Surrey Covid-19 Community Impact Assessment

Mental Health Rapid Needs Assessment

November 2020

Executive Summary

Definition: According to WHO, Mental disorders comprise a broad range of problems, with different symptoms. However, they are generally characterized by some combination of abnormal thoughts, emotions, behaviour and relationships with others. Examples are schizophrenia, depression, intellectual disabilities and disorders due to drug abuse. Mental illness is closely associated with many forms of inequalities, which include living in poverty, low-quality work, unemployment, housing, lack of support to access health and preventative care, stigma, discrimination, social isolation and exclusion.

Different groups of people in the UK are experiencing the COVID-19 pandemic and the lockdown very differently. One area of concern is the impact of the pandemic on mental health and how this is affecting some groups much more than others.

Stakeholders and community member engagement

Over 20 interviews were conducted with stakeholders, key informants and elected members. A focus group with current service users was held.

Common themes

MH services were experiencing lack of resources before the pandemic, particularly the dementia services and some of the care pathway being fragmented. Certain criteria thresholds for MH interventions were often too high, which meant a specific cohort of people who experienced MH problems were often left unsupported.
Key drivers for worsening MH were social isolation, loss of coping mechanisms, fear of becoming infected, conflicting information and working in frontline jobs. The latter was associated to both fear of infection and PPE access.

During the lockdown, rapid efforts were mobilised to offer digital/virtual consultations to current patients. Other positive aspects included the development of Technology Integrated Health Management (TIHM) project, distribution of digital devices to enable remote working/consultation, GP In-Reach into mental health wards, provision of care home mental health support package and prioritising the workforce to access psychological interventions.

Some service users welcomed having remote or virtual consultations, whereas others found it challenging due to the lack of digital devices and or privacy at home with other family members being present.

Priorities

- Effective communication to raise awareness about MH services and how/when they can be accessed (easy read and simplified- with some positive messages to give hope.
- Investment to reduce digital inequalities
- Improve Access to Psychological Therapies (IAPT) services
- A support offer particularly for people with dementia living on their own.
- Build capacity in voluntary sector services to enhance community- based support.
- Investment in 24/7 crisis lines, alternatives to admission and strengthening community services to help people to stay well and avoid escalations.
- Build resilience and empower communities to support the most vulnerable in their neighbourhood.

- Addressing the determinants of poor mental health that are being affected by COVID-19, such as financial difficulties and debt, unemployment, bereavement, domestic violence and abuse, risky alcohol consumption, substance misuse, and gambling addiction.
- Putting in place local offers to support health and social care frontline staff, ensure they have access to PPE and testing.

Mental Health Rapid Need Assessment for adult with pre-existing

1.Brief definition of group

According to WHO, Mental disorders comprise a broad range of problems, with different symptoms. However, they are generally characterized by some combination of abnormal thoughts, emotions, behaviour and relationships with others. Examples are schizophrenia, depression, intellectual disabilities and disorders due to drug abuse. Mental illness is closely associated with many forms of inequalities, which include living in poverty, low-quality work, unemployment, housing, lack of support to access health and preventative care, stigma, discrimination, social isolation and exclusion.

Different groups of people in the UK are experiencing the Covid-19 pandemic and the lockdown very differently. One area of concern is the impact of the pandemic on mental health and how this is affecting some groups much more than others.

2. Population profile of people with MH disorder

Prevalence of common mental health disorders

Indicator	Surrey	England		Definition	Source
Estimated prevalence of common mental disorders: % of population aged 16 & over	12.8	16.9	2017	The estimated proportion of the population aged 16 & over who have a common mental disorder (CMD), where CMD is defined as any type of depression or anxiety. Indicator computed by PHE (based on 2014 Adult Psychiatric Morbidity Survey (APMS) source data owned by NatCen and NHS Digital)	PHE fingertips - Mental health and wellbeing JSNA
Estimated prevalence of common mental disorders: % of population aged 65 & over	7.9	10.2	2017	The estimated proportion of the population aged 65 & over who have a common mental disorder (CMD), where CMD is defined as any type of depression or anxiety.	PHE fingertips - Mental health and wellbeing JSNA
Depression: Recorded prevalence (aged 18+)	8.9%	9.9%	2019	Local authority: The recorded depression prevalence is the estimated number of people with depression recorded on their practice register as a proportion of the practice list size, aged 18 years or over, allocated to a local authority boundary using the postcode of the practice. Quality and Outcomes Framework (QOF), NHS Digital	PHE fingertips - Mental health and wellbeing JSNA Data can be found on the NHS digital - website
Depression and anxiety prevalence (GP Patient Survey): % of respondents aged 18+	10.4%	13.7%	2018	The percentage of all respondents to the question "What is the state of your health today?" who	PHE fingertips - Mental health and wellbeing JSNA

				answered "moderately anxious or depressed", "severely anxious or depressed" or "extremely anxious or depressed". GP Patient Survey (NHS England) https://gp-patient.co.uk/	
Depression in population aged 65 years and over	10.6%	-	2019		Calculated from mosaic populations data
Taken a remedy for stress (% of pop aged 65 years and over)	8.8%	-	2019		Calculated from mosaic populations data
Taken a remedy for anxiety (% of pop aged 65 years and over)	8.1%	-	2019		Calculated from mosaic populations data

Prevalence of common Psychotic disorders

Indicator	Surrey	England		Definition	Source
Mental Health: QOF prevalence (all ages)	TBC	TBC	2019	The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses as recorded on practice disease registers.	PHE fingertips -Mental health and wellbeing JSNA
Long-term mental health problems (GP Patient Survey): % of respondents	TBC	TBC	2019	DH, GP patient survey Question 31. Percentage of all respondents to the question "Which, if any, of the following medical conditions do you have?" who answered "Long-term mental health problem".	PHE fingertips -Mental health and wellbeing JSNA

Early Onset Dementia

Indicator	Surrey	England	Year	Definition	Source
Dementia: Crude Recorded Prevalence (aged under 65 years) per 10,000	2.15 per 10,000	3.21 per 10,000		The crude recorded dementia prevalence is the number of people with dementia (aged under 65 years) recorded on GP practice registers, as a proportion of all people (aged under 65 years) registered at each GP practice. Data from each GP practice is then aggregated at CCG and local authority level.	PHE fingertips -Mental health - Dementia profile

Substance misuse and Mental Health

Indicator	Surrey	England	Year	Definition	Source
Emergency Hospital Admissions for	169.5/100,000	185.5/ 100,000	2017/18	Emergency Hospital Admissions for Intentional Self-Harm, directly age standardised rate, all ages, Persons. Calculated by Public Health England:	PHE fingertips - Co-occurring substance misuse and mental health

Intentional Self-Harm				Knowledge and Intelligence Service from data from NHS Digital - Hospital Episode Statistics (HES) and Office for National Statistics (ONS) - Mid Year Population Estimates	issues / Mental health and wellbeing JSNA
Admission episodes for mental and behavioural disorders due to use of alcohol (Narrow)	45.3/100,000	69.2/100,000	2017/18	Admissions to hospital where the primary diagnosis is an alcohol-attributable mental and behavioural disorders due to use of alcohol code. Children aged less than 16 years were only included for alcohol-specific conditions and for low birth weight. For other conditions, alcohol-attributable fractions were not available for children. Directly age standardised rate per 100,000 population (standardised to the European standard population).	PHE fingertips - Co-occurring substance misuse and mental health issues
Concurrent contact with mental health services and substance misuse services for drug misuse	23.9%	24.3%	2016/17	Number of individuals who entered treatment at a specialist drug misuse service and were currently in receipt of treatment from mental health services for a reason other than substance misuse at the time of assessment, as a proportion of all individuals entering specialist drug misuse services – from National Drug Treatment Monitoring System	PHE fingertips - Co-occurring substance misuse and mental health issues
Concurrent contact with mental health services and substance misuse services for alcohol misuse	24.0%	22.7%	2016/17	Number of individuals who entered treatment at a specialist alcohol misuse service and were currently in receipt of treatment from mental health services for a reason other than substance misuse at the time of assessment, as a proportion of all individuals entering specialist alcohol misuse services	PHE fingertips - Co-occurring substance misuse and mental health issues

3.Relevant legislation/ programmes that support

Universal population mental health promotion and prevention services are commissioned by Public Health in Surrey County Council. Adult mental health services are commissioned by both the CCGs and Surrey County Council and have providers from NHS, independent and voluntary sectors. Prison and criminal justice services are commissioned by NHS England. Commissioning of MH services can be classified into the following four tiers:

- Tier 1 Universal Population Services.
  The mental health promotion service – (e.g. First Steps booklet). The Time to Change Surrey programme is currently provided by local voluntary sector organizations and Virgin Care and is overseen by a multi-agency steering group.
- Tier 2 Primary Community Services
  These include improving Access to Psychological Therapies (IAPT) IAPT service providers, Parent and Infant Mental Health (PIMH) Services, Perinatal Mental Health Services, and other services provided by the voluntary and charitable sector (VCS) organisation (e.g. Community connections, specialist mental health CAB advisors for people with severe/enduring mental health problems) and employment services.

- Tier 3 Specialist Services
  The main local provider; Surrey and Borders Partnership NHS Foundation Trust and two small boundary trust contracts.
- Tier 4 Complex Specialist Services
  Limited services in the main local NHS trust, so services are commissioned via contracts or individual spot purchase basis with providers in the independent and NHS sector

4. Impacts on services

According to the key informants and stakeholders, the MH services (provided by the NHS and as well as VCS) were facing a number of challenges before the pandemic. Reported challenges confronted by the MH services pre-pandemic included:

- lack of funding and resource
- insufficient workforce for service delivery
- high thresholds for meeting the criteria in order to receive psychological support-although some stakeholders felt that this was due to inappropriate consideration of the level/type of intervention and insufficient usage of lower level MH interventions
- fragmented care pathways (in particular dementia services)
- access barriers due to physical barriers (location, timing, availability of appointments)
- insufficient outreach to certain groups such as BAME, homeless, drug and alcohol dependent individuals.
- Some VCS organisations also highlighted a lack of awareness about their organisations' support offer by GPs and other partners across Surrey who may come in contact with people with MH needs.

At the initial phase of the pandemic there was a significant reduction in the number of face to face consultations and appointments as the lockdown measures were introduced. This was accompanied by a reduction in the number of referrals to the Single Point of Access partly, as the number of non-urgent GP consultations decreased (Figure 1). Similarly, there was a reduction in the number of referrals to IAPT services which was most significant in April & May 2020.

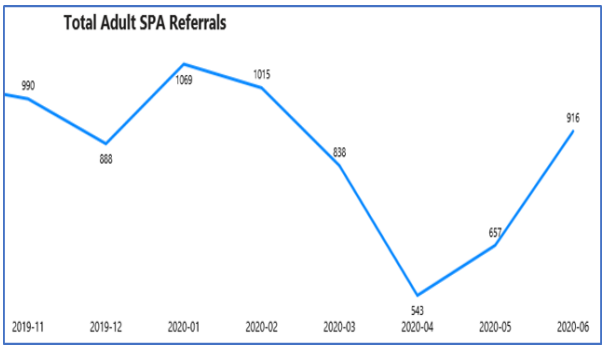


Figure 1 Adult Referral into SPA from November 2019 to June 2020
Source: SABP

Due to the limited number of face to face consultations available, decisions were made by the NHS mental health providers in Surrey to prioritise patients on MH wards, 24hour crisis services, home

treatment services and Integrated Mental Health Support in Primary Care (GPIMHS)[1] to ensure they can continue to deliver care to the most severely ill patients. Although there was a reduction in the number of referrals to the SPA and IAPT services, the data from community crisis services showed an overall increase in activity from March 2020. This was more marked in the number of phone and email communications as the community crisis services changed their provision from face to face to phone or video consultation (Figure 2). This required rapid mobilisations of teams and equipment into the community. Phone appointments were offered to those who did not have access to the technology. Although some face to face consultations were taking place for the most critical cases, difficult decisions had to be made regarding patient prioritisations as access to PPE was limited.

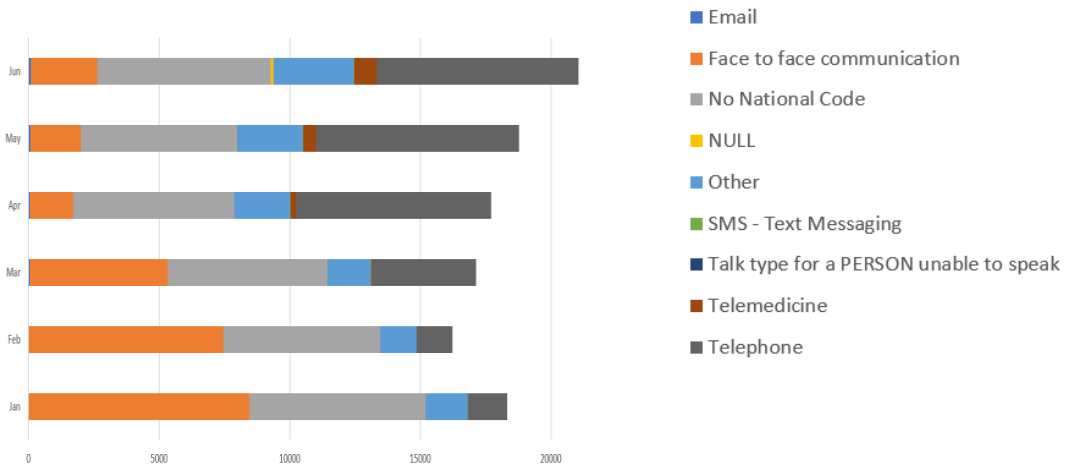


Figure 2 Community and Community Crisis Activity (all ages)
Source: SABP

In preparation for the anticipated increase in the number of Covid-19 patients, some wards in the acute setting were allocated to Covid-19 positive patients. This led to a reduction in the number of bed capacity in admitting new MH patients and as a consequent, an increase in the number of out of SABP out of area bed occupancies.

Unlike the NHS providers, some Charity, Volunteer Community Sectors (VCS) organisations faced a greater challenge to switch from face to face to remote service provision. This was partly due to the lack of resource and access to appropriate technology and partly due to the client's reluctance to receive support via non-face to face appointments. Despite such challenges, significant efforts were made by the VCS organisations to support the clients. This was demonstrated by an increase in the number of welfare checks completed by one VCS organisations (Figure 3).

[1] . The GPIMHS service has seen more than 2,000 people to date, offering support in GP surgeries. Since the lockdown GPIMHS has been extended to an additional 4 Primary Care Network (PCNs) during May and June.

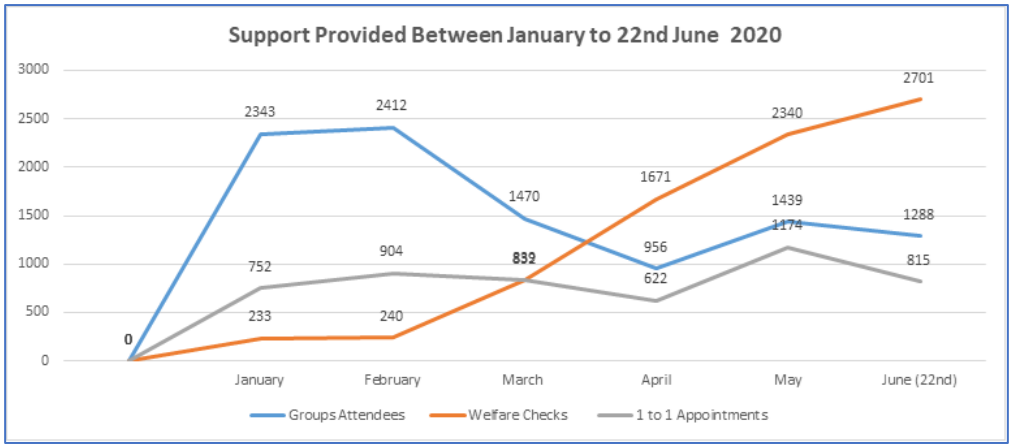


Figure 3 Support provision by Community connections from Jan 2020 to June 2020
Source: Community Connections

As the lockdown continued the early MH impacts of the pandemic became more apparent. This was evident by an increase in the number of calls made to the community helplines across Surrey. For instance, both Surrey Drug and Alcohol Care (SDAC) helpline and Community Communications reported an increase in the number of calls and referrals respectively (Figure 4). Increase in the presentation of MH related issues were also reported by the local community helplines set up during the lockdown by the District and Boroughs primarily to provide logistical support. However, with time the presenting issues became more complex which required a higher level of support. This put some pressure on the frontline staff who were dealing with such challenging issues. It also highlighted a need for further upskilling of the volunteers/staff to enable them to recognise the warning signs and signpost people to services appropriately.

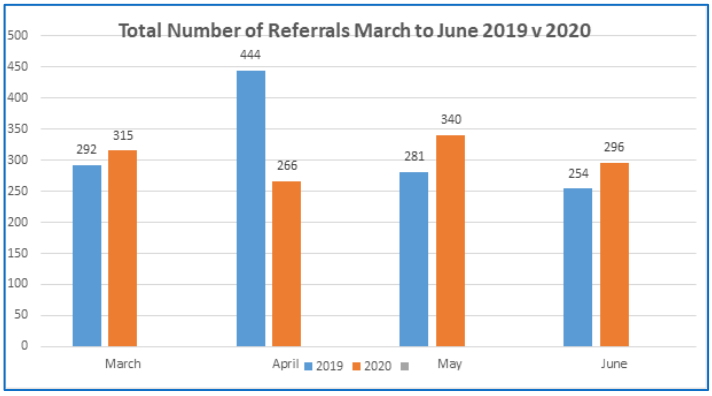


Figure 4. Change in the number of referrals to Community Connection before and during the pandemic. *Source: Community Connection*

There was also a significant increase in the use of the Emergency MHA (Mental Health Act) Powers. This was demonstrated by an increase in the MHA Detention rate of 37% in 2020 compared to 30% and 31% in previous 2 years (Figure 5A). This increase could be possibly attributed to **an increase in the complexity** of cases and/or because of **delayed access to seeking support**. The rise in Mental Health Act detention rate is likely to exert more pressure on Surrey Police, Surrey County Council (AMHPS), Adult Social Care and increase the number of admissions into SABP Mental Health Beds.

Data also shows an upward trend both in the number of people with Mental Health Social Care package and the average cost of the package (Figure 5B). This can further indicate that there is a

growing need for increase in the level and intensity of the support provision as the need is becoming more complex. It also highlights the importance of early prevention and improved access to self-care support in the community to maintain good mental health and work towards recovery.

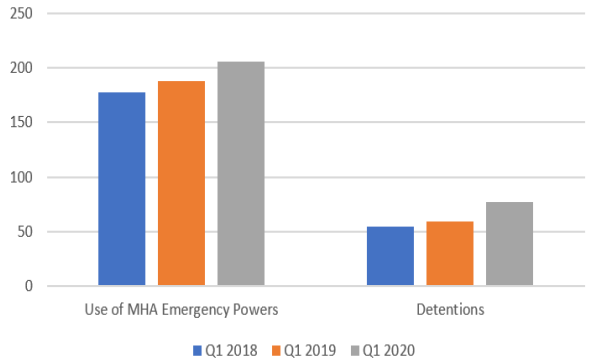


Figure 5A change in use of Emergency MHA and detention rate from 2018 to June 2020

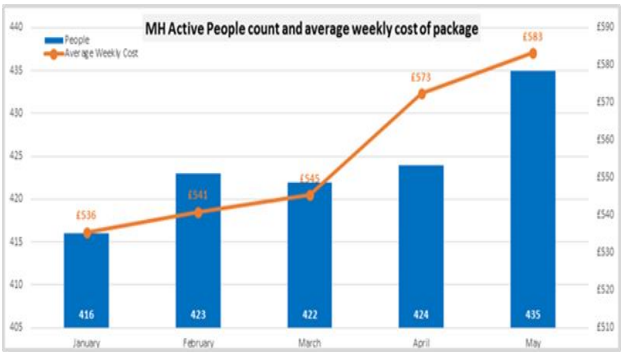


Figure 5B Trend in number of people and average weekly cost of Mental Health package from Jan 2020 to June 2020

5. Risk factors for Covid-19 impact

According to a recent study, about 69% of adults in the UK report feeling somewhat or very worried about the effects of covid-19 on their lives. The most common issues affecting wellbeing are worry about the future (63%), feeling stressed or anxious (56%) and feeling bored (49%). Local surveys are being conducted to assess the psychological impacts of covid-19 on the local population.

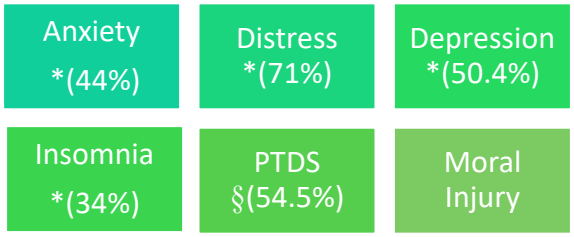
While some degree of worry is understandably widespread, more severe mental ill health is being experienced by some groups. There are several known risk-factors which make people more likely to experience mental health difficulties. These include unemployment, poverty, racism and discrimination, traumatic experiences, violence or abuse, genetics, physical illness, bereavement, chronic loneliness and a lack of access to support.

IFS analysis of longitudinal data from the Understanding Society study found that, taking account of pre-pandemic trajectories, mental health has worsened substantially (by 8.1% on average) as a result of the pandemic. Groups have not been equally impacted; young adults and women – groups with worse mental health pre-pandemic – have been hit hardest. There may also be a greater impact on people with pre-existing long-term conditions and those are clinically vulnerable (shielding) as well as those with drug and alcohol dependencies. In Surrey there are currently 40,164 people on the NHS shielding list and 161,492 reported as to have one or more long-term conditions.

Evidence also suggests that the economic shock of COVID-19 has had an almost immediate effect on people's mental health. Both the Mental Health Foundation and ONS have reported far higher levels of anxiety among those financially impacted by the pandemic. One fifth of people surveyed by the Mental Health Foundation, who identified as unemployed, reported suicidal thoughts in the previous fortnight. This compared with 9% of those in employment. School closure also had an impact as some families (particularly mothers) were no longer able to work.

Housing and ability to afford housing are strong influences on mental health. The percentage of adults in Surrey in contact with secondary mental health services who live in stable and appropriate accommodation – independently, is lower than for England 45.3% vs 59.7% (2014/15). However, this is likely to change as the eviction ban are lifted by the end of September 2020.

Another risk factor for being disproportionally impacted is working in frontline roles. Some of these are illustrate in Figure 6. Front-line key workers, such as healthcare providers and emergency first responders but also other non-healthcare-related staff (e.g. social workers, prison staff), may be especially vulnerable to experiencing moral injuries[2].



Factors Associated With Mental Health Outcomes Among Health Care Workers Exposed to coronavirus Disease 2019 (https://pubmed.ncbi.nlm.nih.gov/32202646/. § Morbidities and Chronic Fatigue in Severe Acute Respiratory Syndrome Survivors https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/415378

6. Impact on people with Mental Health issues

In Surrey, the lockdown had a broad range of impacts on people with MH conditions. For instance, some who found it hard to get out of the house before the pandemic found the lockdown quite comforting whereas, those who relied on social connections and community support groups found it quite challenging. The focus group we held with the service users in Surrey identified that the main drivers for the worsening of MH disorders were social isolation due to the lockdown (particularly on working-age adults living alone and those in poor health), loss of coping mechanisms (e.g. ability to connect with friends and family, access to green spaces), bereavement, fear of becoming infected, worrying about their families becoming infected, job loss worries, conflicting information (e.g. in patients with OCD) and ability to access care (patients as well as carers).

The service users particularly found the initial phase of the lockdown difficult as the pace by which it happened was very rapid and triggered their anxiety and depression. The food shortage at some supermarket and inability to book food delivery on-line and access to medications also contributed to increased levels of panic and anxiety amongst this group. Those with underlying health conditions/poorly relatives, disability and those who were shielding were

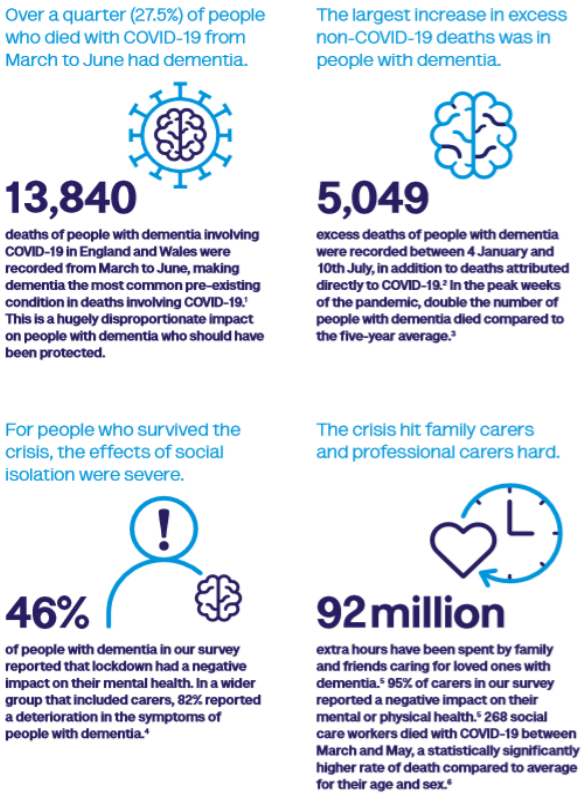
[2] Moral injury: the profound psychological distress which results from actions, or the lack of them, which violate one's moral or ethical code. Therefore, during this time, a lack of resources may mean they are unable to adequately care for those they are responsible. A lack of resources, clear guidance or training may also mean staff perceive that their own health is not being considered by their employers and feel at increased risk of disease exposure.

more likely to experience higher levels of anxiety due to being at a higher risk for Covid-19 infection. Also, those who were living alone in small accommodations and flats found it particularly difficult.

Some of the service users who had previous experience trauma found wearing the facial covering very distressing. But they were worried others would judge them. Therefore, they felt that the general public need to become aware that people with Mental Health issues can also be exempt from wearing the mask.

The key themes that were emerged from a focus groups we held with current MH service users are depicted in the word cloud above. As the figure shows, access to **mental health information and support** services during the lockdown were considered key. However, most found the media coverage of the pandemic quite overwhelming and sometime unhelpful, affecting their level of anxiety and fear. Similarly information posted on social media added to their level of anxiety- especially since there was no way of filtering the information.

The key informant also highlighted the need of patients with dementia, in particular those who were living on their own during the lockdown. A recent national report, people with dementia were the second largest group for excess deaths during the lockdown as shown in the figure opposite (a report by Alzheimer' Society)[3].



7. Severity of Covid-19 impact

Given the socioeconomic gradient in loss of income and jobs, the mental health burden and the long-term health impacts of job losses will also be unequally distributed across the society. In addition, older, younger people, homeless, BAME, people with drug and alcohol dependencies who don't access the services under normal circumstances are more likely to be impacted by further lockdowns. The service users also highlighted that those with caring responsibility experienced an increasing level of anxiety as they worried about their family members. Although outside the scope of this Rapid Need Assessment, there are indication that younger age group were also affected by the lockdown, in particular those between the age of 16 to 24. Likely contributing factors could be linked to closure of the schools, effect on exams, more time at home with potential caring responsibilities, safeguarding, domestic abuse, loss of contact with peers and friends. More research is required with this age group to better undertenant how the impact on the younger age group can be reduced during future lockdowns.

Evidence also suggests the long-term impact of MH on frontline staff and healthcare workers looking after the Covid-19 patients.

8. How has Covid-19 further affected service access

[3]Worst hit: dementia during coronavirus(Alzheimer's Society): https://www.alzheimers.org.uk/sites/default/files/2020-09/Worst-hit-Dementia-during-coronavirus-report.pdf

Services were already stretched with many providers reporting an inability to meet the demand rising prior to the pandemic, and lockdown is adding pressure that is likely to increase in future. There are also concerns by some of the key informants that people are staying away and not seeking help early until they reach the crisis point. This can result in a flood of exacerbated and untreated mental illness after the pandemic, putting extra pressure on already stretched MH providers.

The impact of lockdown has also widened some of the mental health inequalities in relation to accessing services as described above. Additionally, reduced access to services is particularly an issue for the **digitally excluded** individuals who do not have access to equipment or are unbale to receive support remotely. Concerns about loss of contact with mental health services are especially serious for **older adults**, which may mean they miss assessments.

Some stakeholders also reported that although there are still some physical/face to face appointments being offered (e.g. provided by Safe Haven), the uptake remains rather low. They believe this could be attributed to either fear of becoming infected with covid-19 or lack of awareness about the service.

The feedback from service users regarding access was mixed but centred around three key themes: **how information about service change was effectively communicated**, **appropriateness** of remote consultations and **quality of service provision**. Some service users indicated that the care provider contacted them soon into the lockdown to update them about the service change and how they can access care, whereas others did not receive any update for a while. This left the service users anxious and worried as they were not sure if they still be able to access the service or not. Despite this, those that had been able to reconnect with the care provider were satisfied with the care they received. Some indicated that they had contacted their GPs to seek help, but due to uncertainty of the situation at the initial phases the lockdown, the GPs were unable to advice on how best to get support.

The service users also stressed the importance of having some visual contact. Although phone calls were often used to follow up, the service users felt that seeing someone even virtually could be quite reassuring. The service users did however mention the issues such as safeguarding and confidentially should be considered. They also highlighted that although they have been able to access remote consultation, they were aware of people who did not have access to the internet or appropriate equipment.

Service users indicated that as more services were on-line they felt more reassumed that they can still access care. However, since the databases are not linked, often the service users said that they often have to repeat their medical history every time they make contact which can be stressful.

9. Resilience- evidence of recovery

Despite all the challenges there has been numerous success achievements through partnership working, breaking the traditional organisational boundaries and pulling resources together across Surrey. Most providers have demonstrated a great degree of flexibility to adapt their service provision

at speed to fulfil the need with the limited time and resource that they had available. However, they all admit that there has also been some learning to meet the need of people more effectively.

Through partnership working between NHS, Community Connections, Surrey Coalition of Disabled People and Surrey County Council, a Virtual Wellbeing hub was set up to offer support for people during the lockdown. The hub offered a broad range of interactive courses as well informal sessions and has generated positive feedback. This initiative is being constantly reviewed and assessed to increase its reach and effectiveness.

The Tech to Community Connect Project developed by the Surrey Coalition of Disabled People aims to reduce social isolation by providing technological support was initiated before the pandemic. As part of this project, a group of "Tech Angels" (a group of volunteers) would visit participants and support them. However due to the current social distancing restriction, support is being provided via telephone or text in the interim. Schemes such as this project can add real value and help with reducing the effects of digital exclusion on accessing MH services.

At the beginning of the lockdown a Mental Health and Emotional Reference group was set up to respond to some of the early MH impacts on the pandemic primarily on the workforce. This group includes representatives from NHS MH providers (SABP, IAPT), Public Health (SCC), Ault Social Care (SCC), MH commissioners and Volunteer Sectors Organisation (Community Connections, Surrey Coalition of Disabled people). A broad range of training materials and support offer were put together and developed by this group to help the key frontline workers. These resources were published on the Healthy Surrey Website. Surrey County Council Public Health team also commissioned 400 training posts to provide Mental Health First aid training to call handlers and care home staff. This group is also in the process of developing a recovery plan for the local population with a focus on prevention, optimising support and addressing MH inequalities.

The service users highlighted that despite the challenges of the lockdown they have been able to use various methods to look after themselves, for example by gardening, physical activity and reconnecting with family and friends through virtual platforms and taking part in on-line courses and workshop. They also found MH apps and on-line resources such as the Virtual hub and Healthy Surrey Website helpful. Some mentioned that having a mental health comfort kit containing their favourite items and self-care martials beneficial.

10. Recommendations

There has been a lot learning by all stakeholders through this crisis. The following recommendations listed below reflect the learning that have emerged from this rapid need assessment:

Communication

- Effective communication to raise awareness about MH services and how/when they can be accessed by the public and by the professionals for signposting.

Building capacity and investment

- Build capacity and invest in voluntary sector and charity organisations to enhance community- based support.
- Investment in prevention of mental ill health and empower the people to selfcare
- Investment in 24/7 community helpline and crisis lines, alternatives to admission and strengthening community services to help people to stay well and avoid escalations.

- Investment in adult social care mental health services to ensure the increasing numbers of people with more complex needs are supported to stay well in their communities, to enable whole system efficiencies

Improve access and support

- Improving access to Psychological Therapies (IAPT) services for the particularly for older, people with long-term conditions and those from BAME groups.
- Develop a support offer particularly for people with dementia living on their own.
- No wrong door policy for people with dual diagnosis and reducing barrier in referring people with a drug and/or alcohol issue to Community Mental Health Recovery Services (CMHRS).
- Extension of the Integrated Mental Health Support in Primary Care (GPIMHS) in GP practices offering support in Primary Care.
- Improve MH care pathways by enhancing service integration to prevent people from falling through the gaps.
- Increase in mental health training offer to frontline staff, volunteers and community call handlers
- Putting in place local offers to support health and social care frontline staff, ensure they have access to PPE and testing

Addressing MH inequalities

- Investment to reduce digital inequalities
- Addressing the determinants of poor mental health that are being affected by COVID-19, such as financial difficulties and debt, unemployment, bereavement, domestic violence and abuse, risky alcohol consumption, substance misuse, and gambling addiction.
- Inequalities in mental health to be put front and centre of all planning and service recovery and development by increasing investment in VCFS and peer support programmes to improve access, embed co-production, getting the basics right of knowing who accesses the services and the outcomes they achieve and reducing MH stigma.
- Implement a robust suicide prevention action plan at District and Brough level in line with Surrey Suicide Prevention Strategy
- Parity of esteem to value mental health equally to physical health

Partnership working

- Embedding the partnership working in future sustainability, collaboration and innovation.
- Joined up discussions across commissioning to provide high-quality and sustainable services to improve health and wellbeing.

11. Lessons learned

- Better communication with people about accessing care during the lockdown (easy read and simplified)-with some positive messages to give hope.
- Support provision to the most vulnerable groups not just those in crisis, especially those who have a disability or long-term health condition, many of whom have been shielding or isolated during lockdown
- Better data collection to be aware of detailed information including ethnicity, age, whether someone was known to mental healthcare services, previous experience of abuse or trauma, and socio-economic circumstances.

- Increase investment in building community-based service where people can access support where they live.
- Implementing support interventions for people with pre-crisis needs who don't not meet the threshold criteria.
- Build resilience and empower communities to support the most vulnerable in their neighbourhood.