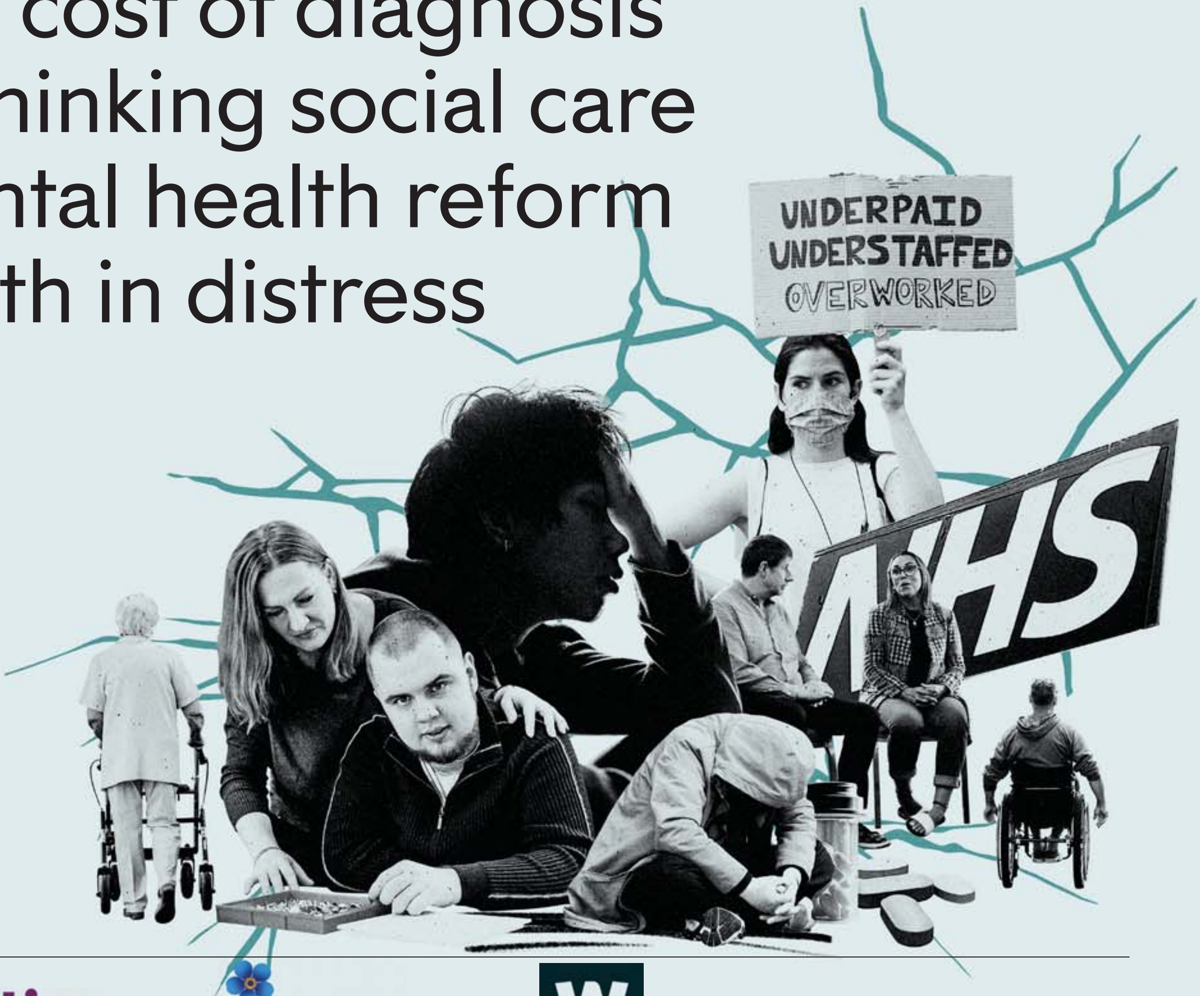
THE NEW STATESMAN

Spotlight

Thought leadership and policy

Healthcare: Vulnerable Britain

- The cost of diagnosis
- Rethinking social care
- Mental health reform
- Youth in distress



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At breaking point

Across Britain, some of the people most in need of healthcare provision increasingly find themselves struggling hardest to access it. Long waits for mental health and neuro-developmental assessments. Mounting pressures in social care. Persistent inequalities in women's healthcare. Overstretched support for vulnerable children and the elderly. It all points towards the same problem: systems designed to protect the vulnerable are often only responding once people have already reached crisis.

The pressures are not confined to the NHS. Poor housing, insecure work, social isolation and shrinking community services shape health outcomes long before patients ever enter a clinic or hospital. As support elsewhere in the state has weakened, healthcare has increasingly become the place where wider social and economic problems surface.

That has created growing pressure across institutions already struggling to cope. Systems designed around prevention operate in crisis mode, while access to support depends upon navigating fragmented bodies spread across healthcare, education, housing and social care.

This edition of *Spotlight* examines how those failures are affecting the groups most vulnerable when the system breaks down. On page 8, Harry Clarke-Ezzidio visits Childline's London operation and the volunteers confronting the mounting mental health crisis among our young people. We also explore the implications of the rise in diagnoses within this group through a look at the initial findings from the government's review into mental health conditions, ADHD and autism (page 18).

On page 14, Rhi Storer investigates how reforms to the Mental Health Act could negatively impact vulnerable people with autism and learning disabilities. Elsewhere, we hear views on perceived failings of the Women's Health Strategy (page 6); a call to reconsider how we finance social care for the elderly (page 7); and the need for Neighbourhood Health Services to address the financial drivers of poor mental health (page 20).

Taken together, these pieces raise a broader question about the future of healthcare and public services in Britain: what happens when access to support becomes increasingly dependent on navigating overstretched systems – and when vulnerability itself risks becoming invisible until crisis hits? ●

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Advertorial

We must stop neglecting dementia

The Modern Service Framework is an opportunity to show ambition and make transformative change

In association with Alzheimer's Society

Dementia is a devastating disease, which one in three of us born today will develop in our lifetime. Sadly, it is only becoming more prevalent. Dementia is now the UK's leading cause of death, accounting for more than 76,000 deaths in 2024, with figures rising year on year.

Despite this, it has long been neglected as a health condition, with late diagnosis, substandard treatment and insufficient support for families all common problems. According to research from University College London, it takes roughly three and a half years to receive a diagnosis after first symptoms, while a third of people with dementia in the UK are undiagnosed.

But why has dementia – a condition which cost the UK economy £42bn in 2024 – not been taken more seriously? Michelle Dyson, CEO of Alzheimer's Society, says the misconception still exists that it is a normal part of ageing.

"Society has not recognised dementia as a condition," she says. "Part of what we need to change is to get people to recognise that it is – it can be prevented, diagnosed and treated."

Last year, the UK government announced a Modern Service Framework for Dementia and Frailty, to improve the quality of dementia care and treatment in England. The interim product is expected to be published this autumn.

The new framework is a "great opportunity to show ambition" and make transformative change, says Dyson. Its two ultimate aims should be to reduce deaths and, importantly, enable people with dementia to live better lives outside of care homes for longer, she says. This will require a two-pronged approach of prevention with earlier diagnosis and intervention, and needs to be backed by departments across UK government with urgency and the same level of ambition that has been seen for other conditions such as cancer.

Late diagnosis and misdiagnosis are perennial problems that can lead to worse outcomes for patients, explains Paresh Malhotra, professor of clinical neurology at Imperial College London. For example, many clinical trials, where patients can try life-changing new treatments, are only available to those in the early stages of dementia.

"[We need] earlier, specific diagnosis for everyone," he says. "Everyone in the country deserves an MRI scan and blood

Those with dementia are waiting far too long for diagnosis and treatment

SYEDMKIMI/SHUTTERSTOCK

tests that are specific when they present [with symptoms] rather than waiting several years for them to be referred back and forth."

Linsey Farnsworth, Labour MP for Amber Valley, experienced misdiagnosis with her father, which led her to become an advocate for better dementia provision. He was initially misdiagnosed with depression and anxiety, then eventually Alzheimer's. Several years later he received a CT brain scan and it was confirmed that he had frontotemporal dementia, meaning his treatment until that point may have been ineffective.

"Those drugs are costing the NHS money and probably weren't really doing anything," she says. "Specific diagnosis is something that I would like to see."

The UK is falling behind in its ability to deliver world-leading treatments for dementia due to blockers in the approval process, explains Dyson. Two new "disease-modifying therapies" – donanemab and lecanemab – which slow down Alzheimer's disease progression rather than just manage symptoms, were approved by the UK's medicines regulator in April 2025. They are being used in private healthcare settings, but have not been recommended by the National Institute for Health and Care Excellence (NICE) for use in the NHS because NICE found their benefits "remain too small to justify the additional cost".

Yet their full benefits will not be realised until they are used in clinics, says Malhotra. "As with all treatments, whether it's stroke, cancer or dementia, these things are iterative," he says. "The first ones tend to be controversial. They don't work as well as the next generation, and they don't work as well as the generation after that. As new treatments are developed, if you start using combinations of therapies… then you're more likely to have success."

There also needs to be a concerted effort to increase access to clinical trials, he says. Research environments are crucial for making breakthroughs, but often pioneering treatments can also be incorporated into participants' clinical care. He believes all dementia patients should have the opportunity to be on a national or local research database so that trial teams can contact them.

Many patients are not made aware of trials, and organisations like Alzheimer's Society are helping to change this. As well as hosting a "trial finder" on its website, it has invested £3m into a nationwide team of specialist dementia nurses who assess patients in clinics on their suitability for research.

Dementia patients are often discharged from specialist care (for example, neurologist or psychiatrist) back to their GP after diagnosis, resulting in sub-optimum treatment as well as a lack of support for families.

The new framework should seek to create a coherent dementia patient pathway, says Malhotra, where people get continuous care from specialists and information is shared between GPs, specialists, social care settings such as care homes and clinical research programmes.

New data shows only 55 per cent of care staff have received any dementia-specific training, but people living with dementia make up roughly 70 per cent of older-age residential care in England.

Farnsworth realised the value of specialist care first-hand when her father was hospitalised due to a gallbladder infection. He was placed in a general hospital ward and did not get out of bed for weeks. But when a dementia nurse took a shift on his ward, he encouraged him to stand up. "The difference was that he was trained and he knew how to interact and care for my dad beyond the clinical issue that he had," she says.

In parliament, Farnsworth has backed Alzheimer's Society's call for dementia-specific training for the social care workforce.

Dame Louise Casey is currently undertaking an independent commission on reforming adult social care, and is calling for the creation of a dementia tsar. Such a role could help to reduce death rates, says Dyson, as the creation of a cancer tsar did more than 20 years ago.

Better public health messaging – similar to how the government invested in "stop smoking" campaigns for cancer – could also raise awareness of the 14 lifestyle factors that increase dementia risk. Nearly half of dementia cases globally are preventable, with major contributors being mid-life hearing loss, loneliness, physical inactivity and high blood pressure.

Similarly, Malhotra believes we need to shift from thinking about treating dementia to addressing the diseases that cause it in the first place – doctors treat high cholesterol to prevent heart disease, and they should think about preventing dementia in the same way.

There also needs to be more support for families and unpaid carers, says Farnsworth. Many people feel left in the dark after a diagnosis due to the lack of information and being discharged back to primary care: "I think there needs to be a holistic approach from start to finish."

Dyson believes a "bold and ambitious" Modern Service Framework is a once-in-a-lifetime opportunity to seize the opportunities presented by the research and catalyse systems to respond to the immense challenge of dementia.

With an ageing population, the dementia crisis isn't going anywhere. It is time for the government to take it seriously and use its upcoming framework to change the trajectory. ●

Comment

MARTA SIGNORI

Paul McDonald
Chief campaigns officer,
Health Equals

“The NHS cannot solve women’s health inequalities alone”

The renewed Women’s Health Strategy comes with big promises: adding a decade to healthy life expectancy in poorer areas and aiming to clamp down on ‘medical misogyny’. It is important that political attention is focused on women’s health, as it is undeniable that change is needed. The solutions, however, stretch far beyond the NHS.

Our health is shaped by the world around us – from quality homes to stable jobs, the money in our pockets and neighbourhoods with green space and clean air. These are known as “the building blocks of health” because they influence the opportunities we have to be healthy. For example, we can only eat healthy food if we can afford it, access it, cook it. This, in turn, means reliable transport, affordable energy bills and homes with safe, functioning kitchens. Not everyone in our country has these options. Evidence shows that these building blocks have far more influence over health than the NHS, genetics or personal behaviours. That’s why any strategy that ignores these factors will fail in its attempt to deliver longer, healthier lives.

In the government’s renewed Women’s Health Strategy, housing, cold homes and fuel poverty are not addressed as determinants of women’s health – despite recent Health Equals data showing that women are more likely than men to live in homes with issues such as damp, cold and mould, and suffer with health conditions as a result of them. Income and social security support are also notable by their absence.

Women are losing healthy years of life long before they reach any kind of care, and women in the UK’s poorest areas are missing out the most. Sadly, this is a trend that exists across the country. Recent ONS data on healthy life expectancy by deprivation told two alarming stories. There is a 20-year gap in healthy life expectancy between the UK’s richest and poorest communities. And those in the UK’s poorest areas are seeing worse life expectancy now than they were before the pandemic.

These gaps haven’t appeared overnight. They are the result of years of widening inequalities due to things like financial insecurity, insecure or physically demanding work and poor-quality housing that fall disproportionately on some groups of society and quietly wear down health.

And that’s why, when the government is presented with a chance to tackle these wider determinants of health in a renewed strategy, it is disappointing that it is so narrowly focused on treatment.

The Women’s Health Strategy rightly acknowledges that women have been let down by the health and care system, and this inequality needs to be taken seriously. While it’s a great step, healthcare reform alone cannot deliver the wider ambition to close the health gap. Yes, services can help women manage illness once it is diagnosed, but they cannot undo the damage caused by years of inequality.

In their election race, Labour made a pledge as part of their health mission: to halve the healthy life expectancy gap.

To achieve that, all the evidence points to the need for a plan that spans government and brings health into every decision – be it on housing, transport, town planning or economics. The health impacts should always be at the forefront of policymakers’ minds.

The government wants to ‘Get Britain Working’, but if Charlie Mayfield’s review into unemployment in the UK has taught us anything, it’s that Labour’s growth agenda hinges on the UK public being in good health. The Women’s Health Strategy is hugely important, but it is an example of the government failing to see the bigger picture.

Focusing solely on the NHS and care services to tackle health inequalities uses too narrow a lens. The ask is simple: zoom out. ●

Comment

Simon Kaye
Director of policy and research, Re:State

“Failing to fix the disappearance of dignity in later life will be a blot on all our records”

Why are we more comfortable with the decline of social care than with the same phenomenon in the NHS?

Consider the endless column inches devoted to consternation at overlong treatment waiting lists and the additional billions poured by this government, like so many others, into its endlessly voracious budgets. Meanwhile, social care overspends are taking many councils to the brink of bankruptcy.

During the pandemic, we were exhorted to “protect the NHS” – while safeguards for care homes often seemed like an afterthought.

We are sleepwalking toward a version of the welfare state that treats bodily illness as a matter of high-priority public concern and frailty, dependency and decline as something halfway between a family burden and an asset test.

That marginalisation ignores how central social care is to other policy questions whose significance is not in doubt.

The state of adult social care has a massive bearing on hospital flow, local government solvency, intergenerational fairness and the scale of women’s unpaid labour.

There is no parity of esteem between these two parts of our public services, and that, more than any single policy idea, is surely what drives the current vogue for a “National Care Service”.

But if that is to be anything more than a rebranding exercise, it will require a radically new approach to funding. This is the area where decline matters most. The collapse of the funding model helps explain the underinvestment, workforce pressures and unmet need that have become normalised across the system.

The current model is what happens when a decades-old settlement collides with contemporary demography, a new demand profile and the diseases of old age that come with it. Working-age adult social care used to be a relatively small part of the spend; now it accounts for around half. And we used to live shorter lives.

The extraordinary advances in medical science, nutrition and living standards have brought with them a simple reality: most of us will one day need some amount of care, some of us a great deal of it, and this is a normal and predictable part of the human life course.

That makes later-life care a classic case for collective risk-pooling. In our new report, *Beyond Caring*, we argue that England should stop bundling working-age and later-life care together as though they raise the same ethical and fiscal questions.

For later-life care in particular, the case is for a new social insurance settlement: one in which people contribute during working life to a genuinely pre-funded national pot, invested for growth to meet their cohort’s care costs in old age, with clearer entitlements and stronger protection against ruinous expense.

No more council tax precept. No more default reliance on general taxation. And the transition should be supported by asking the wealthiest older people to contribute more.

If we can prise this debate a little further open, we will have done our job. If we fail to fix the system, the disappearance of dignity in later life will be a blot on all our copybooks. ●

MARTA SIGNORI

Feature

Inside Childline

A direct line to Britain's youth reveals increasing angst, depression and fear of the future

By Harry Clarke-Ezzidio

Ground zero of Britain's shadow operation to tackle the mental health crisis among young people is located on the base level of a red-brick building in the heart of east London.

Straight on from reception inside the NSPCC's Shoreditch office is a keycard entry system – which many of the charity's staff don't have the ability to bypass – and a glass partition separating the outside world to Childline's command centre. Behind the glass, headsets on, arranged around circular shared desks, are just a small number of the 1,200 Childline volunteers who field calls from children in various states of emotional and mental distress 24 hours a day, seven days a week. They delivered 162,018 counselling sessions in 2024-2025. The largest proportion of those, 53,858 in total, related to poor emotional and mental health.

Off to the side of the main operation is a small "debrief room". It is furnished with comfy seating, "Reasons to smile"

Childline gave 53,000 counselling sessions relating to poor mental health in 2024-25

BODY STOCK / SHUTTERSTOCK

note jars and vibrant displays with achievement certificates not too dissimilar to those found in school classrooms. Perched on the edge of a grey corner sofa, Childline service lead Barry Larker commands a sturdy yet casual presence – donning a relaxed navy shirt, beige trousers and matching trainers. "At Childline we see a constant flow of young people coming through to us for… support, often in crisis," Larker tells me. Primarily, it is "a crisis of mental health". The key drivers of the crisis? The cost of living, social media, lockdowns necessitated by the pandemic, general "worries of the world" – the list goes on. "But it can be difficult to point to any one thing in particular," Larker adds.

"For our volunteers, it's important after a session to unpack it all," the Childline lead says of the emotionally "gruelling" counselling shifts, which last four hours in total. The hardest part is not knowing what happens at the other side of the line when a call ends. Sometimes a young person may hang up after getting through due to nerves, which causes less angst. The toughest, Larker outlines matter-of-factly, are "high-risk" conversations that end abruptly. "Ones where a child tells you they're by the side of a railway or on top of a bridge – and the phone cuts off." He takes a moment. Such instances are among the few triggers for the volunteer counsellors to break strict confidentiality rules. "But even then," Larker says, citing unresponsive and stretched police forces, "it can be weeks before you hear a follow-up on a case you raise. And it's not always good news." Such situations – where young people put themselves in life-threatening positions – are slowly "increasing", according to Larker who, after spending two decades in education, has been at Childline for four years.

However you look at or define it, the tide of mental ill-health among young people is rising. Research commissioned by NHS England in 2023 found more than one in five children are living with a probable mental disorder. That was up from 12.5 per cent in the same cohort in 2017. In turn, our young people and the systems that are meant to support them are struggling to cope.

The number of young people accessing NHS-funded mental health services leapt by nearly 80,000 on the previous year in 2025 – an 11 per cent increase. In England, across 2024-2025, 1.2 million children were in contact with secondary mental health services. In its funding and service quality, the NHS Children and Adolescent Mental Health Service (CAMHS) is widely considered an uneven entity. A 2023 *The House* investigation into CAMHS revealed that, across the UK, spending per child is four times higher in some parts of the country than others, and the average wait for a first appointment varies between ten days and three years. The effects of this can be devastating – numerous studies and surveys of those in the treatment backlog shared that they have thought about or attempted to take their own lives while waiting for formal support to begin. (Childline delivered 18,981 counselling sessions where the child's main concern was recorded as suicide between April 2024 and March 2025.)

In various areas of life across the country, third-sector actors increasingly provide services and sanctuaries that were once delivered by the state. Most have struggled to keep up with growing demand and stretched resources. As a charity, Childline is not immune. With growing need and relying on the goodwill of a relatively shallow resource pool, it has had to adapt. Despite the data suggesting that more children are suffering from increasingly complex issues, it is actually taking fewer calls. In the last full year before the pandemic, it provided more than 250,000 counselling ones; that figure has since dropped by around 90,000. (This, Childline notes, can partly be attributed to shifting some resources to web chats and email; "while demand from young people certainly hasn't decreased, their needs have changed", it said.)

The support, whether text-based or over the phone, can also take an incredible emotional toll on those tasked with delivering it. "Of course we are," Larker answers when I ask if Childline is finding it increasingly challenging to ▸

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Barry Larker: "Young people come to us for support, often in crisis"

BARRY LARKER

keep up with demand. His previously open body language becomes noticeably more guarded, his words more measured. "It's difficult to handle all that you hear." Yearly volunteer attrition was once at 30 per cent; Larker has strived to slash that to 20 per cent. "You're working as a volunteer, and you hear the most harrowing things. People find a way to deal with it in different ways." Some "let it all out", teary, in the debrief room (the space is noticeably not lacking for tissues). Others get on the train home "and decide that by a certain stop to not think about it anymore". A few "take it home with them".

Compartmentalisation – however one achieves it – is key for longevity. Larker seems that personified. When asked, he is quick to remember the call that has stayed with him most, but then takes a moment. "I'd rather not go back over it."

On average, a child contacts Childline every 45 seconds. With the approval of those who have reached out, the charity shared transcripts of their conversations with *Spotlight*.

The children bear it all: problems big and small, old and new. "I feel so depressed and alone. It's been going on for months but [has] been getting worse recently. I can't eat, can't sleep, can't remember the last time I felt good or happy," a boy, aged 16 and living in Scotland, tells the service. "No one takes me seriously when I try to say I'm depressed. I want help but I'm scared to ask again." A girl, aged 17 and living in Wales, says: "I don't feel like I belong anywhere or see my life going anywhere. How can I imagine a future for myself when I feel like this? I can't see a way out of how I feel." In England, a girl, aged 17, contacted the service to open up: "Recently my 'friend' cancelled on me, then later I saw she was out with other friends when she posted about it online. I feel so let down and so alone."

It is not just children who call (some of whom can be as young as eight): adults concerned about a child's welfare can contact and ask for advice. In 2024-2025, Childline responded to nearly 70,000 communications from people who were concerned about a child's welfare.

Childline has 12 bases across the UK. They open on a rotational basis, with a few live at any given time. Volunteers are given 12 weeks of training. The busiest shifts – three and a half hours, bookended by short briefings – take place in the evenings and overnight, as children are in school during the day and less likely to call. "When things get busy, it gets *busy*," Larker notes. This time of year, early spring and exam season, sees traffic increase "exponentially".

"It can be a lot," Larker adds, "and sometimes we can't get to everyone." Some may have to wait a while before speaking to a volunteer – around ten per location are likely on shift at any given time. To manage the load efficiently without undermining service quality, time spent talking is capped: 20 minutes for phone calls and double that for text chats. The thinking is that this is enough time to understand a child's situation and give a sufficient ear or necessary advice. Volunteers are told as part of their training to extend if they see fit. "Canny" regular callers have figured out the system. "Some, when they realise they may be up to the limit," Larker explains with a rye smile, "may drop in a tidbit of information to keep the person on the phone hooked and talking."

> "I'm depressed. I can't think of the last time I was happy"

Inadvertently, charities like Childline and similar third sector organisations have moved to the front lines of tackling our mental health crisis. What was once a supporting role has become a leading one. Austerity and its effects on the education sector's ability to help young people is frequently mentioned by Larker, himself a former teacher. The cuts were "devastating". Places like Childline take greater prescience and load.

Despite the crisis at hand, behind the glass partition all is calm. Whispering is the standard method of communication. A handful of headset-wearing volunteers make notes at their desktops. "Hi there," one female volunteer greets a caller, in a warm, soft tone. After a minute, the volunteer raises their hand and a manager comes over to consult. Another minute passes and the call suddenly cuts. A knowing raised eyebrow from Larker: "That happens. Could be a million reasons why. They may call back later." He points towards a wall display of green hearts, laid out vertically in six rows of three: each represents 100 significant contacts with a child. It is branch-specific and updated every month; "1,800 calls in April alone," Larker whispers. "It's difficult to think what those young people – many facing significant mental distress – would have done if they did not have this outlet." ●

Advertorial

Policy reform in severe mental illness now needs to match the positive progress in wider mental health

Great strides are possible with focus

By Dan Beety

In association with Bristol Myers Squibb®

The UK health system faces a paradox of progress in mental health: while growing attention to common conditions such as anxiety and depression has driven welcome gains, it has also exposed a persistent failure to meet the needs of those with severe and enduring mental illness (SMI).

With one in five adults living with a mental health problem in England, there is increasing recognition of the challenges posed by mental ill-health — particularly in relation to growing levels of economic inactivity among young people — and an increased emphasis on early intervention and prevention to address them. This progress matters. But it has not been universal, notably when you consider the unmet needs of those with SMIs.

SMI, including conditions such as schizophrenia and bipolar disorder, remains one of the most complex and costly areas of healthcare. While access to support for common conditions has expanded through services such as NHS Talking Therapies and early intervention initiatives, progress for SMI has been more limited. People living with SMI experience poorer physical health, reduced life expectancy and repeated cycles of relapse and hospitalisation, demonstrating the persistent and widening health inequalities faced by this population.

I am not suggesting care for common mental health conditions is perfect. But those with the most severe and enduring conditions face the greatest disadvantage, and that needs to change. At the same time, if we are serious about treating mental health on par with physical health, we must change how we view and care for people with SMI.

Across much of healthcare, innovation is transforming what is possible. In areas like cancer and cardiovascular disease, advances in diagnostics and treatment have reshaped pathways and significantly improved outcomes. By contrast, there have been few significant step-changes in SMI treatment in recent decades.

This is not an argument against progress in other conditions but a challenge to all of us that if we would not (rightly) tolerate such limited progress in cancer treatment, why is it OK in SMI?

The challenge in SMI is complex and hard to overcome. However, I see real opportunity to improve outcomes

Independence, stability, social participation and the impact on caregivers are important outcomes for mental health

ADOBE

through three key areas, particularly around the current medicines pathway.

First, the clinical trial challenge: Mental health patient populations are heterogeneous, treatment responses vary, and clinical trials must navigate ethical constraints – including the use of placebo over extended periods. Outcomes are often measured using clinical scales that may not fully align with what matters most to patients, like side-effect management. Decades of limited innovation in mental health have left the NHS, like other systems, without the trained specialist capability needed to deliver standardised assessments and consistent data crucial for commercially attractive trials.

Second, rethinking how we define value in mental health care: In England, the National Institute for Health and Care Excellence (NICE) provides a robust and internationally respected framework for assessing new medical interventions. However, mental health raises specific challenges for how value is defined and measured within that system. Outcomes that matter most in SMI – such as independence, stability, societal participation and caregiver impact – are not always fully captured by conventional appraisal measures. The lack of innovation in this space also means new interventions are often assessed against longstanding and relatively low-cost standards of care. This creates a cycle where it is harder to demonstrate benefits of novel innovations in an area where progress has been lacking for some time.

Finally, fragmentation and lack of service funding: Care pathways for people with SMI are often fragmented, spanning primary care, specialist services, and community support. Access to core services, including early intervention and crisis care, varies significantly across the country. Add to that workforce pressures, infrastructure constraints and current commissioning arrangements such as the widespread use of block contracts and we are in a situation where the system is not always configured to adopt new innovations, which means people miss out.

We have a great responsibility and opportunity to achieve national mental health ambitions, as outlined in the government's 10 Year Health Plan. The NHS shift towards more integrated, community-based care, alongside the development of the Modern Service Framework for mental health, provides us with a moment to make a real difference to people with SMI. A moment to create an environment where SMI is prioritised. We must not miss it. ●

Dan Beety is senior director, market access and external affairs at Bristol Myers Squibb
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Feature

Out of hospital, into nowhere

Campaigners fear Mental Health Act reforms could leave autistic people and those with learning disabilities at even greater risk

By Rhi Storer

According to recent NHS data, more than 2,000 people with learning disabilities and autism remain housed in mental health hospitals across England and Wales. An independent review into the use of segregation for people with learning disabilities and autism, published in 2023, found that a significant number were being held in solitary confinement – some for as long as 20 years.

Wide-ranging reforms to the Mental Health Act (MHA), in place since 1983, received royal assent in December 2025. Previously, learning disability and autism fell within the act's broad definition of "mental disorder" and could be used as grounds for detention.

That is no longer the case. Now, in theory at least, you cannot be sectioned solely because you suffer from a neurodevelopmental condition.

The intention is clear: to reverse the over-reliance on inpatient placements and instead provide greater community support. Those requiring compulsory care but not demonstrating a mental health condition should now be able to receive it without the threat of institutionalisation.

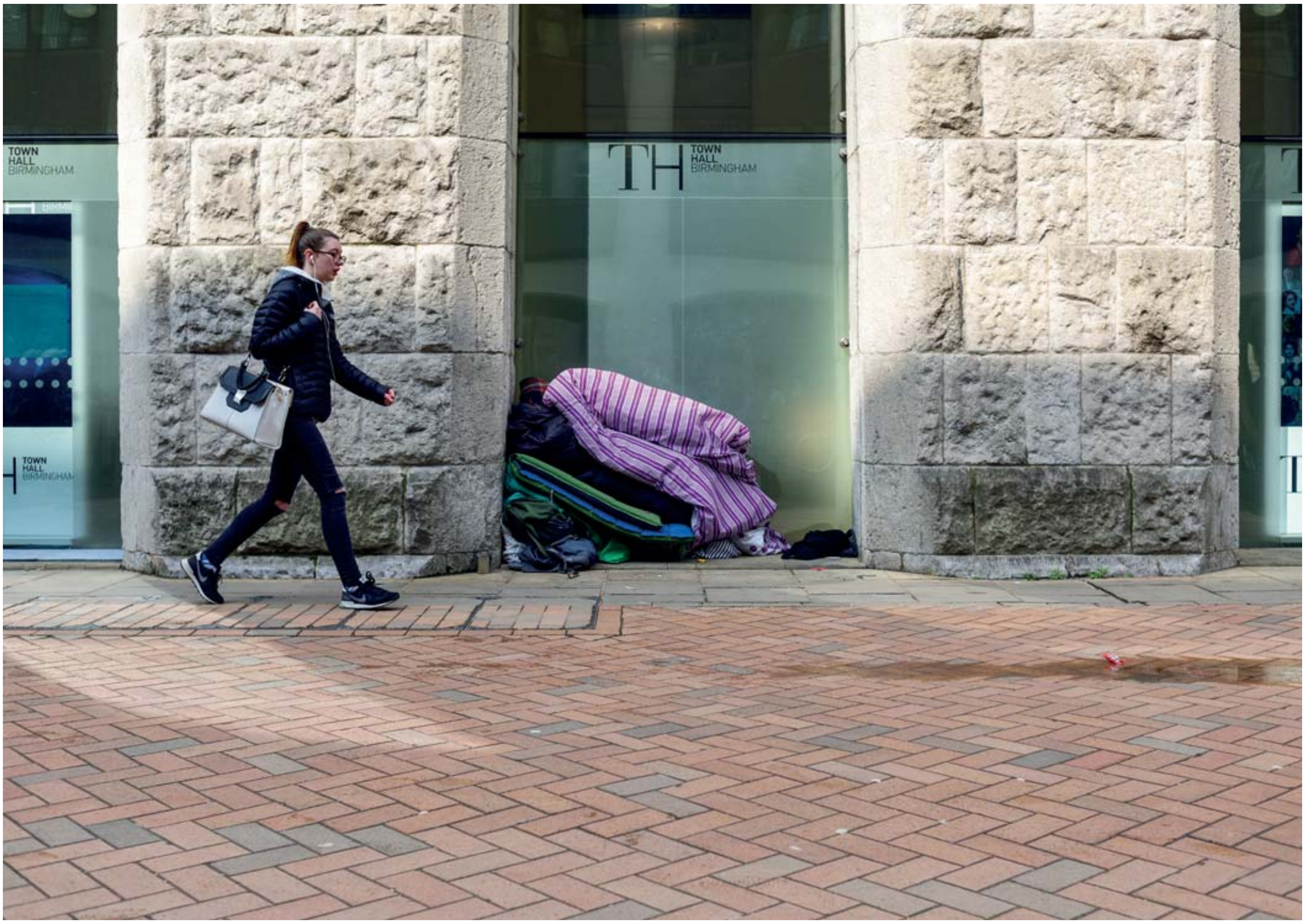
Critics warn, however, that without significant investment in community services, the changes risk leaving some of society's most vulnerable people without any adequate support. They are no longer detained, but not properly cared for either.

Autistic people's rights will still be at risk, they say, increasing the threat of crisis, neglect or even entanglement with the criminal justice system.

The consequences of getting this wrong are not abstract. Behind the legal complexity are real people – often non-verbal, unable to advocate for themselves – for whom the difference between a hospital bed and a prison cell may hinge on how these reforms are funded and implemented.

Jen Craft, chair of the Learning Disability APPG, has urged the government to set out how it will provide support to people with autism and learning disabilities when they leave mental health hospitals.

"There currently doesn't seem to be any kind of articulation of what sufficient community support looks like, or how we are going to get there, and that's where my real issue with it lies,"



Those who cannot be detained within a hospital, or find access to community support, risk losing their accommodation

the Labour MP tells *Spotlight*. Craft cites a structural tension between the NHS and local authorities threatening to fundamentally undermine the reform. "If [the individual] is in an NHS setting, the local authority is not paying for it. Once they return to the community, [councils] then have to find the money to house them and fund that care package.

"So you have budgets constantly competing against each other, there is a temptation to look at what you can reasonably afford at that point in time."

The result, in the most extreme cases, is that people end up trapped and held indefinitely in inpatient settings, at enormous cost to the public purse, because no local authority will fund the community package needed to discharge them.

> "They're just locked away, out of sight and out of mind"

Craft believes that the cost of keeping someone in long-term segregation – in some cases over £1m per person per year – would often be better spent elsewhere.

"[Families] tell me if you literally gave us the money you were paying to keep their loved one in long-term segregation, we can put the support in place for them in the community." But the money, she argues, is only part of the problem. The deeper issue is that this group of people has never commanded the political attention needed to force change. "They're just locked away, out of sight and out of mind. Being in a locked mental health unit is possibly the worst place that they could be," she says.

"Treatment for someone with those conditions in that situation is completely and utterly impossible. The scandal of people being detained is the tip of an iceberg of how adults with learning disabilities and autism are treated as a whole. And what's underneath it, I think, is horrific."

Dr Peter Beazley, a clinical psychologist and mental health law specialist at the University of East Anglia, fears clinicians will seek alternative legal routes to detain patients now that section three is no longer available to them.

The most obvious alternative, the Deprivation of Liberty Safeguards (DoLS), he says, is "without question a much more poorly safeguarded option" than the MHA.

DoLS are legal measures designed to protect those who lack the capacity to consent to their care arrangements. However, critics argue the system offers limited access to appeal, patchy legal representation and no guaranteed funded aftercare support on discharge.

But Beazley's central concern is what happens to people with autism or ▸

+2,000

Inpatients with learning difficulties or autism currently detained in English and Welsh mental health hospitals

20

Some have been held in solitary confinement for up to 20 years

2029

Key MHA reforms are not expected to be implemented for another three years

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◂ learning disabilities who cannot be detained in hospital, in a system where community services are already stretched beyond their limits.

In a submission to the Commons Mental Health Bill Committee last June, he warned that without intervention, more autistic people and those with learning disabilities risk being sent to prison because of "unmanaged and unnecessary escalation of risk in the community".

Beazley outlines a hypothetical situation to *Spotlight*: a person with a significant learning disability, living in a residential home, seriously assaults a support worker.

Previously, that person would have been detained under section three of the MHA, if they are at risk of harming themselves or others due to a 'mental disorder'. Their future care, then, would be planned in a way that doesn't involve the criminal justice system.

Under the reformed MHA, that option disappears.

A criminal justice outcome is unlikely, he argues, because the Crown Prosecution Service will decline to press charges either where a person lacks the mental capacity to form criminal intent, or the case itself is not in the public interest.

The government's assumption, he says, is that cases like this would instead be handled through DoLS. But DoLS, Beazley points out, can only be used where a person is not actively objecting to those arrangements. Someone in acute crisis, distressed or resistant falls outside that framework entirely. "If the person is objecting," he says, "there will be no route to use this framework as a means to authorise detention."

If non-verbal individuals have residential provisions, sharing many of the restrictions of hospitals but without any of the safeguards, what will happen to these people?

"They would then have to be discharged," he tells *Spotlight*. "By that time, they've been made homeless, so they can't go back to their accommodation. There's no way the local authority could have sorted another place. The criminal justice system isn't going to be doing anything about it. So the person is on the street."

Beazley worries there could be a new cohort of vulnerable individuals "essentially left with nothing".

Most people with autism or a learning disability, he stresses, present no greater risk to the public than anyone else. But the reforms, he argues, dismantle the very process designed to support those who do without replacing it with anything adequate.

"We are removing a process that can deal with and support that in a way that doesn't involve that person going through the criminal justice system," he adds.

Dan Scorer, head of policy and public affairs at Mencap, agrees that the DoLS could be used "inappropriately" to keep the same people in the same hospitals, under a weaker legal framework with fewer safeguards.

"The government needs to be vigilant when these changes are brought in. That's something we absolutely do not want to see happening", he adds.

A major risk is more autistic people being sent to prison

Community support presents a "chicken-and-egg" problem, he continues. "We need the government to commit to investing in and planning the community support so that they can meet their commitment to bring in this vital change to the [MHA]."

Some areas have already shown what properly resourced community support can look like.

In the West Midlands, Black Country Healthcare NHS Foundation Trust has worked with care provider Empowering U to develop crisis support to help families and social care providers. This includes a 24-hour crisis hotline and 'crash pads' – alternative short-term accommodation in the community that can be used in crisis situations.

"They've got a special provision that people can go to in a crisis situation and be supported, as opposed to being sent out of the area to an inpatient setting. They've not admitted anyone for years," Scorer says.

For Scorer, the Black Country model shows what is possible. Without a government commitment to fund and replicate it nationally, he fears the legislation will continue to stay at a standstill.

"Unless we get that plan and that investment for community support and housing, we are all massively worried that this huge change in legislation will never be brought about," he says.

"We fear that, a bit like [Liberty Protection Safeguards], this is a legislative provision that will never actually be brought into force."

What does that mean for those who cannot advocate for themselves?

"It means people locked up in a cell and fed through a hatch, potentially for months on end. Families holding their loved one's hand through a hatch in a cell door.

"These are conditions people would think were eradicated 100 years ago, but it's still happening now."

Nobody, including those who fought hardest for these reforms, can say when the waiting to see them properly enacted will end.

Scorer tells *Spotlight* he does not expect the changes to come into force until at least 2029. The people these reforms were written to protect have already been waiting long enough. ●

Advertorial

Kidney care is the test the NHS cannot afford to fail

Reframing kidney care around a home-first model

In association with

Vantive

The government's 10 Year Health Plan promises a shift from hospital to community, from analogue to digital and from sickness to prevention. Kidney care, including how and where services are planned, funded and delivered, is where that ambition is tested.

A central part of that shift is moving care into patients' homes. Yet in kidney care, home-based treatment remains underused and is going backwards nationally.

Few areas of the NHS cut across so many priorities at once. Kidney disease sits at the intersection of prevention, long-term conditions, digital monitoring, community care and specialised care. It should be an exemplar of reform. Instead, it risks falling short.

The scale alone demands attention. Around 7.2 million people in the UK are living with chronic kidney disease, and more than 72,000 are already on dialysis or living with a transplant.

Early diagnosis is rightly becoming a greater policy priority. But policymakers should be clear-eyed: identifying more patients earlier is essential, yet on its own it will not reduce the number of people progressing to kidney failure or needing dialysis or transplantation. This makes the case for a different model of care not just desirable but necessary.

Unless earlier diagnosis is matched by reform in how kidney services are planned, funded and delivered, it will simply expose greater unmet need in a system already under strain.

We are already seeing the consequences. The transplant waiting list is at a record high, with over 8,000 people waiting. In-centre dialysis continues to expand. Yet the very model of care the NHS says it wants – treatment at home, closer to patients' lives – is going backwards. Home dialysis accounts for just 16 per cent of patients, with wide variation between centres.

This is not a failure of clinical ambition. The policy direction is clear. But intent alone is not enough. Without the right incentives, accountability and delivery support, change will not happen at scale.

Kidney care still lacks the strategic focus given to other major long-term conditions, and risks being diluted within broader cardio-metabolic policy. That would be a mistake. Kidney disease is not a subcategory – it is a system pressure point.

What is needed is a dedicated Modern Service Framework for Kidney Disease, backed by a home-first model of care with clear national ambitions for home dialysis – 30 per cent by 2030 and 40 per cent by 2035.

Delivering this shift will require genuine partnership across the system, with patient organisations, clinicians and industry working alongside the NHS to support pathway redesign, digital adoption and service transformation. Home-based care should become the default where clinically appropriate.

Kidney care can become one of the clearest examples of NHS reform working in practice – or it can continue to fall short.

Realising that ambition means kidney care is no longer an afterthought. It is the test the NHS cannot afford to fail. ●

UK-RC00-260006

Cost of support

Is access to vital services now too dependent on a diagnosis?

By Phin Foster

In late March, the government published the interim findings of its independent review into mental health conditions, ADHD and autism. Reactions were predictably polarised.

For some, the review appeared to validate fears that ministers were preparing to question the legitimacy of rising diagnoses. Others argued it showed a system being gamed by those seeking clinical recognition as a route to increased support and welfare provision.

The review, led by the clinical psychologist Professor Peter Fonagy, arrives at a moment when demand for both mental health and neurodevelopmental services has surged beyond what the NHS can comfortably absorb. Waiting lists for autism and ADHD assessments stretch into years in some parts of the country, while referrals to children's mental health services remain far above pre-pandemic levels.

At the centre of the review is a politically explosive question: why?

The findings are nuanced enough to frustrate significant numbers on both sides of the debate. Fonagy does not argue that rising diagnoses are illegitimate. Instead, the report presents a system in which medical recognition is increasingly the price of accessing any help whatsoever.

"When support is tied tightly to diagnostic labels, demand for diagnosis will rise," Fonagy wrote. "When early, accessible help is limited, difficulties escalate."

One finding is that children and young people are increasingly pushed towards pursuing diagnoses in order to access support.

That language was seized upon by elements of the right-wing press. "The review does not conclude that children are being 'incentivised' to seek diagnoses," Dr Amanda Roestorf, director of research at Autistica, said of more sensationalist responses. "It highlights that demand is increasing in a system where diagnosis is the main path to support. The real issue is that people are waiting too long. Many are left without help for months or years, which can make things worse."

That creates a chain reaction across the healthcare system. "We are concerned that people are increasingly being diagnosed in educational settings or self-diagnosing because the system that should be there to help them is overwhelmed," acknowledged Dr Lade Smith, president of the Royal College of Psychiatrists.

"They should be able to access support which can prevent their condition from deteriorating at much earlier stages from more appropriate social services, as well as assessments and care."

Demand has risen sharply across multiple services at once: CAMHS, adult mental health care, autism pathways and ADHD assessment services. NHS waiting lists have struggled to keep pace. Private diagnosis providers have expanded rapidly through Right to Choose pathways.

With diagnoses having become increasingly tied to access, diagnostic services now carry pressures far beyond medicine alone.

The review cites the erosion of earlier forms of support. Youth services have disappeared from many communities. Educational psychology services are overstretched. Social care systems remain under severe pressure. Schools are increasingly expected to manage complex emotional and behavioural needs with shrinking resources.

Under those conditions, clinical diagnosis can begin to function as a form of institutional recognition: proof that somebody's difficulties are serious enough to count.

"The main message is that a whole systems approach is required across society – not just the NHS," said Dr Sameer Jauhar, a clinical associate professor at Imperial College. "While we have encouraged people to talk about distress and mental health, we need to be more clear on what this actually means, and how this can be tackled at individual, family, school and societal levels."

Fonagy suggests we otherwise risk creating an increasingly medicalised system in which distress, disability and social difficulty become channelled through healthcare services because other routes to support have weakened.

"It is positive the review places emphasis on shifting to a model that responds to people's needs, rather than one that is overly dependent on diagnosis to unlock support," said Alexa Knight, director of policy and influencing at the Mental Health Foundation. "This

As access to support becomes increasingly tied to diagnosis, many fear vulnerable people are being left to struggle alone

ELENA ROSTUNOVA/SHUTTERSTOCK

should mean appropriate support can be offered across the spectrum of distress, rather than dividing people into deserving or undeserving or waiting until issues become more acute."

But headlines around people being "incentivised" to seek diagnosis have created tangible tension, even if they do not fully reflect the spirit of the report's findings. "We have been concerned from the outset that this review could fuel the increasingly polarised debate about autism," acknowledged Mel Merritt of the National Autistic Society. "Unfortunately, we are now seeing exactly that. Too much attention is being placed on questioning people's motivations for seeking a diagnosis, instead of recognising the very real distress that people and their families experience."

The politics surrounding the review have heightened that sense of conflict. Ministers have increasingly linked long-term sickness and mental ill-health to economic inactivity and pressures on the welfare system. Critics fear debates around "over-diagnosis" could easily slide into arguments about benefit dependency or exaggerated illness.

Wes Streeting said when launching the review that the government needed "an evidence-based understanding" of rising diagnoses and mental health demand. But the report lands in a country where trust in public systems is already fragile.

At the same time, NHS clinicians warn that the current model is becoming unsustainable. Mental health services remain under immense pressure, particularly for children and young people. The review suggests failures in early intervention may be pushing more people towards specialist clinical pathways later on.

The report stops short of recommending sweeping restrictions on diagnosis. Instead, its interim conclusions point towards earlier intervention, broader community support and less reliance on specialist medical pathways alone. The implication is that many problems currently arriving at the NHS in acute form might have been managed earlier elsewhere.

That would require investment far beyond psychiatry clinics. It would mean rebuilding youth services, improving school support, expanding community mental health provision and reducing the barriers people face before receiving help. It would also require a political willingness to treat mental ill-health and neurodevelopmental conditions as social and economic questions as much as clinical ones.

What makes the Fonagy review so politically combustible is that it touches a deeper anxiety inside modern Britain: too many people feel that support only appears once their distress has become medicalised. Diagnosis has become not just a clinical process but a route into legitimacy.

The review's critics fear ministers may ultimately focus on reducing demand rather than rebuilding support. Its defenders argue the report is simply describing a system that has become increasingly reactive and crisis-driven.

Both sides agree on one thing: the status quo is failing. And that failure is no longer confined to mental health services. It reaches into schools, workplaces, welfare policy and the wider debate about who receives help in modern Britain – and who is left to struggle without it. ●

Opinion

We must stop the revolving door

The government has a vital opportunity to address the financial drivers of the nation's mental health crisis

By Helen Undy

Countless column inches have been dedicated to debating the causes of the UK's mental health crisis, which saw referrals to mental health services in England rocket by nearly 38 per cent between 2019 and 2024. Much of this media debate has centred on concerns around 'over-diagnosis'.

But much less attention has been paid to how cost-of-living pressures might be impacting people's wellbeing – and the need to tackle financial difficulty as a driver of poor mental health.

The reality is that financial and mental health problems go hand in hand. Nearly half of people in debt also have a mental health problem, while new analysis by my charity Money and Mental Health shows that people with mental health problems are three times as likely to be behind on household bills than the rest of the population.

And 3.6 million people with mental health problems tell us that in the past year they have been worried about not having enough money to put food on the table.

But despite the clear link between financial difficulty and poor mental health, more often than not, people do not get joined-up support for these issues. Only one in seven (14 per cent) people who are accessing NHS mental health support say they have received help with their finances too.

This is despite research showing that being in debt makes mental health recovery take longer and makes readmission more likely.

Our analysis also shows that joining up mental health advice with talking therapies could double recovery rates for people struggling with debt and depression, as well as bringing significant savings for the NHS. Conservative estimates suggest that every £1 invested in these kinds of interventions would generate a financial gain of £14 to £27.

The case for joined-up money and mental health support is therefore clear. In July 2025, the government announced ambitious plans for 'Neighbourhood Health Services' to provide support for socio-economic factors such as debt and employment issues alongside treatment for mental and physical health conditions.

This is part of a wider focus on

shifting the NHS towards a more community-focused healthcare model, giving local leaders more decision-making powers to shape accessible, integrated care in communities.

This offers a once-in-a-generation chance to tackle one of the main drivers of the country's mental health crisis. But concerns remain that the government might already be downgrading its ambitions.

While the initial government press release explicitly stated the commitment to include debt advice support through Neighbourhood Health Services, subsequent government and NHS guidance on how these services should be delivered make next to no mention of it.

The government needs to return to the ambition it announced last year, by giving local leaders a clear steer that money advice should be widely offered across Neighbourhood Health Services.

Without clear guidance from the government setting out this as a priority – and how it could be delivered – the current scenario of most people missing out on integrated support will persist or worsen.

The Neighbourhood Health approach also offers government and health commissioners an ambitious chance to deliver services in new and innovative ways – and to draw on the approaches that already exist in small pockets of the NHS.

Take, for example, Sheffield Mental Health Advice Service, which provides welfare advice to people receiving in-patient mental health care (who often struggle to access mainstream advice).

By co-locating advice within in-patient settings, routinely screening all patients for social welfare problems when they are admitted, and ensuring advice staff have the right training to support people with mental health problems, the service has reduced the length of time people need to stay in hospital, as well as cutting rates of relapse and homelessness.

Similar factors are in play at the Advice on Prescription project, run by Liverpool Citizens Advice, which provides free expert social welfare advice at all GP practices and mental health settings around the city. People who present to their GP with non-medical issues can get quick access to free expert advice, which has resulted in improved psychological wellbeing for almost all clients and reduced demand on GP services, and generated significant savings for the NHS.

Money advice should be widely offered across Neighbourhood Health Services

RICHARD JOHNSON / SHUTTERSTOCK

People's lives are complicated, and helping those with complex and overlapping needs requires genuinely holistic support.

That is evident in the Health Justice Partnership (HJP) in Coventry and Warwickshire. Commissioned by the NHS, but led by Central England Law Centre Coventry, this cross-sector partnership offers people receiving mental health care specialist advice for housing insecurity, debt and employment issues.

This expansive support has helped reduce homelessness, improve mental and physical wellbeing and generate income amounting to £1.2m each year for people using the services through improving access to benefits and other financial support.

These examples point to the promise of joined-up care. The solutions are there, but delivering them consistently across Neighbourhood Health Services will require government focus and priority. In the wake of the local elections, this is a chance for the government to introduce tangible policy to reduce cost-of-living pressures and to deliver on its prevention agenda in communities across the country.

It is an opportunity to transform support for those at the sharp end of the UK's mental health crisis and rising costs. ●

Helen Undy is chief executive of the Money and Mental Health Policy Institute

Advertorial

A revolution in mental health science is taking place – we need to seize the opportunity

New solutions must be scaled to reach the people who need them

By Professor Miranda Wolpert

In association with

Groundbreaking. Cutting edge. Transformative. Revolutionary. These might not be words that you commonly hear in connection with mental health treatments, but I'm hoping to persuade you that this will change.

The vast challenges when it comes to mental health are understandably much better known. Mental health problems affect one in two people globally. Nearly half of all mental health problems emerge by the age of 18. They can go on to disrupt people's education and careers, holding them back in life.

In my previous role as a clinician in the NHS and in schools, I was very aware of the need for more tailored, personalised and effective treatments to help people at the earliest opportunity.

I have a different vantage point now. In my current role as director of mental health solutions at Wellcome, a charitable foundation which funds science to advance health outcomes, I have the privilege of seeing how new scientific findings are going to transform how we address anxiety, depression and psychosis at the earliest possible point.

They span pharmaceutical, psychological, social interventions and digital approaches. Wellcome is one of the world's largest funders of mental health research. In all our work, we are informed by the expertise of people with lived experience of mental health problems.

I'll give you just a taste of the exciting new mental health interventions that are emerging. Virtual reality is being used in a novel treatment to help people stand up to distressing voices that are undermining their mental health.

The first new type of antipsychotic in over 50 years, Cobenfy, was approved for use in the US two years ago. There is a new digitally supported therapy which can help slow down people's thoughts who are experiencing paranoia. Community interventions such as group singing have been shown to address postnatal depression.

We can now fit the right antidepressant to the right person, using a tool that combines the best available evidence on pharmacological treatments with an individual's data, and optimise the right treatment for them. The first oral drug to treat moderate or

Researchers and clinicians are developing a new generation of personalised mental health treatments

SOLSTOCK/GETTY IMAGES

severe postnatal depression, zuranolone (Zurzuvae), was approved in the UK just last year. Researchers are driving forward research on psychedelics and ketamine to treat severe depression.

The latest neuroscience findings related to sleep and exercise could lead to new, highly scalable and cost-effective interventions for depression and anxiety. Meanwhile, AI has enormous potential for diagnosis and treatment if we mitigate the risks.

Despite new innovations emerging, the barriers to uptake remain significant. We need new, cost-efficient interventions that can help people without overwhelming public finances. The demand is there. A poll from More in Common, commissioned by Wellcome, found that 75 per cent of people in Britain want the government to do more to improve mental health services, a reflection of mounting pressure to move beyond rhetoric and deliver change.

As part of this gathering momentum, and in response to the persistent gap between discovery and delivery, we have launched the Wellcome Prize for Mental Health Science with *Nature*. This is the world's largest prize for mental health science and the first of its kind. It is designed to champion bold, credible and transformative advances in the treatment of anxiety, depression and psychosis. The prize, ultimately, aims to raise public awareness of advances in mental health research.

We hope to capture decision-makers' attention to make these new treatments available to all and accelerate progress in this growing field. The prize is open to research groups and small and medium-sized enterprises from around the world. The winner will receive $1m, with three finalists awarded $250,000 each.

We hope the prize provides visibility, connections and practical support to help winning interventions progress towards adoption and policy integration. And, critically, to help bring to light the huge potential of a new generation of mental health interventions to transform people's lives and signal where greater public investment and political leadership are now needed. This in turn should catalyse greater investment in mental health from foundations and governments.

Researchers have already made enormous progress on mental health. The next step is to help scale up and implement promising discoveries, to make sure that effective personalised treatments reach those in need. With ambition, this is possible.

Professor Miranda Wolpert is director of mental health at Wellcome

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