NHS Confederation

No wrong door

A vision for mental health, autism and learning disability services in 2032

In partnership with

Centre for Mental Health

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About us

NHS Confederation

The NHS Confederation is the membership organisation that brings together, supports and speaks for the whole healthcare system in England, Wales and Northern Ireland. The members we represent employ 1.5 million staff, care for more than 1 million patients a day and control £150 billion of public expenditure. We promote collaboration and partnership working as the key to improving population health, delivering high-quality care and reducing health inequalities.

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Centre for Mental Health

Centre for Mental Health is an independent, not for profit organisation. We are dedicated to eradicating mental health inequalities and fighting injustice by changing policy and practice.

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Key points

- Mental health, autism and learning disability services need to change. This report sets out a vision for what these services should look like in ten years' time, for people of all ages in England.

- Commissioned by the NHS Confederation and written by Centre for Mental Health, the report brings together research and engagement with a wide range of stakeholders, as well as people who bring personal and professional experience about what these vital services should be like in 2032.

- It identifies ten interconnecting themes that underpin the vision and three key requirements that would turn the vision into reality.

- While there have been many vision statements for mental health, autism and learning disability services over the years, few are ever realised in practice. This report explores what might help and what could hinder the vision, calling for action on funding, workforce and reform to enable faster access to care.

- As the case studies featured in this report show, every element of the vision is already a reality somewhere in England. The ambition is to see it realised everywhere.

- By making the changes outlined here and investing in the vision, people's lives can be improved.

Summary

Mental health, autism and learning disability services need to change. In ten years' time, our vision is that these services will look very different in the following ways:

1. **Prevention.** In 2032, greater effort will be made to protect and promote our mental health throughout every stage of life and to ensure autistic people and people with learning disabilities are properly supported to have fulfilling and independent lives. Locally and nationally, government and public services will take a systematic 'population health' approach to reducing the social and economic risk factors for poor mental health and boosting protective factors in individuals, families and communities.

2. **Early intervention.** In 2032, services will not wait until someone is in crisis to offer help. Instead, early intervention will be the norm, with support front-loaded at an early stage to prevent more serious difficulties developing later on. Services will meet people where they are at, including online, at school, and in community spaces where they feel comfortable.

3. **Access to quality, compassionate care.** In 2032, there will be no wrong door for anyone seeking support for mental health, autism and learning disability needs. People will be able to present at any point in the system – from pharmacies, advisory services and community groups to education, social services, the criminal justice system and primary care – and get the right support.

4. **Seeing the bigger picture.** In 2032, mental health, autism and learning disability services will see the big picture as they support people to live their lives. People will get support with what matters most to them and services will help people with money, work and housing – with a package of support that is not limited to 'healthcare' per se.

5. **Whole-person care.** In 2032, services will support people with their physical and mental health and social needs together. Services will treat people as a whole person, being mindful and respectful of their needs, assets, wishes and goals.

6. **Equality focus.** In 2032, mental health, autism and learning disability services will be proactive in addressing structural inequalities and injustices. They will understand and challenge the intersecting inequalities that underpin the unequal risks of poor wellbeing and the subsequent inequities in access to support, experiences of services, and outcomes achieved.

7. **Co-production.** By 2032, there will have been a shift in the power imbalance between people who use mental health, autism and learning disability services and the organisations that provide them. Coproduction as an equal partnership will be the norm in the design, development and delivery of services.

8. **Autonomy, human rights and community support.** In 2032, service users will be reaping the benefits of a major investment in community support. As changes to the Mental Health Act will have channelled investment away from institutional and inpatient services, comprehensive support in the community will have risen up to meet people's needs.

9. **A stronger workforce.** In 2032, there is a thriving workforce of clinicians, mental health professionals, allied professions, multi-disciplinary teams and diverse experts. Resources have been put in place to buy enough of people's time and recruit those with the requisite skill levels. Coherent workforce planning has secured this capacity for the long term.

10. **Outcomes that matter.** In 2032, services at all levels will be holding the outcomes that matter to service users as their lodestar. They will be able to measure these outcomes and be held to account for them. The system will no longer be driven by the outputs that matter to institutions, but by the outcomes that matter to people.

There are three key requirements for this vision to become a reality:

1. **Sustained and sufficient investment** to expand services and meet increased needs, but also to have the stability to innovate and transform what they offer, rather than having to respond to crisis levels of demand and acuity, and to replace outdated facilities.

2. **Effective long-term workforce development and planning**, both to ensure that enough people are working in mental health, autism and learning disability services and to diversify the workforce and locate support where it is most needed.

3. **A deep commitment to large-scale reform, innovation and change**, starting with reform of the Mental Health Act and transforming the nature of what is offered so that people get access to services they trust, that meet their needs and that treat them equitably.

Introduction

> "There's never been a more important time to talk about our future vision for mental health, learning disability and autism services.
>
> The issues affect people from all walks of life, all ethnicities, and all backgrounds. We need to stop people 'falling through the gaps' and always see the whole person."
>
> Evelyn Asante-Mensah OBE, Chair, Pennine Care NHS Foundation Trust

Centre for Mental Health was commissioned by the NHS Confederation in early 2022 to identify a vision for mental health, autism and learning disability services in ten years' time, for people of all ages in England. We did this through research and consultation with a wide range of stakeholders, reading and hearing about people's hopes and beliefs about what these vital services should be like in a decade's time. We spoke with people who could bring personal and professional experience to the topic. More details about our approach are provided in the appendix.

This report sets out the results of that work. We have brought together the ideas and priorities of the people we spoke to and the documents we reviewed under ten themes. In combination, these ten interconnecting themes comprise the key elements of the shared vision for mental health, autism and learning disability services in ten years' time.

For too long, services for autistic people and people with learning disabilities have held a 'Cinderella' status, not receiving the attention they need and deserve. The ten themes of this vision are

as central to these services as they are for mental health ones. We recognise that services for autistic people and people with learning disabilities have distinctive priorities and ways of working, and we have sought throughout this report to reflect these and highlight specific priorities where necessary.

There have been many vision statements for mental health, autism and learning disability services over the years. Few are ever realised in practice. So we have also explored what might help and what could hinder the vision being realised within a decade. The vision we set out will only be achievable if there is investment in services and the people who work in them, and a willingness to change – and change radically – over the next ten years. And the vision is not just wishful thinking; the report also includes case studies demonstrating that every element of the vision is already a reality somewhere in England.

The scope of this project was to focus on publicly funded mental health, autism and learning disability services for people of all ages in England. We know that the lives of people using these essential health and social services are influenced by wider policies, structures and processes in society. While these are outside the scope of this report, we acknowledge the important role of services in preventing, mitigating and reversing discrimination, exclusion and disadvantage throughout.

> "Social factors continue to undermine our collective ability to find solutions to the issues we face.
>
> As we seek to build a mental health system fit for the future, we need to ensure that there is an all-encompassing adoption of an equity lens and a shift of resources towards those who experience discrimination and inequality."
>
> Peter Molyneux, Chair, Sussex Partnership NHS Foundation Trust

Why mental health, autism and learning disability services have to change

£119 billion

was the **economic and social cost of mental health problems** in 2019/20, and this is set to grow in the next decade.[1]

About

10 million

more people, 1.5 million of them under 18, **will need extra support** for their mental health because of COVID-19.[2]

Only

1/4 to 1/3

of people with a **mental health difficulty receive treatment** for it.[3]

4x

as many black people than white people in England are **likely to be sectioned under the Mental Health Act** and ten times more at risk of getting a community treatment order.[4]

More than

75 per cent

of **autistic people sought support for their mental health** in the last five years.[5]

1 in 6

children had a mental health difficulty compared with 1 in 10 in 2004 and 1 in 9 in 2017.[10]

Higher rates

of most common **mental health difficulties are in women and girls** than men and boys.[6]

3x

more likely to find a **mental health difficulty in children with a learning disability**.[9]

More than

2,000

autistic people and people with a learning disability are in a mental health hospital, the vast majority under the Mental Health Act.[7]

An average of

15-20 years

shorter life expectancy in people with learning disabilities and people with long-term mental health problems compared with the general population.[8]

NHS Confederation

Centre for Mental Health

References: www.nhsconfed.org/articles/reference-list

The ten key elements of the vision

1. Prevention

In 2032, greater effort will be made to protect and promote positive mental health throughout every stage of life and to ensure autistic people and people with learning disabilities are properly supported to have fulfilling and independent lives.

Locally and nationally, government and public services will take a systematic population health approach to reducing the social and economic risk factors for poor mental health and boosting protective factors in individuals, families and communities. With a 'mental health in all policies' approach, national government, local authorities and public services will assess the mental health impacts of their decisions and make choices that maximise protective factors and minimise risks. That may mean changing policies relating to social security, education, planning and climate resilience.

Mental health, autism and learning disability services have an important part to play in building a system that prevents distress and exclusion and that maximises people's chances of having good mental health and fulfilling lives.

Like all statutory health and care services, mental health, autism and learning disability services have the potential to be anchor organisations in their communities: paying all of their staff and contractors at least the Real Living Wage, using their buying power to support local businesses, and creating opportunities to

employ people from the communities they serve. In 2032, this will be the norm in all areas. And through integrated care systems, this approach will extend to the other public services they work alongside.[1]

Early years services, schools, colleges, universities and businesses will seek to promote wellbeing and inclusion among the people who work and learn there. In education settings, infants, children, young people, families and staff will become mental health literate and neurodiverse learners will receive appropriate support for their mental health. Employers will seek to create mentally healthy and inclusive workplaces, adopting agreed standards to ensure they promote and protect mental health, such as those set out by the Greater Manchester Good Employment Charter.[2] Businesses will make reasonable adjustments to ensure they treat customers with mental health difficulties or who are neurodiverse equally.

Specific support will be provided to families with very young children, employing proven early years interventions to give every child the best possible start in life. This will include support for maternal and parental mental health, offered routinely and proactively by midwives, GPs and health visitors, with speedy access to psychological support when it's needed.[3]

2. Early intervention

In 2032, health and social services won't wait till someone is in crisis to offer help. Rather than designing eligibility criteria to gatekeep people out of services, there will be an offer for every level of need. Support will be front-loaded at an early stage to prevent more serious difficulties developing later on.

Health and social services will meet people where they are at – in the spaces they are already in and where they feel comfortable, which for some people will include digital media. This means working more effectively in the community and with voluntary,

community and social enterprise (VCSE) organisations, schools and non-healthcare providers, ensuring that both online and face-to-face options are available so people can access the support they need without delay and no one misses out because of digital exclusion.

Agencies across the system will coordinate their data systems, using monitoring information to identify individuals and communities who are at heightened risk. Proactive support will be offered to those who are facing higher risk factors and services will be developed with their needs in mind.[4] This will ensure that people don't have to reach crisis point in order to get help. Family hubs, school-based mental health support teams and Youth Advice, Information and Counselling Services (YIACS) for example will be available nationwide so that infants, children and young people get timely access to help without the need for a formal referral to a clinical service.

> "We envision a mental health system that never turns us away for being 'too ill' or 'not sick enough' to access services."[5]

Diagnostic assessments for autism and learning disabilities will happen earlier. Sufficient resources will be available to community services for autistic people and people with learning disabilities so that waiting lists are significantly reduced and families are not forced to battle for help. Professionals across the health, social care and education systems will recognise that autistic children and children with learning disabilities face a high risk of mental health problems, and young people and their carers will be given strategies to protect their wellbeing before difficulties arise.

> "In ten years' time, I hope I wouldn't have to choose between waiting for years and paying thousands of pounds to get an assessment for my autistic son. Having an early diagnosis is crucial for unlocking the support he needs."
>
> Mother of an autistic child

Children and young people with more complex needs will have a keyworker whose role will be to coordinate care across agencies and to change systems of support more widely so that earlier help is the norm, not the exception, and the future risk of needing institutional care is averted as much as possible.[6]

Early intervention will ensure that people with severe, enduring and chronic mental health conditions get access to help before their needs escalate to crisis point. People will not have to wait until they are 'ill enough' to access care. For example, access to eating disorder services will not be determined by arbitrary weight or BMI measures.

Access to specialist mental health services will be easier and when people first need support. The mental health clinically led review of standards[7] will be fully implemented, systems will have the resources they need to meet the standards and we will continue to develop waiting times standards for all mental health conditions.

For young people moving from child to adult services, transition planning will occur much earlier on to support a smooth transition and this will be based on individual need and choice, rather than arbitrarily by age.

Intervening early to protect the health of people with long-term mental health difficulties and people in later life will be given equal priority. Early intervention can be just as effective in later life as it can in youth, and older people will benefit from timely access to mental health support that meets their needs.

3. Access to quality, compassionate care

In 2032, there will be no wrong door for anyone wanting support for their mental health or neurodiverse needs. People will be able to present at any point in the system – from pharmacies, advisory services and community groups to education, social services, the criminal justice system and primary care – and be guided to the right support without delay.

> "In ten years' time, I hope I won't have to fight to get support. Because I can string a sentence together I'm not eligible for advocacy, but I've been without care for months now."
>
> Expert by experience

People will not have to repeat their stories again and again. Support will be available in many more places and without the need for restrictive and bureaucratic referrals, thresholds or eligibility criteria. Professionals will use assessments as an opportunity to relate to people in a human way, demonstrating a social connection to them and a commitment to their human rights.

There will be a single, trusted assessment that unlocks the right pathway for people and builds a care package around what they want and need. Up-to-date information about what support is available for a range of different needs will be readily available and proactively communicated. Inter-operable data systems with strong governance will enable people to access seamless support from different agencies.

There will be a sufficient supply of high-quality, evidence-based services, including specialist support for autism, learning disability and mental health. Reasonable adjustments will be offered proactively and made effectively without prolonged waits or

complex referral processes. People from racialised communities and others who have not always been well-served by traditional services will have access to interventions that work for them. People will not have to choose between having the wrong support or having nothing.

Digital and online options will reduce the postcode lottery of what is available, and ensure that speedy access to high-quality help is secured. In localities, commissioners will use granular multi-agency data to calibrate their offer to the needs of their local populations and ensure no group of people is left with inadequate or ineffective provision.

Across the board, quality improvement will be embraced as the norm. Rather than signalling inadequacy, a culture of reflective practice and continuous development, informed by lived experience, will be a badge of honour for every part of the workforce.

Case study: Connecting up primary and community mental health services in Sheffield

Sheffield was one of 12 national early implementer sites testing and delivering the community mental health framework in England.

Sheffield Health and Social Care NHS Trust, Primary Care Sheffield, NHS Sheffield Clinical Commissioning Group, Sheffield City Council, Sheffield Mind and Rethink Mental Illness came together, with a pooled transformation budget, to develop the primary care and mental health transformation programme.[8] Initially, the collaboration focused on the four primary care networks (PCNs), covering 30 per cent of the city where there was the highest deprivation. Rather than being referred to an anonymous clinician in secondary care and having to be

seen in a secondary care setting, people could access mental health services through their nominated GP and be linked up with support from within their local community. They worked with the voluntary sector to employ community connectors and health coaches to tackle the mental and physical health challenges for people with serious mental illness.

A series of local stakeholder and patient/public engagement events were undertaken within each PCN to identify the local community needs in relation to the mental health, physical health and social needs of each community. This resulted in a bespoke needs analysis for each PCN which was used as the basis to commission local VCSE services to provide additional support.

The collaborative used the apprentice scheme to fund ten places on a new clinical associate psychologist programme (graduate psychologists who are trained to master's level), increasing capacity to deliver psychological therapies. They also brought in specialist mental health pharmacists to support primary care and help people to manage their medication.

Working with the voluntary sector, and through a population health approach within PCNs, has enabled the project to work closer with communities and tap into unmet demand. Prior to undertaking the new model of care, the access rate for minority ethnic groups to the community mental health service single point of access was 11.6 per cent. Within the four transformed primary care networks the access rate for minority ethnic groups increased to 22 per cent.

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4. Seeing the bigger picture

In 2032, mental health, autism and learning disability services will support people to live their lives holistically, and actively tackle discrimination, exclusion and disadvantage.

> "We feel that we should be treated as individuals and offered support that reflects the contextual factors which affect our mental health. These factors include financial concerns, bullying, peer pressure, racism, educational struggles, identity, sexuality, relationships, social media, social pressures and body image."[9]

While high-quality clinical care and support is vital, services and the bodies that commission them will understand that people live in an economic and social context that is fundamental to their wellbeing: that our 'ecosystems' are crucial to our health and inclusion.

Specialist welfare advice will be routinely available universally within mental health, autism and learning disability services, and it will be offered proactively, so that people always have ready access to support to deal with money issues, from maximising benefit entitlements to dealing with problem debts.

Mental health, autism and learning disability services will support people with paid employment, using the Individual Placement and Support approach to enable people to find the right jobs for them, when they want to, at their own pace.

Health and social services will ensure that people are safe and secure in their housing, and that their rights are maintained, including if they need a spell in hospital. No one will be discharged from hospital or released from prison homeless.

Services will support people in their family lives and relationships, including in their role as a parent or carer, working with whole families where appropriate to provide wraparound support.

> "I care and worry about my family – help me to [look after them] well."
>
> Service user.[10]

Services will have an important role in tackling isolation and loneliness. That means understanding the causes of isolation and the 'compound discrimination' many people experience in their lives as a result of poverty, poor housing, poor public transport and digital exclusion.

> "Loneliness is made worse by the lack of public transport where I live. The buses stop at 6pm. I live on my own, I don't drive, my friends don't drive so evenings are hard."
>
> Service user.[11]

Mental health, autism and learning disability services will have an active role in tackling discrimination and exclusion: they will not be bystanders. Working alongside service users and community organisations, they will support social action to create a fairer society. This approach is exemplified in many of the YIACS currently in place across the country, such as the Young Person's Advisory Service (see the case study below).

Case study: Young Person's Advisory Service (YPAS)

YPAS began in Liverpool in 1966. It uses the YIACS model to provide evidence-based interventions to young people from age 5 to 25 in Merseyside.

It offers one-to-one counselling and open access youth activities that allow young people to come and be part of a group. Its parenting service has increased capacity in the last year, after the pandemic demonstrated the importance and the need for a whole-family approach to reach best outcomes for children and young people.

YPAS works with both primary and secondary schools in Liverpool. Since the introduction of mental health support teams in local schools, YPAS has provided additional support for children with more complex needs as well as offering information, advice and liaison to schools. Similarly, it provides liaison services with GP surgeries that see both parents and young people at their local practice.

YPAS has also developed a partnership with CAMHS locally. Trust has been built between them because YPAS is seen to offer evidence-based interventions, carried out by suitably trained and supervised staff, with routine outcome measures used to demonstrate impact.

Young people who engage with the service can set their own goals, and these are measured routinely. Once they have finished, they are able to go back for advice if they need it. There are services targeted towards young people with specific needs, including LGBTQ+ and trans young people.

Groups of young people have been supported by YPAS to lead research and social change projects with a view to changing policy and practice more broadly. For example, 13 young people are employed as peer researchers and are currently undertaking a participatory research and social action project to reduce youth violence.

Contact
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5. Whole-person care

In 2032, services support people with their physical and mental health together, and treat people as a whole person, respectful of their needs, assets and goals.

From the moment a person receives a diagnosis of mental ill health, autism or learning disability, they will get tailored support to maintain their physical and mental health. This may include advice on the effects of any medication they are prescribed, access to suitable physical activity, and help to quit smoking if it's needed. The SHAPE programme in Worcestershire has been putting that approach in practice for some time for people with mental illness diagnoses.[12]

People using mental health, autism and learning disability services will have easy access to liaison physical health support, for example from dentistry, cardiology and sexual health services. They will have access to preventive services such as cancer screening, and vaccinations against infectious disease will be offered equitably, with reasonable adjustments made where they are needed for both mental health and neurodiversity.[13]

People receiving treatment for a long-term physical condition will likewise have ready access to support for their mental health and wellbeing. Health workers will have enough knowledge and skill to offer basic emotional support to people with long-term conditions, and have easy routes to get access to psychological interventions that are tailored to their needs.[14]

For children and young people, a whole-person approach will involve closer collaboration with schools, children's social services, family hubs and youth services. Children with special educational needs and disabilities (SEND), children in the care system, refugee children, and young carers among others, will proactively get help for their mental health alongside other services. Schools will ensure that their policies and practices align with efforts to improve children's mental health, for example in supporting behaviour. This has been set out in numerous reviews and policy documents, two of the most recent being from the Children's Commissioner for England[14] and from the Commission on Young Lives.[15]

If a person has a dual diagnosis that includes both mental health and substance use (of alcohol or drugs) they will not be turned away or passed from pillar to post. Services will be integrated so that people get effective support for their whole needs at the same time.

Talking therapy services will be more diverse, better adapted to people's individual needs, and better integrated with other services. The Improving Access to Psychological Therapies programme will have become more comprehensive so that no one is rejected because their needs are 'too complex,' so that reasonable adjustments are always available (and offered proactively), and so that Eurocentric approaches to psychological intervention are not the only available offer.[16]

People will get health and care support that builds on their strengths, wishes and personalities. Social prescribing opportunities and personal budgets will be more easily available, with a range of options for self-directed support based on preference, not a one-size-fits-all approach.

Primary care will be a pivotal location for whole-person care. Mental health workers located in GP surgeries will be able to knit together support and provide easy-to-access help while also upskilling the rest of the primary care team.[17]

Case study: Integrating holistic care through Primary Care Psychological Medicine (PCPM) Service, Nottingham

The Primary Care Psychological Medicine (PCPM) service has been operating in Rushcliffe, Nottingham, since 2016 and has recently been expanded to two other localities. It offers support from a multi-disciplinary team in GP surgeries or in people's homes. The service assesses and treats people with complex persistent physical symptoms and complex long-term mental and physical health conditions. Prior to the service, people were seen across various specialities without an overarching assessment or treatment plan that combined their whole needs, from a mental and physical health perspective.

People are assessed in a primary care setting or in their own home by a team member to understand their needs holistically and formulate a personalised biopsychosocial treatment and care plan. Each plan is tailored to the person's individual needs and includes input from physical and mental health perspectives, meaning they are seen by different members of the team at varying levels of intensity depending on their situation.

Treatment can include:

- management and review of medication
- a range of psychological interventions
- physiotherapy and occupation therapy interventions
- identifying and reducing barriers to social participation and care support worker input to assist in these areas.

The team includes liaison psychiatry, mental health liaison nursing, physiotherapy, occupational therapy and care support work. While working alongside GPs to provide this care direct to patients it also provides training, supervision and support for GPs and other professionals.

The PCPM has demonstrated that it not only provides a valuable new service for people who were previously neglected, it creates reductions in the costs of other services[18] and has been able to sustain those over time.[19]

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Case study: Supporting complex needs at Turning Point Connect, Nottinghamshire

Turning Point Connect provides a 14-week programme for people with complex mental health needs in Nottingham and Nottinghamshire. It was set up in November 2020 in collaboration with Nottinghamshire Healthcare NHS Trust and has recently expanded from the city to the surrounding county.

Turning Point Connect offers a learning programme with a mixture of one-to-one and group work for groups of eight people. It is available face-to-face or online. It includes sessions on crisis management and mindfulness techniques.

The programme works with people with a range of needs, including some who have been given personality disorder diagnoses. Turning Point Connect complements existing provision of support for people with these diagnoses, including psychological therapies offered by the NHS trust.

No one is excluded from the programme on the basis of risk, but plans are made collaboratively with service users to manage any risks they might face.

The programme is run by a team of psychologists and peer support workers, who work in partnership so that every course is jointly and equally led by experts by profession and by experience.

The programme has adapted based on feedback from participants. This includes setting up a peer-led 'Keeping Connected' group that offers ongoing mutual support to people who have graduated from the programme. There is also a five-session programme for carers.

Turning Point Connect routinely measures outcomes, both in wellbeing and people's personal goals. Wellbeing measures consistently show significant improvements from the beginning of the programme to the end.

Access to Turning Point Connect comes through local community mental health teams. There is currently a six-month waiting time so Turning Point uses a 'waiting well' approach to stay in contact with people while they are waiting and link them up with support.

Turning Point Connect aims to continue to expand its offer across the county and to develop further the peer roles that it has created, including from graduates of the programme itself.

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6. Equality focus

In 2032, mental health, autism and learning disability services will be proactive in addressing structural inequalities and injustices.

Services will actively tackle inequality in its multiple dimensions. They will understand and work with the intersecting inequalities that underpin the unequal risks of poor mental health and the subsequent inequities in access to support, experiences of services and outcomes achieved.

To do this, mental health, autism and learning disability services will have had to change what they provide and how they provide it, to offer genuinely equitable access to effective support for everyone who needs it.[20]

All mental health, autism and learning disability services will be anti-racist in their approach, seeking to mitigate and address the social and economic injustices that put people from racialised communities at greater risk of both mental ill health and of coercive responses to distress. They will work in partnership with community and user-led organisations to offer a culturally competent service that can achieve equitable outcomes. Statutory services will have worked consistently to recognise how systemic racism, power and oppression can reinforce rather than mitigate racial injustice in society[21] and they will have earned the trust of marginalised communities by demonstrating that their services are safe, respectful and equitable.

Mental health, autism and learning disability services will be gender-responsive, for example by creating safe, gender- and trauma-informed environments for women and girls[22] and challenging stereotypes and assumptions about gender and neurodiversity.

Health and social services will actively ensure that they are friendly and safe places for LGBTQ+ people that will demonstrate an

understanding of the nature of their marginalisation, will affirm their identities, and support young people to develop themselves.[23]

Services will be adapted and adjusted where necessary to meet people's needs. For example, psychological interventions will be adapted to the needs of autistic people and people with learning disabilities, people with long-term physical health conditions, and those with hearing impairments, building on the ground-breaking Sign Health talking therapies service for members of the deaf community.

Services will be rurally inclusive, with models of care designed to reach people living outside cities and especially those with limited transport access.[24] This may mean providing support in new ways, such as using village halls and schools, to make sure help is visibly there and easy to access without long journeys to clinics or relying on online provision only.

Case study: Building support around young people at Project Future, Haringey

Project Future is a psychologically led mental wellbeing project delivered directly to a community in Haringey, North London. It is a partnership that includes Barnet, Enfield and Haringey Mental Health NHS Trust, Haringey Council, and Haringey Mind. It was developed from three previous projects, in two other London boroughs (Camden and Southwark) by the charity MAC-UK.

Clinical psychologists work alongside other professionals such as youth workers, and with young people to co-produce the project. Some of these young people will be employed to work as part of the core project team. The project works with young men aged 16 to 25 with experiences of the criminal justice

system, specifically those exposed to serious youth violence. Most of the young people do not seek help from formal

services for issues surrounding mental wellbeing, general wellbeing and for social and broader issues, often even when in severe need.

Project Future works not just with the young person but with their family and social networks where needed. It addresses the factors affecting a young person's wellbeing, for example if they're at risk of being excluded from school or in financial difficulty. And it uses a range of different approaches, including psychological interventions, creative arts, sports and physical activity. Where young people have the most complex needs and risks, Project Future works alongside statutory services who provide clinical care while the project addresses their wider needs.

Project Future makes a wider impact beyond working with individuals. Through social action projects it seeks to influence how public services are commissioned, creating platforms for young people to campaign for change. These include the production of a video and an art exhibition that demonstrated the factors that can lead to exclusion, poor mental health and involvement in offending. Creating these works provided young people with work experience that later led to employment opportunities and it has informed policies and strategies locally and nationally.

There is no limit to the number of times a young person can come to Project Future. The team has found that this does not place excessive pressure on the service.

Project Future has been evaluated extensively and created a wealth of practice-based evidence that has informed both its own practice and approaches to working with young people in surrounding areas.

For more information
www.centreformentalhealth.org.uk/publications/unlocking-different-future

7. Co-production

By 2032, there will have been a shift in the power imbalance between the organisations who provide mental health, autism and learning disability services, and the people who use them. Co-production will be the norm in the design, development and delivery of services.

In 2032, statutory mental health, autism and learning disability services will be working routinely in partnership with community organisations. They will not be merely subcontractors in a large chain or routes for occasional 'involvement' or consultation exercises, but equal participants in the design, development and delivery of services. This means that decision-making processes within local systems will be transparent, participative and shared.

Lived experience practice and leadership will be a feature of statutory mental health, autism and learning disability services, meaning that people who are using services will be in positions of power within the organisations that provide them. And crucially, the 'seat at the table' will no longer be tenuous, temporary or conditional; it will be guaranteed and representation will be continuous and comprehensive.

Contracting processes will not force voluntary and community organisations to compete with one another for scarce, short-term funding or constrain their freedom to speak out when things go wrong.

User and peer-led services will have a well-understood and equitably valued part to play in service delivery. There will be no single model for peer support but a range of approaches and opportunities throughout the system.

Families and carers will be fully supported and included as important participants in mental health, autism and learning disability services.

Personal budgets will also be more widely used to enable people to manage their own care and support. Paternalistic assumptions about the scope for self-directed support will have been replaced by an understanding that, for some people, personalised services are best achieved by holding their own budgets.

Where service users or families make complaints about their treatment and care they are believed and heard, efforts are made to resolve problems quickly, and services learn when things have gone wrong.

Case study: Collaborative commissioning of mental health services in Somerset

The county of Somerset has been a trailblazer site for transforming community mental health services, bringing together NHS services, community groups and local charities to deliver the support that people with mental health difficulties want.

The commissioning model was developed in partnership with experts by experience, who prompted reflection on how conventional care pathways can lead to people feeling bounced around the system and falling through gaps because they are either too unwell, or not unwell enough. This generated the vision of 'no wrong door; no shut door; no door at all' – an open model where people experiencing mental health difficulties are immediately 'in' the system and able to access the care they need, no matter where their first point of contact is.

A crucial pillar to this is an interoperable IT system, through which a person can have one coherent care plan that is shared across all the different services who support them. An information-sharing agreement between GP services and VCSE partners enables service users to access care from a

single trusted assessment, rather than having to repeat their stories multiple times. VCSE partners can not only view and edit this information in line with agreed standards, but also initiate care records – improving access for those who might not be in contact with traditional services or might be reluctant to engage.

Behind this digital framework sits a commissioning structure that is designed to facilitate equal partnership between VCSE and NHS services, and between VCSE organisations of different sizes. A formal network brings together VCSE organisations that elect an accountable organisation to hold the contract, while a large number of community groups are affiliated as wider partners. Experts by experience are renumerated for their time on service design groups and working groups, bringing a co-production approach through the full commissioning cycle.

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8. Boosting autonomy, human rights and community support

In 2032, service users will be reaping the benefits of a major investment in and transformation of community support. As changes to the Mental Health Act will have shifted investment away from institutional services, comprehensive support in the community will have risen up to meet people's needs more effectively and close to home.

There will be fewer out-of-area placements, which means individuals will be able to maintain relationships and ties to their communities. They will find it easier to 'get their lives' back after periods of illness, because they won't have lost so much of their lives in the first place.

Intensive community support will be the norm. Beds will be available where and when required, but stays will be shorter and there will be less requirement for hospital stays under the Mental Health Act.

Care and support will be built around the individual needs of service users, wrapping around them and their families to enable greater autonomy and choice. Autistic people and people with learning disabilities will have access to a range of community services that enable them to live their lives without a reliance on mental health hospitals.[25]

A human-rights-based approach will ensure that people's entitlements, such as the right to decent housing and family life, are met alongside health needs. Bespoke housing will enable those with the most acute needs to live in the community for the majority of the time, rather than being confined indefinitely to institutional care.

> "He's a person, not a job."
>
> Professional caring for a person with profound learning disabilities and autism

Health and care services will need to take a leading role in stimulating investment in supported housing services so that there are more alternatives to the use of institutional care for people who need additional support to live independently.

> "The default of moving people into more restrictive environments – such as out-of-area locked rehab – due to gaps in local markets, lack of long-term strategy and market development is neither desirable nor sustainable. It also leads to poor clinical outcomes."[26]

Above all, professionals will be de-institutionalising the way they work, offering support that appreciates the person they see in front of them. Care planning will never be about staff members ticking responsibilities off their list. Instead, the personal preferences, goals and interests of service users will set the direction and determine the priorities of the support that's available to them.

The cycle of trauma, restrictive practices and 'challenging behaviour' will be broken. At every turn, care will be designed to recognise and unlock what service users are capable of.

Internationally recognised human rights frameworks, including those created by the United Nations[27] and World Health Organization,[28] will be used as a benchmark for how well mental health, autism and learning disability services in England are supporting people to live 'rightful lives.'

Case study: Choice Support

Choice Support is a social care charity that supports autistic people and people with a learning disability or a mental health need. It has been established for almost 40 years and employs around 3,000 staff to support 2,300 people. The organisation's purpose is to create opportunities for people to be happy, aiming to understand people and strive to give them what they really want. This means recognising people's hopes and dreams, as well as their needs.

For example, Choice Support has been supporting George, who is 56, is autistic and has moderate learning disabilities and has been diagnosed with borderline personality disorder. George had spent more than half his life in secure inpatient and institutional-style residential care. Choice Support was selected to support him to move out of a secure hospital and enable him to live in the community.

The team spent time getting to know George and learning about his interests and aspirations, so that they could design his new home and support arrangements just for him. He chose furnishings, the colours of his rooms and asked to buy a shed so he could start learning woodwork. A bespoke recruitment process was used to find support staff with similar interests and values, making it easier to build rapport. The new team undertook relevant training, including positive behaviour support.

With more choice and control over his life, a supportive team and an environment that is designed to meet his needs, George's verbally aggressive outbursts have fallen by half and reduced in duration from up to 24 hours to an average of 30 minutes. His diet has improved, he exercises daily, and he has been exploring new interests in cooking, woodwork and owning a guinea pig.

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9. A thriving, diverse and effective workforce

In 2032, there will be a thriving workforce of mental health professionals and others working in multi-disciplinary teams across organisational boundaries to provide people with holistic, needs-led support. Resources will have been put in place to buy enough of people's time and recruit those with the requisite skill levels. Coherent workforce planning in both health and social care will have secured this capacity for the long term.

Across different disciplines, the workforce will have a broad appreciation of the societal issues that affect autistic people, people with learning disabilities and people with mental health difficulties during their lives. People in professional roles will have received training delivered by people with lived experience of being autistic, having a learning disability and living with mental ill health.

From GPs and teachers to housing officers and care home staff, people working in public services will consistently help people to get the right support and understand the context of people's lives. Having been trained to recognise the human factors, they will be equipped to deliver person-centred, holistic care and bring humanity and compassion to all their interactions.

> "I think there is that, sort of, dismissal of who you are, and not seeing the person as a person. They just see the diagnosis."
>
> Service user.[29]

Leaders will be championing systemic change from the highest level. Racialised communities and other marginalised groups will no longer be under-represented in leadership roles, and culturally safe services will be delivered across the board.[30]

Skills sharing with communities and wider services such as housing, schools, faith groups, hairdressers and barbers, will ensure that expertise is extended so that more people can offer brief advice or support when it's needed.

The contributions of peer support workers and experts by experience will be remunerated and offer career progression, including up to senior positions within organisations providing services. People with experience of using mental health, autism and learning disability services will be encouraged to join the workforce, and members of the workforce will feel safe and supported to be open about their own experiences and seek help when they need it.

> "I think the best people are people that have lived experience of mental health. Because...they can actually say, 'I understand', or, 'I've been there,'...and they mean it, it's true."
>
> Service user.[31]

Staff wellbeing will be taken seriously by compassionate organisations. Having recharged their batteries after the exhaustion of the COVID-19 pandemic and working in burn-out mode for many years, staff will have the headspace to lift their eyes and see the person standing in front of them. The flame that originally guided them towards joining caring professions will be kindled by their managers, colleagues and the system around them. As a result, recruitment and retention will flourish, and staff will have the emotional capacity to provide compassionate care.

Case study: Broadening workforce training through Mental Health TV

Mental Health TV (#mhTV) is a weekly online television and podcast series that is bringing new voices into nursing training and the wider mental health field, by encouraging debate and critical thinking, and creating a community of practice that brings discussion and innovation to a wide audience.

In its first two years, #mhTV hosted over 90 episodes with 98,100 people having seen something about #mhTV, 40,620 minutes viewed on YouTube and 67,100 minutes on Facebook. The most watched episode had 2,700 views.

Co-founded by a Middlesex University nursing academic, Unite the Union's Mental Health Nursing Association and the online community for mental health nurses (@WeMHNurses), the weekly show hosts a diverse range of speakers, including 16 per cent who identify as service users who share their experience of mental distress.

#mhTV places mental ill health in a wider context by bringing together speakers with diverse expertise on an equal footing, and complementing traditional task-oriented training with a reflective space for discussion. While conventional training often takes a top-down instructional approach, #mhTV encourages people working in mental health to get curious, think for themselves and engage in a richer range of conversations about wellbeing and recovery.

The sessions consider the interconnections between professional practice and other forms of support within the mental health sector and beyond, and sets the stage for more integrated and holistic care by exploring a range of topics

from homelessness to racism, moral injury to spirituality. By breaking down siloed thinking, the audience has expanded beyond trainee nurses and is bringing together a cross-sector community around innovative mental health practice.

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10. Measuring the outcomes that matter

In 2032, health and social services at all levels will be holding the outcomes that matter to service users as their lodestar. They will be able to measure these outcomes and be held to account for them. The overarching question that determines whether mental health, learning disability and autism services are assessed as good is: 'do service users say the service feels good to use?'

No longer will the system be driven by the outputs that matter to institutions, instead they will lead with the outcomes that matter to service users. If service users are off-rolled and pushed away from the services they need, this will not be counted as a success.

> "In ten years' time, I hope they'd be looking at things from my point of view – not just trying to do what's easiest for them."
>
> Mental health service user

Services will be harnessing the opportunities of the information age, using intelligent data systems that anticipate service users' needs and offer them personalised and timely care options.

Technology will give service users more choice and put them in a driving seat for planning their care. Technology will enable people to access the care they want, and hold services to account if they don't receive it.

Transparent and granular data will ensure inequalities in outcomes are in plain view. Health and social service providers and commissioners will be asking questions that orientate them towards quality and innovation for all. They will actively listen to what service users are saying about their care, as well as feedback from staff. Across the board, the whole system will be incentivised to measure success in terms of the health, wellbeing and lives of service users, and whether they are able to live the lives they want.

Case study: The Local Government Association's framework for benchmarking what good support feels and looks like

The Local Government Association/Association of Director of Adult Social Care's Care and Health Improvement Programme has been developing a framework to identify the outcomes that matter. Its goal is to facilitate the development of a practical and focused sector-led improvement offer to raise the quality of care offered.

One of the conclusions of this work is that it is easy to make services sound good with jargon and fancy words, so the CHIP framework aims to help directors of adult social services and their partners to go beyond the words and tell if services actually are good. It identifies a set of benchmarks for 'what good feels like' from a service user's point of view, and 'what good looks like' – that is, the observable characteristics that should be used to assess the quality of services. The work suggests that these observable characteristics can complement conventional metrics of 'how many, how much and how long' to assess whether support is really delivering what

matters. It puts the perspectives of service users at the heart of quality assessments to ensure that these are holistic, valid and robust.

The framework has the potential to unsettle assumptions. Many contributors to its development reported that they came away having realised that what they thought was a good service wasn't so good after all.

The approach foregrounds inequalities and the structural disadvantages faced by racialised and marginalised communities, and also the practical and strategic ways that local authorities can play their part in tackling injustice. The framework surfaces the distinctive opportunities of local authorities to prevent mental ill health, provide rounded support and promote collaboration between different agencies. It prepares the ground for practical support for leaders so that these opportunities can be seized.

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> "To ensure those who access mental health, autism and learning disability services receive meaningful care, a vision for the future and clear direction is key. Focusing our attention on prevention, early interventions, reducing the barriers to accessing care, and seeing the whole person will result in better, more compassionate outcomes for all."
>
> Mel Coombes MBE, Chief Executive Officer, Coventry and Warwickshire Partnership NHS Trust

The current policy environment

The vision we have drawn together is one of services that look and feel very different from much of what exists today. While every element is present to some extent in services that are available now, overall the vision we are reporting on represents a transformation in the way mental health, autism and learning disability services work. Achieving that much change in a decade is challenging – not least in a decade that has begun with a global pandemic and a nationwide cost-of-living crisis – but it is possible.

Historically, services for people with mental health difficulties, autistic people and people with learning disabilities have been underfunded. Short-term policies and workforce planning cycles have prevented them from operating sustainably. The erosion of social care and public health funding in the years of austerity in local government funding has left many local areas with limited early help or support. Inattention to inequities in services have meant that groups of people with the poorest mental health have got the poorest support. And year after year, rates of Mental Health Act use have gone up, with people from racialised communities facing a far higher risk of being subject to coercion.[32]

More people than ever are seeking help for their mental health, and this is likely to continue for some time to come in the aftermath of the collective trauma of COVID-19[33] and the cost-of-living crisis.

Mental health, autism and learning disability services in England are currently tasked with implementing the 2019 NHS Long Term Plan, which set targets for the expansion and reform of services over five years. During that time, the COVID-19 pandemic has made many of those plans more difficult to implement, while also speeding up others, such as in providing 24/7 crisis lines nationwide. At the time of writing, NHS England is updating the plan in response to the

changed environment and to extend it beyond its original end date of 2024. It has set out four new clinically led waiting time standards for mental health care to speed up access to services for both children and adults.

At the same time, the government has been consulting with the public on a new ten-year cross-government mental health and wellbeing plan. The plan will cover not just mental health services, but how government departments and society as a whole can create the conditions for good mental health and prevent mental illness.

In relation to autism and learning disability, the ongoing Transforming Care agenda is continuing, with the aim of boosting people's rights and participation in society and reducing the use of restrictive and coercive practices in services.[34] For children and young people, the NHS Long Term Plan keyworker programme is now expanding towards nationwide adoption by 2024.[35]

Social care for both adults and children is fundamental to the functioning of services for autistic people, people with learning disabilities and people with mental health difficulties. The government has made a number of announcements about plans for funding adult social care and reforming children's services. However, serious concerns remain about how far those plans will address the funding gap for adult social care in particular.[36]

Consultation is also taking place on a new draft mental health bill, which aims to modernise the 1983 Mental Health Act and improve care for people in acute mental health crisis. This is intended to improve choice and limit the use of compulsion, especially for autistic people and those with learning disabilities but without a mental health diagnosis.

At the same time, the health and care system in 2022 has undergone a significant change with the introduction of integrated care systems and provider collaboratives in the NHS. Underpinned

by the Health and Care Act, the new system emphasises collaboration and integration, with duties to tackle health inequalities embedded in the legislation.

Policy choices being made now afford opportunities to realise the vision set out in this report. The NHS Long Term Plan seeks to expand and improve community mental health services, crisis care and talking therapy access for adults and children alike. It will provide an important starting point for the further changes this report advocates longer term. A reformed Mental Health Act could dramatically reduce the risk of autistic people being detained in hospital for long periods and turn the tide on rising rates of coercion across the mental health system, with keyworkers playing a critical role in preventing vulnerabilities from escalating early in life to the point where institutional responses are required. The cross-government mental health and wellbeing plan could bring about concerted action to tackle the determinants of mental health and the life chances of people with mental health difficulties. And integrated care systems could provide the organisational apparatus to realise some of these ambitions on the ground by creating more collaborative ways of working and shared priorities across agency boundaries.

We need to be ambitious. We need to have high expectations of what can be achieved. We need to set a clear direction of travel towards the vision of proactive, holistic and equitable services that has been set out in this report, and take the first steps on that path. And we need investment and workforce plans that will place services on a clear path to implementation.

How will we get there?

We are confident that this vision is achievable. To make it happen, we need three things:

1. Investment

Mental health, autism and learning disability services will need sustained investment over the next ten years to meet growing demand for help and to change the ways they work so that the vision can be realised. To achieve this, it has been estimated that to meet increasing demand, funding for mental health needs could have to rise to as much as £27 billion by 2033-34.[37] This figure is based on prepandemic levels of need, which we know have increased, and with current levels of inflation, the actual amount is likely to be even higher.

Austerity policies need to end. They lead ultimately to the erosion of early help and support, leaving it until people hit crisis point to get a service. This is costly, and it becomes self-reinforcing as scarce resources become more and more tight and restricted to emergency responses.[38]

We must take advantage of targeted investment. The children's mental health New Models of Care programme has demonstrated that additional funding can be deployed to reform service provision and spend money better, and very differently, longer term.[39] Integrated care systems and provider collaboratives are ideally placed to lead the way in reinvesting resources to where they are most needed.

It's time to unblock the stalled progress of the Transforming Care programme for autistic people and people with a learning disability, which has thus far failed to go beyond small-scale changes and

continues to rely on institutional responses to people's needs.[40] A recently published action plan to strengthen community support and reduce reliance on hospital admissions may provide the necessary impetus to turn this around.[41] But it cannot be done cheaply. Effective, flexible and holistic community-based support requires substantial investment and may not release substantial 'savings' compared with the ongoing use of institutional settings.[42]

Sufficient investment would enable mental health, autism and learning disability services across England to look beyond the here and now and plan for the next decade. Currently, high levels of demand for acute care are commanding attention, and in integrated care systems the focus has largely been on physical health services dealing with pressures in elective care, emergency services and general practice. Investment is needed that will help not just to cope with current pressures but to bring about a shift in the way resources are used so that earlier intervention builds up as a proportion of what is spent.[43]

Investment in updating the mental health, autism and learning disability estate is also vital. Too many hospitals are outdated and unsafe.[44] Upgrading mental health hospitals is an opportunity to rethink about the sort of facilities we need so that as many people as possible get services close to home in safe, welcoming and trauma-informed environments that reduce the need for institutional care.

Investment also needs to go beyond the NHS. Funding is urgently needed in local authority social services, in public health, in housing (general needs and specialist supported accommodation), and in youth services – to name but a few – to ensure mental health support is truly holistic and effective. Adult social care alone faces a funding gap of £7 billion[45] and public health services have lost £1 billion since 2015/16.[46] This will require open and honest debate with the public about where, and how much, investment is required to tackle the social and economic determinants of distress while also offering the best possible personalised support at every level of need.

2. Workforce

Throughout this project, we have heard that building the mental health, autism and learning disability services workforce is critical to achieving the vision. Partly, this is about numbers. Shortages of mental health workers of all types have held back expansion and reform, leaving services in persistent crisis mode. In quarter 1 of 2022/23, there are about 132,000 full-time-equivalent vacancies across the whole NHS, and just under a quarter of these (nearly 29,000) were within mental health.[47] A tenth of consultant psychiatrist posts were vacant in 2021.[48] There were just under 47,000 nursing vacancies in England in quarter 1 of 2022/23 and just over a quarter of these (about 13,000) were from the mental health section.[49]

We need the number of people working in mental health, autism and learning disability services to grow sufficiently to meet rising demand. Otherwise, the system will continue to struggle with under-staffing and the consequent strain this places on the existing workforce.

The last few years have seen a welcome increase in the size of the NHS mental health workforce in England. It is clear that this needs to continue. And it needs to grow in its diversity in terms both of the multi-disciplinary roles that people bring to the mental health workforce and of the backgrounds people come from. The Advancing Mental Health Equalities strategy is an important starting point to build a mental health workforce that is more diverse and representative of the communities it serves. And for the workforce to have a wider range of contributions from different disciplines, the way services are regulated may need to change.

To make this possible, we need long-term workforce planning backed up with adequately resourced training and opportunities for placements. Nationally and within every integrated care system, it is essential to start planning now, in 2022, for the workforce that

needs to be in place in 2032. Workforce planning on five-year policy cycles is not enough; we need always to be looking at least a decade into the future to do this well.

Robust workforce planning needs to include action to address the barriers to joining the mental health workforce among people from marginalised communities, and the discrimination that keeps too many people from advancing their careers and gaining senior leadership positions. Inequities in the workforce reinforce and exacerbate those in the services they provide.

As well as opening up recruitment, training and advancement opportunities, we need to make mental health, autism and learning disability services healthy places to work where you can gain job satisfaction, work flexibly and have a rewarding career in a mentally healthy workplace.

3. Reform

Plans to modernise the Mental Health Act are an essential starting point for achieving the vision. We have a once-in-a-generation chance to reshape services to rely less on the use of coercion, to respect people's autonomy and dignity, and to share decision-making more equitably. Without a change in the law, it is clear that autistic people and people with learning disabilities will continue to be subject to mental health legislation for prolonged periods with little benefit.[50]

However, updating the Mental Health Act must be just the start. The organisations that design and deliver mental health, autism and learning disability services must also be willing and able to change radically. Systems, processes and cultures within organisations can favour inertia over innovation, especially when innovation means having less power and facing up to past and present shortcomings. But where organisations have overcome these obstacles, the rewards can be considerable.

Robust implementation with clear accountability is needed to ensure that rights enshrined by legislation are secured in practice. As the Care Act, the Carers' Act and the Autism Act have all demonstrated, the promise of new laws does not always get realised as much as it should.[51] National policies and strategies can provide powerful motivation and back-up for local action to improve services and target investment in priority areas.

Achieving the vision requires a significant improvement in the quality, consistency, relevancy and transparency of data about mental health, autism and learning disability services. Integrated care systems and their constituent parts need to know and communicate what services they offer, who receives them (and how quickly), how they are experienced and what outcomes they produce. Gaps need to be identified quickly and addressed systemically, with monitoring in place to ensure they are filled effectively.

Mental health, autism and learning disability services also rely to a great extent on effective relationships between a range of organisations. It is evident that good relationships support better services. Too often today they are fractured and fractious. Successful implementation of the vision will be built on shared effort between the NHS, local government, voluntary, community and independent sector organisations, a range of other public services, and civil society. For example, the provision of keyworkers for children and young people who are autistic or have a learning disability[52] will make a difference if it brings about systemic change in the way agencies work together, what services they offer and how responsive they are prepared to be to families' wishes and needs.

A willingness to reform means that mental health, autism and learning disability services will need to acknowledge and engage with the injustices and inequities of the past and present. Accepting that existing practice can be dehumanising, discriminatory or inadequate can help to create the conditions for people to come together to develop something very different.

Being willing and able to change also requires a commitment to robust research, evaluation and learning. Mental health research is poorly funded and narrowly focused. Innovations must be robustly tested and evaluated, and we need to value practice-based learning. Over the next decade we need more, and more equitable, mental health, autism and learning disability research.

Reform must also go beyond health and care services. The broader geopolitical context, economic situation and climate challenges set the boundaries within which services operate. National and local government, combined authorities and integrated care systems, can all create a healthier and more inclusive society by adopting 'health in all policies' approaches to decision-making. Reducing poverty, tackling hate crime, creating inclusive schools, improving the environment and addressing racism can make a marked difference to people's lives and wellbeing and preventing later difficulties. When these structures have changed, mental health, autism and learning disability services will have the best chance of making the transformation to the vision set out in this report.

Conclusions

Realising this vision will not be easy. Some of what is required is in the gift of politicians, and some is in the gift of system leaders, workers, advocates and citizens. Their ability to act depends, in turn, on the political will of the public and requires a national conversation about the challenges and choices we face.

We can all play our part. Whenever someone who uses services or a carer asserts their rights, challenges inequality or offers feedback, we get a step closer to the vision. Professionals at every level in every part of the system can take steps towards the vision every day, through reflecting on their practice and working with colleagues and service users to improve. No step is too small to make a difference to millions of people with mental health difficulties, autistic people and people with learning disabilities.

This is not a zero-sum game. As the case studies in this report have demonstrated, every element of the vision is already a reality somewhere in England, right now. Our ambition is to see it happen everywhere, and incorporating all ten elements. Our belief is that by making these changes and investing in the vision, people's lives will be improved immeasurably. And our conviction is that, in 2032, it can be a reality nationwide.

Appendix: Methodology

This report was written by Centre for Mental Health on behalf of the NHS Confederation:

- We reviewed relevant literature, including previously published vision statements, national and local policy documents and other written documentation. These covered the full spectrum of mental health, autism and learning disability services, from early years to later life. We especially sought literature written by people with personal experience of using mental health, autism and learning disability services about their aspirations and ambitions for the support they would like to get.

- We hosted a series of five roundtable workshops and further one-to-one interviews with people with personal and professional expertise relating to mental health, autism and learning disability services. We sought people who could bring knowledge and personal experience of inequalities in mental health, autism and learning disability services, and we sought people who could bring a wide range of perspectives. We organised a dedicated roundtable to discuss autism and learning disability services, which are too often overlooked and undervalued within the mental health system.

- We sought examples of existing services and organisations that embody elements of the vision that emerged from the literature review and roundtable workshops. The examples shared in this report are not intended as blueprints simply to be copied, but they provide inspiration for what can be achieved in practice.

We would like to thank everyone who spoke with us and shared their knowledge, experience, aspirations and understandings. This report is only possible because of the thoughtful and inspiring conversations they had with us.

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