

7. ADULTS

7.5 Mental health and wellbeing

Good mental health is more than the absence of a mental disorder. It is a “*state of wellbeing in which the individual realises his or her own abilities, can cope with the normal stresses of life, work productively and fruitfully and is able to make a contribution to community*”¹. Mental illness is common. In the UK, 1 in 4 people will experience mental illness during their lifetime, with 1 in 6 experiencing mental illness at any one time². Most mental illness begins early and may persist over a lifetime. Half of all diagnosable mental illness starts by 14 years of age and three quarters by mid-twenties³. These problems impact on individuals, their families, communities and society as a whole with immense associated social and financial costs.

This chapter covers mental health and wellbeing and considers the subject from feelings of wellbeing and how to enhance these, the current situation with regards diagnosed mental disorders, through to suicide and suicide prevention. This chapter should be read in conjunction with the JSNA chapters on children’s mental health and perinatal mental health.

1. *The impact of poor mental well-being, poor mental health, and suicide*

Good mental health and resilience is fundamental to our physical health, our relationships, education and work, our ability to cope with life’s problems and make the most of life’s opportunities, and achieve our potential. It is the foundation for wellbeing and for functioning effectively both as individuals and communities. Good mental health should be considered as equal to good physical health as they impact on each other.

Personal wellbeing, people’s thoughts and feelings about their own quality of life, is an important aspect of wellbeing. Research shows that happier people, those with a positive subjective sense of wellbeing, can add at least 7.5 years to their life⁴. People who report higher levels of wellbeing tend to be more involved in social and civic life⁵ have better family and social relationships⁶ and are more productive at work⁷. Conversely, people with severe mental illness die on average 20 years earlier than the general population, largely because of physical health problems⁸.

Mental illness is generally categorised into Common Mental Disorders (CMD) and Severe Mental Disorders or Severe Mental Illnesses (SMD/SMIs). CMDs are those conditions that cause clear emotional distress and interfere with daily living, but do not usually affect people’s insight or cognition; such as anxiety, depression, obsessive compulsive disorders and post-traumatic stress disorder⁹. SMIs are conditions that are severe enough to distort the perception of reality and include psychotic and personality disorders such as schizophrenia, affective psychosis and bipolar disorder.

The Centre for Mental Health estimates that the aggregate cost of mental health problems in England in 2009/10 was £105 billion, including £21.3 billion in health and social care costs, £30.3 billion in lost economic output and £53.6 billion in human suffering. These costs increased by 36% between 2002/03 and 2009/10, with a particularly large increase in the costs of health and social care (over 70%)¹⁰. The direct financial cost of treating people with

mental health problems is the tip of the iceberg, as many individuals have caring and family responsibilities and so the economic and emotional impact on families and community is enormous.

Suicide is a devastating public health issue affecting individuals, families and communities. It also has a significant economic impact. The economic cost of each death by suicide in England for those of working age is estimated to be £1.67 million (2009 prices). This includes intangible costs (loss of life to the individual and pain and suffering of relatives), as well as both waged and unwaged lost output. Between 2000 and 2008, 27% of people who died as a result of suicide had been in contact with mental health services in the previous 12 months¹¹.

2. Mental health and well-being and the links to social inequalities

The Government Strategy 'No Health without Mental Health' (2011) recognises the importance of social determinants of mental health and that socio-economic deprivation and social isolation can both contribute to the development of mental health problems and result from them.

Mental health problems are an important cause of social inequalities as well as the consequence. Low income¹², debt¹³, and unemployment¹⁴ are key risk factors for mental health problems and experiencing mental health problems further exacerbates social inequalities because of its impact on employment and housing status.

3. Information on mental well-being, mental health and suicide in Buckinghamshire

3.1 Mental wellbeing

Personal wellbeing data is collected nationally within the Annual Population Survey. This asks respondents aged 16 and over across the UK the following questions about their wellbeing:

- Overall how satisfied are you with your life nowadays? (Life satisfaction)
- Overall to what extent do you feel the things you do in your life are worthwhile? (Worthwhile)
- Overall how happy did you feel yesterday? (Happiness)
- Overall how anxious did you feel yesterday? (Anxiety)

People respond on a scale of 0 to 10, where 0 is 'not at all' and 10 is 'completely'. Average (mean) scores for each question are calculated. Scores for the happiness, satisfaction and worthwhile questions are grouped into 'low' (score 0-4), 'medium' (5-6), 'high' (7-8) and 'very high' (9-10). Scores for the anxiety question are grouped into 'very low' (0-1), 'low' (2-3), 'medium' (4-5) and 'high' (6-10).

In England and the UK, reported personal wellbeing has improved every year since September 2011 to September 2012, when data were first collected. Possible reasons attributed to this are reduced unemployment and greater financial stability¹⁵. However,

2015/16 sees the first instance where there has not been an annual improvement across all of the measures. When comparing 2014/15 and 2015/16 life satisfaction was the only measure which did increase. Average ratings of feeling that things done in life are worthwhile, happiness and anxiety did not improve.

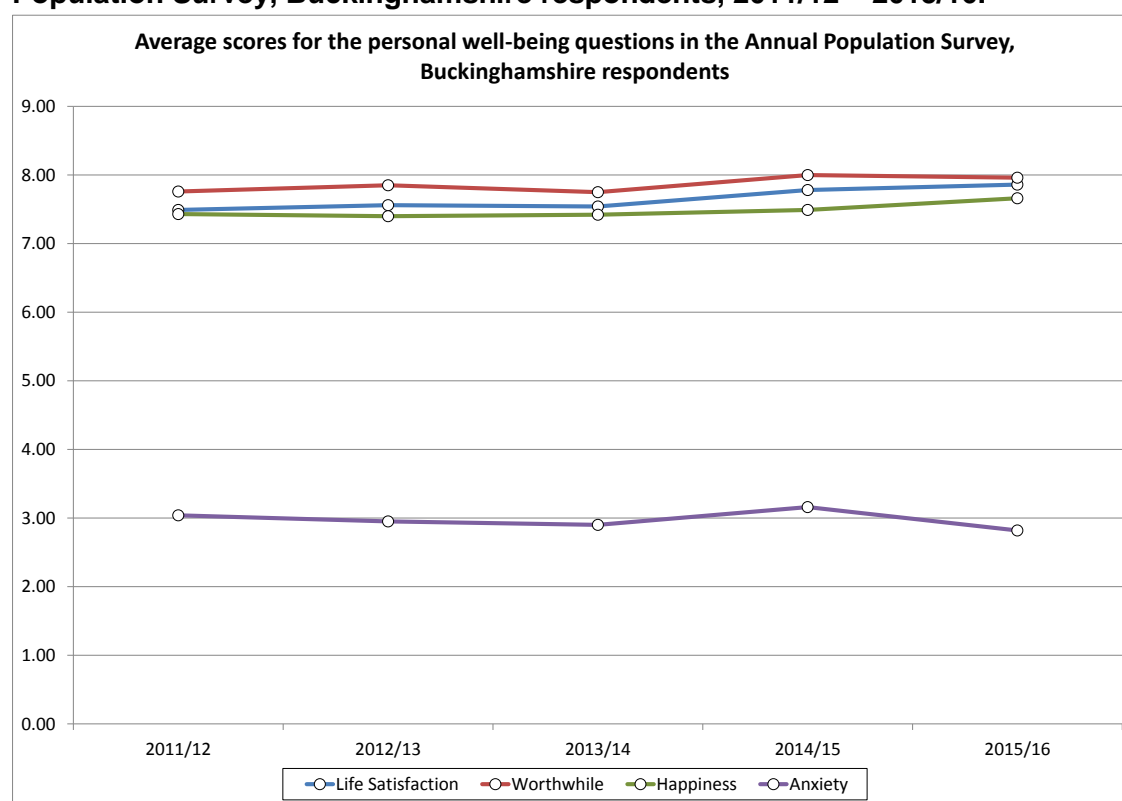
In 2015/16, there were 870 respondents in Buckinghamshire. In response to the question 'Overall how satisfied are you with your life nowadays?' the Buckinghamshire average has increased from 7.5 to 7.9 over the last five years (table 1 and figure 1). This trend is significant ($p = 0.02$, chi-square test for trend), and has been significantly higher than the England average since 2014/15. The responses to questions 'Overall to what extent do you feel the things you do in life are worthwhile?' and 'Overall how happy did you feel yesterday?' have remained at a similar level over the period of the survey. Similarly, the question 'Overall how anxious did you feel yesterday?' shows no significant change, but is currently at the lowest level in the period.

Table 1. Average scores for the personal well-being questions in the Annual Population Survey, Buckinghamshire respondents, 2011/12 – 2015/16.

Wellbeing question	Year				
	2011/12	2012/13	2013/14	2014/15	2015/16
Life satisfaction	7.49	7.56	7.54	7.78	7.86
Worthwhile	7.76	7.85	7.75	8.00	7.96
Happiness	7.43	7.40	7.42	7.49	7.66
Anxiety	3.04	2.95	3.16	3.16	2.82

Source: Annual Population Survey, Office for National Statistics

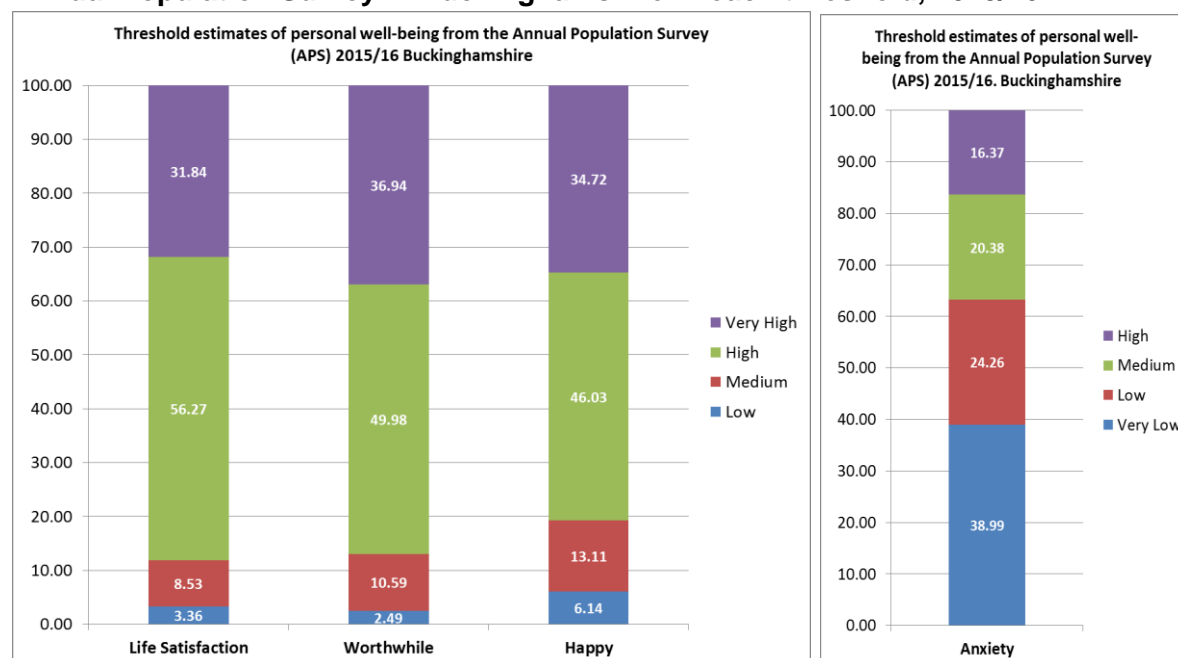
Figure 1. Average scores for the personal well-being questions in the Annual Population Survey, Buckinghamshire respondents, 2011/12 – 2015/16.



Source: Annual Population Survey, Office for National Statistics

88.1% reported their life satisfaction as high or very high, 86.9% reported feelings that the things they do in life are worthwhile as high or very high and 80.8% reported their happiness as high or very high (figure 2). When asked how anxious they felt yesterday 63.3% reported very low or low anxiety.

Figure 2. Proportion of respondents to the personal well-being questions in the Annual Population Survey in Buckinghamshire in each threshold, 2015/16.



Source: Annual Population Survey, Office for National Statistics

Table 2 shows how people responded to the question ‘Overall how satisfied are you with your life nowadays?’ in Buckinghamshire and the District Councils in 2015/16. The pattern of responses across the District Council areas was similar to those from Buckinghamshire as a whole.

Table 2. Proportion of respondents to the question 'Overall how satisfied are you with your life nowadays?' aged 16 and over in Buckinghamshire, England and the South East, 2015/16.

Area Names	Thresholds - Proportion of respondents in each threshold (%)			
	2015/16			
	Low 0-4	Medium 5-6	High 7-8	Very High 9-10
ENGLAND	4.55	14.29	52.39	28.77
SOUTH EAST	3.81	12.74	53.10	30.4
Buckinghamshire	3.36	8.53	56.27	31.84
Aylesbury Vale	x	9.34	57.75	30.66
Chiltern	x	x	x	x
South Bucks	x	x	51.75	34.54
Wycombe	x	x	56.72	30.85

Question: Overall, how satisfied are you with your life nowadays? Where 0 is 'not at all satisfied' and 10 is 'completely satisfied'
 x Data have been suppressed as the co-efficient of variation > 20% or unavailable, or the sample size is insufficient.

Statistical Significance (compared to England): **Lower** **Similar** **Higher** **Not calculated**

Source: Annual Population Survey, Office for National Statistics

Table 3 shows how people responded to the question 'Overall how happy did you feel yesterday?' in Buckinghamshire and the District Councils in 2015/16. A statistically higher proportion of people in Buckinghamshire reported 'high' happiness (46.0%) than in England (40.0%) and a statistically lower proportion in Buckinghamshire reported 'medium' (13.1%) and 'low' (6.1%) happiness than in England (16.5% and low 8.8% respectively).

Table 3. Proportion of respondents to the question 'Overall how happy did you feel yesterday?' aged 16 and over in Buckinghamshire, England and the South East, 2015/16.

Area Names	Thresholds - Proportion of respondents in each threshold (%)			
	2015/16			
	Low 0-4	Medium 5-6	High 7-8	Very High 9-10
ENGLAND	8.75	16.52	40.65	34.08
SOUTH EAST	7.99	15.84	41.31	34.86
Buckinghamshire	6.14	13.11	46.03	34.72
Aylesbury Vale	x	11.01	45.59	36.60
Chiltern	x	x	41.34	41.44
South Bucks	x	x	47.32	26.48
Wycombe	x	14.51	48.49	32.38

Question: Overall, how happy did you feel yesterday? Where 0 is 'not at all happy' and 10 is 'completely happy'.
 x Data have been suppressed as the co-efficient of variation > 20% or unavailable, or the sample size is insufficient.

Statistical Significance (compared to England): **Lower** **No difference** **Higher** **Not calculated**

Source: Annual Population Survey, Office for National Statistics

Table 4 shows how people responded to the question ‘Overall to what extent do you feel the things you do in life are worthwhile?’ in Buckinghamshire and the District Councils in 2015/16.

Table 4. Proportion of respondents to the question ‘Overall to what extent do you feel the things you do in your life are worthwhile?’ aged 16 and over in Buckinghamshire, England and the South East, 2015/16.

Area Names	Thresholds - Proportion of respondents in each threshold (%)			
	2015/16			
	Low 0-4	Medium 5-6	High 7-8	Very High 9-10
ENGLAND	3.55	12.90	49.32	34.23
SOUTH EAST	3.28	11.89	49.79	35.04
Buckinghamshire	x	10.59	49.98	36.94
Aylesbury Vale	x	8.81	48.65	40.10
Chiltern	x	x	x	x
South Bucks	x	x	49.15	36.09
Wycombe	x	x	50.51	34.75

Question: Overall, to what extent do you feel the things you do in your life are worthwhile? Where 0 is 'not at all worthwhile' and 10 is 'completely worthwhile'.

x Data have been suppressed as the co-efficient of variation > 20% or unavailable, or the sample size is insufficient.

Statistical Significance (compared to England):

Lower

No difference

Higher

Not calculated

Source: Annual Population Survey, Office for National Statistics

3.2 Common Mental Disorders

It is estimated that common mental disorders may affect up to 15% of the population at any one time. The vast majority are diagnosed and treated in primary care. However, many individuals do not seek treatment, and both anxiety and depression often go undiagnosed¹⁶.

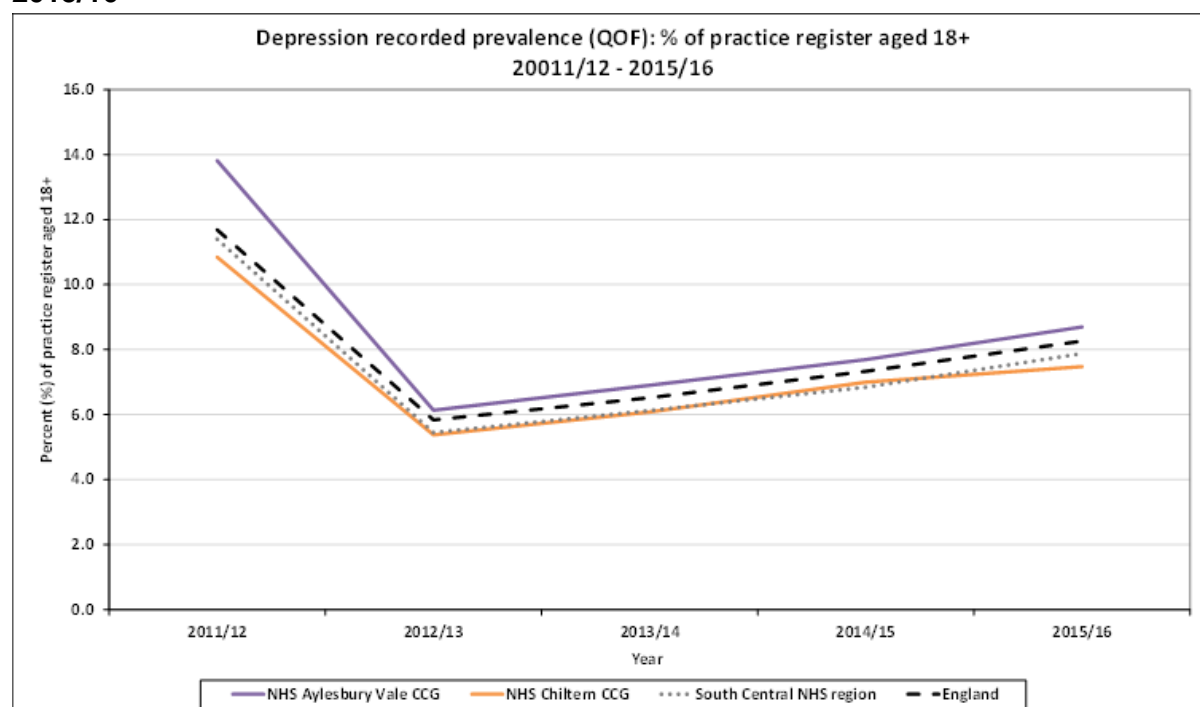
The Adult Psychiatric Morbidity Surveys provide data on the prevalence of both untreated and treated mental illness. The 2014 survey identified 1 in 6 (15.7%) people with symptoms of CMD. Women were more likely to be affected than men. 1 in 5 (19.1%) of women had CMD symptoms compared with 1 in 8 (12.2%) of men. Women were also more likely than men to have severe symptoms. Working age people were twice as likely to have symptoms of CMD as those aged over 65 years.

When these estimates are applied to the Buckinghamshire population it is estimated that in 2015 there was an estimated 71,650 people aged 16 and over with a CMD.

GP Practices record patients aged 18 and over with depression on a depression register. In 2015/16, 8.7% of patients in NHS Aylesbury Vale CCG (14,128 individuals) and 7.5% of patients at NHS Chiltern CCG (19,724 individuals) had a diagnosis of depression. The prevalence in Aylesbury Vale CCG is statistically significantly higher and the prevalence in Chiltern CCG statistically significantly lower than the prevalence of 8.3% in England¹⁷. Both CCGs show a decline in the proportion of patients aged 18 and above on GP depression

registers between 2011/12 and 2012/13, and then a steady increase to 2015/16, figure 3. This trend is also seen in England and in all comparator CCGs.

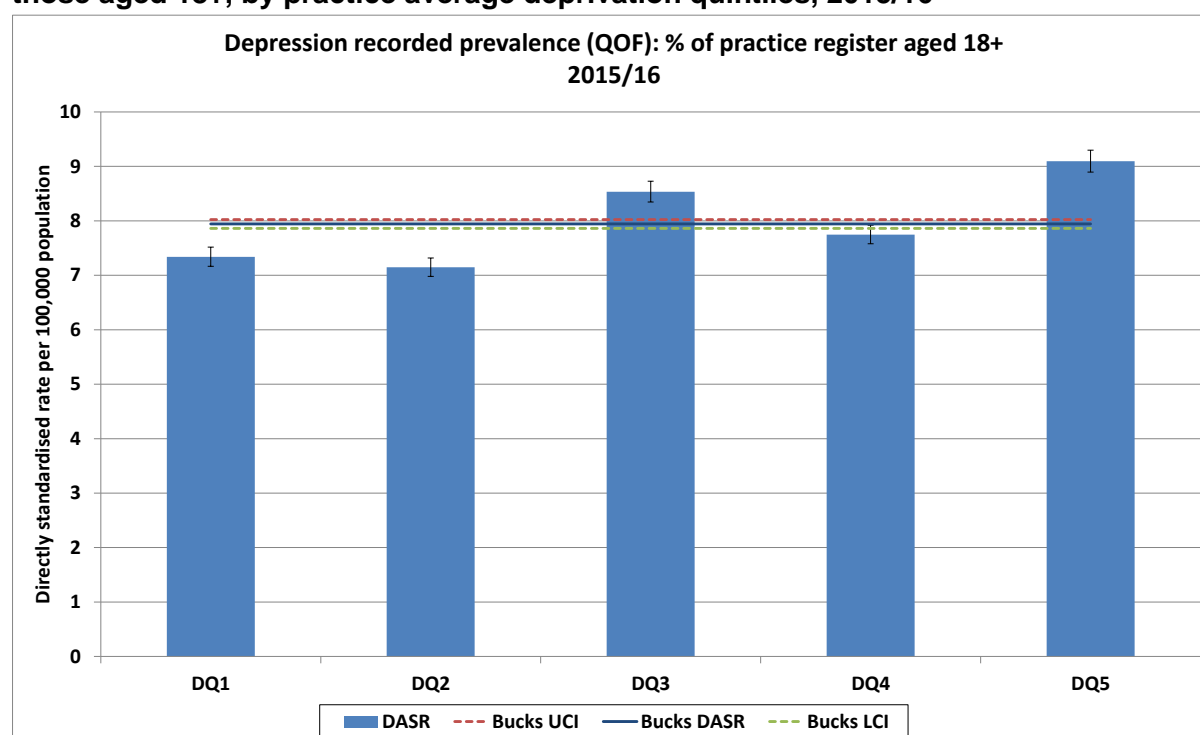
Figure 3 Recorded prevalence of depression in Buckinghamshire CCGs 2009/10 to 2015/16



Source: Quality and Outcomes Framework

The prevalence of recorded depression varies across Buckinghamshire. In the least deprived 20% of GP practices (deprivation quintile 1) the directly standardised rate of recorded depression is 7.3%, and in the most deprived 20% of GP practices (deprivation quintile 5) it is 9.1%. This difference is statistically significant (figure 4).

Figure 4. Directly standardised rate of recorded depression in primary care among those aged 18+, by practice average deprivation quintiles, 2015/16



Source: Quality and Outcomes Framework

It is estimated that 50% of patients attending their GP practice with CMDs do not have their symptoms recognised¹⁸. In 2015/16, when asked 'what is the state of your health today?' 10.0% of patients in the National General Practice Survey among those aged 18 and over from NHS Aylesbury Vale CCG and 8.4% from NHS Chiltern CCG responded "moderately anxious or depressed", "severely anxious or depressed" or "extremely anxious or depressed". These are statistically lower than for England (12.7%). These figures are slightly higher than the numbers of patients cited on the GP depression register.

Individuals can receive support for CMD from Improving Access to Psychological Therapy (IAPT) services. IAPT services provide evidence based treatments for people with anxiety and depression implementing NICE guidance. Individuals in Buckinghamshire can self-refer or be referred by their GP or other designated professionals. In Buckinghamshire in September 2016, 16.3% of people (235 people) in NHS Aylesbury Vale CCG and 14.1% (305 people) in NHS Chiltern CCG estimated to have anxiety or depression entered IAPT services. This was statistically similar to England (15.5%) and most comparator CCGs in the South East. In quarter 2 of 2016/17, 478 per 100,000 population entered IAPT treatment (765 people) in Aylesbury Vale CCG and 422 per 100,000 population in NHS Chiltern CCG. Although the rates for both CCGs are statistically lower than England (540 per 100,000 population) the trend in the rate is increasing for both CCGs.

3.3 Severe mental illness

Combined data from the 2007 and 2014 Adult Psychiatric Morbidity Surveys identified 1 in 200 (0.5%) people with symptoms of functional psychosis (schizophrenia, schizoaffective

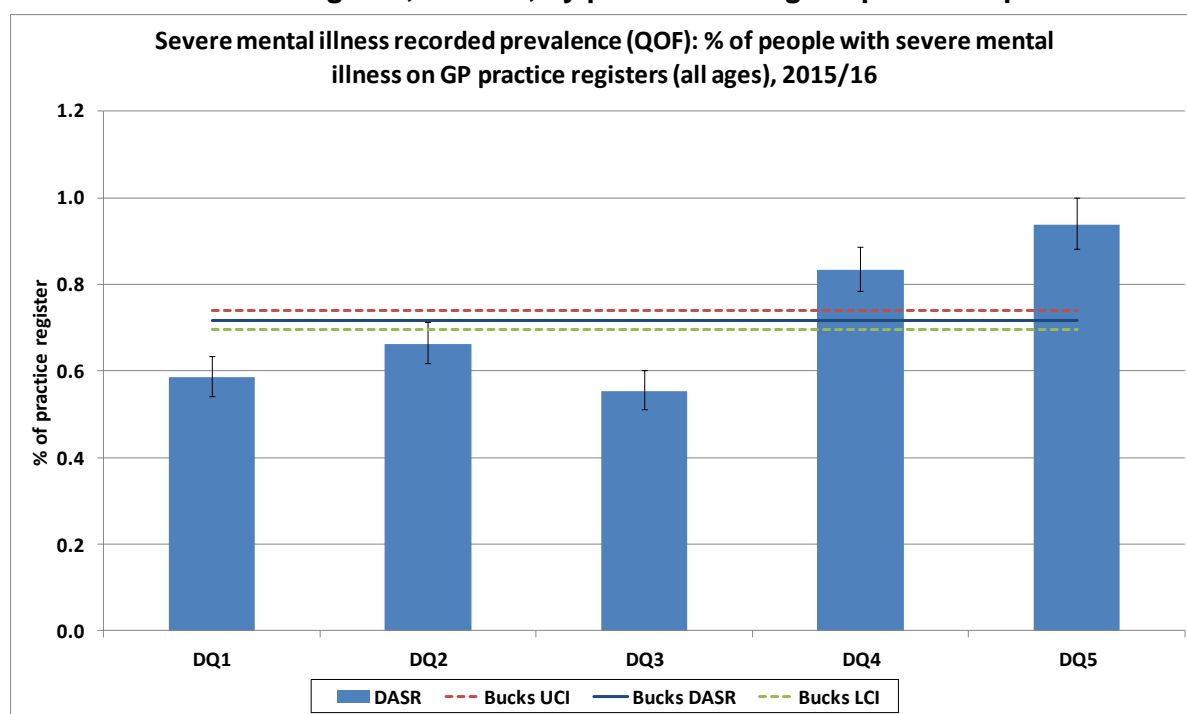
disorder and affective psychosis). This excludes organic psychosis, such as dementia and Alzheimer's disease. Prevalence did not vary significantly in women (0.6%) and men (0.5%). The highest prevalence was in people aged 35 to 44 years.

When these estimates are applied to the Buckinghamshire population it is estimated that in 2015 there could have been 2,316 people aged 16 and over with symptoms of functional psychosis.

GP practices produce a register of patients of all ages with SMI, which includes schizophrenia, bipolar affective disorder, other psychoses and patients on lithium therapy. These patients should then receive a comprehensive care plan and receive health promotion and prevention advice appropriate to their age, gender and health status.

In 2015/16, the prevalence of SMI in the combined Buckinghamshire practices was 0.72%. 0.73% of NHS Aylesbury Vale CCG patients (1,528 individuals) were on the GP SMI register and 0.71% of NHS Chiltern CCG patients (2,393 individuals). This was lower than England (0.90%), and the South Central NHS region (0.76%). For both CCGs this has stayed relatively stable since 2012/13. In Buckinghamshire, prevalence of recorded SMI varies; in the least deprived 20% of GP practices prevalence is 0.59%, and in the most deprived 20% of GP practices the prevalence is 0.94%, which is statistically significantly higher (figure 5).

Figure 5. The percentage of people registered with a Buckinghamshire practice, and on the mental health register, 2015/16, by practice average deprivation quintile.



Source: Quality and Outcomes Framework (QOF). <http://content.digital.nhs.uk/qof>

The number of new cases of psychosis per year is in line with comparator counties. In 2011 (the most recent available data) there were 19.1 new clinical cases of psychosis per 100,000

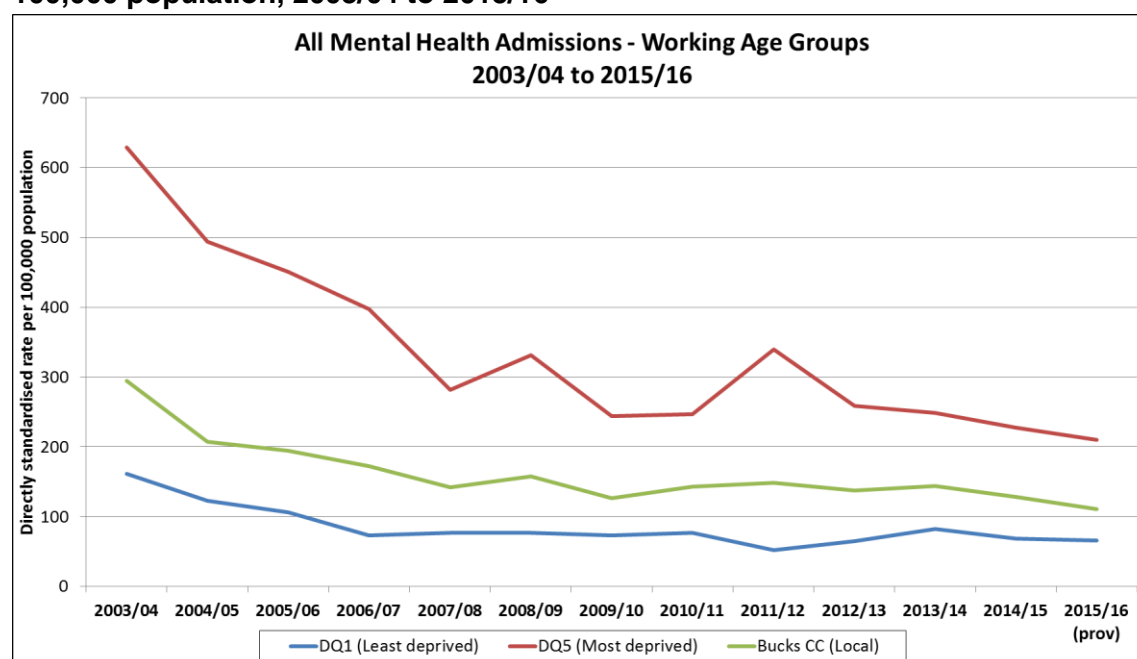
population aged 16 to 64 in Buckinghamshire (crude rate). This was higher than the England (18.1) and South East values (18.4), but not statistically different.

3.4 Admissions

Admissions to hospitals for a mental disorder should be avoided wherever possible through the use of community based services and crisis teams. The directly age standardised rate of admissions to hospital for a mental illness in among people of working age (aged 16-59 for women and 16-64 for men) in Buckinghamshire decreased from 295 per 100,000 population in 2003/04 to 111 per 100,000 population in 2015/16. This decline was most pronounced among people living in the most deprived areas, deprivation quintile 5, with a reduction from 629 per 100,000 population in 2003/04, to 210 in 2015/16 (Figure 6).

The size of the gap between the rate of the most and least deprived areas reduced during this period. However the rate for the most deprived areas remained consistently above the Buckinghamshire rate, and the rate for the least deprived areas remained consistently below it. This was statistically significant (Figure 6).

Figure 6. Directly standardised rate of admissions to hospital for a mental disorder among people of working age (age 16-59 for women, and age 16-64 for men) per 100,000 population, 2003/04 to 2015/16

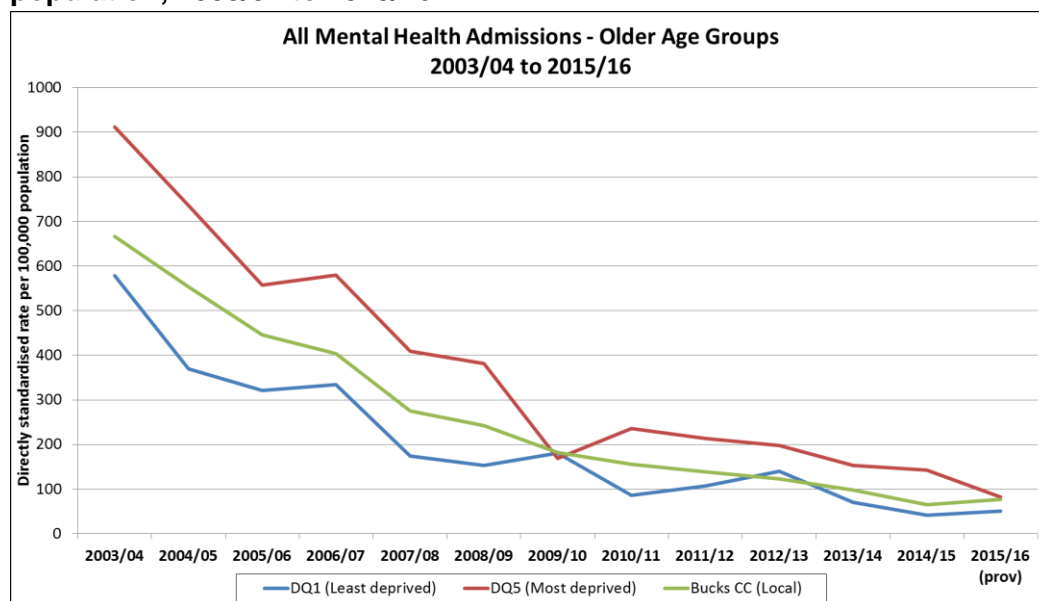


Source: Local Data: 2003/04-2007/08 SUS APC via OxNET; 2008/09 onwards SUS APC via INFOHUB. Population data: ONS Small Area Population Estimates (SAPE) Mid-2001 to Mid-2015. Deprivation Quintiles: Department for Communities and Local Government (DCLG), English indices of deprivation 2010

The directly standardised rate for older age groups, (age 60+ for women, and age 65+ for men) in Buckinghamshire also showed a decline from 665.8 per 100,000 population in 2003/04 to 76.9 per 100,000 population 2015/16. A greater rate of decline from 911 per 100,000 population in 2003/04 to 82 per 100,000 population in 2015/16 was seen in the most deprived areas (deprivation quintile 5) than in the least deprived areas extensively

reducing the gap between them so that in 2015/16 there was is no statistical difference between them (figure 7).

Figure 7. Directly standardised rate of admissions to hospital for a mental disorder among older age groups (age 60+ for women, and age 65+ for men) per 100,000 population, 2003/04 to 2015/16



Source: Local Data: 2003/04-2007/08 SUS APC via OxNET; 2008/09 onwards SUS APC via INFOHUB. Population data: ONS Small Area Population Estimates (SAPE) Mid-2001 to Mid-2015. Deprivation Quintiles: Department for Communities and Local Government (DCLG), English indices of deprivation 2010

3.5 Suicide

Every day in England around 13 people take their own lives¹⁹. The effects reach into every community and have a devastating impact on families, friends, colleagues and others²⁰. For every person who dies at least 10 people are directly affected²¹. Suicide is also an indicator of the underlying rates of mental ill health. Suicide is not inevitable and suicides are preventable. 'Low' comparative rates of suicide as compared to other areas should not be used as a justification for not taking preventative action²².

Suicide is a growing concern. Rates in England, the South East and Buckinghamshire have increased since 2001-03 (figure 8), and in 2014, rates in England were the highest since 2004. Nationally, suicide is the leading cause of death among people aged 15 to 24; among young men; and among new mothers. In addition, rates in prisons in 2015 were the highest seen since 2007.

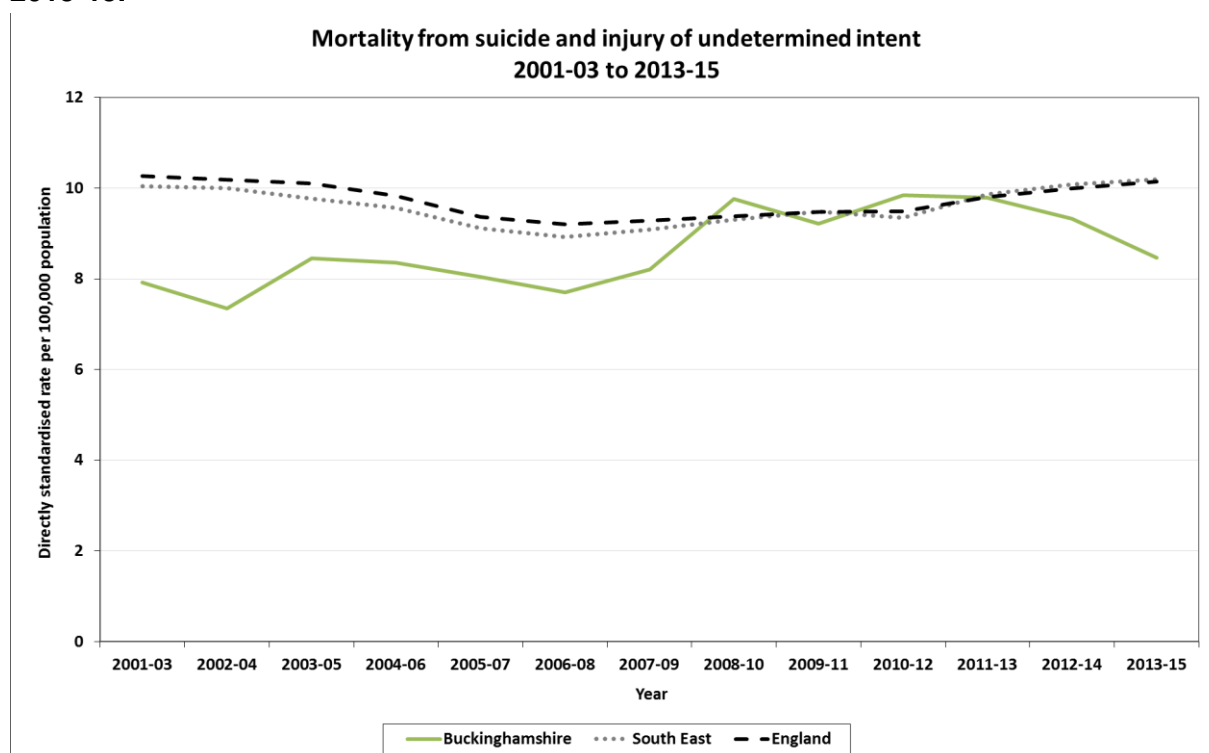
Data on suicides and undetermined injury are combined in the data below because suicide is a conclusion reached by a coroner following an inquest. To reach a conclusion of suicide a coroner must be satisfied that the evidence demonstrates an individual carried out the act which resulted in their death, and that they intended to take their own life. Both elements must be proven at the higher criminal standard (i.e. beyond reasonable doubt).

Undetermined injury is a narrative or an open conclusion, which means the higher standard may not have been formally met, but it is still possible that the death may have been suicide.

In 2015, there were 4,820 registered deaths from suicide or undetermined injury among people aged 15 and over residing in England, with 34 of these people residing in Buckinghamshire. Numbers fluctuate year on year, so three year averages are often used. Between 2013 and 2015 (inclusive), there were 113 deaths from suicide or undetermined injury recorded for Buckinghamshire residents, averaging 38 each year.

Taking a three-year average, the directly age-standardised rate of mortality from suicide and undetermined injury for people aged 15 and over for the years 2013-15 in Buckinghamshire was 8.5 per 100,000 population. This was not statistically significantly different to the England (10.1), and South East (10.2) rates²³, and the rate of peer comparator Local Authorities. However, figure 8, shows an increase in the suicide rate for England, the South East and Buckinghamshire since 2001-3.

Figure 8. Directly age standardised rate of mortality from suicide and injury of undetermined intent per 100,000 population, three year rolling average, 2001-3 to 2013-15.

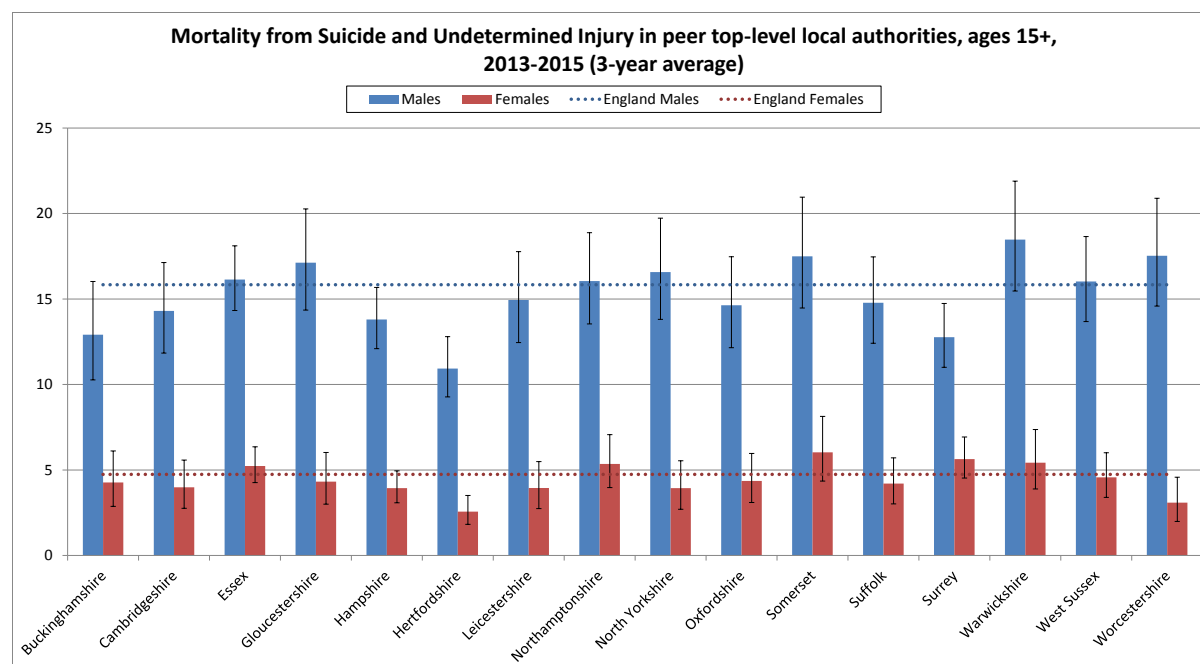


Source: Public Health Outcomes Framework

Population groups at risk of suicide are: men, especially middle-aged men; people vulnerable due to economic circumstance; people who self-harm; people under the care of mental health services; people who misuse drugs or alcohol; people in contact with the criminal justice system; specific occupational groups including nurses, doctors, veterinary workers, farmers and agricultural workers²⁴. These groups are discussed below, with the exception of people under the care of mental health services which is discussed earlier in this chapter and specific occupational groups as data is not available:

- Men: Nationally 3 in 4 deaths by suicide are among men²⁵. This is also the case in Buckinghamshire. In 2013-15, the directly standardised rate of suicide and undetermined injury among males was 12.9 per 100,000 population, and among females 4.3 per 100,000 population. The gender specific rates were not statistically significantly different to England (figure 9).

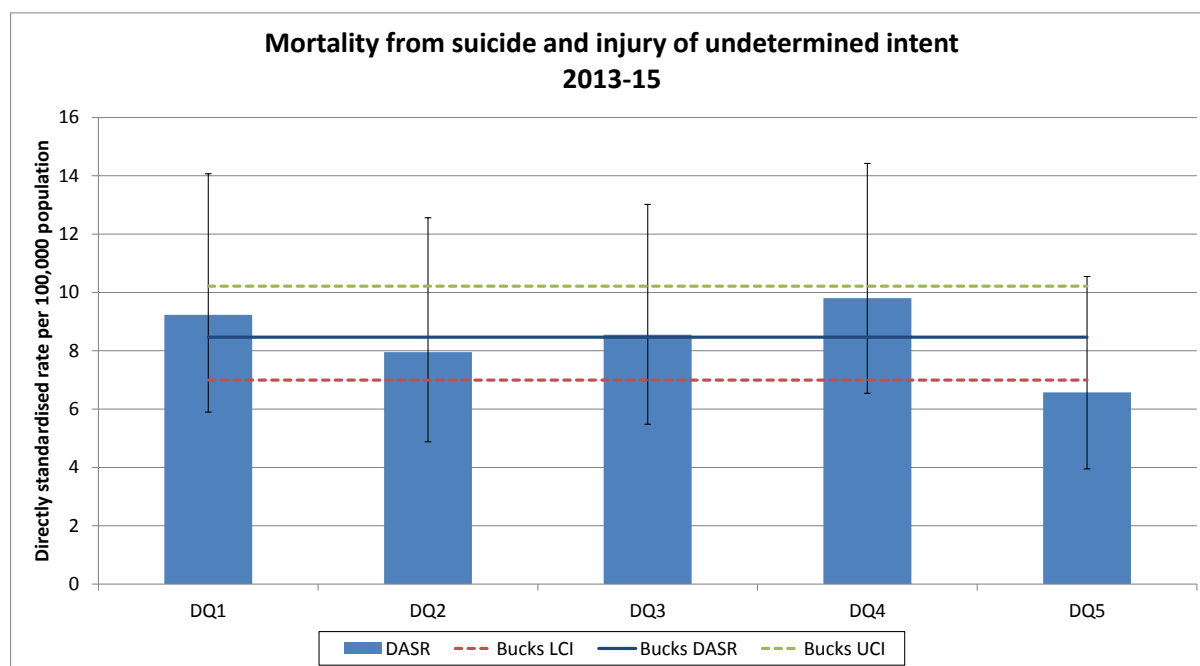
Figure 9. Directly age standardised rate of mortality from Suicide and Undetermined Injury among men and women in CIPFA peer local authorities, ages 15+.



Source: ONS

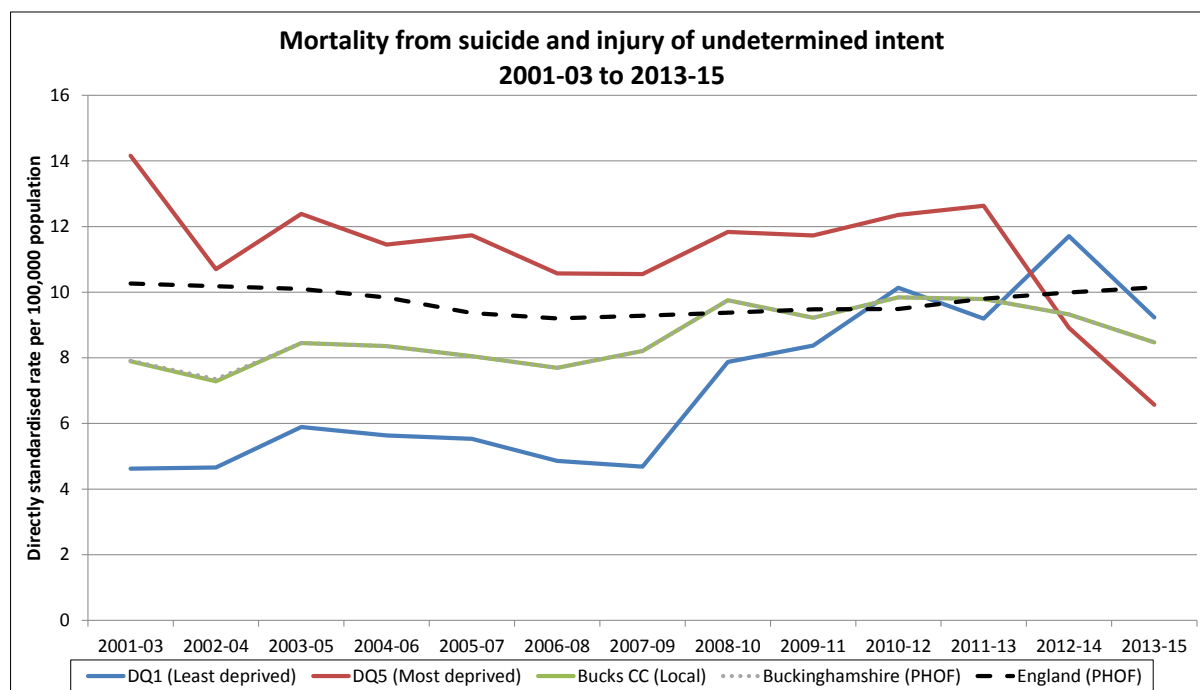
- Economic circumstances: Nationally, people in the lowest socio-economic group and living in the most deprived geographical areas are 10 times more at risk of suicide than those in the highest socio-economic group living in the most affluent areas²⁶. There was no statistically significant difference in the levels of death by suicide and undetermined injury in Buckinghamshire for 2013-15 between the most (deprivation quintile 5) and least deprived areas (deprivation quintile 1) of Buckinghamshire. However, the small number of deaths each year within each deprivation quintile will make it unlikely that a statistical difference would be detected (figures 10 and 11).

Figure 10: Mortality from suicide and injury undetermined in Buckinghamshire (DSR per 100,000 population) deprivation comparison



Source: ONS Annual District Deaths Extract

Figure 11: Mortality from suicide and injury undetermined 2001-03 to 2013-15



Source: Comparator data: Public Health Outcomes Framework (PHOF); Local data: ONS Annual District Deaths Extract; Deprivation Quintiles: Department for Communities and Local Government (DCLG), English indices of deprivation 2010

- Self-harm: There is a shortage of reliable information about self-harm as only people who present to hospital are captured²⁷. Self-harm results in approximately 110,000 inpatient admissions to hospital each year in England. The directly age sex standardised rate of emergency hospital admissions for self-harm in 2014/15 in Buckinghamshire was 135.1 per 100,000 population. This was significantly lower than England (191.4 per 100,000 population), and significantly lower than around half of CIPFA comparator counties. The majority of people who self-harm (usually through deliberate cutting or scratching) are aged between 11 and 25²⁸.

The 2014 Adult Psychiatric Morbidity Survey found that the prevalence of self-harm was 7.3% in people aged over 16 years. Young women were more likely than young men to self-harm (25.7% of women aged 16 to 24 years compared to 9.7% men). Young women were also more likely to self-harm than older women. 1 in 4 women aged 16 to 24 years reported having self-harmed compared with 1 in 100 women aged 75 years and over.

- Substance misuse: The estimated crude rate of opiates and/or crack cocaine use among people aged 18-64 in Buckinghamshire in 2011/12 (the most recent available) was 4.81 per 1,000 population (1,568 people). This was lower than the South East (4.99 per 1,000) and England (7.32 per 1,000)²⁹. In 2015/16 23.7% of drug users and 22.6% of alcohol users receiving treatment, were also receiving treatment from mental health services for reasons other than substance misuse. This was similar to the rates for England (drugs: 22.1% alcohol: 20.8%) and the South East (drugs: 22.8% alcohol: 23.5%).
- People in contact with the criminal justice system: Buckinghamshire has two adult prisons, HMP Grendon Underwood and HMP Spring Hill. In September 2014 there were 958 prisoners in Buckinghamshire³⁰.

4. Conclusions

Currently access to community-based and acute Mental Health Services are in line with national access requirements. However, numbers of CMDs seen in GP practices is lower than in England and lower than estimated numbers, supporting the finding that many people do not present at primary care with symptoms of anxiety and depression and/or these symptoms are not recognised by primary care.

Emphasis moving forward should therefore be on: improving mental wellbeing across the population overall; early recognition and diagnosis of mental disorders; and on ensuring prevention and diagnosis of physical conditions among those with a diagnosed mental illness. There should be particular attention to people living in the most deprived areas, and a renewed focus on prevention of suicide.

Specific actions recommended are:

- Improving the wider determinants of health, particularly basic issues such as housing and employment as these all impact positively on wellbeing.
- Prioritisation of population based activity to encourage early recognition of mental disorders, reduce stigma, and promote help seeking. This should be combined with greater emphasis on recognition of symptoms of CMDs in primary care. An example of current good work is the Buckinghamshire HeadsUp Campaign - www.thisisheadsup.org
- Improve the physical health of people with mental illness
- Improve the commissioning and delivery of services for people with coexisting mental health and substance misuse problems to improve access to treatment, promote recovery, and reduce the risk of suicide.
- Multi-agency commitment to delivering the Buckinghamshire's Suicide Prevention Plan. A reinvigorated plan is in development and includes the need to raise community and frontline staff awareness, evidence based suicide prevention training, and ensure populations at greatest risk can access support services.

5. Public Views

The Mental Health Commissioning Strategy for Buckinghamshire gathered views from people with a mental health diagnosis. Service users raised the importance of work to reduce mental health stigma. They requested commissioners consider the physical issues people with mental health problems may be experiencing, as well as the need for family members to be involved in people's care and care planning in order that they 'know what to do'.

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