THE NEW STATESMAN

Spotlight

Thought leadership and policy

Healthcare: Parity of esteem

Sojan Joseph MP
Jeremy Hunt MP
Suzanne O'Sullivan
Brian Dow

VERSUS ARTHRITIS
ROYAL COLLEGE of PODIATRY
Alzheimer's Society

The age of anxiety

With waiting lists at record highs and alarming rises in anxiety, depression and self-harm, the current state of mental health services in the UK has been described as "a national emergency" by healthcare professionals and campaigners. The issue cuts across party lines, influencing policy on everything from school counselling provision and social media regulation to benefits and NHS reform.

For some, invoking an "emergency" risks framing deep-rooted, systemic failings as temporary and fixable with short-term interventions. For others, it is a necessary alarm bell, demanding urgent and ambitious action. The issue is further clouded by arguments that mental health issues are at risk of being "over-diagnosed", not least in recent comments from Wes Streeting.

This edition of *Spotlight* explores the complexities behind addressing what all agree is at best a creaking system, incorporating voices from across the political spectrum, the third sector, academia and front-line care. Our symposium on page 10 puts Streeting's supposition to a number of those individuals directly: Are we over-diagnosing mental health conditions?

Elsewhere, NHS nurse turned Labour MP and APPG on mental health chair Sojan Joseph calls for reform within and outside the system if we are to achieve parity of esteem, the principle of putting mental health on an equal value footing to the physical (page 4). Samir Jeraj looks at the evolution of said principle over the 15 years since it was unveiled as an early commitment of the coalition government – and asks why reality is yet to meet the rhetoric (page 16).

A secretary of state for health and social care in that coalition, Jeremy Hunt, now argues from the back benches that no progress can be made until local decision-makers are empowered and centralised health targets scrapped (page 5). And Penelope Campling, a practising psychiatrist for almost 40 years, paints a distressing portrait of a profession fast losing confidence that adequate progress is now even feasible (page 22).

If the first stage in recovery is acknowledging the problem exists, then perhaps there is some cause for optimism in the pages that follow. But there are also clear frustrations and disagreements over classifying symptom and cause. While that remains the case, parity of esteem still feels a long way off.

Contents

Spotlight

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A view from parliament

Sojan Joseph
Labour MP for Ashford, former mental health nurse, and APPG on mental health chair

Parity of esteem has never been delivered. We need a new approach

Before becoming an MP, I worked in the NHS for 22 years, primarily in mental health services. In my previous profession, I had seen the worst of it: children as young as nine self-harming, and people taking their lives whilst on waiting lists. The so-called "parity of esteem" the coalition government had spoken about was never delivered. In fact, mental health services were some of the first to be cut as the NHS's budgets tightened in the austerity period.

But since then we have seen drastic social changes which have worsened young peoples' mental health. Generation Z are more dependent on social media and more isolated from their peers. Technology has become both more central to their daily lives and accessible from an early age. As a result, their need for mental health services has increased at a time when they have been depleted and it's harder than ever to access treatment.

Our system and attitudes towards mental health are outdated. The fact it has taken 42 years to update the UK's primary piece of mental health legislation is perhaps the biggest indictment of how reluctant we have been to address it. I was pleased to hear in the King's Speech that this government is ready to grasp the nettle of mental health reform and pass a new Bill that addresses the multifaceted issues caused by the 1983 Mental Health Act. That includes the lack of autonomy given to patients, and the class and racial disparities of those detained under the provisions of the law.

Many patients are reliant on the NHS for long-term care after being discharged, and we cannot solve the crisis unless we look at a wider approach which encompasses social care, local agencies to support patients who need rehousing, and, most importantly, rethink what we expect from the NHS. Legislation can only take us so far. I know from my own experience that recruitment and retention is something the government must consider in their Workforce Plan – expected to be published this summer. Fewer people want to become mental health nurses, and it's understandable why: hours are long, and the pay is low compared to the private sector. This means that we rely on huge numbers of foreign workers, which is unsustainable. The long-term solution is to incentivise local people to begin lifetime careers in the NHS. That means investing in the workforce, not trying to constantly do more with less.

We must be willing to talk about the merits of other reforms outside of the healthcare system – such welfare reforms in the government's *Get Britain Working* plans. I know from my previous profession that many people with mental health issues and long-term health conditions can thrive in the workplace when given the necessary support, and it can hugely benefit their mental wellbeing. The Work and Pensions Secretary Liz Kendall was correct in her assessment that health and welfare are "two sides of the same coin". This can be seen most of all in young people. The Neet population (not in employment, education, or training) has been growing – it is around one in eight people aged 16-24. These people have disproportionately high mental health issues. We currently have 2.8 million people locked out of work due to long-term health conditions – 200,000 of whom are actively searching for employment. Part of the future of the mental health system will be providing the correct support for people – helping them raise their living standards and improving their mental health.

The mental health system will be in a constant state of evolution. My former colleagues in the mental health sector will be learning to grapple with issues faced by a generation increasingly dependent on technology which makes them more connected with the rest of the world, yet more isolated from their peers and more in need of mental health services than ever before.

MARTA SIGNORI

A view from the opposition

Jeremy Hunt
Conservative MP for Godalming and Ash, and former health secretary

Targets won't fix the NHS or help with waiting lists for mental health

It's an old cliché that politics is the art of the possible (in fact, Bismarck said something much more interesting, namely that "politics is the art of the possible, the attainable – the art of the next best"). But in the case of the NHS, the Overton window of what is possible for a Labour government with a large majority is much larger than it has been for any Conservative government. After all, it was Labour's Alan Milburn who brought in private providers to successfully bring down waiting lists. It would have been condemned as an egregious example of NHS privatisation if it had been done by a Conservative government. But will the Health Secretary, Wes Streeting, use the opportunity he now has?

After the pandemic, the issue is not money. The UK spends less than France and Germany on health, it's true. But at 10.9 per cent of GDP it is well above the OECD average of 9.1 per cent. The question instead is why its outcomes are so much worse even than countries like Denmark and Australia, which spend less.

As the longest-serving health secretary in UK history and author of a book on the NHS called *Zero*, I have thought about this a lot.

My conclusion is that the NHS, as the world's largest healthcare system, has become just too big and bureaucratic. Managers are weighed down by hundreds of operational targets in a way that would be inconceivable in other countries. Even GPs have nearly 80 "quality and outcome" targets. It is the most centralised healthcare system in the world. Faced with job-threatening operational targets that have to be delivered within weeks, how can a hospital chief executive possibly implement long-term strategic change such as a new IT system, improvements in patient safety (say, maternity units) or AI-enabled note-taking for nurses?

When Streeting announced the abolition of NHS England I said it would work if it led to fewer targets, but fail if it just switched to micromanagement from the Department of Health and Social Care instead. Since then, former health secretary Patricia Hewitt has sounded the alarm. She runs Norfolk and Waveney Integrated Care Board and told the *Health Service Journal* that exactly what I feared is now happening: "The real problem is combining the abolition of NHS England with hugely increased micromanagement from the centre," she said. "If [Streeting] was proposing to combine abolition with decentralisation... then I'd be all for it. But as it stands, it's one more tightening of the screw, I fear."

As a prospective parliamentary candidate I actually slept out overnight in Parliament Square as a protest against a local reconfiguration. Patricia Hewitt was trying to push through in my patch. But I came to have high regard for her, even asking her when I was chancellor to do a report on how to decentralise the NHS. She did, and we implemented her recommendations. NHS England targets in the planning guidance were massively reduced.

Now is the moment to go further and scrap national targets altogether. When Home Office targets were scrapped in 2010, police forces were freed up to allocate resources in the smartest way. Crime (at least non-computer crime, which was all that was measured then) fell dramatically. The story was the same with school standards, which have soared since we freed up heads (something Labour is foolishly trying to reverse for academies). If we want to transform the NHS we should empower integrated care boards (ICBs) and hospital senior leadership teams in exactly the same way: full accountability for standards of patient care, including safety, quality and waiting times through transparency – but total freedom as to how to get there.

Indeed, why not go the whole way and make ICBs report to local mayors rather than the Health Secretary, as happens in Scandinavia? It would stop the NHS being turned into a political football at elections. It would unleash local innovation and transformation on a scale and at a pace quite impossible under the dead hand of Whitehall bureaucracy. It would be bold – but the NHS will not be fixed by timidity. ●

MARTA SIGNORI

The Policy Ask

Sebastian Rees: "Some of the biggest health gains won't need legislation at all"

The influential Institute for Public Policy Research (IPPR) think tank's lead on health talks devolution, community healthcare, and London's best commute

How do you start your working day?
With a bike ride along the stretch of the Thames between St Paul's Cathedral and parliament – easily the best commute in the city!

What has been your career high?
Joining the IPPR at what feels like the most important time for health policy in decades. It's make or break time for the NHS and having the chance to inject ambitious, progressive thinking into debates on its future is a huge privilege.

What has been the most challenging moment of your career?
Every day has its challenges, but a constant has been trying to address the acute, short-term problems facing the NHS while carving out time and space to think about the bolder, long-term reform necessary to build a healthier nation.

If you could give your younger self career advice, what would it be?
Put down the reports a bit more often and spend time listening to people working in and using the NHS. A few hours in an A&E, a GP waiting room or a hospital discharge lounge can teach you more than an (ever-growing) stack of think tank publications.

Which political figure inspires you?
Julia Gillard. As Australia's first female prime minister – and now chair of the Wellcome Trust – she brought bold thinking and real political courage to health and care reform. The creation of Australia's pioneering National Disability Insurance Scheme under her leadership was a landmark. Even after leaving frontline politics, she's continued to champion health equity and mental health in particular.

What UK mental health policy or fund is the government getting right?
Reforming the Mental Health Act has been a long time coming, but when it finally passes, it will be a major step forward. Modernising this outdated legislation is essential if we want a mental health system that's fairer and genuinely puts people first.

And what policy should the UK government scrap?
There is still further to go for government to end its culture of micromanagement of the health system. Loading up NHS providers and systems with more and more targets is a dead-end when it comes to improving services for patients. But when things aren't going well there is always a temptation to add in more. Let's hope that the ten-year plan moves us in a different direction!

What upcoming UK policy or law are you most looking forward to?
I'm really interested in the potential of the upcoming English Devolution Bill. Most people I speak to in policy – especially in health – agree that hoarding control in Westminster and Whitehall is holding public services back. But shifting that culture will mean some very tricky conversations about accountability and funding. And it raises big questions about where the NHS – arguably our most centralised and most cherished institution – fits into that picture.

What international government policy could the UK learn from?
We've made real strides in the UK in recent decades when it comes to mental health, but there's still so much more to do to put people truly at the centre of their care. There's still a lot to learn from community-based approaches like those in Geel, Belgium, and Trieste, Italy – where support is deeply embedded in local life and relationships, not just services.

If you could pass one law this year, what would it be?
It's great to see the government legislating on issues like smoking, employment rights and housing, where law really can improve public health. It's not just about health legislation – it's about a whole agenda. But some of the biggest health gains don't need new legislation at all. They just need us to do the basics well – consistently, and for everyone.

MARTA SIGNORI

A view from the third sector

Shaun Friel
Director of Childline at the NSPCC

Rising mental health needs in children and young people are far outstripping service capacity

It's clear to see that our children and young people are talking about mental health more than ever before. At Childline, the number one reason young people contact us is to discuss their mental health.

In 2023/24, over 50 per cent of our contacts were related to mental health, which amounts to nearly 100,000 conversations on the topic. In Childline counselling sessions, children are telling us that they feel lonely, sad and overwhelmed with everything going on in their lives. Many have expressed that they don't know how to talk about and handle their emotions. They're also finding anxiety and stress a daily part of their lives.

We live in a society that encourages conversation about mental health, and the stigma is slowly being lifted, which might account for why so many children are contacting us about this topic.

MARTA SIGNORI

However, it could also be because children can't easily access mental health support services due to long waiting lists and high thresholds for treatment. The average wait time for a first appointment with Children and Adolescent Mental Health Services (CAMHS) is five months.

Last year's Darzi Report, an independent investigation into the state of NHS England, highlighted that rising mental health needs in children and young people are far outstripping service capacity. This leaves babies, children, young people and their families without the support they so desperately need.

We urgently need action from the government to ensure that mental health support teams (MHSTs) are implemented in every school and college across England. These teams bring together parents, teachers and mental health professionals to prevent children's mental health issues from escalating.

MHSTs reduce pressure on child and adolescent mental health services by providing early evidence-based support. This can avoid the need for more specialist services further down the line. However, MHSTs are currently only available in half of schools.

Children and young people's mental health problems cannot be left to spiral. Without the right support, mental health problems can lead to social isolation and affect their chances of academic success, which in turn will hold them back at such a crucial stage in their young lives.

Schools serve as vital places for children to access mental health support and with the right training and resources, teachers – who encounter children daily – can help to identify when mental health is becoming an issue and make appropriate referrals.

Parents and carers reading this will want to do what they can to support their children, even though the responsibility of supporting children's mental health cannot fall solely on them.

At Childline, we believe it's important to create a safe environment for children and young people and reassure them that you are there to listen without judgement. If a child wishes to discuss a challenging topic, such as their mental health, it's best to choose an appropriate time to talk, for example, avoid early mornings if they're more of a night owl.

We advise parents to remain calm, allowing the young person the space to share their thoughts when they feel comfortable. Often, they may approach you first to discuss these topics, so give them room to express themselves. Listen carefully to what your child is saying and resist the urge to respond immediately once they finish speaking.

We want to remind children that Childline is always available for support, online or by phone. Our trained counsellors are here 24/7 to assist young people with any worries, concerns or questions. They can visit childline.org.uk or call 0800 1111.

Advertorial

Better dementia diagnoses can lessen waiting list pressures

Easing dementia's huge burden is key to hitting NHS targets

By Kieran Winterburn

In association with

Alzheimer's Society

Dementia, the UK's biggest killer, puts massive pressure on our health and social care system – especially when it's undiagnosed. The King's Fund argues that delivering improvements on dementia is a litmus test for the success of integrated care systems to address system-wide challenges. Getting dementia right and going further and faster on diagnosis could therefore be a massive enabler to achieving the Government's three key shifts in healthcare and meeting its targets on 18-week waiting times, against which impressive progress has already been made. Ensuring this continues requires decisive action on dementia, which isn't getting the attention it needs.

A third of people living with dementia in England don't have a diagnosis. For those that do, people live with symptoms for an average of 3.5 years before getting diagnosed. Waiting times for dementia diagnosis are also steadily increasing, from 13 weeks in 2019 to 22 weeks by 2023, according to latest available figures. Some integrated care boards have told Alzheimer's Society that improving dementia diagnosis rates in their areas will be less of a priority since it was removed from the 2025/26 NHSE operational planning guidance.

People with dementia need an early and accurate diagnosis. Often, this will have to be confirmed via an MRI, CT or PET scan, or a lumbar puncture. But scan waiting times are rising, too. There's also huge variation in access to a diagnosis, with the number of patients at memory assessment services who have a scan varying from 0-90 per cent. The Government's pledge to double the number of CT and MRI scanners could help address these challenges, but we need to see additional capacity specifically used to support this.

Although around one million people in the UK live with dementia, it's never been prioritised as it should be. When we consider the burden that dementia represents for the system and the economy, it can be difficult to understand why.

In 2024, dementia cost the UK economy £42bn. Without action, this is set to rise to £90bn by 2040. People with dementia occupy one in every six hospital beds, make around one million A&E visits each year, and account for over 36 million contacts across primary, secondary, specialist and mental health

care services annually. Earlier and better diagnosis could help reduce the enormous impact that dementia is having on the system. For example, evidence commissioned by Alzheimer's Society shows a lack of diagnosis risks increasing healthcare use. Undiagnosed people are 1.5 times more likely to go to A&E than someone with mild, moderate or even severe dementia. The same research found that, on average, someone with severe dementia who has an unplanned admission stays in hospital for a month.

By focussing on getting more people a dementia diagnosis, we have huge potential to free up hospital beds and avoid emergency hospital admissions altogether. That means reduced pressure on the NHS, and a significant step towards moving care from hospitals to communities.

The Institute for Fiscal Studies has said that "the government will more likely than not miss this 18-week waiting time target." To reach its goal, the UK government must ensure more people with dementia get a diagnosis, so they can access help and maintain independence for longer in the community, away from hospital settings. In contrast, failing to address the impacts of undiagnosed dementia, and dementia as a whole, will make it far harder for government to achieve its goals on healthcare.

As well as helping people access care, a diagnosis also means they can plan for the future. It provides the simple dignity of clarity for the people affected. Evidence shows the support unlocked by a diagnosis can keep people with dementia out of crisis, out of hospital and living in their own homes, freeing up beds. In turn, this will help with reducing waiting times across the NHS.

By prioritising dementia diagnosis, we are also helping to ready the healthcare system for new disease-modifying treatments. These can slow progression of Alzheimer's disease, but they rely on early and accurate diagnosis.

At the World Dementia Council Summit 2025, Patrick Vallance, Minister for Science, Research and Innovation, spoke about the opportunity to align the 10-Year Health Plan with the Life Science Healthcare Goals. If the government wants to be a leader in dementia, and prioritise the condition relative to its impact, it's key the system is ready for such breakthrough treatments.

Winterburn: earlier diagnoses help both patients and the system at large

The current target timeframe for a dementia diagnosis is six weeks from the point of referral, but this only happens for 10 per cent of patients at memory assessment services Meanwhile, just 1.4 per cent of all dementia healthcare spend currently goes on diagnosis and treatment.

The government's efforts on elective care show what can be achieved when there is focus and drive on a specific issue. Chief Medical Officer for England, Chris Whitty, argues that early dementia diagnosis "helps to avoid unnecessary admission to a care home or hospital", providing "substantial savings on long-term care costs." By investing in diagnosis now, and ensuring new scanning capacity is utilised for dementia, we could see more people diagnosed early and accurately, which benefits both the person and the healthcare system at large.

In the future, blood tests could also be used for diagnosis on the NHS – Alzheimer's Society is proud to be co-funding work to make that a reality sooner – but we need the government's help to drive the action that's needed. Right now, we have a target that two-thirds of people living with dementia in England should get a diagnosis. But with prevalence on the rise, that's just not ambitious enough.

We need to see bolder targets, from ensuring all diagnoses include dementia type and happen early in disease progression as long as the patient chooses it, to empowering clinicians through better access to imaging and staff who are trained to read scans.

A situation where so many people don't get a dementia diagnosis is not good for them or the NHS. Waiting times are falling, but to maintain and accelerate progress, there must be action on dementia too.

We can't leave people with dementia waiting. It's time to make dementia a priority. Doing so could be the missing piece of the puzzle that enables the Health Secretary to meet his targets. ●

Kieran Winterburn is Alzheimer's Society's head of national influencing

ALZHEIMER'S SOCIETY

Are we over-diagnosing mental health conditions?

Wes Streeting seems to believe so, but for many experts the picture is a lot more nuanced

Britain is in the grip of a mental health reckoning. Once taboo, the language of anxiety, depression, trauma and neurodivergence is now part of everyday conversation. Public campaigns have encouraged us to speak openly about mental well-being. But as awareness has surged, so too has a thornier question: are we diagnosing too much, too readily?

In March, Health Secretary Wes Streeting argued that we are. "Not every feeling of sadness is depression, not every feeling of worry is anxiety," he said, warning that Britain is at risk of "over-diagnosing" mental health conditions, especially in young people. His comments sparked fierce debate. Is the surge in diagnoses a long-overdue recognition of hidden suffering? Or are we at risk of medicalising life's ordinary struggles?

The numbers are striking. Demand for NHS mental health services has more than doubled since 2017. Yet questions are growing over whether those services – already overwhelmed – are being diverted from those in greatest need. Are we mistaking everyday emotions for clinical disorders? Or does broader diagnosis simply reflect how far we've come in confronting mental illness?

This is not just a clinical debate – it is a political one. The way we define and diagnose mental illness shapes the policies and resources that follow: whether that's school counselling budgets, workplace well-being schemes, GP referral pathways, or access to talking therapies. Over-diagnosis risks diluting resources and excessive medicalisation; under-diagnosing leaves silent suffering unaddressed. While one finds a range of views, even among our experts, there is one clear consensus: the system itself is in dire need of support.

IT'S LACK OF ADEQUATE CARE, NOT OVER-DIAGNOSIS

Dr Lade Smith CBE
President, Royal College of Psychiatrists

It is no surprise that there has been an increase in mental illness diagnoses. Risk factors associated with mental ill-health – financial, housing and food insecurity, loneliness and isolation – have increased over the past decade. We have seen a 20 per cent increase in the number of people classified as disabled because of anxiety and depression – both eminently treatable conditions, both driven by social determinants.

With earlier intervention and assertive treatment, anxiety and depression can get better within months – long before a person's condition deteriorates into disability. However, the number of people waiting for mental healthcare has grown by 29 per cent in the last two years and now stands at 1.6 million.

Moreover, severe mental illnesses, such as bipolar disorder and schizophrenia, are under-diagnosed or diagnosed far too late. This is particularly important for younger people, because 75 per cent of all mental health conditions arise before the age of 24.

With illnesses like bipolar disorder or schizophrenia, it can take up to ten years before people receive a diagnosis and treatment, significantly impacting them achieving their potential.

During this time of no diagnosis, their illness is likely to curtail their ability to complete education, function at work and form healthy relationships.

They may even become homeless or come into contact with the criminal justice system.

It is essential that people with mental illness have access to an evidence-based comprehensive assessment from a trained psychiatrist or qualified mental health professional, which formulates their problem, clarifies their diagnosis and provides a package of care and treatment to enable that person to recover and have the best quality of life they can.

When misdiagnosis does occur, it is largely driven by people being left to diagnose themselves or being assessed by those with no or inadequate specialist skills and training.

We must be careful not to encourage stigma and discrimination. People with mental illness are not 'fake sick'; the UK's productivity has not been undermined by over-diagnosis, but by poor access to timely and effective care.

The Darzi investigation noted that mental illness is 20 per cent of the disease burden in the UK but receives 10 per cent of health funding. The treatment gap created by chronic under-resourcing results in a failure to quickly ascertain who is ill and who is not, and to assertively treat those who actually need it.

Over-diagnosis is far less of an issue than lack of access to good-quality timely assessment and treatment by well-qualified mental health staff.

RISING DIAGNOSES, DWINDLING WELL-BEING

Dr Suzanne O'Sullivan
Consultant neurologist, UCL

Any discussion about over-diagnosis needs to start with a clarification of the meaning of the term. Over-diagnosis should never be read to imply a person is not struggling or in need of support. It simply asks if medicalising that suffering is the best way forward for them. Mental health conditions don't come with biological markers, so nobody can truly identify the point at which psychological distress moves from being part of the normal human experience into being a medical concern. Therefore, over-diagnosis can only be recognised by looking at how the growing number of people with a mental health diagnosis are benefitting in the long term. If the diagnoses are appropriate, they should lead somewhere positive and allow an easier progression through life.

With that definition in mind, it feels impossible to say that mental health conditions are not over-diagnosed. Consider how the prevalence of autism has grown from affecting one in 2,500 children decades ago to more than one in 100 children today. More inclusive diagnosis promised to improve long-term mental health and well-being for young people. And yet, mental health diagnoses in adults, particularly young adults, are also steadily growing. This is the very definition of over-diagnosis — more early diagnosis, but no downstream improvement in well-being. Worse, these statistics suggest that the growing population of young people diagnosed as neurodivergent may actually be faring worse in adulthood than any population that has gone before. A medical label is not inert. It has a power all of its own to make people sick. When you tell a child that they have a neurodevelopmental condition, you risk encouraging that child to focus on what they cannot do. It could create the impression that the difficulties that child is experiencing cannot be overcome. You lower others' expectations for that child. The diagnosis can impact identity formation and become a self-fulfilling prophecy.

Diagnostic labels make social and psychological struggles seem set in stone, which gets in the way of an examination of life that might have a more lasting positive impact on well-being. A thirst for finding mental health diagnoses in milder forms and the growing number of mental health awareness campaigns risk pathologising ordinary differences and encouraging people to worry unduly about the natural highs and lows of mood. We need to learn how to recognise and support struggling people, and children in particular, without medical labels because the current system is not working. Better lives for children, social change, is how you create healthier, happier adults.

Suzanne O'Sullivan is the author of "The Age of Diagnosis: Sickness, Health and Why Medicine Has Gone Too Far" ▸

SIMPLIFYING THE DEBATE IGNORES THE ROOT CAUSES

Minesh Patel
Associate director,
Mind

It's hard to imagine that if the rates of cancer screening and diagnosis went up through public campaigns encouraging people to be aware of symptoms, to not suffer in silence and to seek support, it would not be a cause for celebration.

But when it comes to mental health, that's where we are. And for many, it's treated as evidence that "mental health culture has gone too far". This is despite the fact that the threshold for a diagnosis hasn't changed.

Several senior politicians from across the spectrum have made the argument about over-diagnosis or self-diagnosis, or a variation of it, in the last year.

But I think, especially when it comes to the interventions of politicians, it's important to consider the context in which the debate is taking place.

We are talking about a time of tight public finances, a rising welfare bill, and increasing numbers of people unable to work due to mental health problems.

We are living in the shadow of a once-in-a-generation pandemic and cost-of-living crisis, both of which we know, from the people we speak to every day, have been substantial drivers of mental health problems.

There are 1.6 million people on mental health waiting lists, with those on low incomes experiencing some of the worst health outcomes.

While it has become convenient, or in some cases politically expedient, to deny that the scale of rising mental health problems is real, such denials inevitably lead to policymakers not pursuing a proper appreciation of what might be driving such rises. This increases the burden on both the healthcare system and patients, as the earlier the intervention, the more treatable these issues become.

Our starting point has to be one of understanding the factors behind increasing levels of poor mental health and addressing the delays in people getting support. The solution certainly does not lie in making claims about over-diagnosis, which have little evidence to support them. This is especially the case when many of the people experiencing poor mental health are already facing the sharpest impacts of poverty and will be those hit hardest by proposed welfare cuts.

It's clear we still have a long way to go when it comes to equal treatment of physical and mental health, a point made more real by the proportion of the NHS budget going to mental health falling next year.

What's needed now is a conversation that is careful not to stigmatise people's real experiences and does not undermine the expertise of medical professionals. It must instead focus on how we can best create a mentally healthier society – one where fewer people experience poor mental health in the first place.

LABELS ARE PRIORITISED OVER EXPLANATIONS

Joanna Moncrieff
Professor of critical and social psychiatry, UCL

With the increasing diagnosis of mental health problems, we are medicalising a variety of human situations that are not medical problems. This has negative consequences for individuals and for society.

Diagnosis is a medical activity. It implies that people have an underlying biological abnormality that is the cause of their symptoms.

This is not the case with mental health problems. When someone is diagnosed with depression, anxiety or ADHD, this is simply a description of their problems. It is a label. It is not an explanation. It does not mean there is an underlying biological deficiency.

The widespread belief that depression is due to a chemical imbalance has never been demonstrated, for example, and biological mechanisms have not been established for any other mental health condition.

As a result, the process of making a mental health diagnosis is highly subjective. It depends on the beliefs and circumstances of the individual doctor and patient, and it is influenced by general social and economic conditions.

Yet, giving people a mental health diagnosis creates the impression that there is an underlying biological problem.

This is harmful because it results in people feeling pessimistic and powerless to change anything. It can

lead people to limit themselves. It also results in unnecessary exposure to medical interventions, such as antidepressants. Despite being widely used, there is little evidence that antidepressants are helpful, and plenty of evidence that they can have serious adverse effects.

Moreover, giving people a diagnosis risks overlooking the real problems. It focuses everyone's attention on the symptoms of the condition, rather than the problems that caused them originally. Overwhelmingly, these problems are social, such as poverty, unemployment, relationship problems, loneliness and lack of meaning.

Diagnosing the understandable consequences of these features of our society as medical conditions inhibits social change. It enables politicians to ignore the inequality, insecurity and social fragmentation that have resulted from neoliberal political and economic policies, and which cause so much misery and stress.

In the short term, medicalisation provides financial security for some through the benefits system, but this could be (and in some cases is) done differently, on the basis of need.

In the long term, medicalisation perpetuates the system that is causing our mental health crisis in the first place.

Joanna Moncrieff is the author of "Chemically Imbalanced: The Making and Unmaking of the Serotonin Myth"

DIAGNOSIS IS OFTEN THE ONLY WAY TO ACCESS SUPPORT

Brian Dow
Deputy chief executive,
Rethink Mental Illness

There is lots of talk about the over-diagnosis of mental health conditions. But for most people living with mental illness, the reality is often a struggle for a timely diagnosis and access to the right treatment.

Our charity's research found the majority don't receive support quickly enough, with four in five experiencing a deterioration in their mental health while they waited. The consequences are serious: crisis, suicide attempts and lost livelihoods.

Of course, as in any area of medicine, misdiagnoses do occur. Some people in recovery may come to feel that a diagnosis no longer serves them. And yes, we should be doing much more to prevent people from falling out of education or work, rather than simply writing them off.

On the other hand, a diagnosis is often the only way to access life-saving support. And we don't suggest that cancer awareness-raising campaigns are problematic because most people who get checked won't have cancer. Quite the opposite: we encourage people to seek help, knowing that early intervention saves lives. So why discourage the same approach for mental illness, when the effects can be just as devastating?

This is a complex issue that requires nuance, not oversimplification. Right now, there's no compelling evidence of over-diagnosis, but there is ample evidence of a rising tide of mental distress and under-resourced services failing to meet demand. Recent research from the Institute for Fiscal Studies shows that mental health difficulties, particularly among young people, are increasing.

Mental illness has never reached parity with physical health in either investment or priority. Our analysis of NHS data shows someone is eight times more likely to wait over 18 months for mental health treatment than for physical healthcare. The government's target for 92 per cent of patients to start treatment within 18 weeks does not currently include any commitment to tackling waits for mental health services. Against this backdrop, we must be extremely cautious we don't deter people from seeking help. We also need to do more to tackle the drivers of poor mental health, especially given that mental illness often begins young and becomes entrenched without support. That means investing in school-based support, housing, tackling poverty and reducing isolation. This is not soft policy; it's a pragmatic way to reduce pressure on an already overburdened system.

While different conditions require different responses, all mental illness, from mild to severe, is distressing to the individual. What matters is delivering the right support, in the right place, at the right time.

The question isn't whether we're over-diagnosing. It's whether we're doing enough to help.

Advertorial

The government will fail to meet its goals without a solution to achieving good musculoskeletal health

Deborah Alsina on the government's long-term plan for health

In association with

VERSUS ARTHRITIS

Arthritis and related musculoskeletal (MSK) conditions affect 20 million people in the UK, with one in six people (or more than ten million) living with arthritis itself. Aside from the great personal toll, data shows it comes at great cost to the NHS and wider health service, and to the economy. One in three GP visits relates to MSK conditions, and it is the second-most-recorded reason for people being off, or out of, work.

Though they mostly affect bones and joints, the overall impact of these illnesses can have a far greater reach – affecting patients' ability to work, their physical and mental health and well-being and their overall experience of life. Contrary to popular belief, arthritis can be diagnosed in childhood, or indeed at any age, as people navigate education, build careers and raise families.

Health Secretary Wes Streeting has set out stridently on his mission to reduce NHS waiting lists and improve overall care, abolishing NHS England and taking more direct control of the health service himself. Arthritis and MSK conditions are often lost in the noise around tackling the crisis in healthcare in the UK, but a crucial part of Streeting's mission will be to develop a more holistic and long-term plan for the treatment of these conditions given the depth and breadth of their impact. As the leading cause of disability in the UK, having a plan to tackle the impacts of arthritis and MSK needs to be an essential part of the government's plans for the NHS and for its mission to get more working-age adults in the UK into employment.

Deborah Alsina, the chief executive of Versus Arthritis, the UK's largest charity dedicated to supporting those living with arthritis and other MSK conditions, told *Spotlight* that arthritis has a huge impact in "three distinct ways". They are: "the impact on people, the impact on the NHS and the impact on the economy". Alsina explained that the way these conditions impact the individual are through "pain, fatigue and limitations in mobility and dexterity". She added: "Pain and fatigue are huge issues for people with arthritis and that can fluctuate. They come in and out; they're not just one thing all the time." Alsina pointed out that people living with arthritis and other MSK conditions are often "also living with other long-term

conditions as well". For example, if you have osteoarthritis – a degenerative joint disease that leads to cartilage breaking down – you are 60 per cent more likely to live with diabetes and three times as likely to develop cardiovascular disease.

Alsina is clear that the government and the health service therefore need to think more holistically about arthritis and MSK conditions to reduce other major conditions. "If we want to reduce the risk of cardiovascular disease, maybe we need to go a bit more upstream and think about how we reduce osteoarthritis or treat it more effectively," she told *Spotlight*, "because some research suggests it can be causative for cardiovascular disease."

She also pointed to the considerable impact that living with arthritis and MSK can have on individuals. Not being able to exercise the full range of motion you once could, feeling like a burden to family or carers, or being unable to engage in certain activities, can all weigh heavily. As the country's leading cause of disability, it can also keep people out of work, with one in four people not working living with an MSK condition.

"If you're living with severe pain, it has a huge impact on your mental health," Alsina said. Versus Arthritis runs a helpline for patients living with these conditions. Alsina explained that there have been "quite a lot of people who phone our helpline with suicidal ideation because they can't stand it any longer. It's all very interconnected."

So, there is a challenge here; not only to deal with arthritis and MSK conditions as they currently present themselves within the NHS but also to tackle some of the key causes of these conditions. They need to be viewed as long-term conditions in and of themselves and be tackled as such. Alsina explained that health inequalities can have a large bearing on a patient's likelihood of developing arthritis or another form of MSK condition.

"If you are living in a deprived part of the UK, you are likely to develop arthritis or an MSK condition ten to 15 years earlier than if you're living in an affluent area," Alsina said. It is also more likely that those living in deprived areas have one or two other long-term conditions too.

Tackling this will require a programme of action from the government that goes wider than immediate healthcare. "We have to have a much tighter way of thinking about all the things that are social determinants of health," Alsina said. "That means poor housing, lack of employment, being in a food desert; all of those different things have an impact on people."

VERSUS ARTHRITIS

One in three GP visits is for poor musculoskeletal health

With a Labour government, the next few years could present an opportunity, a clean slate. What else would Alsina and Versus Arthritis like to see? A crucial ask is for the NHS. "We want to see permanent, sustainable MSK leadership in the NHS," Alsina said, reflecting that efforts to date to improve MSK health have been piecemeal. "It needs a budget, so that it can do much more in terms of coordination," added Alsina, who was clear this sustainability should not only be a priority at the national, Whitehall level, but must be at a "local level as well".

A crucial area of focus must also be diagnosis. "At the moment, diagnosis is patchy," Alsina explained. "For example, if you have suspected rheumatoid arthritis, there are some brilliant early diagnosis clinics, but they're not available everywhere consistently."

Therefore, more work needs to be done to improve consistency of diagnosis across the country, so those in more deprived areas who are more at risk of arthritis or MSK can be caught earlier. This was underlined in a report in February by the National Confidential Enquiry into Patient Outcome and Death, which found that a lack of awareness of childhood arthritis among health professionals was resulting in children "bouncing around the NHS", with swift diagnosis "too often based on luck".

Part of this is in the training given to healthcare professionals. Alsina added: "In order to aid diagnosis, we need to ensure frontline health staff are given the training they require... we need to make sure we're using the full workforce."

Streeting clearly has his work cut out for him. What would Alsina's advice to the Health Secretary be? "Don't make the error of ignoring arthritis and musculoskeletal conditions," she said. "Good musculoskeletal health underpins our lives and our ability to move, to work, to do our thing as humans... it requires focus and attention to ensure that we can all live the lives we choose. In short, what we need is an MSK action plan to help deliver on the government's long-term ambitions to transform health in the country."

Deborah Alsina is the chief executive of Versus Arthritis

Feature

“It’s gone backwards”

Promises to fund mental health services at the same level as physical health have yet to be kept

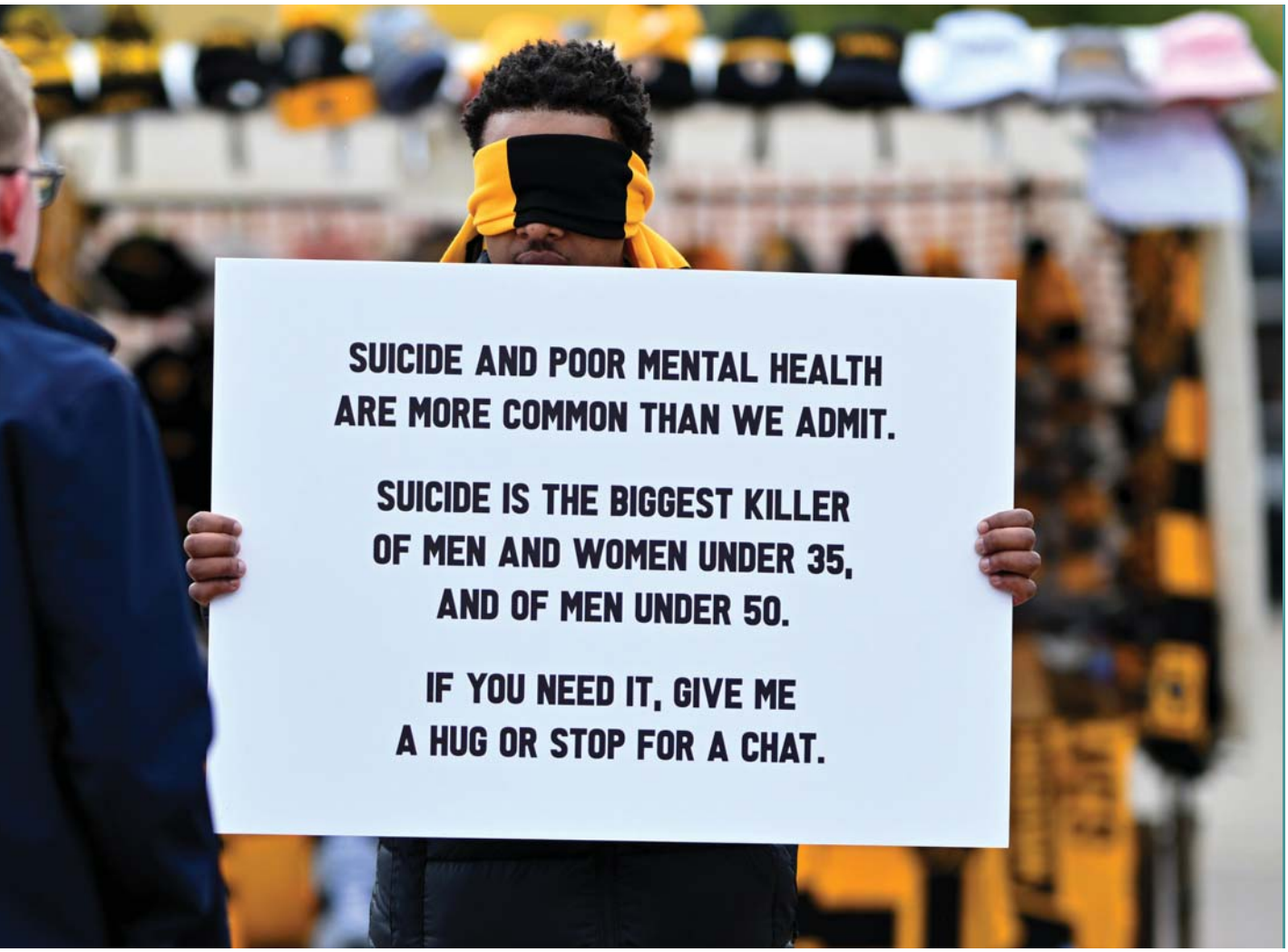
By Samir Jeraj

GETTY

Georgia-Leah was a student at drama school when she started to develop difficulties with walking. Eventually she had a seizure and fellow students dialled 999. She was diagnosed with functional neurological disorder (FND), where there are problems with how the brain receives and sends information to the rest of the body.

Georgia-Leah’s past experiences of poor healthcare for a previous mental health condition meant she was wary of services, and of asserting her rights. “I didn’t like the way they spoke to me [in mental health services]. I didn’t feel treated well,” she said. Nor did she feel she had any choice, information about her treatment, or that staff had time to spend with her. “It didn’t feel like I was being respected,” she said.

It took a long time, and at several points clinicians attempted to shunt



Discussion of mental health has become normal, but services have yet to catch up with demand

her back into mental health services (despite the fact she had long since been discharged from mental health services), but Georgia-Leah found good healthcare for her FND.

The promise of "parity of esteem" for mental health has its origins in the first year of the Conservative-Lib Dem coalition government when then deputy prime minister Nick Clegg announced £400m to back up the recommendations of a strategy called No Health Without Mental Health.

It was a bold commitment, to equalise the service provided to the nearly one in four people who would experience a mental health condition during their lifetime. However, it wasn't part of either party's 2010 manifesto or in the coalition agreement, which mentioned mental health once and only in relation to veterans. It was, according to those involved in mental health policy at the time, the initiative of Paul Burstow, the Lib Dem MP serving as minister of state for health and social care.

The idea was also a powerful one and reflected the shift in public attitudes towards mental health. By 2012, parity of esteem would be the law, set out in the 2012 Health and Social Care Act and then in the 2013 NHS Constitution. A target of 2020 was set with a plan to deliver equality of access, but the target of parity was still far off, with the BMA calling for a doubling of funding in a report published the year it was meant to be achieved, noting: "Mental health services remain a long way behind most physical health services in terms of their resourcing, patients' ability to access care and overall patient outcomes."

But the political commitment has persisted. Subsequent iterations of the Conservative Party have kept parity of esteem in their policy platforms, with one section of their 2015 manifesto proclaiming, "We will continue to take your mental health as seriously as your physical health", and their 2024 manifesto stating, "Mental health should have parity of esteem with physical health". Keir Starmer's Labour Party similarly promised, "we will reform the NHS to ensure we give mental health the same attention and focus as physical health".

However, reality has yet to meet the rhetoric. The National Audit Office noted in 2023 that while the mental health workforce had increased by 22 per cent since 2016, referrals to mental health services rose by 44 per cent in the same period; 1.2 million people were on waiting lists and eight million with mental health needs were not in contact with any services. ▸

◂ Planned spending on mental health services is expected to be £15.6bn in the current financial year, but the Royal College of Psychiatrists says that figure should be closer to £36bn to achieve parity of esteem and meet the needs of people with mental health conditions.

"What everyone's been talking about is the seven and a half million people on the waiting list, but that's because they're only talking about the ones with physical health problems, not the ones with mental health problems," said Dr Lade Smith CBE, president of the Royal College of Psychiatrists.

Smith argues that there is a strong economy and public finance case for parity of esteem. "Over the last two or three years, we've been putting evidence to government and to the opposition parties, etc, and everyone's starting to recognise it," she said.

Broadly, mental health conditions emerge in the earlier part of life and, with good treatment, they can be resolved and people can live long, happy and productive lives – something that both contributes to the UK economy and reduces the healthcare burden on the NHS.

However, with long waiting lists and poor access to effective therapies, the risk that these conditions become chronic "relapsing remitting" illnesses increases.

"We thought, 'OK, there's going to be at least an increase in funding or a prioritisation of mental health, particularly in children and young people.' But not only has that not happened, but there's actually been a reduction in funding," Smith said.

Last month, the government confirmed that mental health funding would fall as a proportion of overall NHS funding.

Parity of esteem also goes beyond access to services too. It means matching achieving targets for waiting times, as is done with physical health, and a right to access to treatments certified by NICE – neither of which are currently a requirement in the UK.

"We've still got a system which defaults towards physical health," said Andy Bell, CEO of the Centre for Mental Health, regardless of what government says, and partially, "regardless of what it does, the system reverts to factory settings, unless that's very actively pursued."

Politicians will have a much greater say on what the NHS funds

The abolition of NHS England, another big structural change that is meant to make services more directly accountable to politicians, and cuts to jobs across non-clinical roles, will also have an effect. For Bell, it is whether the short-term chaos and loss of experiences and expertise unleashed by these changes will mean that mental health is a priority for current and future politicians working with these new arrangements.

The Mental Health Investment Standard, which since 2015 has required mental health spending to increase as a proportion of NHS spending, "kept the wolf from the door", according to Bell.

However, at the end of 2024, there were signals that the standard would be abolished and remove the safeguard from mental health spending, prompting an intervention from the former NHS England chief executive, Simon Stevens, in the House of Lords. While the standard has been retained for now, several mental health charities have accused the government of "de-prioritising mental health".

Mental health funding will fall as a proportion of NHS funding

Bell would like to see the NHS adopt a clear and transparent system for waiting times in mental health services to help drive parity of esteem.

"Mental health waiting times continue to be relatively hidden, and that is ultimately what holds us back and disadvantages us by comparison to what happens in certainly the acute system, because we know that waiting time standards rightly or wrongly shape where funding goes," he said.

"We would like an evidence-led, clinically driven approach, because they knew that that's what works," said Smith. She believes that without specific measures to ring-fence, protect and increase funding for mental health, patients will not get timely quality services.

"If you only fund a system to 50 per cent of the need, then what happens is that either only 50 per cent of people get good standard of care, or everyone gets a less than good standard of care," she said. ●

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Advertorial

The need for greater investment in podiatric care

Prioritising recruitment into the sector has the potential to save the NHS hundreds of millions annually

In association with

ROYAL COLLEGE of PODIATRY

The NHS is undergoing a fundamental shift from a reactive, sickness-based model of care to a system rooted in prevention and early intervention. This move has been widely welcomed across the healthcare industry.

Podiatrists play a critical role in supporting people across the life cycle, from childhood all the way to geriatric care; managing complex foot and lower limb conditions across primary care, community health, acute care, social care and the independent sector.

They help reduce hospital admissions, facilitate early discharge, prevent amputations and promote long-term health and mobility. As the demands on the healthcare system continue to rise, investment in podiatry services must be recognised as a cost-effective strategy that delivers profound prevention benefits to individuals and public health as a whole.

Foot and lower limb complications, particularly those associated with diabetes, renal and vascular diseases, can lead to severe, life-altering consequences if left untreated. NHS podiatry services are instrumental in preventing unnecessary hospital admissions by facilitating early detection, diagnosis and intervention. Studies and pilots indicate that integrated podiatric care can significantly reduce the risk of admission through targeted preventative strategies, ultimately mitigating the need for more invasive, high-cost treatments such as major amputations.

And for patients with diabetes, podiatry is particularly crucial. Diabetic foot complications, including foot ulceration and infection, are a leading cause of hospital admissions in the UK. It is estimated that more than 7,000 diabetes-related amputations, and similar numbers of non-diabetes-related limb amputations, occur annually in England alone due to foot ulceration, many of which could have been prevented with timely podiatric interventions.

The financial and human cost of such complications is immense, costing the NHS an estimated £1bn in England alone. Preventative podiatry services have been proven to reduce these outcomes, demonstrating their

immense value to the health service and society at large.

Of the 5.8 million people estimated to be living with diabetes in the UK, 1.2 million of those will require regular podiatry appointments. Investment in early detection and preventative care is more critical than ever. The National Diabetes Footcare Audit has demonstrated that podiatric interventions can cut major amputation rates by 50 per cent in pilot regions, underscoring the importance of timely access to foot health services. In diabetes care, estimates suggest that proactive podiatry services could prevent up to 80 per cent of amputations. Given the high cost of managing foot complications in diabetes patients, scaling up podiatry services represents a prudent financial investment.

We need an adequate workforce to meet the demand. The NHS faces a worrying decline in the number of trained podiatrists and commissioned podiatry posts. There has been a 10 per cent drop approximately over the past decade, and the number of newly qualified clinicians entering the field is declining. Without urgent intervention, access to foot health services may become increasingly restricted, jeopardising the NHS's ability to provide essential preventative care.

The role of podiatrists extends beyond acute interventions. They provide support to patients with long-term conditions, particularly among elderly populations where mobility restrictions can lead to social isolation, increased reliance on care services, and diminished quality of life. Foot pain and gait dysfunction are among the leading causes of falls in older adults, contributing to hospital admissions and longer-term care requirements. By keeping patients mobile and independent, NHS podiatry services play a critical role in alleviating the burden on community care resources.

Prevention is not only beneficial for patient outcomes but also represents significant cost savings for the NHS. Beyond the health benefits, investing in NHS podiatry services makes sound economic sense. Preventative foot care reduces the need for expensive hospital admissions, emergency treatments and long-term disability support. For every £1 spent on preventative foot care, the NHS could save several times that amount in avoided costs related to hospitalisation, surgeries and ongoing care needs. If NHS services were to reduce the prevalence of diabetic foot ulcers in England by one third, the gross annual saving could be more than £250m.

A national podiatry workforce strategy is urgently needed to address this shortfall. This would drive sustainable workforce planning, allocate funding for training and development, and promote collaboration with non-NHS sectors. A substantial section of the podiatry workforce provide services in the independent sector, working in collaboration with NHS services, thereby relieving pressure on the NHS.

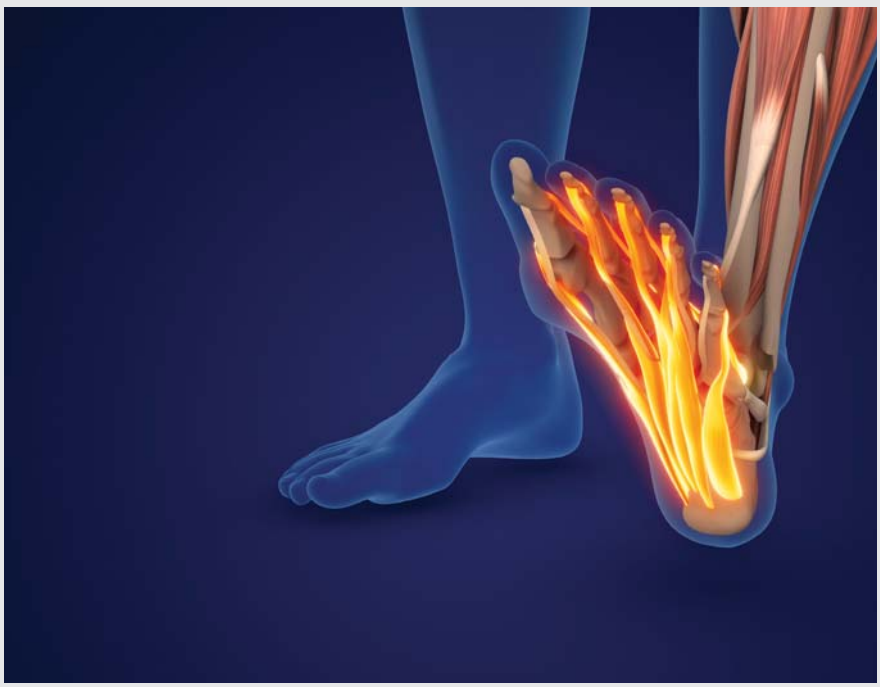
By investing in the long-term structure of the podiatry workforce, the NHS can safeguard the availability of these vital services and continue to deliver high-quality, preventative foot care to those who need it most.

The professional body and trade union for podiatrists in the UK, the Royal College of Podiatry, is working hard to increase recruitment into the profession. CEO Jane Pritchard said: "It is imperative that there is a fully functioning podiatry workforce across all areas of the NHS and the independent sector in the UK to ensure the health benefits of mobility and prevention can be realised. We want to work with government to realise this goal for the benefit of a healthy, fully functioning society."

As the NHS shifts towards a prevention-first approach to healthcare, the importance of podiatry becomes increasingly clear. Podiatrists play a crucial role in preventing hospital admissions, reducing the risk of amputations and preserving mobility and independence, particularly among elderly populations, making them vital to improving public health outcomes. Keeping people of all ages healthy and mobile will go a long way in helping manage the cost, both in terms of the cost to the health service and the personal toll.

These are health priorities the government has outlined, and by prioritising podiatric care and educating the workforce to meet the growing need, we can build a healthier, more resilient healthcare system for the future – one that prevents illness rather than simply treating it. ●

For more information, visit www.rcpod.org.uk



ROYAL COLLEGE OF PODIATRY

Left untreated, foot complications can lead to life-altering consequences

Opinion

British psychiatry is on the brink

Underfunded and with bad incentive structures, the industry needs rescuing

By Penelope Campling

Too much energy within mental health services is focused on keeping people out of the system: devising exclusion criteria to restrict access; limiting clinical engagement by restricting the length of sessions and duration of contact; and endlessly driving bed numbers down. These are simplistic "solutions" to a basic mathematical problem: the amount of need vastly outweighs what the service is equipped to provide. The effects – forcing patients to get worse before they can access the basic care they need – are perverse, and the system is both inefficient and inhumane.

And what does it do to psychiatrists themselves? Rejection and neglect have become part of everyday work, fostering an attitude of self-protectiveness in staff. Many struggle with the moral distress involved: the gulf between what is good professional practice – therapeutic interventions they know would be helpful – and what they can actually offer their severely distressed, high-risk patients.

The burden for some is overwhelming; they fall ill themselves. Others resign. But there are some who are so used to letting people down in this callous system that they hardly notice the impact any more.

When I became a consultant in the early 1990s, at the heart of the service were highly skilled, multidisciplinary community-based teams, within easy reach of our patients and well known to the local GPs.

Relentless rounds of cost savings have meant that many such teams are now based in soulless office blocks miles away from where those who need them live. Waiting times are longer, bureaucratic demands have increased workloads, while time allocated for seeing patients is increasingly squeezed. Fragmented care is the norm, and the task psychiatrists are expected to address has become frustratingly narrow.

For example, if you decide your patient needs hospitalisation for their safety, the decision is passed on to another team. Admission is often refused by the hospital's "bed bureau". And at the end of their stay, most inpatients find themselves referred to a different consultant and team altogether.

The pressure on outpatient

The burden on psychiatry professionals can be distressing and, in many cases, overwhelming

psychiatrists is to diagnose and prescribe and get that done quickly – sometimes within half an hour. Yet we know that what many severely ill patients really need is a long-term therapeutic relationship. Psychiatrists are encouraged to ignore what was learned in training, and are increasingly put in impossible positions, no longer able to offer safe or dignified care.

Although psychiatrists are given responsibility, held to account and blamed when things go wrong, most would say they feel marginalised and lack the power to improve the system. This isn't the case everywhere, but exemplary practice is rare, and even "good enough" practice is not widespread.

Some of my most talented trainees, along with many others, have already left the profession, worn out with fighting a losing battle to maintain standards. The appointment of locums has escalated, in what has become a vicious circle of shortsightedness, mismanagement and denial. Many of these doctors are recruited from overseas; some work exclusively online, a small number never setting foot in the UK.

Imagine struggling with severe mental health problems and, after nine months on a waiting list, receiving a Teams link – your long-awaited "help" consisting of no more than talking to an overseas psychiatrist with little knowledge of the NHS.

Some locums are well qualified, choosing the work because the money is better and the responsibility less. But there are many with questionable skills and incomplete training. Such a situation would certainly not be tolerated elsewhere in medicine.

Who is going to lead us out of this mess? In my nearly 40 years of membership, the Royal College of Psychiatrists has never seemed so remote and out of touch with the day-to-day experience of psychiatrists or the patients they serve.

True, it has worked hard to support its overseas membership, and has had a lot to say on topics such as racism and LGBT issues. It produces clinical guidelines and has helplines that offer advice. But its tone sounds to me self-congratulatory and complacent, cautious and over-concerned with its reputation.

It is no longer confidently fulfilling its important role of giving a voice to psychiatry within medicine and the NHS, and for the wider public. There is a disconnect between the exacting academic (and extremely expensive) hoops psychiatrists are put through to become members and the reality of psychiatric practice throughout much of the UK.

A tangle of forces has taken hold and threatens to undermine our therapeutic connection with patients. The Royal College can't change things on its own. But it needs to challenge the perverse incentives within the system that are eroding the essence of what it is to be a psychiatrist.

If it doesn't, I fear psychiatry is in danger of becoming a warped – and much diminished – version of itself. ●

Penelope Campling is a fellow of the Royal College of Psychiatrists, and author of "On the Brink: Stories of Harm and Healing from a Lifetime in Psychiatry"

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