The Fonagy Review: Building a Better System of Care, Not Simply a Different One

Keys Health's considered response to the Independent Review into Mental Health Conditions, ADHD and Autism

Our position in brief

We welcome the direction of reform and the scrutiny that comes with it. Earlier, needs-led support should be available before a diagnosis where it can help, but it must not become a substitute for specialist assessment or treatment when these are clinically indicated.

Our position is simple: reform should improve people's lives. Success should not be judged by fewer diagnoses, fewer referrals or shorter lists alone. It should be judged by whether people receive safe, timely and effective help, whether care continues when it is needed, and whether outcomes improve.

All providers, whether NHS or independent, should be expected to demonstrate quality, safety, equity and value through consistent standards and meaningful oversight. Reform also needs the workforce, funding, specialist capacity and transition arrangements to make it work in practice.

For people currently seeking help, the transition matters as much as the destination. No one should be left without meaningful support, lose access to clinically indicated assessment or treatment, or be removed from a waiting list simply because the system is being redesigned.

1. Understanding rising demand without oversimplifying the evidence

The review examines rising mental distress, increasing recognition of ADHD and autism, and changing demand for assessment and support. These issues are related, but they are not interchangeable.

Recorded diagnoses, estimated prevalence, referrals and service activity measure different things. An increase in recorded diagnosis does not, by itself, show that people are being diagnosed inappropriately. Equally, uncertainty in the evidence should not be used to claim that practice is uniformly consistent or that inappropriate diagnosis never occurs.

Many people who approach services have experienced significant difficulties for years. Their concerns should be taken seriously whether or not an assessment ultimately results in a diagnosis. Better national data, contemporary prevalence research, consistent outcome reporting and methodological transparency are essential if policy is to be based on evidence rather than assumptions about demand.

ADHD, autism and mental health conditions can coexist and interact, but they are not synonymous. Reform should recognise their different clinical characteristics and support needs rather than treating them as one problem with one pathway.

2. Needs-led support must mean real help

We strongly support the ambition to move towards a needs-led plus diagnosis model. People should not have to wait for a formal diagnosis before they can access reasonable, practical help in education, work, family life or their community.

However, needs-led support must represent an expansion of meaningful support, not simply a new referral threshold or another stage before specialist care. People should not be moved from one waiting list to another, offered generic support that does not meet their needs, or diverted away from clinically indicated assessment.

A safe pathway should include clear eligibility, clinical escalation, review of whether support is working and a route back to specialist care when needs change. People whose presentation or risk indicates specialist assessment or treatment should be able to reach it without avoidable delay.

This is particularly important during implementation. People already waiting for assessment or receiving treatment should have continuity and clear communication about what any pathway change means for them.

3. Protecting high-quality, whole-person assessment

Diagnosis should not be the only route to help, but a high-quality clinical assessment remains important when it is indicated. Assessment is not simply the assignment of a diagnostic label. Done well, it considers developmental history, strengths, functional difficulties, co-occurring conditions and the wider circumstances affecting a person's life.

We support proportionate, comprehensive assessment grounded in established diagnostic standards, professional judgement and multidisciplinary input where required. Whole-person assessment may include physical health, sleep, mental health, trauma, developmental factors and, where clinically relevant, hormonal factors or other conditions that could contribute to or complicate presentation.

Whole-person care should not become indiscriminate mandatory screening. Additional requirements should be introduced only where there is evidence that they improve safety, diagnostic accuracy or outcomes. Thoroughness and proportionality need to sit together.

Services should also remain alert to differences in presentation and barriers to recognition, including for women and girls, adults presenting later in life and underserved communities.

4. One expectation of quality, regardless of provider

We welcome scrutiny of variation in assessment quality, clinical governance and oversight. People should be able to expect clinically appropriate assessment, evidence-based treatment and meaningful accountability regardless of whether their care is delivered by an NHS organisation, an independent provider or another commissioned service.

We support clear and consistent national standards, consistent regulation, transparent quality measures and robust clinical governance. All service providers should be able to demonstrate quality, safety and value rather than asking the public or commissioners to accept assurances on trust.

Concerns about quality should be addressed through comparable standards, credible evidence, effective oversight and clear routes for people to raise concerns. Organisational ownership, by itself, should not be treated as a proxy for quality.

5. Care must continue beyond diagnosis

Diagnosis should not be the endpoint of care. People need access to appropriate support and treatment afterwards, according to clinical need, evidence and personal preference.

For ADHD, this may include medication, psychological or behavioural approaches, psychoeducation, environmental adjustments and ongoing clinical review. For autistic people, support may include reasonable

adjustments, communication support, occupational or psychological interventions where appropriate, and help with co-occurring mental or physical health needs.

Continuity matters. Reform should protect access to clinically indicated medication and specialist treatment, avoid unnecessary disruption for people already receiving care, and ensure that responsibility is clear when care moves between specialist and primary care services.

Outcomes should include functioning, wellbeing, treatment experience, safety and participation in everyday life, rather than relying only on diagnostic activity or waiting-time measures. We also support stronger evaluation of non-pharmacological interventions so that people can make informed choices about approaches that have evidence of benefit.

6. Recognising the whole person and inequalities across the life course

People's needs do not sit neatly within organisational or diagnostic boundaries. Mental health, neurodevelopmental differences, physical health, family circumstances, education, employment and social environments can interact and affect outcomes.

Reform should pay particular attention to people whose needs have historically been overlooked or poorly understood, and should consider access, experience and outcomes rather than assuming equity because a pathway exists.

Early intervention for children and young people is essential, but adults must not become an afterthought. Adults who have lived for years without appropriate recognition or support, and people moving between children's and adult services, need explicit protection in pathway design.

We also welcome consideration of neurodevelopmental needs beyond ADHD and autism (such as dyslexia, dyspraxia, dyscalculia, Tourette's, developmental language delay and other neurodevelopmental conditions), whilst recognising that different conditions require different expertise and responses and that co-occurring conditions must be appropriately supported.

7. Health, education, employment and communities must work together

Healthcare alone cannot meet the full range of needs described in the review. Schools, colleges, employers, local authorities, community organisations and families all have a role in creating environments in which people can participate and thrive.

In schools and colleges, earlier support needs an appropriately trained workforce, safeguarding, and access to specialist advice when difficulties are complex or escalating. In employment, reasonable adjustments, accessible information and practical support can help people participate and remain in work.

Integration must not mean transferring responsibility away from specialist services without the expertise, capacity, resources or accountability to manage it safely. Joined-up pathways need clear responsibilities, appropriate information sharing, trained staff and routes to specialist advice.

8. Digital innovation should support, not replace, good clinical care

Digital tools can improve access, communication, data quality and coordination. They may also support administrative work, information gathering and elements of pathway management.

Artificial intelligence and other digital approaches should be introduced with clear clinical accountability, human oversight, transparent decision-making, privacy safeguards and evaluation of safety, effectiveness, accessibility and bias. People who cannot or do not wish to use digital routes should retain access to appropriate alternatives.

Technology should support clinical judgement rather than substitute for professional assessment and oversight where these are required. Any digital model should be tested against the same question as any other service change: does it improve care and outcomes safely and equitably?

9. Reform must be properly resourced and realistic to deliver

Needs-led pathways will not succeed through redesign alone. They require sufficient workforce capability, specialist capacity, community support, infrastructure, governance and evaluation.

Commissioning decisions should consider both transition costs and ongoing costs. Savings should be treated as hypotheses to test, not assumptions. The system should also consider the wider determinants of health and the consequences of unmet need and delayed treatment, including disruption to education, employment and family life and avoidable use of other services.

For primary care, any proposed shift in longer-term management needs clear agreements about specialist advice, prescribing responsibilities, clinical review, escalation and workforce capacity. New responsibilities should not be assumed to be deliverable without the resources and clinical support required.

Implementation should be phased, measurable and independently evaluated, including unintended consequences such as re-referrals, unmet needs, digital exclusion and additional pressure elsewhere in the system.

10. From recommendations to meaningful improvement

The review creates an opportunity to move beyond polarised arguments about diagnosis and redesign services around what genuinely helps people. That requires government, commissioners, clinicians, professional bodies and providers to examine their own responsibilities, and it requires people with lived experience to be involved in decisions that affect their care.

We believe five priorities should guide the next phase:

- Earlier, meaningful support without creating new barriers to specialist assessment or treatment.
- Consistent clinical standards and regulation across all providers.
- Continuity and patient protections, including support while waiting, clear escalation, adult access and protection for people already receiving treatment.
- Joined-up pathways across health, education, employment and communities, backed by sufficient specialist expertise and workforce capacity.
- Transparent outcomes, realistic funding and independent evaluation so that reform is judged by what changes for people, not simply by recorded demand.

Keys Health is committed to contributing constructively alongside NHS partners, clinicians, researchers, policymakers and people with lived experience. We do not claim that any single provider or model has all the answers. We do believe that better outcomes are possible if reform is evidence-led, transparent about uncertainty and supported by genuine collaboration.

The real opportunity is not simply to change how people enter the system. It is to improve what happens when they ask for help, during the wait, through assessment and treatment, and beyond diagnosis.

Annex A| References and reading

- Independent Review, executive summary and ten recommendations: https://www.gov.uk/government/publications/independent-review-into-mental-health-conditions-adhd-and-autism-final-report/independent-review-into-mental-health-conditions-adhd-and-autism-executive-summary
- DHSC government response: https://www.gov.uk/government/news/government-pledges-earlier-support-to-tackle-mental-health-crises
- Parliamentary written statement: https://questions-statements.parliament.uk/written-statements/detail/2026-10-12/hcws364
- NICE NG87: ADHD: https://www.nice.org.uk/guidance/ng87
- NICE CG142: Autism in adults: https://www.nice.org.uk/guidance/cg142
- NICE CG128: Autism Recognition and Diagnosis (Children & Young People to age 19): https://www.nice.org.uk/guidance/cg128
- NICE CG170: Autism Support and Management (Children & Young People to age 19): https://www.nice.org.uk/guidance/cg170