Mental Health

Consultation Paper 158

Autumn Conference Bournemouth 2025

Background

This consultation paper is presented as the first stage in the development of a new party policy on mental health. It does not represent agreed Party policy. It is designed to stimulate debate and discussion within the Party and outside; based on the response generated and on the deliberations of the working group a full policy paper will be drawn up and presented to Conference for debate.

The paper has been drawn up by a working group appointed by the Federal Policy Committee and chaired by Dr Mohsin Khan. Members of the group are prepared to speak on the paper to outside bodies and to discussion meetings organised within the Party.

Comments on the paper and request for speakers should be addressed to Alexander Payne, Policy Unit, Liberal Democrats, 66 Buckingham Gate, London, SW1E 2AU. Email: policy.consultations@libdems.org.uk. Comments should reach us no later than Friday 3 October 2025. Responses are not necessarily expected to answer all the questions.

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1. Introduction

1.1 This consultation paper summarises current Liberal Democrat mental health policy, and invites party members and others to respond with their ideas on how party policy should evolve (see page 1 for details of how to submit comments). Taking into account your views, the new mental health policy working group established by the Federal Policy Committee will produce a full paper for the Committee to consider and submit for debate to the spring conference in 2026.

1.2 The impact of mental illness, when good quality treatment and support is unavailable, is a growing threat to our dignity and our freedom. It undermines our ability to make rational choices about how we want to lead our lives, changes our behaviour, and can lead to incarceration. As Liberal Democrats, we firmly believe in ensuring that everyone has a sufficiently high level of wellbeing such that every individual has the capability to lead a dignified and fulfilling life of their choosing. As such, we recognise the urgent need to end and reverse the rising rate of

mental ill health in the UK and promote good mental health through a proactive, preventative agenda.

1.3 Until recently, we weren't alone in recognising that need. Decades of hard campaigning, led by our party, had chipped away at the stigma, shame, and culture of disbelief that surrounded mental health. That consensus is now over, and the Government has allowed mental health to fall as a share of health spending, and has scrapped nearly all mental health targets. In a recent survey conducted by Mind, over half of UK adults say there is still a great deal of shame associated with mental health conditions, and many fear that mental health services will continue to disintegrate as the Government turns a blind eye.

1.4 As Liberal Democrats, our beliefs are evidence-led and rooted in lived experience, and we know that mental illness is real. Just as we all have physical health, we all have mental health too. And just as physical health can suffer due to injury or illness, so can our mental wellbeing – often as a result of trauma, stress, isolation, or pressure. One in four of us will experience a mental health problem at some point, which means every street, every family, and every workplace is or will be impacted. We can't afford to pretend this issue isn't real.

1.5 Since the pandemic, more people in England are living with mental health issues, and for many, those are now more urgent, more expensive, and more time-consuming to treat. The number of people in contact with NHS-funded secondary mental health services in England is 24% higher than before the pandemic, and almost 9 million people in 2023/24 received NHS-prescribed anti-depressants, up from 6.8 million in 2015/16. Suicide rates in England and Wales are the highest they have been since 1999, and the number of people reporting self-harm has more than quadrupled between 2000 and 2024. Furthermore, only half of people finishing a course of talking therapy have recovered, with recovery and improvement rates varying significantly between social groups and geographic regions. This increase in demand for mental health treatments has not been matched with an increase in NHS services.

1.6 Anyone of us can experience problems with our mental health, regardless of our background, age, gender, race, or socioeconomic status, but our challenges are not the same:

- People from ethnic minority communities are more likely to access mental health services via the criminal justice system.
- Lower socio-economic status appears to have a direct correlation with an increased risk of depression.
- The suicide rate in the North West of England is more than double the rate in London.
- Rural communities have unique challenges too, with 36% of the farming community probably or possibly depressed.
- Men and women also have different challenges; women are three times more likely than men to experience common mental health problems, and suicide is now the biggest killer of men under fifty.
- The rate of mental health problems in people with a learning disability is double that of the general population, and there are currently 2,020 autistic people and people with a learning disability detained in mental health hospitals in England who are being let down by the current system.

- More than 40% of carers of disabled children have considered suicide.

As Liberal Democrats, we believe in equality, and recognise that our mental health policies need to reflect the different challenges faced across our society.

1.7 The continued failure to address these issues is becoming increasingly costly for our country, for those living with ill mental health, and for the families and communities that are supporting them. Spending across mental health services is planned to increase to £18.22 billion in 2024/25. This continues the annual increase in spend achieved each year from £12.51 billion in 2018/19. Furthermore, mental health conditions now account for almost one in ten sick days in the UK, and of the 2 million people with work-limiting mental health conditions, only 40% are employed. The number of people claiming disability benefits for mental health conditions has doubled since the pandemic. Being forced out of work can create a vicious cycle, further worsening mental health crises.

2 The Liberal Democrat approach

2.1 Liberal Democrats last set out our approach in Policy Paper 137 Save the NHS and Stop Brexit. Our programme of action was evidence-led and ambitious, and some of our proposals have been appropriated and implemented. Mental Health Support Teams in schools were introduced under the NHS Long Term Plan, and now cover 35% of pupils in England. Our call to make the NHS 111 mental health crisis line available 24/7 was also adopted, and now supports 200,000 people each month.

2.2 Our previous policies included:

- Increase staffing by 35,000 by 2023 and 70,000 by 2028, including psychiatrists – 2,000 by 2023 and 4,000 by 2028 – plus mental health training for all GPs.
- Set waiting time standards:
    - 50% of children with diagnosable conditions treated by 2020, 100% by 2025.
    - 70% of adults by 2022, all by 2025.
- Bring forward legislation to implement the recommendations of the Wessely review of the Mental Health Act, to modernise the law

governing how mental health is legislated for. with guaranteed emergency beds.

- Equal access to talking therapies for older people and people from ethnic minority communities by 2020; remove age boundary at 25 between children and adult services.
- Increase services/facilities so nobody travels unreasonable distances, especially care leavers.
- Pilot reduced business rates for employers investing in staff wellbeing and training.
- Improve awareness of eating disorders in health professional training.
- Remove barriers between mental health trusts, local authorities, hospitals for seamless integration; ensure 24-hour mental health services, including liaison teams in all hospitals.
- Standardise LGBTQ+ diversity monitoring, provide LGBT-inclusive materials, backed by staff training.
- Require universities to ensure students have access to local primary care, linked to their home GP, via a home/away network.

- Provide information on local mental health resources at the start of every term.
- All on-site counsellors must be accredited.
- Introduce a Mental Health Lead on University Boards tasked with oversight of campus services.
- Offer peer-training enabling students to support and signpost others.
- Introduce a whole-school approach to young people's mental health, modelled on work in Richmond via the South West London Health & Care Partnership.
- Deployment of mental health support teams coordinating with schools, students, and parents, to foster honest conversations and connect to services.
- Services to include online peer-support, mental health first aid training for teachers, and parental courses on emotional wellbeing.
- Investment in mental health counselling in schools and colleges.
- Trauma and neglect screening in early years and primary settings.

- Training for teaching staff to identify mental health issues.

2.3 Our 2024 Manifesto, For a Fair Deal, committed to:

- Opening walk-in hubs for children and young people in every community.
- Offering regular mental health check-ups at key points in people's lives when they are most vulnerable to mental ill-health.
- Putting a dedicated, qualified mental health professional in every school, as set out in chapter 8.
- Ending out-of-area mental health placements by increasing capacity and coordination between services, so that no one is treated far from home.
- Extending young people's mental health services up to the age of 25 to end the drop-off experienced by young people transitioning to adult services.
- Increasing access to clinically effective talking therapies.

- Taking an evidence-led approach to preventing and treating eating disorders, and challenging damaging stigma about weight.
- Making prescriptions for people with chronic mental health conditions free on the NHS, as part of our commitment to review the entire schedule of exemptions for prescription charges.
- Transforming perinatal mental health support for those who are pregnant, new mothers and those who have experienced miscarriage or stillbirth.
- Tackling stigma through continued support for public education including Time to Talk.
- Cutting suicide rates with a focus on community suicide prevention services and improving prevention training for frontline NHS staff.
- Recognising the relationship between mental health and debt, and providing better signposting between talking therapies and debt advice.
- Ending inappropriate and costly inpatient placements for people with learning disabilities and autism.

- Modernising the Mental Health Act to strengthen people's rights, give them more choice and control over their treatment and prevent inappropriate detentions.
- Creating a statutory, independent Mental Health Commissioner to represent patients, their families and carers.
- Widening the current safety investigation into mental health hospitals to look at the whole patient experience, including ward design and treatment options.

2.3 Since Policy Paper 137 Save the NHS and Stop Brexit was published, the UK, like the rest of the world, has lived through the pandemic and the associated non-pharmaceutical interventions, such as lockdowns and physical distancing. This triggered a 25% increase in prevalence of anxiety and depression worldwide. Research from Mind found that around a third of adults and young people in the UK said their mental health has got much worse since March 2020.

2.4 The Conservatives bear much of the responsibility for the state of our mental health services. Over the course of nine years, mental health was consistently deprioritised, and crucially, underfunded. From abandoning its own 10-Year Mental Health and Wellbeing Plan after less than a year, to dragging their heels on reforming the Mental Health Act and scrapping the mental health funding for NHS staff, the record of the consecutive Conservative Governments on mental health was shameful. Then-Liberal Democrat health spokesman and former health minister Sir Norman Lamb challenged their plans, describing the Conservative's targets as "built on thin air" due to their refusal to provide any new money for mental health services.

2.5 Despite running on a message of change, Labour have failed to make any improvements. As the impact of the pandemic on the UK's mental health began to emerge in 2023, Labour MP Rosena Allin-Khan resigned as Labour's shadow minister for mental health after her portfolio was inexplicably downgraded from a shadow cabinet post. In power, Labour have closed the Farming Resilience Fund, which supported the mental health and wellbeing of farmers, and have scrapped key targets on mental health, and allowed mental health to fall as a share of health spending. Furthermore, the Government's

proposed changes to PIP (Personal Independence Payment) and Universal Credit would undermine support for many people with mental ill health and unpaid carers, while failing to cut mental health waiting lists and improve community services, which would be an effective way of helping people recover and access work.

2.6 The Government's recently published 10 Year Health Plan for England identifies the impact caused by years of Conservative neglect that has pushed the NHS to breaking point, but offers little optimism for those living with mental health issues or their families. It was disappointing that the Mental Health Investment Standard (MHIS), which has been the only mechanism that has protected mental health services from real-term cuts to their funding, received no reference in the plan, let alone any indication that this Government is remaining committed to it. It's hard to view this omission as anything other than a deliberate and callous move following the Government's own admission that the proportion of health spend directed towards mental health has dropped compared to the last financial year. This is the first time this has happened in several years.

2.7 As Liberal Democrats, we believe that untreated ill mental health is an affront to fairness and freedom. We believe that any plans to improve NHS mental health services must ensure that the services are:

- **Accessible:** Anyone can experience mental ill health, through no fault of their own, so everyone must be able to access diagnosis, treatment, and ongoing support. We know that there is a strong likelihood for physical and mental multimorbidity, so our services should recognise this, and be designed in a way that means anyone who needs them can access them – irrespective of age, gender, race, or postcode.
- **Fair and equitable:** Resources in our mental health services too often gravitate towards only the severest cases. We want to ensure that everyone receives the best care available to them, without having to wait for their mental health problems to get worse.
- **Built around choice:** New treatments, like digital enabled therapies, continue to be developed and approved for use. When the evidence supports the adoption of these treatments, so will we, but only as a part of a menu of options that can be chosen from and

that individuals are empowered to understand. An individual's mental health journey is deeply personal, so their treatment programme should be too.

- **Rooted in community:** Families and communities play a crucial role in the lives of patients with mental illness, either as a source of resilience or stress. They also bear a lot of the burden of supporting them and helping them make sense of decisions on offer. Mental health services should acknowledge their role, and provide support for them when wanted.
- **Evidence-led:** In a time of both rising scepticism towards mental health and of new and developing treatments, we will continue to ensure our policies are based on scientific evidence and lived experience.
- **Able to take care of the people taking care of us:** Mental health conditions are responsible for almost one in ten sick days in the UK, so a healthier NHS workforce would have more time and capacity to diagnose and treat mental illness. That is why we would reverse the Conservatives' cuts to mental health funding for NHS staff. The same principle applies for

others, like unpaid carers, who should not just be seen as system partners, but also as people in their own right with their own support needs.

2.8 The remainder of this paper sets out a possible agenda for the new mental health working group established by the Federal Policy Committee, together with questions to which we would welcome input. These questions are not exhaustive, and we welcome all comments.

Questions

Q1. Does the direction of our existing policies need a major change, given the rising scale of the challenge and changes in wider society after the Pandemic?

Q2. What new policies and approaches should we embrace?

Q3. Do you agree that these are the values that should be at the heart of our mental health policies? Are there any others that you would include?

Q4. What is the best mechanism for measuring the quality of mental health care? Should we have a target for this?

3 Prevention

3.0.1 We all have mental health, which will change throughout our lives. During periods of disruption, our mental health needs may change, and we may temporarily need additional support. Some people, either due to their immutable characteristics or exposure to particular social determinants, need additional support throughout their lives to prevent them developing mental health problems. That's why we should take a public health approach to mental health, and why we must ensure that the right level of support is accessible, so everyone has the capability to live a life of their choosing and the tax-payer isn't left footing the bill for hospital stays and expensive treatments. We remain committed to offering regular mental health check-ups at key points in people's lives when they are most vulnerable to mental ill-health, and will take evidence to develop the best mechanisms for this.

3.1 Poverty

3.1.1 Poverty is the leading social determinant of mental ill health, and people with financial problems are three times more likely to develop mental health problems. Whilst many of the solutions to this harmful relationship between poverty and poor mental health,

like scrapping the two child limit and the benefit cap, are beyond the scope of this paper, mental health services could be better integrated with debt and money advice services. For instance, Liberal Democrats tabled amendments to the mental health bill that would have ensured mental health inpatients benefit from debt respite and that plans for a patient's discharge also address their financial and housing needs. This would potentially enable treatment plans to better deal with the symptoms and root causes of mental illness at the same time.

3.2 Substance abuse

3.2.1 Comorbidity between substance abuse and mental illness is very common, and reflects both a high risk for substance use in people with mental illness and a high frequency of psychopathology triggered by substance use. Breaking this chicken-and-egg problem requires a joined-up central and local government response, which is why Liberal Democrats in Parliament have pressed for a new national addiction strategy that addresses the drivers of addiction to harmful substances and behaviours. People with complex needs come into contact with a range of services, which cut across departmental responsibilities, including those connected with

mental health, homelessness, employment, accommodation, education and justice. These services need to provide joined-up support to reduce the risk of people falling through the net, which will require breaking down silos in their budgets, and reforming how they measure their different organisations' respective progress.

3.3 Social media

3.3.1 Unlike financial troubles and substance misuse, the link between social media and mental health problems is much more recent. Young people seem particularly vulnerable to this, which is exacerbated by the fact that 79% of 12- to 15-year-olds and 32% of 8- to 11-year-olds own a mobile phone, and approximately 86% of 9- to 16- year-olds belong to a social networking site. Ofcom research found that children aged 5 to 15 are now spending an average of 5 hours and 24 minutes per day engaged in social media activity, despite most being at school for seven hours (five days per week), and spending roughly 10 hours asleep.

3.3.2 Between 2016 and 2024, child contact with mental health services increased by 477%, rising from 96,000 to 458,000 cases – and those are just the ones reaching out to those services. There has

been a fivefold increase in eating disorders among 11 to 16-year-olds, particularly girls. Our young people are struggling, and social media's role cannot be ignored.

3.3.3 Social media can also play a positive role in mental health, by making human connection and the sharing of advice and information between mental health service users easier. We also recognise that it can make it easier for some neurodiverse people to communicate, and that there are some upsides associated with privacy and anonymity that could help young people when they are learning more about themselves.

3.3.4 The Government is considering limiting social media usage for children, so now is the time to look carefully at international precedents and introduce effective, practical and implementable policies to keep children safe. We will take evidence to develop the Liberal Democrat position on this further.

Questions

Q5. To what extent should we integrate mental health support and financial support into a single service? Can we build on this to better help people

transition between periods of recovery, relapse, education, employment in a non-linear fashion that can sometimes be the case with severe mental illness or adverse life events?

Q6. What are the fairest ways of breaking the link between poverty and poor mental health?

Q7. Are there any cost effective policies that would help break the link between poverty and poor mental health?

Q8. What policy solutions and clinical interventions do you think would be most impactful in preventing longer-term and entrenched mental health issues linked to poverty, social media, and addiction from developing, and which do you think would be most cost effective and simplest to implement?

Q9. Would you support an age restriction for social media? Should it be the government's or parent/caregiver's responsibility to enforce this? What age should this be set at?

Q10. Given the wide range of social determinants of mental ill health, does it make sense for mental health to be a part of a single department? Is it worth having a new Minister that attends Cabinet meetings who would be uniquely responsible for helping departments collaborate on mental health?

Q11. Is there a role for greater mental health provision in supported and sheltered housing in tailoring them to individual needs for those who experience severe mental illness?

Q12. Given the impacts on unpaid carers' own health, should there be a legal obligation on health professionals to identify family members and unpaid carers and consider their support needs, or is this the responsibility of civil society organisations?

Q13. How confident are you that the new health equalities duty for strategic authorities will include a sufficient focus on mental health?

4 Access, diagnosis, and treatment

4.1 Parity of esteem

4.1.1 In government, we legislated to improve parity between mental and physical health under the law. However, the potential for parity of esteem was squandered by successive Conservative Governments. Mental illness currently only gets 10% of the funding, but provides 20% of the disease burden, and has knock-on and costly effects on physical morbidity. When there is poor access to care and treatment, mental illness can drive up demand for acute trusts, ambulance service providers, fire and rescue, and other public services.

4.1.2 Furthermore, because mental health is not included in the definition of elective care, this Government is disincentivised from prioritising it. Sir Keir Starmer set out his Government's plan to tackle waiting lists in January, but by exclusively focusing on physical healthcare, it has left 1.6 million mental health people needing mental health treatment waiting for the same prioritisation. Mental illness can be treated most effectively when it is treated early, so this deprioritisation threatens to increase the number of complex cases of mental ill health that the NHS has to treat. It also threatens to increase the eventual

number of physically unwell people that NHS and social care has to later manage and leaves unpaid carers having to pick up the pieces whilst the person waits for support.

4.2 Access

4.2.1 The number of people in contact with NHS-funded secondary mental health, learning disability or autism services in England was 24% higher in 2022/24 than before the pandemic.

4.2.2 Key mental health targets, including access to therapy and community services were scrapped by the Government earlier this year. There are no targets for how long patients are having to wait between being assessed and receiving treatment once this has been decided to be appropriate. Furthermore, we also lack targets for community-based mental health crisis services, mental health needs in an emergency department, and non-urgent community mental health care.

4.2.3 In addition to gaps in service coverage, there are significant disparities in access to mental health care across different demographic groups. People from ethnic minority backgrounds, LGBTQ+ individuals, areas with a higher proportion of working

class people, and those with co-occurring conditions such as substance misuse, neurodiversity, or physical disabilities can face barriers in accessing timely support. Earlier this year, NHS England published principles for using digital technologies to support mental health providers and clinicians. With the rise of web-based interventions and mobile mental health technologies, it is right that equity of access is one of those principles, but, given 13% of the UK have 'ultra-low' levels of digital skills, there must be safeguards in place to ensure continued parity of service between online and offline services. We are also aware of ongoing and growing access issues related to rurality and intend to take evidence on this.

4.3 Diagnosis

4.3.1 The process of receiving a mental health diagnosis in the NHS is often lengthy, inconsistent, and marked by inequality. Many patients in England are experiencing delays of months or even years before being formally diagnosed, something mirrored for SEND conditions like ADHD and autism. These delays can be upsetting, prevent timely treatment, and can cause people to deteriorate before they are able to access appropriate care.

4.3.2 Diagnosis pathways vary significantly by condition, age group, and geography, creating a fragmented and often confusing system. For example, some regions offer streamlined diagnostic services for children, but have no equivalent provision for adults. Meanwhile, some individuals receive informal diagnoses without follow-up support or formal recognition, limiting their access to specialist care, benefits, or workplace adjustments.

4.3.3 There is also growing concern about under-diagnosis and misdiagnosis among marginalised groups. Women, people from ethnic minority communities, and older adults are less likely to be correctly diagnosed or referred for specialist assessment, partly due to bias in clinical presentation models and insufficient training for frontline staff. This contributes to unequal outcomes and further entrenches health inequalities within the mental health system.

4.4 Treatment

4.4.1 Some parts of the NHS mental health system benefitted tremendously from the introduction of talking therapies under the New Labour Governments, but they are currently underused by

older people and ethnic minority communities, and there are concerns that a lack of choice of treatment is contributing to low completion rates. There is a clear case for expanding both the uptake and provision of talking therapies by making them more culturally appropriate, more bespoke, and more easily accessible by tackling crucial gaps in the workforce.

4.4.2 There are currently seven NICE (National Institute for Health and Care Excellence) approved digital therapies, which are designed to support people with PTSD, paranoia, insomnia, and intrusive memories. As Liberal Democrats, we feel that it is right to embrace new treatments, if there is enough evidence for them, and if patients retain the choice to opt for more traditional treatments. We should pilot these new treatments across NHS trusts to further develop the evidence base, be open to new conditions that may be effectively treated by digital therapies, and monitor digital exclusion in healthcare.

4.5 Eating disorders

4.5.1 Eating disorders are the most deadly of all mental health disorders. Anorexia has the highest mortality rate of any psychiatric disorder, and bulimia is associated with severe medical complications.

4.5.2 It is intolerably wrong that some people with an eating disorder are now being told that they have to hit a lower BMI to reach the threshold to qualify for treatment due to overstretched resources. Eating disorders can be fatal, but if they are treated quickly they can be recovered from. With treatment, four in five patients with anorexia will either fully recover or be improving, but outcomes following delayed treatment for mental and physical health disorders, of which eating disorders are a combination of both, are less successful and less cost-effective, requiring longer treatment.

4.5.3 There has been a national access and waiting time standard for children and young people with eating disorders in England since 2016. We believe that an equivalent national waiting standard time, which has already been drafted by NHS England, must be implemented for adult services, or else commissioners may continue to deprioritise and underfund them.

4.5.4 The Parliamentary and Health Service Ombudsman's 2017 inquiry, Ignoring the Alarms, found that, at that time, most doctors in the UK received less than two hours of teaching related to eating disorders across their entire education, and

that around a quarter of doctors received none at all. This has contributed to the problem of non-specialist doctors too often relying on BMI alone for referral decisions, which is contrary to NICE guidance. The progress that has been made then, primarily by the Royal College of Psychiatrists, and the General Medical Council, is positive, but the additional training that has been made available is only voluntary and underutilised. We would require all UK medical schools and postgraduate training programmes to include a minimum number of hours of teaching on eating disorders, and expand the number of psychiatry rotations in resident doctors' Foundation Programme, to give more of them hands-on experience.

4.5.5 Our working group will continue to take additional evidence related to eating disorders, including on calorie labelling rules, before writing our policy paper, so that we can further understand how to deal with these challenges.

4.6 Services for Children and Young People

4.6.1 The fall-out from the COVID-19 pandemic continues to have a significant impact on the mental health of the country's children and young people. It is estimated that 1 in 5 children and young people aged

8 to 25 in England have a probable mental health condition.

4.6.2 Although the average waiting time for young people in need of mental health support from CAMHS (Child and Adolescent Mental Health Services) is now a shocking three and a half months, thousands of young people are waiting far longer. Nearly 40,000 children are now waiting longer than two years before they can finally access treatment. Children from the most deprived areas that apply for CAMHS support are twice as likely to be rejected than those from the least deprived. Concerningly, children who have current social work involvement are also more likely to be denied access to NHS mental health services. It is intolerable that the nation's most vulnerable children are both more likely to experience mental health conditions and are more likely to be refused support.

4.6.3 There are other issues with CAMHS services, including a double 'cliff-edge'. If a young person is not in a CAMHS service by the age of 16, it can be very difficult for them to access, partly because waiting lists may mean that the child becomes an adult before a service is available. As a result some 16- or 17-year-olds may be referred straight to adult

services, which may be inappropriate for their needs. Research has found that as few as 4% of young people experience an ‘ideal’ transition from CAMHS into adult services, and a significant proportion stop receiving care completely once they reach 18. There should be a transition plan in place for young people before they become 18 as this jarring and immediate change can be damaging to progress, especially when it leads to delays or the need for a new referral entirely.

4.6.4 A service designed for everyone up to 25 years old would remove these cliff edges, and the one that replaces it is preferable, as a 25-year-old’s brain is more developed, and they tend to be more resilient. It would also reduce the impact of young people experiencing changes in their mental health support at the same time as other common transitions like moving to university or entering the workforce.

4.6.5 We are also concerned about children and young people that are ‘too mentally ill’ to be supported by their school, but not ill enough to be supported by CAMHS. Our 2024 General Election manifesto, For a Fair Deal, committed to putting a dedicated, qualified mental health professional in every school. NHS-funded Mental Health Support

Teams (MHSTs) can currently only be accessed by roughly half of pupils in England. We will continue to take evidence on this to develop our policy further to respond to issues with coverage, quality, expertise, and oversight.

4.6.6 The Liberal Democrats, both in our most recent manifesto and in Parliament, have supported opening walk-in hubs for children and young people in every community. The Government has committed to launching eight early adopter Young Futures Hubs hubs this year, which we welcome, but we are concerned that this Government views these hubs as a crime prevention measure, rather than a measure to improve access to mental health support for young people. Whilst these goals are not necessarily mutually exclusive, many in the sector are concerned that trying to do both will have a stigmatising effect.

4.7 Perinatal, postnatal, and maternal mental health

4.7.1 In England perinatal mental illness affects up to one in four new and expectant mums; around 150,000 women each year. If these mental health issues are not properly diagnosed and treated, it can

have significant, long-term impacts on the woman, child and also other family members.

4.7.2 The Liberal Democrats are committed to transforming perinatal and maternal mental health support, explicitly recognising the differing needs of pregnant women, new mothers, and those who have experienced miscarriage or stillbirth. We also note that men are twice as likely to become depressed in the first year after becoming a dad, and that their needs should be recognised by mental health services.

4.7.3 We firmly believe that all mental health referral and support services should be available following every miscarriage, not just after three, and that there should be annual reporting on waiting times for these patients. This would ensure that no loss remains ‘hidden’ and that families receive consistent, best-practice care.

4.7.4 We will work with stakeholders to secure cross-party support for a strengthened, data-driven perinatal mental health agenda, which may include ring-fencing dedicated perinatal mental health funding, guaranteeing rapid access to specialist teams, and making perinatal mental health training mandatory for relevant health professionals.

4.8 Research

4.8.1 Although our life science industry and universities have a strong international reputation, the UK is currently only middle of the pack for research and development intensity in the G7. Clinical academics, who bridge the gap between clinical settings and academic settings, made up 8.6% of consultants in 2011, but by 2020, this had fallen to 5.7%.

4.8.2 The UK must restore its status as a world leader in science and innovation if we are to make meaningful progress in developing new mental health treatments. Whether it's by reducing the upfront costs for visas, classifying streamlining the planning processes for new laboratories, or increasing the length of funding cycles, a Liberal Democrat government must remove the barriers that are preventing global research talent coming to the UK and developing new ways to prevent, diagnose, and treat mental ill health.

4.8.3 Furthermore, we should work to make the NHS a more attractive place to safely scale interventions by resolving the issues around regulations, duplication of efforts, lack of awareness of new

interventions and benefits that currently make new interventions slow, inequitable, and patchy.

Questions

Q14. Should there be legally enforceable mental health nurse to patient ratios, like in California or some states of Australia?

Q15. What do you believe is behind rising levels of diagnosis of mental health conditions?

Q16. Mental and physical illness are not separate entities, and one often leads to the other. How can we ensure mental health is not seen as an afterthought by policymakers when planning services and health and social care funding?

Q17. In managing public resources and tackling sky-high waiting lists, how do we balance promotion of mental health vs the need to spend heavily on treatment of mental illness?

Q18. How should digital enabled therapies be used in the treatment of mental health? What are the downsides of digital enabled therapies? How can we use them without disadvantageing the digitally excluded?

Q19. Can CAMHS be reformed, or does it need to be replaced?

Q20. People can make lifestyle choices, like gambling or poor nutrition, which increase the likelihood and severity of mental ill-health. Where should the balance lie between their personal freedom and the responsibility the government has both for keeping them safe and for the taxpayer's purse that will have to pay for any treatment?

Q21. Is the Mental Health Investment Standard enough to protect and promote parity of investment? If yes, should it be enshrined in law?

Q22. What support should be provided for children with mental ill health that is too severe for Mental Health Support Teams, but not yet severe enough for CAMHS? How can we better reach those children?

Q23. What issues related to access, the diagnosis, and/or the treatment of eating disorders are you aware of? What should the government do about this?

Q24. Is 'parity of esteem' an easily understandable phrase? Do you think alternatives such as 'equality of access' are better?

Q25. How can we better support the mental health of pregnant women, new mothers, new fathers, and those who have experienced miscarriage or stillbirth?

Q26. What are the best ways of encouraging new investment and research into mental health treatments?

Q27. Does it make more sense for child and adolescent mental health services to support people up to the age of 25? How can we improve the transition between child and adult services?

5 Unfair costs

5.1 Prescriptions

5.1.1 People with diagnosed mental illnesses in England currently have to pay £9.90 for their prescriptions. It is right that some guidance means that pharmacies often only prescribe a week's worth of medication at a time to people at risk of suicide, but this also massively increases the cost to the patient. Furthermore, the rules around entitlement for exemption from prescription charges are overly complicated, as Universal Credit claimants are only eligible for exemptions if their monthly earnings are below a specified level, and some prescription forms do not include Universal Credit as an option. This leads to genuine mistakes and confusion for many people, which is a disincentive for receiving treatment. Many who are living with worsening mental health may find themselves needing many more prescriptions and filling out further paperwork to get them free to be an understandable struggle.

5.1.2 Medication in hospitals is free, in contrast to having to pay in the community. People who have been involuntarily admitted to hospital do however receive free prescriptions afterwards in the

community, whereas people who have agreed to come into hospital do not receive free prescriptions afterwards. This creates a perverse incentive which encourages people to be sicker and not seek help.

5.1.3 The list of conditions that merit free prescriptions was created in 1968. At that time, modern antipsychotics and most of the antidepressants used today did not even exist. The treatment of mental health in the community was also much different. In 2009, cancer was added to the exemption list recognising the changes in outpatient care since the 1960s, but no such update has occurred for mental health despite several revolutions in pharmaceutical treatment since the 1960s.

5.1.4 When people stop taking medication in the community, they may end up involuntarily or voluntarily in hospital because their mental illness worsens. This costs the taxpayer much more, due to healthcare costs, the loss in productivity, and in lost tax revenue, than the cost of the missing medication. It often results in significant restriction of liberty and fracturing of educational and housing and social connections, which may have been avoided if prescriptions were free for the mental health condition.

5.1.5 Our 2024 General Election manifesto, For a Fair Deal, committed to make prescriptions for people with chronic mental health conditions free on the NHS, as part of our commitment to review the entire schedule of exemptions for prescription charges. After taking evidence, we still believe that this policy is correct and necessary.

5.2 Families and community

5.2.1 Families and communities play a crucial role in the lives of patients with mental illness, either as a source of resilience or stress. Mental health services should acknowledge and embrace their role, and provide support for them when it is wanted. But far too often this is not the case. Nearly half of respondents to a Care Quality Commission survey said no support was offered to their family or carers while they were in crisis. We will continue to take expert evidence to determine the best policy mechanisms for achieving this.

5.2.2 It is also right to acknowledge that families and communities bear the brunt of supporting individuals with mental illness, and that they are also harmed by underperforming mental health services. Poor

parental mental health is now the most commonly reported factor in social worker assessments into whether a child is at risk of serious harm or neglect, according to the Association of Directors of Children's Services. Despite this, a study showed that a quarter of mental health practitioners did not even routinely ask whether the patient had dependent children. We will also be taking evidence on how we can reduce the impact of out of area placements on children of patients.

5.3 Insurance

5.3.1 People with a history of mental illness can struggle to get covered by insurers or are charged higher premiums, even if the mental health problem is in the past and the person is fully recovered. There is significant disparity between insurers in terms of the questions they ask about mental health. Some insurance companies and providers of income protection or critical illness cover will not take people with mental illness at all, even if the condition itself were excluded from coverage.

5.3.2 As a result, people with mental illness can face taking on greater financial risk in their lives. They can face difficult choices on whether or not to risk travelling abroad if they aren't able to acquire suitable

travel insurance, which significantly impacts their liberty in practice as well as work, family and social lives.

5.3.3 The actuarial models used in the insurance industry are often worse at differentiating between different forms and severities of mental illness than they are for physical health conditions. The government should encourage research that would improve these models' understanding of the lifetime risk of illness for various mental health conditions, which would lead to fairer insurance costs.

Questions

Q28. What are the key challenges that explain why some groups of people, including older people, ethnic minorities, and people in rural areas, are accessing fewer free services despite having higher need?

Q29. In a world where prescription charges still exist in England, should we expand the current exemption list for free prescriptions to those who have a formal diagnosis of mental illness?

Q30. Should insurance providers be allowed to consider mental ill-health when considering illnesses? If not, how much more would you be willing to pay on your insurance (including car and life) to cover this?

Q31. Should insurance providers be forced to standardise how they question conditions? Should they have to justify their questioning and resultant impact on costs to the Prudential Regulatory Authority?

Q32. Should insurance providers be required to provide more up-front information about what they exclude or how much costs may rise due to different conditions or levels of conditions before application to make it more user-friendly to compare providers?

Q33. What support should be available to families, including children, and communities surrounding people with mental illness?

Q34. How can we help employers to provide better occupational health services for those with mental health conditions? Do smaller employers require further support beyond what already exists, both financial and non-financial?

Q35. Are there any other unfair costs that you think are associated with mental illness?

Q36. Should there be a limit to how long an insurer can consider mental health issues after someone has recovered from them? If so, how long?

Q37. What more can be done to improve support for people on waiting lists for assessment/treatment and their families, other than reducing the length of the wait?

6 The Mental Health Act

6.1 The Mental Health Act, which is the main piece of legislation that covers the assessment, treatment and rights of people with a mental health disorder, has historically been draconian and structurally unfair, and as a result, sectioning was far too often being used to detain people rather than to treat them.

6.2 The Conservatives recognised this, and pledged to replace it in their 2017 manifesto. By 2019, they hadn't, so it went back into their next manifesto too, albeit with a less convincing commitment. Two and a half years later, they published a white paper setting out their Government's plans to reform the Act. By 2023, it had been dropped from the King's Speech, and six years of progress – including evidence taken via a Joint Committee of the draft Mental Health Bill – was shelved.

6.3 An Independent Review of the Mental Health Act, chaired by Professor Sir Simon Wessely of King's College London, found that ethnic minorities had the strongest fear of being subjected to discriminatory practices from mental health services, and that people of Black African or Caribbean heritage were five times more likely to be detained under the Act than white people. Policy Paper 137, Save the NHS and Social Care by Stopping Brexit,

committed to implementing the recommendations of this review.

6.4 The long-awaited Mental Health Bill was finally formally introduced and debated in Parliament late in 2024. The Liberal Democrats welcomed the bill as an important step towards modernising the mental health care system and enhancing patient rights. We are encouraged by the bill's emphasis on empowering patients and giving them greater control over their treatment decisions. However, while we support the overall direction of the bill, we believe there is room for improvement, particularly when it comes to preventative mental health care. It is essential to strengthen measures that focus on early intervention, especially for young people who may face mental health challenges at critical stages in their development. We have put forward amendments to improve prevention – including through mental health checks after key life events, better support people with financial and social stressors, to tackle out of area placements, fix the crumbling mental health estate, address disparities, strengthen inpatient advocacy and better support and identify unpaid carers.

6.5 We will continue to take evidence on ways to improve the Mental Health Act in the future, including about the efficacy of fusing the Mental Health Act and the Mental Capacity Act while ensuring safety all around, and the ways we can better take the views of family members into account when deciding whether someone needs a mental capacity assessment to avoid further tragedies like the murder of Christopher Laskaris. We will also continue to consider the many benefits of introducing a new responsible person role, which would have responsibility for local policy development, training and monitoring of inequalities as well as driving implementation at hospital level in mental health units.

6.6 Police support in mental health crises risks stigma and blurs the lines of what is a health rather than a justice situation, as well as delays in providing support due to the pressures on the police more widely. However, there can be a legitimate need to use involuntary powers to support someone in crisis and at severe risk to themselves or others. Mental health professionals cannot use powers as rapidly as the police can in public and private settings.

6.7 Police officers require a Section 135 warrant to enter someone's home when there is reasonable

cause to believe the person has a mental disorder and is being neglected, ill-treated, or is unable to care for themselves, to take them to a health-based place of safety. This requires a mental health professional to go to a magistrate court and then co-ordinate police arrival afterwards, which can be the source of some delay.

Questions

Q38. What role, if any, should the police have in a mental health crisis?

Q39. Do healthcare staff need any other powers, perhaps similar to what the police have, to help manage those at severe risk to themselves or others? Can this be done safely without breaching the therapeutic relationship and the fact that healthcare professionals are not trained in police-style use of force?

Q40. Is a statutory and independent Mental Health Commissioner the best mechanism to champion patient and carer voices and oversee service standards?

Q41. Do you have any lived experience of discrimination in the mental health system? If yes, and if you are comfortable answering, what specific changes could be made to prevent this happening again?

Q42. What are the best ways to take the views of family members into account when deciding if someone needs a mental capacity assessment?

Q43. Should the need for a magistrate to sign off on a Section 135 warrant be reformed? Should healthcare professionals and police, either alone or together, be able to authorise police officers to enter a private home to provide assistance in a mental health crisis to allow immediate assessment to occur in hospital?

Q44. Many types of healthcare professionals can already apply to become approved clinicians, and so exercise powers often held by consultant psychiatrists historically. Some Mental Health Act powers around involuntary admissions are reserved only to fully registered doctors. Should we expand the pool of professionals who can exercise these powers, given there could be greater risk of inappropriate admissions from this?

Q45. Would merging the Mental Health Act and Mental Capacity Act be a positive step in giving equal

safeguards to all people? Or could it blur the line between coercion and support?

Annexe: Mental Health Working Group remit

The remit of this group is to review the party's policies on Mental Health, and make updated proposals which communicate our values of liberty, equality, democracy, and community in a way which helps secure the election of as many Liberal Democrats as possible, at local, regional and national level, in order to promote our vision of society.

The group will be expected to build on existing policy proposals as set out in the 2024 Election Manifesto, and Policy Paper 137 Save the NHS and Stop Brexit. The group is expected to consider and address Liberal Democrat principles on diversity and equalities in developing their proposals.

This group will as a top priority:

- Develop up to three headline policies on mental health which the party can communicate widely to win votes.

The working group will develop policies on:

- Tackling the stigma associated with mental illness and achieving an equal footing for mental and physical health.
- Addressing the underlying causes of mental illness, including social media, substance

addiction and the links between debt and mental illness.

- Improving early access to diagnosis and treatment, especially for children and young people.
- Tackling inequalities in the mental health system, particularly racial inequalities.
- Reducing unfair costs on those suffering from mental illness, including both prescription charges and insurance costs.
- An evidence-led approach to eating disorders.
- Improving access to effective talking therapies.
- Reducing the suicide rate.
- Transforming perinatal mental health support for those who are pregnant, new mothers and those who have experienced miscarriage or stillbirth.
- Our response to the Government's Mental Health Bill, judging it against the liberal imperatives of respecting the rights and dignity of all.

The group will also consider the need for institutional change at central, regional and local government levels to embed these approaches firmly in policy.

The group will take evidence and consult widely both within and outside the party. This evidence should inform the group's proposals, which will be presented alongside an analysis of costs and an Equalities Impact Assessment.

A policy paper of no longer than 10,000 words should be produced for debate at Spring Conference 2026. Prior to that a consultative session should be held at Autumn Conference 2025, and a draft policy paper should be presented to the Federal Policy Committee by December 2025.

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