Institute for Public Policy Research

TIME TO ACT

FIXING A MENTAL HEALTH SYSTEM IN CRISIS

Sebastian Rees
and **Hollie Wright**

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SUMMARY

The government is developing a new mental health strategy for England. It arrives at an important moment: mental health services are delivering more than ever, spending and staffing have grown over the past decade, and a record number of people are in contact with services. Yet for too many people, it does not feel as though they are getting the help they need.

This report seeks to explain why. Drawing on workshops with people who use and work in mental health services, we found a shared understanding of what good care looks like, but multiple ways in which experience falls short of it.

- **Help does not arrive when it is needed:** people face long waits with little support, and many become more unwell while they wait.
- **People do not feel listened to:** repeated assessment is used to determine what someone is eligible for rather than understand what would help them.
- **Care does not fit the whole person:** services organised around diagnoses or cohorts leave people with complex needs falling through the gaps.
- **Relationships and continuity are lost:** frequent handovers and time-limited support mean people repeatedly start again with professionals who do not understand their needs.
- **People have too little say in their care:** limited options leave people fitting themselves to what is available rather than shaping support around what would help them live well.

Services do not have enough capacity to meet rising need. But this is only a partial explanation for the gap between people's expectations of care and their experience of it. Equally significant is how services have been organised.

Faced with increasing demand, services have managed pressure through waiting lists, tight eligibility criteria and short, episodic interventions. These may help individual services cope; however, together they undermine the system's listening capacity, its ability to understand people, to retain that understanding over time, and to make good decisions about their care.

This report argues that more capacity will be necessary, but not sufficient, to build a more effective mental health system. Unless the forthcoming strategy also changes how care is organised, additional resources risk being absorbed by the same cycle of assessment, referral and return. We conclude by identifying principles for a system built around meeting people's needs, which our second report will develop into a model of care.

1. INTRODUCTION

1.1 A MOMENT FOR REFORM

The government is developing a new mental health strategy for England, having acknowledged that despite increased investment, England's mental health system remains "reactive, fragmented and inconsistent" (DHSC 2026).

The strategy will be informed by two national reviews: Professor Peter Fonagy's review of the prevalence of mental health conditions and what may be driving rising levels of distress (Fonagy et al 2026), and Dr Penny Dash's 'supply-side' review of whether recent investment in services has been used effectively (Peart 2026).

These reviews will provide important insights firstly on why the prevalence of mental ill health has risen, and secondly how effectively additional investment in services has been utilised. But a further question deserves equal attention: how well do mental health services *meet the needs of the people* who use them?

This report contributes to that debate. We argue that there is a pronounced gap between what people expect from services and what they experience. That gap reflects not only insufficient resources, but the way in which services have been designed and organised.

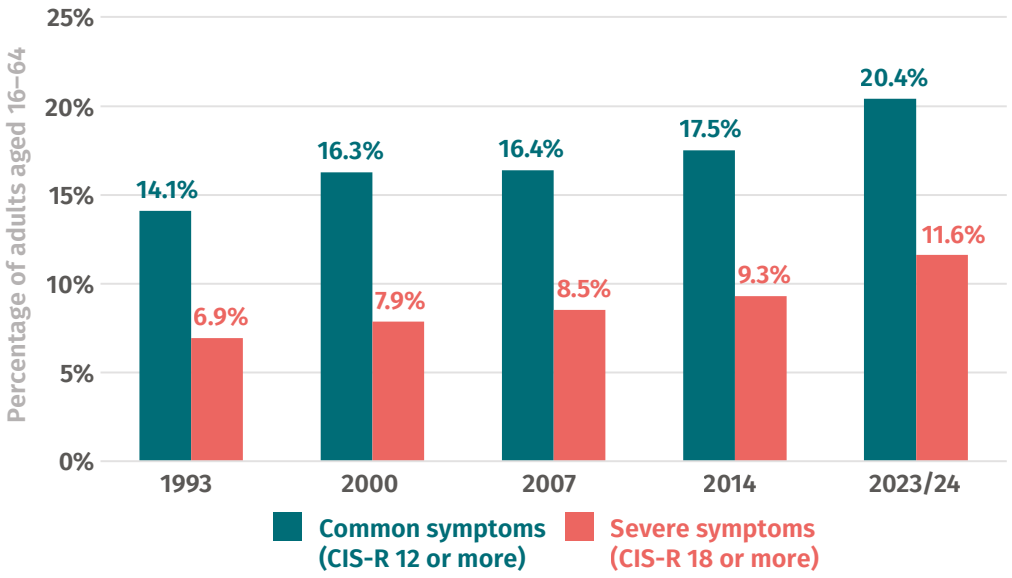
1.2 NEED FOR SUPPORT HAS RISEN

Need for mental health support has grown substantially in recent decades. More people are living with probable mental health conditions, and their symptoms have become more severe.

FIGURE 1.1

The prevalence and severity of mental health conditions has increased in recent decades

Percentage of adults aged 16–64 in England with clinically significant common mental health symptoms (CIS-R ≥12) and severe symptoms (CIS-R ≥18), 1993–2023/4



Source: IPPR analysis of NHS Digital (2025), Adult Psychiatric Morbidity Survey: Survey of Mental Health and Wellbeing, England, 2023/4, table 1.2

Increases have been most pronounced among young adults. The proportion of 16 to 24-year-olds with a probable mental health condition rose from 17.5 per cent in 2007 to 25.8 per cent in 2023/24 (NHS Digital 2025). The government's independent prevalence review concluded that these trends reflect a tangible increase in mental distress affecting everyday functioning, and not just expanding definitions of distress or increases in self-definition (Fonagy et al 2026).

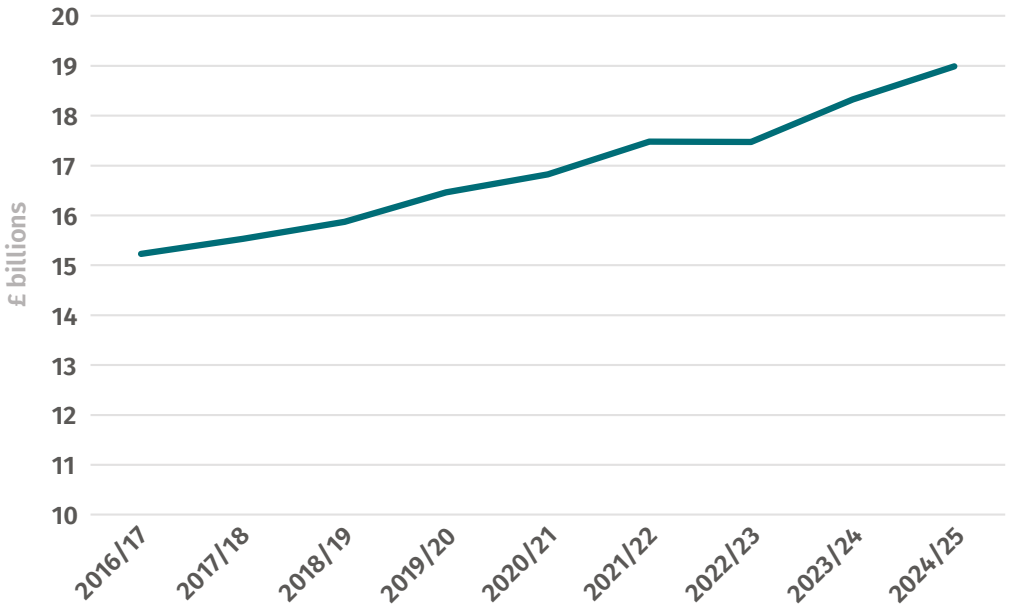
1.3 A PERSISTENT MISMATCH BETWEEN DEMAND AND CAPACITY

Services have not stood still in the face of rising demand. Though data has not been consistently published, we estimate that mental health spending rose by 25 per cent in real terms between 2016/17 and 2024/25 (NHS England 2026a).

FIGURE 1.2

Spending on mental health has grown over the past decade

NHS spending on mental health, including learning disabilities and dementia, England, 2016/17–2024/25 (£ billion, 2024/25 prices).



Source: IPPR analysis of NHS England (2026a) Mental Health Dashboard Q1 2025/26

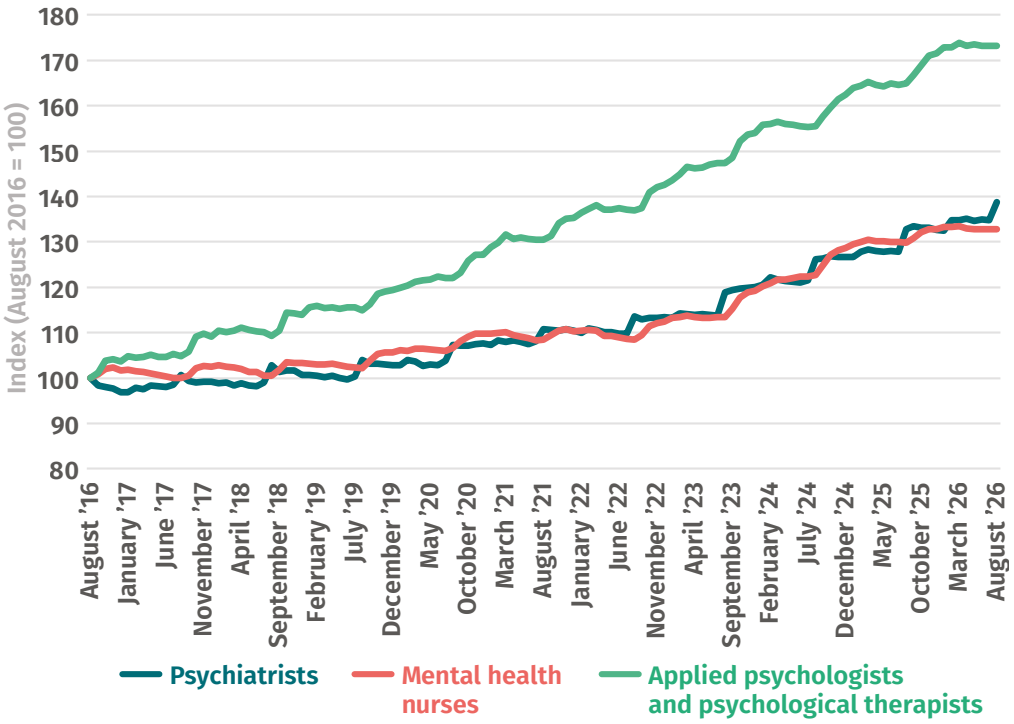
Note: HMT Deflators used to adjust to 2024/25 prices

Additional investment has driven an expansion of the mental health workforce. Figure 1.3 shows the percentage increase in psychiatrist, mental health nursing, psychologist and psychological therapist posts in the NHS since August 2016.

FIGURE 1.3

The mental health workforce has increased

Full-time equivalent psychiatrists, applied psychologists and psychological therapists, and mental health nurses working in NHS trusts and other core organisations in England, August 2016–August 2026



Source: IPPR analysis of NHS Digital (2026b), NHS Workforce Statistics – August 2026

As a result, services are offering more support. Patient contacts in mental health services expanded by 29 per cent between July 2019 and July 2026 (NHS Digital 2026a); and the percentage of England's population in contact with secondary mental health services grew from 5.1 per cent in 2019/20 to 7 per cent in 2024/25 (Harker 2026). The expansion of NHS Talking Therapies for anxiety and depression, and specialist provision in areas such as early intervention in psychosis, has widened access.

Yet capacity still falls short of need. Fewer than half of adults with a common mental health condition receive treatment (NHS Digital 2025). Although the NHS is meeting its waiting time targets in talking therapies and early intervention in psychosis, the Fonagy review concluded that waiting lists in other parts of the mental health system have become "unmanageable" (Fonagy et al 2026). The Royal College of Psychiatrists estimates that 1.8 million people who have been referred for mental health treatment are currently waiting for it (RCP 2026).

Progress in increasing capacity may also be stalling. A recent NHS Alliance survey of 37 mental health providers found that 68 per cent expected to reduce or close some services in 2026/27 and 57 per cent expected to cut clinical staff. Having grown significantly from 2016 onwards, the share of NHS spending on mental health is expected to fall for the third year in a row (Gregory 2026), and maintaining staff numbers is challenging. In June 2026, 8.4 per cent of funded posts in mental health trusts were vacant, compared with 6.7 per cent across the wider NHS (NHS England 2026b).

A decade of investment has allowed services to support more people than ever, but it has not kept pace with the growth in need, and there are signs that the progress made in recent years may now be at risk.

1.4 WHY SERVICE DESIGN MATTERS

Closing the gap between capacity and need must be a central aim of the forthcoming strategy. However, scarcity alone cannot explain the experiences that people described to us in our research. Services facing similar pressures can respond to them in very different ways, and the choices they make about how to manage demand shape what people experience when they ask for help.

Here, service design refers to the rules, boundaries and incentives that determine how care is organised: who is eligible for which services, what assessments are for, how responsibility is divided between teams, and how long support lasts. Faced with more need than they can meet, services have used these levers to manage demand through waiting lists, tighter eligibility thresholds and short, time-limited episodes of care.

Each can be a rational response for an individual service. But taken together, they undermine what we call the system's *listening capacity,* ie its ability to understand people, retain understanding over time, and to make good decisions about their care. They can also prove self-defeating, as people whose needs go unmet become more unwell and return needing more intensive support.

This report develops this argument. Chapter 2 sets out what people expect from mental health services and the ways in which their experience currently falls short, and chapter 3 examines the design choices that help to explain these experiences. We conclude by outlining a set of design principles that should underpin a future model of mental health care.

2. WHEN CARE FALLS SHORT

To understand how well mental health services meet people's needs, we held four online workshops, each involving 10 participants. Two were with people with lived experience of using services, and two with staff working across NHS, voluntary and community services.

What emerged most strikingly was the degree of agreement between the two groups about what good care looks like. Neither described good care in terms of receiving a diagnosis or delivering or receiving a particular treatment. Instead, both emphasised the importance of being understood, of building trust, and of having someone who would remain involved in a person's care over time.

Too often, however, care falls short. People described long waits, repeated assessments, handovers between professionals, limited treatment options and support that ended before they felt ready. Staff described high caseloads, rigid boundaries between services, and spending too much time determining who could receive care rather than providing it.

> ***"I trained to be able to provide care, but in my work, I spend more time having to deny it to people."***
> Staff participant

2.1 WAITING FOR HELP

People expect to be able to access mental health support in a timely way, and to receive help while they wait. Instead, participants described a system in which long waits with little support had been normalised and the impact of waiting on their wellbeing largely went unrecognised.

> ***"When I did see them, it took three months, by which point I was in a different mood state altogether... they said, you're getting diagnosed earlier than average... that's pretty good for us. Well, great for you, awful for me."***
> Lived experience participant

National data tells a similar story. In the Care Quality Commission's (CQC) latest Community Mental Health Survey, 41 per cent of respondents said their mental health had worsened between assessment and their first treatment appointment. This rose to 67 per cent among those who waited more than six months compared with 25 per cent among those who waited less than two weeks. More than a third (38 per cent) were offered no support while waiting (CQC 2026).

Without support from services, participants relied on their own resources and networks.

One participant, living with a chronic pain condition alongside a mental health condition, contrasted the two sides of their care. While awaiting a specialist pain assessment, they were offered pain relief, physiotherapy and a named contact if their condition deteriorated. While waiting for mental health support, they felt they were "going it alone", signposted to resources but left to "cobble together" support themselves.

Others felt they had no option but to pay for care privately. One participant's mental health deteriorated to the point where they could no longer do their job, and paying for therapy felt like the only way to avoid losing it. They recognised the unfairness of a system in which access to basic support depended on the ability to pay.

> ***"It shouldn't be down to luck that I was OK during that wait time. It shouldn't be down to privilege."***
>
> Lived experience participant

2.2 TELLING YOUR STORY, BUT NOT BEING HEARD

People expected assessments to help professionals understand them and identify how they could be supported, not simply to determine whether they were eligible for specialist care. Many instead experienced repeated questioning without progress.

One participant had been assessed seven times in just over a year. Each time, they were told professionals needed to verify their story again, despite having comprehensive notes.

> ***"It's just been assessment after assessment. I'm diagnosed now, but it doesn't mean anything."***
>
> Lived experience participant

Retelling their story could be distressing, particularly when it meant reliving trauma or explaining themselves in crisis. One member of staff, who also had lived experience of using services, described people starting again with several services, including 111 and crisis teams, in a single day.

> ***"You've spilled your guts out... you've cried on the floor, you've done everything, said everything to primary care. Now you're going to secondary care and you're going to start the whole story again."***
>
> Staff participant

Some felt doubted, with each new clinician questioning what had already been established. One described a "dominant presumption" that she would be lying to services.

> ***"If you're going to assume and not trust me at all, not listen to me, how am I supposed to trust you?"***
>
> Lived experience participant

Positive experiences showed how much time and attention mattered. One participant described a GP who offered him double appointments when he first became unwell: "Finally, I didn't feel under pressure. I didn't feel rushed." Small gestures made a considerable difference.

> ***"[the nurse] used to call me after my appointments, and it just kind of communicated that I was more than a time slot in someone's diary."***
>
> Lived experience participant

Being heard, however, is only the first step. Even where professionals took the time to understand someone, what they could offer was shaped by the boundaries of their own service.

2.3 NEEDS FALL BETWEEN SERVICES

People expect support that responds to the whole of their situation. Their mental health is often bound up with trauma, physical illness, problems with housing or debt, loneliness or the breakdown of a relationship.

Yet many described support that addressed only part of their situation. Others received none at all because their needs did not fit any service's eligibility criteria.

> *"They're too well for secondary care, but too complex for primary care. Then they're left with nothing until it gets to crisis point."*
> Staff participant

One participant, living with an eating disorder alongside other diagnoses, was told she was "probably two weeks away from death", yet went unsupported because of a "standoff" between services:

> *"The eating disorder services said they weren't commissioned to treat me because my primary diagnosis was a personality disorder. The trauma service said they couldn't treat me because my problem was my eating disorder. All I wanted was for someone to take control."*
> Lived experience participant

Wider needs also frequently went unaddressed. Participants were asked in detail about their symptoms, but little about their lives. In the Community Mental Health Survey, 38 per cent had received no support with their physical health but would have liked it. Two-thirds (66 per cent) were offered no help with money or benefits, and 45 per cent no help to find a group to join (CQC 2026).

Where more holistic support was available, participants rated it highly. One described several visits to a GP practice social prescriber without referrals being made. The social prescriber helped connect them with a charity that could offer several forms of support immediately: "It's not curing the mental health, but at least it's giving me relief."

Care that fits the person must also understand culture, faith, language and life experience. One carer described professionals making damaging assumptions about her South Asian mother-in-law during repeated A&E visits, before an eating disorder was eventually diagnosed. Another participant felt that his experiences of migration, race and sexuality went unrecognised, and his request for a therapist with relevant experience could not be met. These gaps reflect long-standing inequalities that require attention in their own right, but they are compounded by limited time to listen, and repeated moves between professionals.

2.4 STARTING AGAIN WITH SOMEONE NEW

Participants valued professionals who knew them. Seeing someone familiar meant less time explaining themselves and more time getting support: "I can just get straight to the point", as one put it. Staff, too, recognised the value of investing in relationships from the outset:

> *"We spend our first meetings really focusing on building that relationship – learning about what makes someone tick. Really what's brought them to us… it builds a lot of trust and it kind of pays dividends down the line."*
> Staff participant

Too often, however, the way care is organised makes such relationships difficult to build or sustain. Many participants described frequent changes of professional, uncertainty about who was responsible for their care, and support that ended before they felt ready.

> *"Rather than your care being an umbrella, it's like trying to do a jigsaw."*
> Lived experience participant

One lived experience participant described decisions being relayed through a team she never spoke to, with services assuming others were providing support that was not happening. Many participants reflected on the fact that coordination of care became their responsibility, not the service's:

> ***"Why am I becoming the administrative staff in this process?"***
> Lived experience participant

When a course of treatment ended, people could lose a relationship they had come to rely on. One participant's therapist spent the whole of their final session together explaining how to "play the game" and navigate the waiting list, so that they could continue care that both agreed was making a significant difference once their six-session course came to an end. Another was told it was "time to spread your wings and fly", only to be re-referred six months later into the same service.

Problems of continuity are compounded by high levels of staff turnover. Vacancy rates in mental health trusts are higher than across the NHS as a whole, and each departure can mean a person losing a professional they have come to know and trust. Staff in our workshops described how the pressures of the job led some colleagues to leave, with one recalling new starters saying "this is just too hard and I'm leaving" after only two weeks in post. Where turnover is high, even teams that place real value on continuity can struggle to provide it.

By contrast, one participant described the major improvements they experienced when a psychiatric nurse took the lead in coordinating all the partners involved in their care and support:

> ***"There's a lead professional who's the main person, which is a psychiatric nurse. She'll coordinate everything with everybody. They're all communicating now, even the housing team. It makes you feel a lot safer because they're actually doing something and trying to fix things together."***
> Lived experience participant

Here, continuity of care and clear accountability allowed professionals to understand a person's wider needs, and to coordinate a holistic response rather than providing fragmented care.

2.5 TOO LITTLE CHOICE

Good mental health care gives people genuine choice about the kinds of support they receive. That means a say in their care, a chance to explain what has and has not helped, before and real alternatives when something isn't working.

Participants felt that current provision fell short of this standard, and that services often defaulted to clinical interventions rather than offering more holistic support. As one participant put it, services took a "medicate first, support later" approach.

Medication can be an effective and appropriate treatment for many. But meaningful choice requires other suitable options to be available. Publicly available data suggests that services have become increasingly dominated by medication over the last two decades.

Since 2007, the proportion of adults with common mental health symptoms receiving medication has nearly doubled from 19.6 to 38.4 per cent, while the share receiving psychological therapy has risen at a slower rate, from 10.4 per cent to 17.9 per cent (NHS Digital 2025). Effective support often couples medication with psychological therapy, but the percentage of people who said they were supported with medication only in this period more than doubled from 14.1 per cent to 29.7 per cent (NHS Digital 2025).

Those who wanted support other than medication felt that they had to battle services to receive them. One obtained the therapy she wanted only "after a big fight and a long wait", describing it as "the most helpful thing that I've ever done". Another tried several medications with serious side effects before he "had to literally plead" for psychotherapy.

When treatment had not helped, people felt there was little interest in understanding why or trying something else:

> ***"It's more about here's our system. Can you fit it? If you don't, here's a dismissal letter."***
> Lived experience participant

National evidence also suggests that patients' involvement in decisions about their care is more limited than it should be. In the CQC's community mental health survey, 36 per cent of respondents said they had no choice in how treatment would be delivered, and 28 per cent did not feel in control of care (CQC 2025).

3. HOW SERVICE DESIGN MAKES GOOD CARE HARD TO DELIVER

The experiences recounted above recur across different services and stages of care. They are shaped by decisions about who services accept responsibility for, what assessment aims to establish, how responsibilities for different aspects of support are divided, and what professionals can offer.

Services make these decisions in a context of scarcity, and many of the arrangements are rational responses to the pressures they face. Cumulatively, however, they have produced a mental health system that delivers more but feels like it provides less care.

3.1 ELIGIBILITY BEFORE NEED

Where each service has its own criteria for access, the purpose of assessment becomes establishing whether someone qualifies for that particular service's offer. This can narrow the conversation before there is a sufficient understanding of who that person is and what support they need.

Assessment processes are often closely tied to diagnosis. Diagnosis can be valuable for patients to feel recognised, and in understanding and identifying effective treatment. However, problems arise when diagnostic thresholds determine access so rigidly that people with overlapping needs cannot find a viable route to care.

Participants described rules that excluded them from support because they were already receiving something else. One waited eight months for NHS Talking Therapies before being turned down because she was under the care of a community mental health team. Another was told a peer support group was not appropriate for them because they had been hospitalised.

These arrangements also help explain why people are assessed at so many stages in their care. Each new service must make its own eligibility decision, even when another team has already spent time understanding the person. What a service regards as a necessary assessment can therefore feel, to the person seeking help, like yet another obstacle in their way.

3.2 RESPONSIBILITIES DIVIDED BETWEEN SERVICES

Specialist teams can bring valuable expertise to mental health services. However, dividing provision into separate pathways also creates boundaries that people must cross, and gaps in which it is unclear who is responsible for their care.

> ***"Taken individually, each decision is justifiable, but taken together for the person, it essentially just leaves someone without a viable path to treatment."***
>
> Lived experience participant

Staff described the same problem from inside services. Discussions about which team should accept a person continued while that person waited for help. As one participant in our staff workshop put it, under pressure, "what we can and what we can't accept takes over, rather than actually patient care".

Where each team takes responsibility for one condition or one period of care, nobody may be looking at whether the support works as a whole. Information can be lost at handovers, while physical and social needs become someone else's responsibility.

A senior leader described the system as feeling like a "game of snakes and ladders", in which each move between services was another opportunity to slide back to the start. This is a problem of coordination and accountability as well as access.

3.3 CARE ORGANISED IN SHORT EPISODES

As chapter 2 showed, support frequently comes to an end before people feel ready. This is often the consequence of arbitrary limits placed on treatment length. Offering a set number of sessions can help services reach more people and some treatments work well as a defined course.

Workshop participants spoke about fixed limits on the number of sessions they qualified for, mandated breaks to ration capacity, and repeated returns to waiting lists. Even where staff are aware that someone needs further support, session limits can mean that clinicians are pushed to discharge the person and ask for them to be re-referred rather than simply extending their treatment (Health and Social Care Committee 2025). Staff described near-constant pressures to discharge people from their care: "we were constantly asked: why is this client still here?".

This approach can interrupt relationships before services have fully understood the person, or before they have secured the support they need. It can also turn discharge into the end of a team's responsibility, without resolving what should happen to the person next.

3.4 TOO LITTLE TIME, TOO FEW OPTIONS

Understanding people and responding to their needs takes time, and depends on having suitable forms of support to offer. To do so, professionals need manageable workloads, the flexibility to respond to individual circumstances and a sufficient range of options available to them.

Participants in our staff workshops described caseloads of 90 to 100 people per clinician, leaving little opportunity to get to know the individual they were supporting. One questioned how a 10-minute appointment once every three months could be enough to care for their patients. Publicly available data suggests high caseloads are quite common. In a 2025 Royal College of Nursing survey, respondents working in community mental health reported a median caseload of 33 patients at one given time, and only 12 per cent felt they had enough time to care for patients (RCN 2026).

Even where professionals understood what would help someone, suitable support was not always available. One participant was directed to a local service, whose website showed that provision had been cut, describing "phantom services… still being told that things exist when actually they don't".

Where flexibility was present in the system, staff found it valuable. One staff member described the value of being able to respond to someone's circumstances, rather than expecting them to be "in your window of tolerance at 3.15 PM on a Tuesday".

Another professional described taking a person out of the clinic, meeting their family, and developing an understanding that colleagues said they had previously lacked: “I didn’t talk to them, I listened to them”.

Service design determines how much room there is for this kind of work. When staff are responsible for too many people, when appointments are inflexible and when the options available are limited, it becomes harder both to understand someone and to help them.

3.5 LESS UNDERSTANDING, POORER DECISIONS

Taken together, the arrangements set out in this chapter – tight eligibility rules, defined around diagnosis; responsibilities divided between services; time-limited support; high caseloads and a narrow range of options – affect a service’s listening capacity: its ability to understand what someone is going through, to remember what it has learned about them, and to use that understanding to help them.

Listening capacity depends on time, trust, continuity, professional discretion and having something useful to offer. It is distinct from the capacity to deliver appointments, and a service can see more people while leaving too little room to understand any of them properly.

Understanding, in turn, shapes the quality of the decisions that mental health services make. Good care draws on clinical evidence alongside a clear picture of what matters to the person, what they have experienced before, and what options are available to them. An intervention that is clinically ‘appropriate’ may nonetheless be poorly suited to a particular person if those factors are overlooked.

Repeated eligibility tests, fragmented information and restricted offers can all weaken this process, so that decisions come to be driven by the requirements of whichever pathway is available, rather than by an informed judgement about what would actually help. In this way, service design helps to drive the gap between what people expect from mental health services and what they experience in practice.

3.6 A SELF-DEFEATING CYCLE

As well as giving people less effective support, these arrangements can prove self defeating: approaches designed to relieve pressure on services can end up adding to it. When support does not fit, or ends before someone is ready, needs go unresolved and people often come back.

Staff described “revolving door patients”: people discharged at the end of a course of treatment or a period of crisis, only to be re-referred months later with the same needs. As one lived experience participant put it: “I can’t tell you how many times I’ve had to navigate this”.

When people return, they are often more unwell and need more intensive support, and crisis provision can itself be hard to reach. A quarter of respondents to the Community Mental Health Survey who contacted crisis services waited too long to get through or could not get through at all, and nearly a third (32 per cent) said they did not receive the help they needed (CQC 2026).

The result is a cycle in which pressure on services encourages tighter eligibility and shorter episodes of support; these leave needs unresolved; and people return, adding to the pressure. A system short of capacity can end up spending much of what it has on repeated assessment, re-referral and crisis response that better support at an earlier stage might have avoided. Breaking that cycle requires changes to how services are designed.

4. CONCLUSION: FROM MANAGING PRESSURE TO MEETING NEED

People using and working in mental health services share an understanding of what good care looks like. It arrives when it is needed, starts by listening to the person, fits the whole of their life, and gives them a real say in decisions about their care.

Too often, people's experience of mental health support falls short of these expectations. We have argued that this is in large part a product of service design: the rules, boundaries and incentives that govern who can access support, what assessment is for, how responsibility is divided between teams and how long support lasts. Faced with more need than they can meet, services have made choices that help individual teams manage pressure. Taken together, those choices leave people waiting without support, retelling their story, moving between services and returning in crisis.

None of this diminishes the importance of adequate funding and staffing. Services are supporting more people than before, and rising need and a threatened slowdown in investment make sustained resourcing all the more important. But investment alone will not close the gap. Unless reform also changes how services are organised, new capacity risks being spent on the same cycle of repeated assessment, handovers and re-referral that participants described to us.

The forthcoming mental health strategy should therefore ask questions about service design alongside questions about the adequacy of investment, and set out a model of care built around the system's capacity to listen and make good decisions. Table 4.1 sets out the principles on which such a system should rest. Each responds to one of the ways in which care currently falls short, and each depends on professionals having the time, freedom and resources to put it into practice.

TABLE 4.1

Five principles for a mental health system built around need

Where care falls short	Principle for a future system
Long waits, with little support in the meantime	**Help when it is needed:** An immediate response when people ask for help, and support while they wait for further care where needed.
Repeated assessment to test eligibility	**Listening at the front door:** Assessment that sets out to understand what would help, not just who qualifies.
Needs that fall between services	**Care around the whole person:** Someone takes responsibility when needs cross service boundaries.
Handovers and support that ends too soon	**Holding on to what is learned:** Continuity of relationships and information, so people do not start again.
Fitting people to what is available	**Genuine choice:** A real range of options, shaped with the person and revisited when something is not working.

Source: Authors' analysis

Our second report will develop these principles into a model of mental health support. It will draw on areas in England and internationally that are already pioneering approaches in this direction, to show what a system built around listening and good decisions could look like in practice. The starting point is the question people reasonably expect services to ask: what does this person need, and how can we help?

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