.

11. **How many children (under 18) live in your house? List their ages.**

A large percentage (43%) did not have any children living in their household. 26% had one child and 21% had 2 children. 8% indicated that 3 children lived in the residence and 2% said 4 children.

Section 3: ABOUT YOUR MENTAL HEALTH

12. **How would you rate your Mental Health before the Coronavirus pandemic?**

39% enjoyed excellent mental health, 28% said very good, 26% answered good, 6% had fair mental health and 1% had poor. 1% did not answer.

13. **How would you rate your current Mental Health?**

29% said excellent (a drop of 10% since before the pandemic), 33% said good (an increase of 7% from question 12), 18% said very good (this had fallen by 10%), 15% said fair (increased by 9%) and 5% said poor (increased by 4%). 1% did not answer the question.

14. **Has the Coronavirus pandemic impacted your mental health?**

27% of respondents felt their mental health had deteriorated as a direct result of the pandemic. Whilst 10% of those surveyed said that they felt the pandemic had improved their overall mental health and 3% did not answer.

15. **How has it affected your Mental Health?**

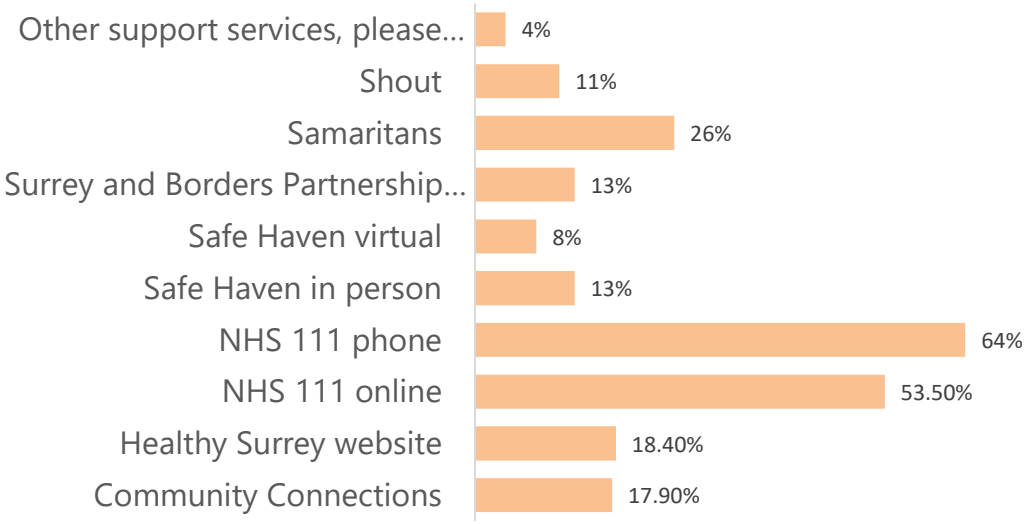
24% stated that were feeling more anxious during the pandemic than they were before and 10% were feeling an increase in low mood. 45% chose not to elaborate on their previous answer.

Section 4: KNOWLEDGE AND AWARENESS

16. **Have you heard of any of the following support services?**

64% of the respondents had heard of NHS 111 phone service, 54% had heard of NHS 111 online, 26% were aware of Samaritans, 18% were aware of either the Healthy Surrey Website and Community Connections. 13% were aware of the Safe Havens and Surrey and Borders Partnership NHS Foundation Trust and 11% had heard of SHOUT crisis text line. 4% listed CAB, Shifa, Liaise, Community Angels, Community Groups, SMEF in the other group.

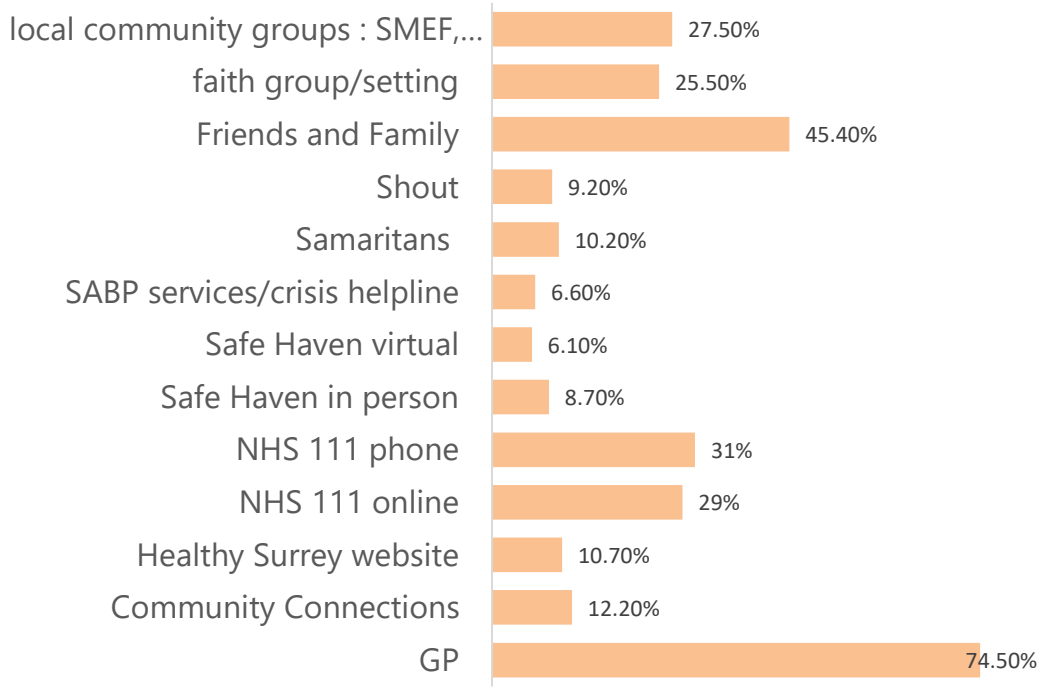
GRAPH 2. AWARENESS OF OTHER SUPPORT SERVICES



17. **If you felt like you needed some help with your Mental Health where would you seek support?**

75% stated that they would first approach their GP, 45% would rely upon their friends and family. 28% would access a local community group, 26% felt their faith leaders would be their first port of call. 13% selected Community Connections and 11% felt that the Healthy Surrey website would provide the support they needed. 10% highlighted Samaritans and 6% would go to a virtual Safe Haven or access Surrey and Borders Partnership NHS Foundation Trust services. 4% did not respond.

Table 3 Who would they approach in time of need



18. **Where is the best place to advertise a new service for you?**

Online advertising via social media & websites was by far the preference indicated by those surveyed as the advertising medium of choice. 59% mentioned Social Media (such as Twitter, Facebook or Instagram), 38% said they get their information from websites, 36% recommended faith leaders, 22% mentioned newspapers. 4% said word of mouth, billboards, GP Surgery or WhatsApp would work best for them.

Section 5: CURRENT SUPPORT

19. **Have you been able to do anything to maintain or improve your mental health?**

64% answered that they had been taking action to maintain or improve their own mental health. 30% answered no to the question and 6% did not respond.

20. **What are you doing to maintain or improve your Mental Health at home?**

52% of the respondents stated that regular exercise had a positive impact in maintaining good mental health. 38% talked to others and 31% said that being involved in activities which were faith based was helpful. 24% were reading or doing mindfulness and meditation. 19% found undertaking arts and crafts activities was helpful for their mental health, and 16% had taken up a learning or training course. Whilst 4% kept themselves occupied with gardening, looking after grandchildren or playing video games.

21. **Have you ever had any help and support with your mental health from organisations or professionals?**

Of the 30% who had responded in the negative to Question 19, 75% had not previously received help from organisations or professionals while 19% had received some sort of professional mental health support in the past. The remaining 6% did not respond.

22. **Do you currently receive any support with your mental health from any organisation or professionals?**

75% of the respondents answered in the negative while 15% answered in the affirmative. 6% did not answer.

23**. If yes, what support have you had?**

Of the people who answered question 22 saying that they are currently receiving support for their mental health, 13% sought help from their GPs and mental health medical teams. 12% approached their friends and family. 7% called NHS 111, 6% used the Ambulance Service, 4% used NHS 111 online. 3% used the Health Surrey website, support phone calls from a charitable organisation or the police. 2% attended some sort of virtual support groups. People who selected other (2%), elaborated that they had contacted either the Pain Management Team, Sickle cell Psychologist or Counsellors.

24. **If no, why have you not had any support?**

Of the respondents who had not sought any mental health support (Question 21) 68% did not consider their needs to be high enough to seek

support, 4% could not access it support and 8% responded other but did not specify. 20% of the respondents did not respond.

Section 6: BARRIERS TO ACCESSING SUPPORT

25. **Would anything discourage you from getting help with your mental health?**

4% answered that they were discouraged from seeking mental health support and 3% answered that they might be. 83% of the respondents answered that they did not feel discouraged from getting mental health support if the situation was serious enough. 11% did not respond to this question.

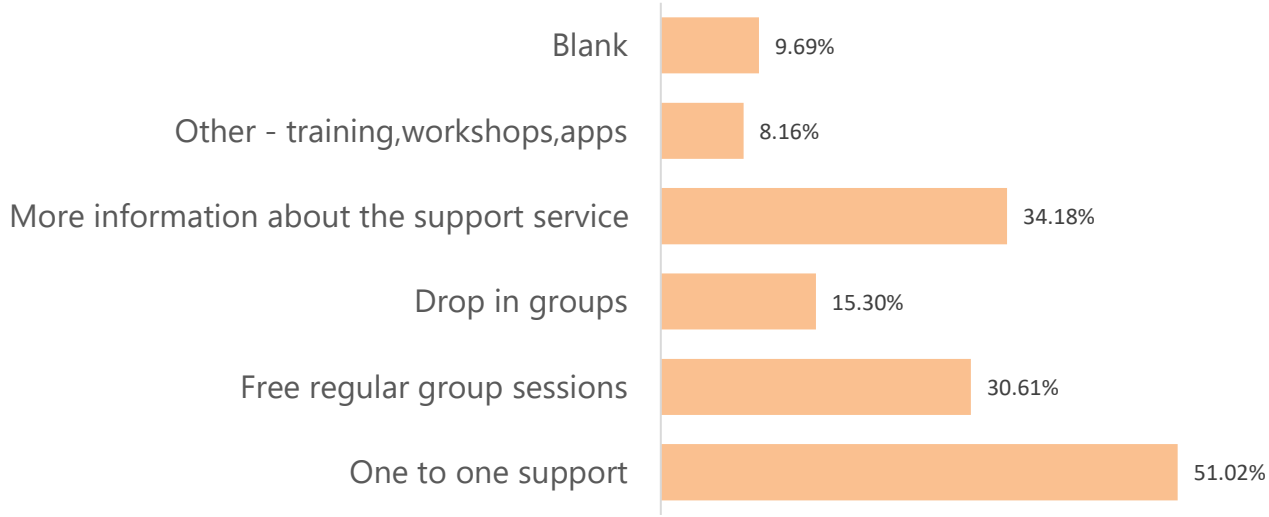
26. **If yes or maybe, what might put you off getting support?**

When looking at what puts the respondents off from getting mental health support, 14% mentioned cultural barriers, lack of confidence, family and community barriers or lack of support and embarrassment as factors that would discourage them from getting help and support. 11% mentioned perceived monetary cost of getting support, 10% considered there to be a stigma in accessing support services, 8% mentioned language barriers and 7% mentioned travel issues. Other responses answered Other but did not specify the barriers they felt impacted their choices.

27. **What would need to happen to enable you to get some support with your Mental Health?**

51% mentioned one to one support and needing to have access to this, 34% said more information about the support service and exactly what it would consist of, 15% wanted drop-in groups, 8% answered other which included training, workshops, phone apps, greater acceptance in the community and less stigma being attached to services. 10% of the respondents did not respond.

GRAPH4: MENTAL HEALTH SUPPORT



28. **Do you have any electronic communication devices, such as smart phone, tablet or computer?**

7% of respondents had no access. 88% of the respondents had electronic communication devices. 5 % did not respond. This question is likely to have been skewed by the demographic (mainly working age adults) and the format of the survey (digital first).

29. **Would you require IT training before you could access online support for your mental health?**

28% of people said they would need technology training to be able to access online mental health services. 62% did not feel that they would need help. 10% did not answer.

30**. If no to question 28: If you were provided with a tablet, smart phone or computer, would you use it to access mental health support?**

52% of the respondents said yes and 13% said No. 36% did not respond.

31. **If yes to question 28: Do you use your device to access mental health support (for example virtual support groups)?**

41% answered Yes, while 27% said No. 32% did not respond.

32. **If no to question 31: Why do you not access mental health support online?**

14% answered that they do not need it or do not have high enough needs. 5% answered that they didn't know what was available, 3% don't know how to use it or had not previously thought about it as an option. A small percentage answered that they preferred face to face mental health support sessions, challenging language barriers, or that they cannot afford it. Other barriers highlighted were that respondents felt they were too busy, had a lack of confidence, do not like using computers or are free of mental health issues.

33. **Do you have WIFI at home?**

83% said Yes, 5% said No and 12% did not answer.

Section 7: WHAT IS MISSING

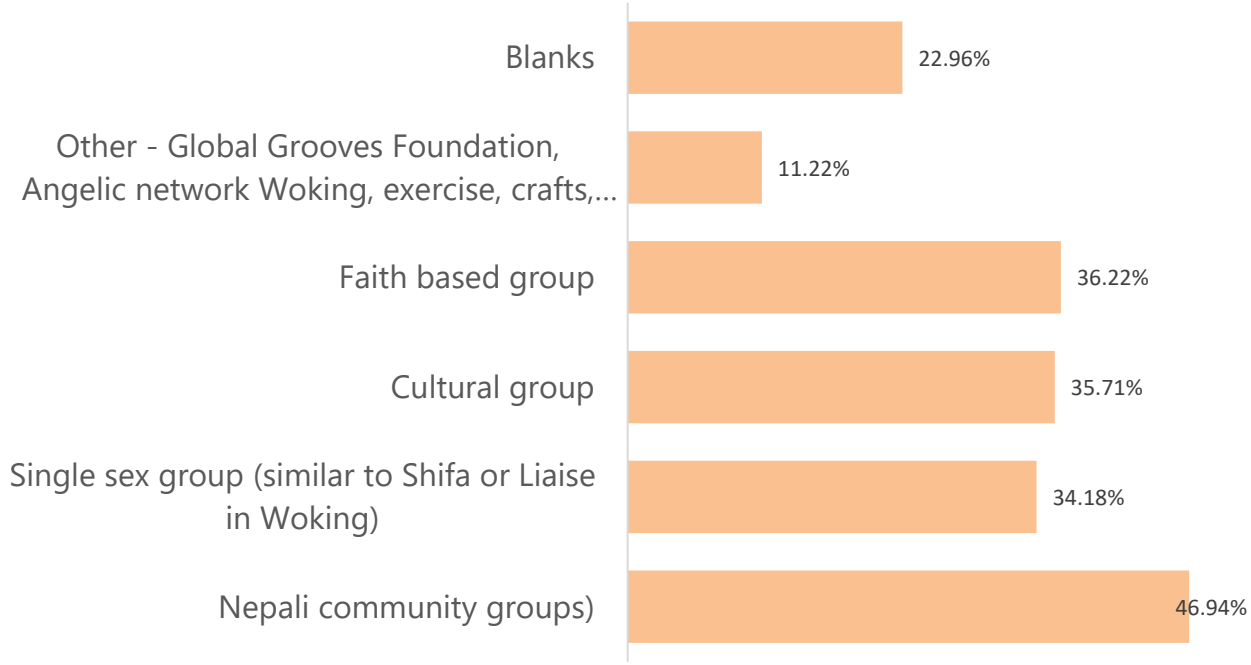
34. **How could mental health support be improved?**

47% said support groups where you can speak their own non-English language would improve their engagement with mental health services.

37% said Faith based support groups would be a positive step, 36% preferred cultural groups. 35% showed a preference increased choice for same sex peer support groups similar to Shifa or Liaise in Woking.

12% answered Other and listed Global Grooves Foundation, Angelic network Woking, exercise, crafts, workshops, counselling, meditation and access to mental health information in other non-English languages.

GRAPH 5: HOW COULD MENTAL HEALTH BE IMPROVED



INTERPRETATION OF ANALYSIS

The respondents largely agreed with the World Health Organisation's definition of mental well-being but when it came to identifying a need for help for their own deteriorating mental health it seemed reliance for support was largely placed on peer relationships and self-help and distraction techniques, whilst uptake of professional mental health services was seemingly low.

The effect of the Coronavirus pandemic on the participants mental health was observed at the start of the first lockdown of 2020 as there was a noticeable negative change in how people identified how they were feeling compared to pre-pandemic. Whilst only 4% felt their mental health had moved from good to poor during the early stages of the pandemic, there was evident negative impact in all good categories, the survey showed a 20% downward shift through all the categories from excellent to fair. This also presented with an identified increase in anxiety and low mood. Over a quarter of the participants acknowledged feeling a deterioration in their mental health that they identified as a direct result of the impact of the pandemic.

Limitations

As the sample was small with a high percentage not responding to every question it was hard to assess how significant the figures were. Nepalis and Black people seemed to be more mental health aware. As the ethnic groups were not stratified equally there is inequality of representation within these groups. The recommendations listed below takes account the limitations of the study. Every answer was taken into account when making recommendations.

RECOMMENDATIONS

We have formed a series of 20 recommendations which sit in 5 broad areas (outlined below).

These recommendations were developed by the Surrey Minority Ethnic Forum (SMEF) steering group and the Independent Mental Health Network (IMHN) and have been formed through analysis of the survey responses, lived experience and local insight.

The recommendations can be grouped into 5 broad categories:

1. **Knowledge and understanding of the offer and reducing stigma**
2. **Improving the diversity and quality of services**
3. **Improved identification and support for Carers**
4. **Improved accessibility of communications and resources**
5. **A sustained commitment to co-production with people from BAME groups**

INCREASE THE KNOWLEDGE AND UNDERSTANDING OF THE SUPPORT AND SERVICES ON OFFER AND REDUCE THE STIGMA SURROUNDING MENTAL HEALTH

BAME communities require confidence building and education in identifying need and accepting mental ill-health. Many of our survey participants recognised symptoms that they, or family/friends, were experiencing but did not equate these with mental ill-health/mental illness. Training is needed for people from BAME backgrounds to know what mental ill-health or deterioration looks like in themselves and others and how to access support available without stigma.

Faith and community leaders are often the first port of call to many members of the BAME community for information and support. It is important for them to receive mental health training and navigator support in order to have the skills needed to support their communities. Upskilling faith and community leaders to be able to talk knowledgeably about mental health, the identification of mental ill-health and of what services are available for support is essential. Faith and Community Leaders are also key to the breaking down of stigma surrounding mental health and

any preconceptions of the level of need that someone should have before they can access support services.

Awareness of what mental health services are available is low amongst BAME communities, particularly the local offers such as the Safe Haven service (in-person and virtual) and the resources available via Healthy Surrey and Surrey Virtual Wellbeing. More awareness is needed about where to go to get self-help information, peer support and community-based support services. Advertising about mental health services on social media and online was indicated as a clear preference to increase knowledge. Posters on local shop windows in different languages; regular TV and Radio announcement in different languages; newspaper advertisements; leafleting in shops in areas identified as more densely populated with BAME communities would also increase awareness of existing mental health services and begin to tackle the stigma of talking about mental health. Identification of such touchpoints that these communities are already getting other types of information will be important for advertising mental health services in future.

The importance of highlighting broader interventions, including complementary therapies is something that has come out of this work. Contributors felt it was very important that the breadth of the mental health support on offer is recognised and communicated to citizens and that groups should be supported to offer appropriate complimentary therapies.

1. Faith and Community Leaders should be offered support and training to recognise mental ill-health, to tackle stigma and to understand how to support their communities in seeking help.
2. The system should consider the role of Mental Health Navigator volunteers or champions (perhaps linked to the Time to Change Surrey campaign).
3. Navigator support (for example, a guide, training, and other resources) should be developed and made available, clearly laying out the offers of support in Surrey both by type of provision and geography. BAME specific services within Surrey and also bespoke national BAME mental health support services such as BAMEStream (who offer therapeutic support in over 20 different languages providing Covid-19 bereavement support to BAME adults in England). Navigator resources and communications should include the ‘mental health offer’

in its broadest sense, including complimentary therapies and other interventions on offer in the community.

IMPROVING THE DIVERSITY AND QUALITY OF THE OFFER

Our insight gathering work has identified a definite need for more culturally specific mental health provision, and availability in a variety of different languages. Increased choice and provision of single sex, faith based, cultural and non-English speaking support groups are needed and would be a positive step in improving engagement with mental health services. Drop-in groups run within BAME community spaces would also allow people to engage on their own terms when needed.

Survey respondents highlighted the helpfulness of physical activity for maintaining good mental health. Respondents explained that culturally sensitive physical activity provision is of real importance if it is going to be accessible for all. The evidence base for physical activity as an intervention is well established and extensively evidenced.

Individuals from BAME groups commonly rely on public transport for travel and often find it difficult to access some services or clinics. Having mental health therapists located within the GP practice (as in the GPIMHS and MHICS models) or in community centres may increase the uptake of services.

Holding peer support groups in faith or community locations familiar to people from the local community and which are also easy to access to those without their own transport would allow more access for a greater amount of people from these underserved communities to engage with mental health services.

Often non-English language speakers rely on translation by a third party (commonly their children or other family members) at medical appointments which is not always appropriate and a clear barrier to accessing services, especially mental health services, an independent translator would remove this barrier. Lack of provision for non-English language speakers is not just an actual barrier commonly faced but also a perceived barrier that could put people off even thinking about seeking support or researching what is available to them as they may believe they

would not be able to interact with the service in a way they can understand and be understood without speaking English. This could be mitigated by introducing an easily accessible translation service either in person, virtually or by using ever improving smart technologies to remove the need for a third person altogether.

The availability of talking therapy through the IAPT (Improving Access to Psychology Therapies) service should be highlighted. The community should also be made aware it is not always necessary to have long term sessions, but one session may be enough to get someone back on the road to well-being.

GPs and other professionals should be made aware of different cultural groups and the importance of cultural sensitivity and understanding that a commonly used approach may not suit the needs of the BAME individual and their carers. Greater understanding of these cultural sensitivities would help put BAME communities at ease. Health professionals should strongly emphasise mental health being normal and not something to be ashamed about.

4. The system should explore the offer of increased choice and provision of support groups, specifically aimed at people from BAME groups, working with the existing community and faith groups in operation.
5. Providers should consider increasing the diversity of the physical activity opportunities that they offer and review the location that these are held at.
6. The IAPT service should be specifically promoted to BAME communities. Faith and Community Leaders should be given more information about what is on offer from IAPT providers.
7. Digital inclusion outreach projects which are being trialled should include a focus around translation apps and developing a training module to teach those who are digitally excluded how to use them.
8. GPIMHS (General Practice Integrated Mental Health Service) and MHICS (Mental Health Integrated Care Service) models should be expanded to cover the entire county and that this service should be very well advertised to BAME communities through Faith and Community Leaders.
9. Future planning, for peer support groups, focuses on locations that are familiar to, and easily accessible by, people from BAME communities.

10. Health and care professionals should be invited to regularly increase their knowledge and cultural understanding. We would recommend that this work would be best delivered by local Faith and Community Leaders.

IMPROVED IDENTIFICATION OF CARERS AND SUPPORT OFFERED

Throughout the survey there was a consistent theme of high reliance on the familial and friendship networks within community groups. It was clear people valued strong local networks based on culture, community or faith. Providing peer support within these pre-built networks would allow people to access support in trusted settings and combat the feeling of exclusion and stigma that may be associated with feeling like the only person seeking support outside of the community. Many people from BAME communities have strong family ties, families usually bear the biggest weight providing support for relatives experiencing mental ill-health, often providing care and emotional support which can be challenging for them if they do not have the necessary training.

Of the respondents who self-identified as a carer of someone with ill health, addiction or disability, only 8% had ever received a carers assessment. As the sample size was 200 people, those identifying as a carer would equate to 44 people, of these less than 4 people would have been offered a carers assessment.

11. Peer support groups for BAME families/carers providing support to a family member or friend should be set up.
12. The system should set a target for carer assessments done with people from BAME groups and work on a carers communication plan for people from BAME groups to aid carer self-identification and registration.

IMPROVED ACCESSIBILITY OF COMMUNICATIONS AND RESOURCES

Perceived monetary cost of getting mental health support was a repetitive theme seen during this work. It seems there is a need to emphasise that

all/most of the mental health support currently offered free of charge from the NHS or charitable organisations when engaging with BAME communities about services. Financial factors for a private therapist and waiting times for the NHS Mental Health Service can be a factor affecting delay or non-acceptance of mental health services.

"If there is no price on the advert then I think it must be very expensive"

Confidentiality should be emphasised as this is not something that is widely assumed and was a big concern for many respondents.

"I don't want everyone to know what I say or talk about. My family and neighbours all talk to each other and go to the same places. Not many services say confidential"

Cultural knowledge and sensitivity of professionals (as well as any lived experience) is something that should be clearly communicated. People report the feeling that they do not want to have to educate the therapist in terms of cultural barriers or common experiences before they can move forward with their therapy.

13. Healthy Surrey's website content should be made available in the most spoken non-English languages in Surrey such as Nepalese, Bengali, Pakistani and Polish.
14. Communications work should always state that services are confidential.
15. Promotional material for services should highlight the diversity of the mental health professionals working across the system and within specific services.
16. Promotional material and messages should state that services are free or include their cost (for services delivered by partners where small charges occur).
17. The visibility of communications campaigns should be improved by being linked to special functions like Gurkha Cup Football Competition, Nepali (Fete) Mela and Victoria Day Function, Diwali, and Eid Melas.

A SUSTAINED COMMITMENT TO CO-PRODUCTION

All future service provision within Surrey should be co-produced with people from BAME groups to understand what would appropriately meet the needs of local communities. Individuals from BAME backgrounds should be involved in co-production of the services from the beginning of the process until the services are live, with services being held accountable to provide the level of provision to BAME communities that the service specification sets out.

There were 4% of people identified by this study who had not accessed mental health services previously but felt they had needed to and that identified the reason they hadn't as not being able to access services. These respondents did not identify why they felt that they could not access the current services available, and we think further (and on-going) insight work is required.

"This is the first time we have been asked about Mental Health and our community. We want to help make things better. You can't assume you know; you haven't lived the same life as my community"

18. The Integrated Care System and all its partners should commit to on-going coproduction with BAME groups and communities. We recommend that providers should be asked to lay out their intentions to co-produce services, specifically with people from BAME groups, and should be held to account for doing so.
19. We recommend that this work (along with the BAME Rapid Needs Assessment completed as part of the Community Impact Assessment) be viewed as a starting point to build on. It is clear further exploration and understanding is required.
20. We recommend that SMEF/IMHN conduct a survey with BAME communities at regular points in the year, to get a dynamic view of what is working for people and what is not.

CONCLUSION

To conclude, our work found that the Covid-19 pandemic caused a negative mental health impact for over a quarter of the people involved in our insight gathering work.

The role that the family and wider community plays in maintaining and improving mental health for people from BAME groups was highlighted clearly.

The recommendations that the steering group identified focus on what is on offer, the accessibility of what is on offer and how aware citizens and community leaders are of it, the need for consistent co-production and engagement and some insightful key communication messages to increase the number of people from BAME groups that access support.

Some of the work identified in the recommendations has already started. We have highlighted the need for this work to be viewed as an initial starting point – this conversation needs to be on-going and sustained. In the meantime, we hope that this report and its recommendations will serve as a useful tool over the coming months as we move into Covid-19 recovery.