

NO WRONG DOOR? A REVIEW

PROGRESS TOWARDS THE VISION FOR MENTAL HEALTH, AUTISM AND LEARNING DISABILITY SERVICES IN 2032



INTRODUCTION

What do we want mental health, autism and learning disability services for people of all ages to be like in ten years' time? That was the question we asked people who use, work in, and support mental health, autism and learning disability services in England in 2022, resulting in our report with NHS Alliance, *No Wrong Door*, a vision for these vital services in 2032 (Pollard and Bell, 2022). It identified ten ways in which they could develop in a decade's time, each based on evidence of what people want and need from mental health, autism and learning disability services, and all, in our view, achievable with the necessary resources and commitment.

We're getting close to halfway to 2032, and now (Autumn 2026) we have the promise of a new cross-government mental health strategy for England, a prospective update to the Government's autism strategy, and 'modern service frameworks' in preparation for children's health and for severe mental illness. We also have a new ten-year NHS plan that sets the overall direction of health care policy and delivery (DHSC, 2025). So, this is a good time to take stock of progress in the evolution of mental health, autism and learning disability services in England and how far they have moved towards the ten elements of the vision we presented.

This review paints a mixed picture. There are some signs of progress towards the vision, and hope that this will be sustained long term so that the ideas are realised in practice. But there are also worrying signs that the vision will remain just that without the necessary investment and level of ambition for the nation's mental health services.



In 2032, our vision is that mental health, autism and learning disability services will look very different in ten key ways:

1

There will be a greater focus on preventing mental health difficulties.

2

Services won't wait until someone is in crisis to offer help. Early intervention will be the norm.

3

From pharmacies and GPs to schools and social services, there will be no wrong door for anyone seeking support.

4

Services will see the bigger picture in people's lives. They'll help people with money, work and housing when it's needed.

5

Services will treat you as a whole person and support your physical health, mental health and social needs together.

6

Services will proactively address structural inequalities and injustices.

7

People will be reaping the benefits of a major investment in community mental health support.

8

Coproduction as an equal partnership will be the norm in the design, development and delivery of services.

9

We will have a stronger, thriving workforce.

10

Services will focus on the outcomes that matter to the people that use them.

1. THERE WILL BE A GREATER FOCUS ON PREVENTING MENTAL HEALTH DIFFICULTIES

The aim of this element was to ensure mental health services connect with other organisations locally to do more to promote and protect population mental health. There is scant evidence of this happening at scale across the country. Mental health service providers are under exceptional pressure from rising demand across all areas, including autism, ADHD and mental health care (Fonagy *et al.*, 2026). This limits their capacity to shift left towards prevention; in many cases, it leads to a very different shift towards 'demand management' and crisis responses.

Placing a greater emphasis on prevention was one of the four core objectives of integrated care systems. While sustained financial challenges, and pressures to focus on short-term national targets have often limited the ability of ICBs to invest consistently in prevention, there is evidence that some ICBs have taken action to try to prevent mental health problems (Mental Health Foundation, no date).

Although reductions in ICB staffing, and ongoing financial challenges mean that it continues to be hard for ICBs to take a long-term preventative approach, there are opportunities to embed upstream prevention through the shift towards strategic commissioning, as is stipulated in guidance from NHS England (2025b).

The emergence of more mayoral strategic authorities, and the potential for ICBs to become more coterminous with them, may create the conditions for greater collaboration around population health and wellbeing over time.

Until recently, national government has done little to prevent mental health difficulties. There has been no formal process or strategy to guide government decisions with public mental health in mind. But this is showing signs of significant change. The independent prevalence review has demonstrated beyond doubt in its report that there is a need for more action to prevent mental ill health and to improve support for neurodivergence (Fonagy *et al.*, 2026). With the promise of a cross-government mental health strategy, there is now an opportunity to embed prevention at the heart of government, embracing a 'mental health in all policies' approach and taking active steps to protect and promote the nation's mental health (Davie, 2023).

National leadership on public mental health can support regional and local action – creating an authorising environment and positive encouragement for strategic and local authorities to focus on, and invest wisely in, mental wellbeing.

2. EARLY INTERVENTION WILL BE THE NORM

This element aimed to shift the NHS from intervening late (often in a crisis) to offering earlier help when someone first seeks support for their mental health or neurodivergence.

There is some evidence of this happening in practice, for example in the expansion of school Mental Health Support Teams (which are planned to cover 100% of schools and colleges in England by 2029). The Government's pledge of a national network of early support mental health hubs for young people has similar potential, but progress has been slow since 2024.

As noted above, in practice many mental health services are shifting away from early intervention due to rising demand, working within resource constraints that make it necessary to raise thresholds or extend waiting times. The absence of national access and waiting time standards for most mental health services means there is inadequate accountability for reducing long waits and improving access to support. This leaves many people waiting many months, and for some children over two years, for an essential service.

Long waits for mental health support, or for an autism or ADHD assessment, are distressing in themselves but can also lead to an escalation of a person's needs while they are waiting.

A shift towards earlier intervention is still, however, possible. Investment in earlier help, drawing on effective models – embedded in communities, and harnessing digital technology safely and effectively – can facilitate this shift over the next ten years. For example, the Future Minds campaign roadmap (2026) describes how a systemic approach to children and young people's mental health support could enable a shift over the next decade towards earlier intervention.

3. THERE WILL BE NO WRONG DOOR FOR ACCESSING MENTAL HEALTH SUPPORT

This element aimed to ensure that anyone needing support for their mental health or neurodevelopmental needs would be directed to the right help, regardless of where they got in contact with the system.

Mental health service providers are seeking ways to achieve this, and increasingly operate, or are at least working towards, a 'no wrong door' policy. Some are instituting 'single points of access' to simplify routes to get mental health support.

The national programme to establish a network of community mental health centres is a significant example of this idea in practice – providing open access to support in an accessible location at a 'neighbourhood' level. The first six sites are now in operation and are being evaluated. The Government is providing capital funding to expand these to around 100 in England over the next three years (DHSC, 2026a). It is unclear what revenue funding will be available to provide for the staffing and day-to-day operation of these centres, but they have the potential to facilitate easier and quicker access to community mental health support.

Too often, however, we still hear about people finding access to mental health services difficult. This is especially the case for people with co-occurring needs – for example those who also have difficulties with alcohol or substance use (Abdinasir *et al.*, 2025), or who are neurodivergent, who have long-term physical conditions, or who are homeless. This compounds the health inequalities that already affect the most excluded groups of people most acutely.

There are particular concerns about access to support for autism and ADHD, with long waits for both children and adults seeking assessment or treatment. NHS England commissioned a rapid review of ADHD services which resulted in a series of reports from the independent ADHD Taskforce in 2025 exploring how to speed up diagnosis and improve support (NHS England, 2025a). It is unclear how, and how far, this is being implemented in practice.

Access to care in a mental health crisis continues to be a major concern. Long waits in emergency departments disproportionately affect people needing urgent mental health care. The 'Right Care, Right Person' initiative has seen police forces withdraw from some situations where urgent help is required, with no national investment in health or social care support to fill the gap. One of the Government's responses to this situation is to roll out and provide capital funding for mental health emergency departments, to sit alongside half of England's major emergency departments over the next three years. This is an untested model, and it is unclear how far it will address the weaknesses in urgent mental health care.

4. SERVICES WILL SEE THE BIGGER PICTURE IN PEOPLE'S LIVES

For many people with mental health difficulties or who are neurodivergent, issues with money, school, work and housing are significant causes of distress. This element aims to ensure people get help with these throughout their contact with mental health, autism and learning disability services.

There has been significant progress in the expansion of Individual Placement and Support (IPS) employment services in the NHS, and increasingly in drug and alcohol services, too. Every year, more people benefit from IPS services, and there are plans for this growth to continue over the next three years at least.

Support with money and housing needs is more sporadic. Evidence suggests that people experiencing homelessness are not able to access effective support to meet their mental health needs (Bell and Boobis, 2024). In some places, welfare advice and help with housing rights are embedded in mental health services (Nava-Ruelas, 2026; Bell, 2024). But this is not universally the case, and that means people are struggling with their mental health, facing more and longer hospital admissions, and are at greater risk of homelessness and destitution, for lack of expert support with matters such as debts, rent arrears, and benefit payments.

People with mental health difficulties still face a disproportionate risk of poverty, marginalisation and discrimination in everyday life. Half of those with a severe mental illness face food poverty (Smith *et al.*, 2024). Mental health services have a long way to go to address these issues meaningfully. Yet the interventions necessary are often very low cost compared with the consequences of these needs being neglected (Centre for Mental Health, 2023).

5. SERVICES WILL TREAT YOU AS A WHOLE PERSON

This element aims to ensure people receiving mental health treatment are given choices about the care they are offered, and get good physical health support. Life expectancy for someone with a mental illness is still 15-20 years shorter than it should be.

There has been some progress in the provision of annual, six-point health checks for people on GP severe mental illness (SMI) registers. In 2024, almost 60% of eligible patients received the full health check (NHS England, 2024). But while this remains on the GP quality and outcomes framework (QOF), it was omitted from the latest planning guidance for the NHS, is no longer subject to as robust data collection, and risks becoming a lower priority.

Wider support with physical health is more patchy. Some efforts have been made to extend smoking cessation services to people in both inpatient and, to a lesser extent, community mental health services. But, despite landmark smokefree legislation being passed in 2026, there is no systematic approach to supporting people with a mental illness to reduce or quit smoking (ASH, nd).

Through Equally Well UK, we are helping mental health services nationwide to improve physical health support for people with a mental illness and sharing evidence and good practice. We know, though, that to really shift the dial there needs to be more emphasis from government to mandate further action and resources for health and care services to meet people's needs more effectively.

The ten-year health plan (DHSC, 2025) makes neighbourhood health care the centrepiece of its vision for delivery of NHS services over the next decade. It is unclear how far the integrated neighbourhood teams being developed now will have a focus on mental health, but they have the potential to enable a greater join up with other health services if they pursue this ambition.

6. SERVICES WILL PROACTIVELY ADDRESS STRUCTURAL INEQUALITIES

This element focuses on how mental health services take assertive action to tackle inequalities systematically.

Racial inequality and inequity in mental health is stark. Racism is toxic to mental health, and recent years have seen a rise in the level of explicit racism in society. The traumatic nature of these experiences is sometimes mirrored in mental health services, including in use of the Mental Health Act, and levels of coercion and restrictive practice in inpatient services (Hassan *et al.*, 2026).

The Patient and Carer Race Equality Framework (PCREF) is a national initiative to address this – bringing for the first time an anti-racism framework for systemic change to all NHS mental health services (NHS England, n.d.). It has the potential to achieve tangible and lasting change, but only if it is embraced fully, used to bring about real and system-wide changes in service provision, and sustained for as long as it is needed.

There has been less progress in some other areas of inequality in mental health and inequity in mental health care. Access to mental health support in later life is still often poor, and mental distress among older people continues to be normalised and neglected (Iskander-Reynolds, 2024). A lack of adjustment to neurodivergence means children and young people miss out on vital mental health support (Higgins and Woodhead, 2026). And the recent Supreme Court Judgement and EHRC Code of Practice on the definition of sex in the Equality Act threatens to make it harder to provide equitable mental health support to trans and non-binary people, especially in inpatient settings (Centre for Mental Health, 2026). While mental health service providers are more aware of structural inequalities and their impacts, there is less evidence of a proactive approach being taken to dismantle them at the necessary scale.

7. A MAJOR INVESTMENT IN COMMUNITY SUPPORT

Moving health services ‘from hospital to community’ is one of the Government’s ‘three shifts’ for the NHS. Mental health care is provided predominantly in community settings, but half of secondary care NHS mental health spending is on hospital-based services (NAO, 2023).

Over the last five years, under the 2019 NHS Long Term Plan, significant investment was made in adult community mental health services ‘transformation’. This has enabled community mental health services to reach record numbers of people at a time of rapidly rising demand (NAO, 2023). It has also given rise to some local innovation, for example to invest in primary care mental health services, or to create alliance contracts with voluntary and community sector organisations. While this has increased capacity within the system, more evidence is needed to understand whether and in what ways services have been transformed through this programme, or what impact it has had on people’s experiences of mental health support.

With a new Mental Health Act now in statute, investment in community support is vital for legal changes to be enacted, especially for autistic people and people with learning disabilities who do not have a mental illness but who are (or might be) detained in hospitals for long periods under the Act.

In June 2026, 2,150 people with a learning disability and autistic people were in a mental health hospital, of whom 1,025 had been there for over two years and 320 had been in hospital for more than a decade (NHS England, 2026a). Achieving the shift 'from hospital to community' for this group of people must be a priority for the Department of Health and Social Care, the NHS, and local government over the next five years.

There is a pressing need to invest in community services to enable the next shift in the balance of care from hospital to home. A key area of focus is housing. A lack of accommodation is one of the biggest reasons for delayed discharges from hospital (NHS England Digital, 2025). Improving supported housing and social care provision is essential to achieve a balance that works better for people using services, while ensuring there is always local inpatient provision when it's needed, averting the need for high-cost out of area admissions to hospital.

8. COPRODUCTION WILL BE THE NORM IN SERVICES

Coproducing the design, development and delivery of mental health services makes them better able to meet people's needs. There are examples from across the country of where coproduction has been beneficial, from the design of new facilities to the development of user- and community-led services, peer support workers, and the continued value of Recovery Colleges. There is also now strong evidence for the value of Open Dialogue, an approach to mental health care that works systemically with people, their families and social networks to design support around their needs, which is being trialled in six sites across England (UCL, n.d.).

This is a significant shift in practice, but it is still limited in scale and often conditional. Coproduction is rarely built into services' governance and power structures. There are exceptions – for example where organisations have leadership roles for experiential practice (Gilbert, 2022) or build sustainable partnerships with community organisations rather than only offering small-scale, short-term funding. Too often still, community organisations are subject to short-term contracts and uncertainty about the long-term future, which means services are hard to sustain.

9. A STRONGER, THRIVING WORKFORCE

The NHS mental health services workforce has grown substantially since 2016 (prior to which it had been in decline during years of austerity). Between September 2019 and March 2023, the mental health and learning disabilities workforce in England grew from 111,791 full-time equivalent clinical and support staff to 138,479 (NHS England, 2026c). More recently, the rate of growth has slowed, reaching the Government's target for this Parliament of 8,500 extra staff within two years (DHSC, 2026b), but with no clear plan to expand any further.

Without (at the time of writing) a long-term plan for the mental health workforce, or an ambition to expand capacity beyond the current level, there is a significant risk that services will continue to struggle to meet demand.

The health and wellbeing of the mental health, learning disability and neurodivergence services workforce remains a major concern. Efforts to address NHS staff wellbeing during the pandemic were reduced or stood down after the immediate crisis, despite evidence of longer term impacts from the traumatic experiences many had at that time. For mental health workers outside the public sector, for example in charities and private providers, wellbeing support is dependent on the resources and priority it's afforded by their employer.

Longer term workforce planning could explore ways to meet the population's mental health needs in the future. With an ageing population (and workforce) this could mean exploring new career pathways for older workers, new opportunities for people from diverse backgrounds to join the workforce, and what skills are required to support people's mental and physical health most effectively (Bell, 2026).

Alongside the workforce, investment in mental health services is also a critical ingredient for achieving the changes set out in No wrong door. It cannot be done without the necessary revenue and capital funding to enable improvement and modernisation. The Mental Health Investment Standard has, for almost a decade, protected NHS mental health budgets from being cut back locally, but it has recently been watered down, presenting a risk that future commissioning of mental health care will not keep up with current spending, let alone what is really needed to build better services for the future.

10. OUTCOMES THAT MATTER

The aim of this element is to ensure that mental health and neurodivergence services are held to account for achieving the outcomes that matter to the people they serve. This requires agreement about the outcomes people want, and regular, transparent data being available to measure them – including across groups of people to identify any inequities that need to be addressed. This, for example, is a critical part of the Patient and Carer Race Equality Framework (PCREF).

While NHS Talking Therapies has routinely used outcome data since its inception, and been held accountable for reaching agreed standards (albeit only for those who complete the course of treatment), other NHS mental health services do not. Outcome measures that reflect what's important to people using mental health, autism and learning disability services, and for which reliable data can be collected, have so far been elusive. In their absence from official data, it is difficult both to hold service providers or commissioners to account, and to demonstrate where they are making a positive impact in people's lives.

The creation of the Personalised Care Framework for mental health services (NHS England, 2026b) may offer a starting point for routine outcome measurement that is coproduced with people using services and that can be used at scale to provide a regular picture of progress as well as areas for improvement.

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BRIEFING 71

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Published October 2026

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