Policy Paper 163

WHOLE-PERSON MENTAL HEALTH

Care, Choice, Community and Combatting Populism

Liberal Democrats

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Contents

1. Introduction

1.0.1 Decades of Liberal Democrat campaigning have pushed Britain's mental health services forward and positively shaped how we as a nation think about mental health. Although we have always recognised the scale of the work left to do, we are proud of the real legislative and funding successes we have achieved both within and outside government - including progress towards treating mental health equally with physical health, improving access to talking therapies, increasing school-based support, and curbing unjust detentions.

1.0.2 Until recently, our greatest success was building a cross-party understanding that mental health matters, and that evidence and compassion should guide policy. There is a danger that the dismissive language of the far right has begun to undo the progress we made by reintroducing stigma and shame into conversations about mental health. Worse still, their framing has allowed both Labour and the Conservatives to soften their language and scale back their commitments.

1.0.3 Labour's recent record is particularly alarming. Once vocal champions of parity between mental and physical health, they have quietly deprioritised the issue in both rhetoric and resource. Promised service expansions have been delayed or diluted, and commitments to prevention have vanished from their agenda. Their decision to scrap mental health targets reflects a dangerous retreat from treating it as a distinct and urgent policy area. Furthermore, their refusal to commit to a dedicated funding settlement or new statutory rights is a sign that Labour lacks conviction.

1.0.4 Now is not the time to retreat from the challenge of fixing our mental health services. The pandemic has transformed both the scale and

visibility of the crisis. It amplified loneliness, anxiety, and grief, pushed NHS, local authority, and school staff harder than ever before. It also left children and young people facing long-term consequences from disrupted education and isolation. Meanwhile, economic insecurity, housing instability, and digital exclusion have deepened the inequalities that drive poor mental health. These effects will persist for a generation unless we act decisively. The Liberal Democrats believe that rebuilding after the pandemic means making rebuilding mental health a national priority, rather than an afterthought tacked onto plans for physical health services.

1.0.5 The pandemic also exposed the structural drivers of distress that have been contributing to the nation's worsening mental health for almost a decade. Stagnating living standards, rising poverty, and the fraying of the social safety net have left millions in Britain living with constant uncertainty about their jobs, homes, and futures. These pressures are not new, but the severity of them is, and the pandemic and its after-effects have widened inequality still further, with those already struggling pushed even closer to crisis.

1.0.6 At the same time, modern pressures are intensifying the strain on people's mental wellbeing. The 24/7 demands of algorithm-driven social media are exposing people to unrealistic comparisons, manufactured division, and misinformation, which is contributing to increases in anxiety and low self-worth and having a negative knock-on impact on schools. These effects are particularly acute for young people, who are growing up in an unprecedentedly online world designed to constantly capture their attention. Yet while the pressures on people have multiplied, and awareness for mental health has increased, the capacity of the system to respond has diminished. Years of underfunding and understaffing across mental health services, compounded by deep cuts to local authorities by

the Conservatives, have hollowed out community support and left services overwhelmed.

1.0.7 The Liberal Democrats take a different view. We believe that policy must be grounded in evidence, shaped by those with lived experience of mental health challenges, and measured by its ability to improve people's lives. That means committing to a fully integrated, community-based mental health system that prioritises prevention and that recognises social determinants of mental health, and that uses every available tool, including clinical, digital, and social, to expand access whilst still giving patients choice. It also requires putting fairness at the centre of every stage: in diagnosis, in treatment, and in reducing the costs borne by people who are already unwell.

1.0.8 Our approach is grounded in evidence and lived experience. We know that mental illness is real, that prevention works, and that modern treatments, whether delivered face-to-face or digitally, can improve lives. New, digital-enabled therapies can be a valuable tool in expanding access, especially in remote areas or for those unable to attend in-person sessions. But technology must empower, not replace, the human relationship at the heart of care. Patients must always retain meaningful choice about how they receive support.

1.0.9 We also know that those who care for or live alongside people with mental illness, such as family members, partners, friends, and unpaid carers, carry enormous emotional and practical burdens. A compassionate mental health system must recognise and support them too, not leave them isolated.

1.0.10 Only the Liberal Democrats are strong enough to stand steadfast and reject the nasty, victim-blaming rhetoric. We have the policies, values,

and track record to rebuild the cross-party consensus that once existed, to repair our services, to remove unfair costs for those living with mental illness, and to ensure that everyone can get the support they deserve.

2 The Liberal Democrat approach

The Liberal Democrats are serious about treating mental health with the same urgency and dignity as physical health, focusing on prevention, early support, and providing fair, accessible services for everyone. Our approach would include:

- A new offer for young people, with mental health walk-in hubs for communities across England and a dedicated, accessible professional in every school.
- Making prescriptions free for people with chronic mental health conditions.
- Legally requiring the NHS to treat mental health like physical health, including by protecting the share of the NHS budget that is spent on mental health.
- Providing routine mental health check-ups for those going through major life events, and for the people that are supporting them.
- Creating a Cabinet-level ministerial role within the Department of Health and Social Care with responsibility for overseeing cross-government work on mental health.
- Tripling the budget of the Farmer Welfare Fund, which would provide greater mental health support and services at livestock markets and county shows.
- Removing the arbitrary cliff edge at 18 for young people's mental health services.
- Reforming the national curriculum and our regulators to give families the power to use social media in a way that is right for them.
- Ensuring that people retain the choice to not use digital-enabled therapies, if they would rather be seen by a person.

- Championing a whole-family approach to supporting mental health, and recognising that mental illness impacts more than just the individual experiencing it.
- Creating a statutory, independent Mental Health Commissioner to represent patients, their families and carers, and introducing a new Veterans' Mental Health Oversight Officer.

2.0.1 Successive Conservative governments bear significant responsibility for the dire state of mental health services in England. For nearly a decade, mental health was deprioritised and chronically underfunded, despite repeated warnings from clinicians, patients, and the Liberal Democrats. Ministers abandoned their own 10-Year Mental Health and Wellbeing Plan before it even got off the ground, stalled reforms to the outdated Mental Health Act, and cut promised mental health training for NHS staff. Their rhetoric on "parity of esteem" was never matched by investment or delivery. As former Liberal Democrat Health Minister Sir Norman Lamb warned at the time, the Conservatives' targets were "built on thin air" because they refused to put in the funding required to meet them.

2.0.2 Labour promised change but have instead allowed a disappointing status quo to harden. Even before entering government, Labour downgraded the mental health portfolio, prompting the resignation of their Shadow Minister for Mental Health just as the pandemic's long-term psychological impact was becoming clear. In office, Labour have shut the Farming Resilience Fund including its mental health initiatives, and scrapped key mental health improvement targets. Their proposed reforms to Personal Independence Payment and Universal Credit risk making life harder for people with severe mental illness and unpaid carers, while doing nothing to cut unacceptably long waiting lists or rebuild community services that help people recover and return to work. A government serious

about prevention, opportunity, and helping more people into work would prioritise support, not strip it away.

2.0.3 The Government's 10-Year Health Plan acknowledges years of Conservative neglect that pushed the NHS to breaking point, yet offers little hope for those living with mental illness or their families. Most notably, it fails even to mention the Mental Health Investment Standard, which is the only safeguard that has protected mental health budgets from real-terms cuts. This omission was not accidental. Days earlier, ministers admitted that mental health's share of NHS spending has already fallen for the first time in years. At a moment when demand for services is at record levels, Labour have chosen to remove protections rather than strengthen them.

2.0.4 As Liberal Democrats, we believe that untreated mental illness 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 illness, 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, class, gender, income, ethnicity, or postcode.
- **Fair and equitable:** Resources in our mental health services too often only kick in at the point of crisis. 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 people 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 the impact the person's mental health can have on them, 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. It is one of the most common reasons for sick leave amongst NHS staff too, accounting for a third of all NHS sick leave in October 2025, a 56 per cent increase since 2019. 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.

3 Prevention

The Liberal Democrats will ensure that as few people as possible develop mental ill-health by:

- Offering regular mental health check-ups for people, and those supporting them, when they are most vulnerable to mental ill-health.
- Ensuring that all mental health services are integrated with money advice, substance abuse, housing, and employment advice services by default, and widen access to services that provide temporary protection from problem debt.
- Introducing structural reforms to both the national curriculum and Ofcom to empower children and parents to use social media in a way that is right for their family, whilst being protected from the risk of mental harm.
- Tripling the budget of the Farmer Welfare Fund, which would provide greater mental health support and services at livestock markets and county shows.

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, for a whole range of reasons, need additional support throughout their lives to prevent them developing mental health problems. That is 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 so the tax-payer is not left footing the bill for hospital stays or expensive treatments.

3.0.2 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. We also recognise that, in the real world, disruptive life events rarely ever impact just one person. Whether it is redundancy, a sudden bereavement, a road accident, or serious illness, traumatic events usually burden others. That is why we would extend this commitment through giving health providers the ability and funding to also offer regular mental health check-ups to the immediate family and/or unpaid carers of someone that is at a key point where they could be vulnerable to mental ill-health. We recognise that these networks are not only valuable support systems that are saving the NHS money, but also as people in their own right with their own support needs.

3.0.3 We would create a Cabinet-level ministerial role within the Department of Health and Social Care that has responsibility for overseeing cross-government work on mental health. Having a minister with the power to operate beyond the normal silos of Whitehall will ensure a Liberal Democrat government can identify and address determinants of mental illness efficiently and effectively.

3.1 Poverty

3.1.1 Poverty is the leading social determinant of mental illness, and people with financial problems are three times more likely to develop mental health problems. This creates an expensive and damaging self-perpetuating system that is leaving many unwell and destitute, and that costs the NHS, the welfare system, and local authorities far more than it would have to prevent it in the first place.

3.1.2 Almost one quarter of people attempting suicide are in problem debt. Outcomes improve for everyone - including creditors - if people with problem debt are given the right support, including respite schemes, to figure out their next steps and a feasible repayment plan. We would also widen the existing Breathing Space scheme by allowing referrals from GPs and community and neighbourhood health teams, so that anyone who has a pressing mental health need for forbearance can receive it. We would also pilot an expansion of the forbearance within the scheme from 60 days to 90 days, which could increase the likelihood of those with mental illness being able to stabilise their situation.

3.1.3 We would also integrate mental health services with money advice, housing, and employment advice services by default, rather than as an optional extra. Services in Winchester and Sheffield that have already taken this step have demonstrated that this integration provides better value for money, addresses root causes, and leads to better outcomes for service users, which is why these reforms ought to be rolled out in every mental health unit. This integration would also require healthcare professionals to ensure that plans for a patient's discharge from a medical setting include clear and easily actionable plans to address their financial and housing needs. We would also issue guidance to GPs and NHS services to help them sign-post patients to places of support, including Citizens Advice and local authority advice services, so they can better help patients deal with the underlying causes of mental illness, rather than just the symptoms.

3.2 Substance abuse

3.2.1 Comorbidity between substance abuse and mental illness is very common, with 71 per cent of adults entering alcohol treatment services requiring mental health treatment, 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.

3.2.2 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. We would also ensure that mental health services are joined up with substance abuse services by default, so people can receive the treatment they need sooner.

3.2.3 Nearly half of all patients under the care of mental health services who die by suicide have a history of alcohol misuse, yet people that are both intoxicated and that have suicidal ideation are frequently dismissed by services. Alcohol and substance use should be recognised as a potential comorbidity or symptom of poor mental health, so we would stop healthcare services from using substance use to exclude people from accessing support for their mental health. Additionally, we would ensure that training on the complex role that drugs and alcohol play in suicide attempts is provided for all staff working in Emergency Departments, to ensure mental health support is provided as quickly as support for physical problems.

3.2.4 It is also important to ensure that local authorities are empowered to work together better in regards to supported and sheltered housing for those with and those recovering from alcohol and substance misuse problems, and their neighbours. Failure to manage this can have knock-on impacts on levels of antisocial behaviour and crime in local communities, and make it harder for people to turn around from addiction.

3.2.5 A Liberal Democrat government would also introduce and fund a National Alcohol Strategy that focuses on the treatment and secondary prevention of alcohol dependence and alcohol-related harm in clinical populations across the health system.

3.3 Social media

3.3.1 Unlike financial troubles and substance misuse, the link between social media and mental health problems is relatively new. Young people seem particularly vulnerable to this, which is exacerbated by the fact that 86 per cent of 9-to-16-year-olds belong to at least one social networking site. Ofcom research found that children aged 5 to 15 are now spending an average of five and a half hours per day on social media, despite most being at school for seven hours (five days per week), and spending roughly 10 hours asleep. There are parallels between addiction to addictive substances and addiction to algorithmically-driven social media for the developing mind.

3.3.2 Between 2016 and 2024, child contact with mental health services increased by 477 per cent, 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. Young people across Britain are struggling, and social media's role cannot

be ignored, so now is the time to introduce effective, practical and implementable policies to keep children safe.

3.3.3 We do recognise that 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 acknowledge that this has been especially beneficial for LGBTQ+ children, and children with disabilities.

3.3.4 As Liberal Democrats, we believe that parents are entitled to choose how they want their children to use social media, but we recognise that many currently don't feel equipped to make informed decisions. We would introduce several immediate, medium-term, and long-term solutions to support children and parents to use social media in a healthy manner that is right for their family, whilst protecting them from the very real harms that social media can create.

3.3.5 Ofcom data shows that nearly half of young people spend longer on social media than they intended, so it is clear that social media is able to undermine their ability to make choices right for them. We would require cigarette-style health warnings on social media apps for under-18s. Clear labelling spelling out those health risks wouldn't stop young people engaging with social media, and it would not stop them engaging with their community, or connecting with friends online. But it would ensure they go into the experience with their eyes open to the risks, and with enough information to make choices right for them about how they use social media, and being signposted to where to find additional support.

3.3.6 The digital world is shaping how young people think, learn, and participate in society, yet the UK curriculum remains rooted in a pre-digital

era. Children and vulnerable adults are often taught how to use devices, but not how to question, interpret, and act responsibly within the online information environment that increasingly defines our civic and social lives. These are now fundamental life skills that are increasingly required for most roles in our modern economy, and to protect ourselves from the endless amount of information served to us by advanced algorithms. We would move from treating digital and media literacy as an optional add-on to embedding it across the curriculum by working with Ofqual and subject associations to embed digital and media literacy outcomes within existing national curriculum subjects from primary to post-16, including but not limited to English, History, Computing, and Art and Design. We would also encourage and support schools to host termly digital literacy evenings for parents and carers, covering topics such as parental controls, online wellbeing, and evaluating online sources.

3.3.7 Our regulators need to be modernised, too. Ofcom is currently toothless by design, which is no longer acceptable in an age of addictive-by-design social media. Ofcom currently has to wait for a new problem to happen before it can add it to their codes. We believe that this is backwards, and that technology companies should be proactively taking steps to prevent harms on their platforms before they happen. We would introduce a legally enforceable duty of care for large social media companies to protect children from harmful content, which would require technology companies to proactively find, remove, and mitigate all reasonably foreseeable harms. We would give Ofcom the power to ensure that this duty is being met, and to require them to set annual targets for harm reduction.

3.3.8 We feel that the proposals laid out in this section will empower families to make the right choices for them about how they engage with

social media. However, social media will continue to rapidly evolve, and new research into the impact of social media on children may demand greater government intervention. We will therefore closely monitor the emerging European consensus around a common "age of digital adulthood", which would be a legal threshold below which parental consent would be required to access certain social media platforms such as TikTok, Instagram and Snapchat or to place limits on their use. This is a complex and far-reaching proposal that demands careful consideration, and we are prepared to act in step with our European partners if an EU-wide standard is adopted, if the evidence shows it is right for Britain. The Liberal Democrats will not hesitate to put pressure on technology firms to adapt their systems and policies accordingly, because we are ready to take tough decisions to protect children online if required, and we will not allow tech companies to dictate the terms of our collective digital future. We also recognise that algorithms and social media services differ in the harm they can pose to young people, that control by the user is important of what they are exposed to, and this must be carefully balanced against the benefits they provide, particularly in finding peer support from others who are often marginalised.

3.3.9 Given social media is a rapidly developing policy area, the party and the Federal Policy Committee may wish to develop additional policies related to social media during this Parliament once we have a stronger evidence base and a clearer understanding of the political context.

3.4 Rurality

3.4.1 Labour do not understand rural life, which has led to rurality being overlooked as a social determinant of mental health. For many people in rural and coastal areas, they have additional challenges that create and

perpetuate additional isolation, stigma, financial uncertainty, and that create barriers to accessing diagnosis and treatment. For those living with or at risk of mental illness, these challenges can be severe, and they require a distinct and tailored response.

3.4.2 The structure of rural life means that many of the protective factors that support mental wellbeing like access to reliable services, social connection, and meaningful employment are harder to sustain. Public transport is limited or non-existent in many rural areas, leaving people unable to reach healthcare appointments, workplaces, or even social events without a car. This isolation can deepen loneliness, particularly among older adults, those who cannot drive, or those living alone. That is why we would boost bus services by restoring the £2 bus fare cap, support local authorities to use powers to franchise services and simplify funding, so that affordable bus routes can be restored or new routes added where there is local need, especially in rural areas.

3.4.3 The farming community, in particular, faces uniquely stressful conditions. Volatile markets, changing subsidies, unpredictable weather, and fluctuating input costs leave many feeling unable to cope. These pressures are compounded by long working hours, social isolation, and a strong culture of self-reliance that can make seeking help feel difficult. It is not hard to understand why RABI data shows that over one-third of the farming community are depressed, and why nearly half suffer from anxiety. A leading stressor in the farming community is inspections, from voluntary farm assurance checks to mandatory Rural Payment Agency (RPA) visits. We believe that the reforms to terminology and signposting that were made to the RPA Inspectorate represent a positive first step, but a recently-reported tragedy in Leicestershire is evidence that we need to go further to make meaningful progress in protecting our nation's farmers and growers. We

would ensure that a poor outcome in an inspection would trigger a mental health check-up for those working on that farm, and those around them, and support a review of the RPA's communications. We recognise that many factors that contribute to mental illness in farming communities are also experienced in fishing communities, so a Liberal Democrat government would work in partnership with fishing and coastal communities across the country to build on their local knowledge to develop the right support mechanisms.

3.4.4 Finally, we understand that people living in rural areas are often time-poor and that accessing health services can take longer for them. That is why we would ensure that mental health check-up services meet people where they are at, including at livestock markets and county shows. Currently, these services are only being provided by a small number of excellent VCSE organisations including Field Nurse and Lincolnshire Rural Support Network. A Liberal Democrat government would triple the Farmer Welfare Fund budget to ensure there is enough grant-funding to support similar initiatives across all of rural Britain, and deliver mental health check-up services where it's convenient for the farming community. Furthermore, we remain committed to trialling mobile youth work teams, which would operate out of existing local hubs or mobile facilities.

4 Access, diagnosis, and treatment

The Liberal Democrats will make it easier to access mental health services, and quicker to receive a diagnosis and treatment by:

- Support digital-enabled therapies, if there is enough evidence for them, and if patients retain the choice to opt for more traditional treatments.
- Make it easier for world-class experts to do essential mental health research in the UK, and for them to conduct crucial research that helps build our evidence base.
- Open a walk-in Young People's Mental Health Hub in every community, with specific support for children that have fallen between school and CAMHS support.
- Remove the arbitrary cliff edge at 18 for young people's mental health services.

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 per cent of the funding, but provides 20 per cent 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 the 1.6 million 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 illness 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.

4.1.3 We recognise that after years of Conservative mismanagement, and a failure by the Labour government to deliver growth, our public finances are in a difficult position. However, when there is funding available, we firmly believe that mental health and physical health services both deserve to benefit from it. A Liberal Democrat government would protect and retain the Mental Health Investment Standard, in line with recommendations from the Health and Social Care Committee, which requires Integrated Care Boards to increase their mental health spending each year by a proportion at least as large as their overall funding increases.

4.1.4 We would also bring mental health care fully within the NHS elective-care performance regime, with clear, enforceable waiting-time standards equivalent to those that apply to physical health services. This would ensure that patients accessing therapy, community treatments, or support receive the same guarantees of timely treatment as those waiting for surgical or outpatient procedures.

4.1.5 A Liberal Democrat government would also extend the principle of parity of esteem into the workplace by requiring all large businesses to appoint trained Mental Health First Aiders, and giving the role the same legal status, protection, and regulatory oversight as physical first aiders. The Health and Safety Executive would be tasked with setting national training standards, renewal intervals, and accreditation requirements, ensuring that every Mental Health First Aider meets a consistent level of competence equal to physical first aiders. At present, the absence of regulation has allowed a patchwork of inconsistent and, in some cases, poor-quality courses to emerge, undermining confidence in the role and diluting its value. Establishing clear and consistently policed standards would uphold the credibility of Mental Health First Aid, demonstrate genuine parity between mental and physical health, and ensure that people in distress across all businesses are assisted by someone that is actually qualified to support them.

4.1.6 We also recognise that many workplaces, particularly small and medium-sized businesses, want to support their staff's mental health but lack the resources to do so. We would introduce targeted guidance that would help businesses create mentally healthy workplaces.

4.1.7 To ensure that we have enough staff to deliver mental health services with the same quality and timeliness as physical health services, there needs to be a national funded workforce plan across the healthcare professions and social care, including medicine and nursing, psychologists, occupational therapists, counsellors, psychotherapists, and social workers, with clear targets for supply and retention specifically around mental health professionals.

4.2 Access

4.2.1 Too many people who seek help for their mental health are still being left without timely support. The number of people in contact with NHS-funded secondary mental health, learning disability or autism services in England was 24 per cent higher in 2022/23 than before the pandemic. This growth reflects both rising demand and a greater willingness to seek help, but service capacity has not kept pace. Many people who come forward for support face long waits or are turned away until they reach crisis point, which has led to some people dangerously turning to wholly-unqualified artificial intelligence chatbots for support.

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 must wait between assessment and treatment, or for response times in community-based crisis services, mental health support in emergency departments, and non-urgent community mental health care. The absence of these guarantees leaves patients without clarity and undermines public accountability.

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, communities with higher levels of deprivation, and those with co-occurring conditions such as substance misuse, neurodiversity, or physical disabilities face disproportionate barriers to timely and appropriate support.

4.2.4 Improving access to mental health support is not only a question of efficiency or service design but of liberal justice and equal opportunity. When people are denied help because of their postcode, income, or

background, their ability to choose how they live their life is curtailed. A liberal society recognises that mental health care is a part of the basic infrastructure that enables individual freedom, because without the means to recover and sustain wellbeing, we do not truly have the ability to live a life of our choosing.

4.2.5 To bring help closer to where people live, Liberal Democrats would expand Community Access Hubs within primary care and neighbourhood health settings. These hubs - delivered through existing GP practices, community centres, or trusted voluntary sector partners - offer same-day appointments or walk-in triage for mental health support. They would provide much needed rapid assessment, brief interventions, and onward referral to therapy, crisis care, or social prescribing, helping people to get help before reaching crisis point. Targeting these hubs in areas with higher deprivation or poor existing access, including rural parts of the country, would help to reduce postcode inequalities while making use of local assets and digital tools to keep costs low.

4.2.6 Many people lack the skills or technology to participate in video consultations, which is creating and exacerbating digital exclusion. A decade of chronic underfunding from both the Conservatives and Labour have cut local authorities' resources to the bone, but where possible, a Liberal Democrat government would encourage local authorities to use libraries and other community estate resources to help people access video consultations. This would be as simple as giving people a quiet place to handle video calls to professionals, and support in using basic software.

4.2.7 We would also establish a targeted Outreach and Navigation Fund to support voluntary and community sector organisations in helping under-served groups access the right care. Local charities, peer networks,

and community leaders are often best placed to reach people from ethnic-minority backgrounds, LGBTQ+ individuals, and others who face barriers to engaging with statutory services. By funding practical navigation, translation, advocacy, and referral support, our approach would help ensure that those most at risk of exclusion receive culturally competent care when it is needed, while strengthening the link between local communities and NHS services.

4.2.8 Finally, Liberal Democrats would enshrine the "no wrong door" principle, that was outlined in the *Suicide Prevention Strategy for England*, into law across mental health and related services. Whether a person first seeks help through their GP, a hospital emergency department, the police, or a voluntary organisation, they should never be turned away or told to start again elsewhere. Instead, whichever service is first approached would have a duty to ensure that the person receives a referral to the appropriate next step within 24 hours, supported by clear protocols between local NHS providers, councils, and voluntary organisations.

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 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 working with key NHS bodies to make them more culturally appropriate, more bespoke, and more easily accessible by tackling crucial gaps in the workforce.

4.4.2 With the rise of web-based interventions and mobile mental health technologies, it is right that equity of access is one NHS England's principles for using digital technologies to support mental health providers, but, given 13 per cent of the UK have 'ultra-low' levels of digital skills, we would

introduce additional safeguards to ensure continued parity between online and offline services.

4.4.3 There are currently seven NICE (National Institute for Health and Care Excellence) approved digital-enabled 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-enabled therapies, and monitor digital exclusion in healthcare.

4.4.4 We would also update commissioning guidance to require providers of NICE-approved digital-enabled therapies to monitor, evaluate, and publish evidence of the efficacy of new therapies and set out measures to ensure equity of access. This would help a Liberal Democrat government better monitor how digital-enabled therapies impact different people in society, and build a better evidence-base that can help inform new approaches and treatments.

4.4.5 It is essential that Britain's health services are fit for the 21st century. NICE guidelines form the basis for approaches to mental health treatments across the NHS and the wider health sector. NICE anxiety guidelines, for example, haven't been fully updated since 2011 despite treatments and social derivatives of poor mental health moving on substantially. Liberal Democrats believe that these guidelines should be updated, and due to the evolving environment in mental health, NICE should review mental health related guidelines at least every five years.

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 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. We need to ensure that every person with anorexia is receiving care, at least as fast as they would for an equivalent, wholly-physical health condition.

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 A 2017 inquiry found that most doctors in the UK are receiving 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. We would require all UK medical schools and postgraduate training

programmes to include a minimum satisfactory standard 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.

4.6 Services for Children and Young People

4.6.1 Young people today are growing up in a world shaped by new social pressures, increased exposure to the internet, and the long shadow of the pandemic. Demand for support has soared whilst access to the right help continues to fall. Too many families find themselves trapped between stretched school-based support and an overwhelmed CAMHS, with thousands of young people missing months of education while receiving little or no help. This is not only a policy failure but a profound waste of potential. We believe that every child should be able to get help early, locally, and without stigma.

4.6.2 The current thresholds for specialist services are so high that many children who are clearly unwell are told they are "not ill enough" for CAMHS but "too ill for school". This missing middle has become one of the most damaging failures in the system. A Liberal Democrat government would introduce a legal Early Support Duty on local authorities and Integrated Care Boards so that any child whose mental health is significantly affecting their ability to attend school receives guaranteed early support. This would include a named keyworker, rapid assessment within fourteen days, and a personalised plan drawing on community services, school support, Youth Hubs, and digital or face-to-face therapies. No family should be left to navigate mental illness alone, and no child should have to suffer before accessing help.

4.6.3 Years of underfunding, insufficient services, and a lack of focus on collaborative practice with parents has undermined many families' faith in CAMHS. To rebuild trust in CAMHS and ensure that the sickest children are not waiting months for help, we would introduce statutory waiting standards for children and young people's mental health from referral to first treatment, and require ICBs to publish quarterly local data broken down by age, postcode, deprivation, and ethnicity. This level of transparency would help drive improvements and expose longstanding inequalities faced by ethnic-minority communities, young people with disabilities, and those growing up in rural and coastal areas.

4.6.4 Schools are vital partners, but they cannot and should not be expected to replace specialist services. Our approach treads lightly: schools should be supported, not burdened. We would place a dedicated education mental health practitioner that has a graduate-level or postgraduate-level qualification in every primary and secondary school, funded in part by increasing the Digital Services Tax on social media firms and other tech giants. These specialists would work with parents, teachers, and external services, giving families the tools and confidence to make informed choices about what is right for their child, and to reduce the amount of children that are falling between school-support and CAMHS.

4.6.5 We would further tackle this by opening a walk-in Young People's Mental Health Hub in every community. These hubs would be delivered in partnership with the NHS, local authorities, and the voluntary sector, offering open-access, self-referral support for all young people up to 25. They would bring together counselling, youth work, brief therapies, and financial and housing advice but unlike this Labour Government's Young Future Hubs, they would be explicitly focused on providing mental health support, not intervening in issues of anti-social behaviour. We agree that anti-social behaviour urgently needs addressing, but widening the purpose

of these hubs seriously risks undermining their accessibility through creating stigma and social pressure.

4.6.6 To improve transitions and close the treatment gap for 16-25-year-olds, we would expand CAMHS to be a seamless 0-25 mental health service. This would remove the arbitrary cliff edge at 18 and ensure continuity of care at moments of major life change, from exam stress to leaving care or starting work. Youth Hubs would form a key and central role as access points within this new model.

4.6.7 Finally, local authorities must be empowered to play a central role in children's mental health. Years of cuts have eroded youth services, early help teams, and community spaces, which are services we need to prevent crises. Our approach places local authorities at the heart of commissioning, coordination, and co-production with young people, supported by clear statutory duties and sustainable funding.

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 father, and that their needs should be recognised by mental health services.

4.7.3 We would ensure 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. Additionally, we recognise that a small number of women will need admission to hospitals for their mental health problems. It is vital that any mother experiencing an acute perinatal mental health crisis has access to a Mother and Baby Unit (MBU), or an interim MBU.

4.7.4 We will work with stakeholders to secure cross-party support for a strengthened, data-driven perinatal mental health agenda by guaranteeing rapid access to specialist teams within our Patients Charter, and making perinatal mental health training mandatory for relevant health professionals. We recognise that fathers and partners also experience profound mental health challenges during the perinatal period, and their wellbeing has too often been overlooked. As a nation, we need to support men to talk openly about their mental health, both for their sake and so they can build stronger families and healthier communities.

4.7.5 The Liberal Democrats are committed to expanding parent-infant relationship services to reach more vulnerable babies and their parents. All mental health trusts should be held to account for providing a comprehensive service for babies, children and young people. The upcoming Mental Health Service framework should also include a focus on wider prevention, including of vulnerable babies and children.

4.8 Peri- and post-menopausal mental health

4.8.1 The menopause is a large but under-recognised driver of mental illness among women. Around 13 million women in the UK are currently peri- or post-menopausal, and up to one in two experience significant anxiety, low mood, or cognitive symptoms as part of the transition. Research from the Royal College of Psychiatrists has found that middle-aged women are one of the groups most at risk of depression, yet NHS mental health services rarely screen for menopause-related causes, and as a result they are often being prescribed antidepressants when hormone therapy or specialist advice would be more effective.

4.8.2 We urgently need to address the root causes of systemic misdiagnosis that is leading to so many women suffering in silence. Our existing proposal for a Patient's Charter would introduce a new legal right to a second opinion across the NHS, building on the roll out of Martha's Rule. We would strengthen this by allowing women who feel their concerns have been dismissed to specifically request a review by a menopause-trained GP or nurse practitioner, and require NHS England to publish guidance and data on second opinions by condition, gender, and ethnic origin. This would ensure that systemic biases or diagnostic gaps in areas like women's mental health are identified and addressed. Our workforce strategy would ensure that these rights are sufficiently staffed over time.

4.9 Suicide

4.9.1 Suicide is the leading cause of death in people younger than 35 in England and Wales. The risk of suicide is spread out unfairly across society,

with the farming community almost twice as likely to die by suicide, and men representing around 74-75 per cent of all suicide deaths in England and Wales. The loss of life to suicide is not inevitable, but it is an ongoing indication of deep structural and social failures, and we believe that mental health services ought to be designed to provide recovery and prevention, in addition to safety.

4.9.2 Certain groups face greater risks due to isolation, stigma, and barriers to accessing help. Among farmers, economic pressures, loneliness, and the emotional toll of caring for livestock and land can combine into an unbearable burden. For men, outdated expectations around masculinity, compounded by toxic "manosphere" online influencers, still prevent too many from seeking help early. Meanwhile, ethnic minorities, LGBTQ+ people, and those with disabilities often face additional challenges.

4.9.3 We remain committed to ensuring all frontline NHS staff are properly equipped to deal with mental health crises, and to ensuring that treatment for those in crisis is recovery-oriented. New evidence supports this approach, but also makes it clear that the benefits of the existing Liberal Democrat approach should be expanded to emergency services, too. Police forces, ambulance, and fire and rescue services are often the first to respond to someone in suicidal crisis, and this is only becoming more common, with the number of suicide callouts to fire and rescue services having tripled within the last decade. Despite this, research from the Samaritans show a huge range in the availability and quality of suicide prevention training currently on offer across emergency service trusts in England. Different research shows that suicide prevention training courses can increase a professional's ability to identify people at risk of suicide by 20 per cent. As such, a Liberal Democrat government would work towards providing suicide prevention training for all frontline NHS staff and

emergency services, so those dealing with suicidality are properly equipped to make safe and effective interventions that save lives.

4.9.4 As Liberal Democrats, we believe that voluntary, community, and social enterprise (VCSE) organisations can often be the most appropriate way to provide key services across our society. Where relevant, the Liberal Democrats would ensure that all VCSE organisations that are delivering NHS services, or delivering alternatives that support the NHS, are represented in all discussions about commissioning, policy, and implementation of interventions. This would recognise civil society's role as key stakeholders, and ensure that there is no duplication of services, which would ultimately enhance the experience that the users of mental health services receive.

4.9.5 Research shows that most men that die by suicide are not in touch with mental health services, but that ninety percent of them are in touch with a statutory service such as emergency services, or that are providing support for problem gambling or debt. Therefore, we are confident that our aforementioned proposals to enshrine the "no wrong door" principle into law across mental health and related services, to provide suicide prevention training to all frontline NHS and emergency services staff, and to ensuring that all mental health services are integrated with money advice, substance abuse, housing, and employment advice services by default, would give a Liberal Democrat government three much-needed tools to identify and make interventions to support men at risk of suicide.

4.9.6 Mental health crises can present suddenly in any number of public locations. We would improve signposting to resources for those in need. Our Liberal Democrat-run council in Richmond-upon-Thames worked with railway partners and Chasing the Stigma to spearhead a Hub of Hope

database initiative at Mortlake station, which is spreading to other stations. This introduced new QR signage that connects people to local and national mental health support services. We would look to roll this out further.

4.10 Research

4.10.1 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 per cent of consultants in 2011, but by 2020, this had fallen to 5.7 per cent.

4.10.2 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. This is especially true following a report recently published by The Royal College of Psychiatrists that found there is currently not enough high-quality evidence to support the routine use of pharmacologically assisted psychotherapy in clinical settings. We support further research into the potential medical benefits of pharmacologically assisted therapy through use of drugs like psilocybin and call for an evidence-based approach when it comes to regulating them for medicinal use, including rescheduling such drugs to permit research. A Liberal Democrat government would give our universities the support they need to carry out cutting edge research and innovation. We would put funding on a more even keel, join various European and international programmes and reform our visa rules. Many researchers, despite being world-class experts, often have salaries below these Home Office thresholds while employers struggle to cover exorbitant 'Global Talent' visa fees needed for top researchers, which are around 20 times higher than in most of our

competitor countries. We would remove these barriers preventing global research talent from coming to the UK by replacing the Conservatives' failed arbitrary salary threshold with a flexible, merit-based system for work visas and reducing 'Global Talent' visa fees. This would be coupled with a long-term workforce strategy focused on addressing skills gaps from within the UK through training and education. We would work alongside employers in each sector to ensure this strategy addressed their specific needs, including universities.

4.10.3 Furthermore, we would introduce reforms that will 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.

4.10.4 We welcome the Government's decision to set new ten-year budgets for the funding of certain research and development projects, including for national threats like antimicrobial resistance. However, we believe that this should be extended so that ten-year budgets are the default for areas of mental health research that help address gaps in our current evidence base, such as for eating disorders, community-based interventions, and inequalities in mental health. Strong longitudinal data will help us design better, more cost effective treatments that will reduce harm and save the NHS money, so we would jumpstart this research with longer funding cycles.

4.10.5 The Liberal Democrats specifically note that men's mental health also deserves focused, evidence-based attention. Suicide remains the leading cause of death among men under 50, yet research has too often failed to investigate how distress presents differently across genders, and

how we can best overcome this. Data from the Samaritans show that greater investment in research and evidence-gathering is needed to improve understanding of suicide risk in men, and that this knowledge must shape the design of training and service delivery. We support greater research into these issues, and support a multi-year funding settlement for voluntary and community sector organisations with a proven track record of reaching men, so that impactful, gender-informed initiatives can be developed and scaled.

4.10.6 Ultimately, better research will deliver better patient outcomes. People with mental illness will be diagnosed faster, will be able to access services closer to their homes, and will have more options for treatments.

5 Unfair costs

A Liberal Democrat government would prevent people with mental illnesses, and those around them, from shouldering the unfair mental and financial costs associated with mental illness by:

- Making prescriptions for people with chronic mental health conditions free on the NHS.
- Introducing a legal duty on health professionals to identify family members and unpaid carers, and to consider their own health and support needs as part of routine care.
- Preventing insurers from discriminating against people with mental health conditions when the risk is unrelated, by requiring fairer underwriting and oversight from the FCA.

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 The Liberal Democrats remain committed to 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.

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.

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.

5.2.3 To change this, a Liberal Democrat government would introduce a legal duty on health professionals to identify family members and unpaid carers, and to consider their own health and support needs as part of routine care. This would ensure that carers are recognised early, treated as partners in care, and connected to information and support that helps them continue in their role without sacrificing their own wellbeing.

5.2.4 To make this duty meaningful, Liberal Democrats would require NHS bodies and local authorities to put in place clear referral routes to carer support services, and to provide professionals with the training and time needed to fulfil their responsibilities. Civil society organisations would remain vital partners in delivering tailored, community-based help, but the

responsibility for identifying carers and considering their needs must rest with the health system itself. By embedding this obligation in law, we would create a culture of recognition and respect for carers across the NHS and social care.

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 many decades 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 and how far back they look. 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 are not 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. We would 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 and fairer questions.

5.3.4 We would work with the Financial Conduct Authority to ban blanket discrimination by changing the rules so insurers will no longer be allowed to deny coverage entirely or charge excessively higher premiums just because someone has or had a mental health condition, unless it is clearly relevant to the specific risk being insured. In practice, this would mean that insurers could still exclude claims directly caused by mental illness, but they could no longer exclude or overcharge for unrelated conditions. We believe this approach would allow people with mental illness to travel without fear, without unfairly burdening insurers.

6 The Mental Health Act

A Liberal Democrat government would continue to reform the Mental Health Act to protect individual liberties and ensure that mental health professionals have the support they need to deliver appropriate care by:

- Creating a statutory, independent Mental Health Commissioner to represent patients, their families and carers, and introducing a new Veterans' Mental Health Oversight Officer.
- Working with healthcare regulators to provide additional, appropriate safeguards on the use of digital monitoring technologies, where needed.
- Ensuring that all forces have a mental health professional in the control room at all times.

6.0.1 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. As a result, 'sectioning' has far too often been used to detain people rather than to treat them.

6.0.2 The Conservatives eventually recognised this, and pledged to replace it in their 2017 manifesto. By 2019, they had failed to do so, and watered their commitment down. 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.

6.0.3 The Mental Health Bill was 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.

6.1 Estate and infrastructure

6.1.1 As liberals, we are strongly concerned by reports that service users and staff are being recorded without their knowledge by other service users. Questions about how digital monitoring technologies, including infrared-sensitive camera sensors mounted in bedrooms, are being used in mental health inpatient units urgently need addressing. We would work with the Care Quality Commission (CQC), Healthcare Inspectorate Wales, and the Information Commissioner's Office to provide additional, appropriate safeguards, including against staff misuse, that ensure all implementation is patient-centred, maintains therapeutic engagement, and supports patients to feel safe.

6.1.2 We are also concerned that the structure and culture of the Act still enable environments that are unsafe for staff and patients. The Independent Review and the CQC found that many mental health wards are providing poor-quality care in unsuitable buildings. Common problems include inadequate seclusion rooms, unsafe physical layouts, and or poor visibility for staff, all of which undermine the capacity of the system to uphold the rights and dignity of people detained under the Act. The independent review of the Mental Health Act and the Care Quality Commission also found that many mental health wards are unsafe for staff and patients, and provide poor-quality care in unsuitable buildings. We would work to ensure that the mental health estate is structurally safe, free from ligature points, and designed appropriately to fulfil the objectives of the Act.

6.2 Protecting patients

6.2.1 It is clear that patients, their families, and carers are not being properly represented within the mental health system. To address this, we would establish a statutory, independent mental health commissioner for England, that would act as a voice at a national level to promote the interests of those who are detained or are likely to be detained under the Mental Health Act. The commissioner would have a strategic, cross-government focus, and would work to promote mental health and tackle inequalities. They would be a much-needed powerful advocate for the rights and wellbeing of those living with mental health problems, and would also play a role in tackling stigma and discrimination. Crucially, unlike the CQC, the commissioner would have the independence to comment on the implementation of the reform of the Mental Health Act and any subsequent changes or issues that arise, which would allow us to identify and address problems before they become critical.

6.2.2 Too often, carers are excluded from care planning, even though they shoulder immense responsibilities and can provide an incommensurable insight into a patient's needs. A Liberal Democrat government would ensure that every hospital has a dedicated liaison service for the carers of patients detained under the Mental Health Act. This would help us support carers during what can be a difficult time and to close blind spots that too often exist when someone is caring for a loved one with serious mental illness. Furthermore, parental mental health is now the most common factor in children's social care assessments, yet only around one third of inpatient professionals ask whether a patient is a parent. As a result, these children are invisible within the system, despite the fact that those children are at much higher risk of developing mental ill health themselves. That is why we would introduce a legal duty on health professionals to identify family members and unpaid carers, and to consider their own health and support needs as part of routine care.

6.2.3 Similarly, Veterans experiencing mental ill health can find themselves in systems that do not fully recognise their service-related experiences. We would introduce a new Veterans' Mental Health Oversight Officer, which would be a dedicated oversight role that would strengthen collaboration across statutory and third-sector bodies, and meet the specific needs of those who have served.

6.2.4 An independent review of the Mental Health Act 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. We remain committed to ensuring that the recommendations of this review are appropriately implemented to prevent anyone being disproportionately impacted. We will also introduce 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. This would be a senior role which could be carried out by an existing member of staff, such as a medical director or director of nursing, and they would actively assist providers in meeting patient and carer race equality framework and Equality Act duties.

6.3 Policing

6.3.1 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.

6.3.2 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. We would undertake a focussed review on how this could be sped up without loss of scrutiny, such as by changing how different professionals exercise their roles and legal powers here.

6.3.3 While some forces have introduced mental-health professionals into control rooms under the Right Care, Right Person model, coverage remains inconsistent. We therefore support the principle of ensuring specialist mental-health expertise is available to police control rooms at all

times, with national minimum standards. Similarly, although some police officers are receiving some mental-health awareness training, there is no national standard for crisis-response capability. Given the importance of ensuring police support helps, rather than hinders, a just resolution to a mental health crisis, we believe that all officers should receive training appropriate to their likely frontline encounters.

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Further copies of this paper can be found online at
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