Mental Health Social Care Summit III

21st January 2026

Introduction

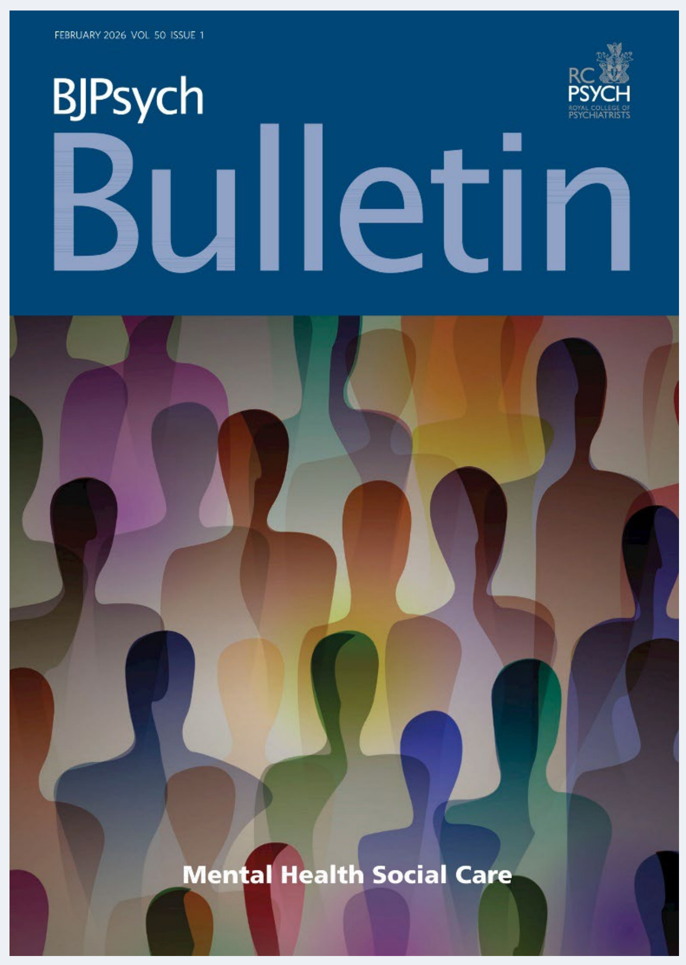
MHSC is a relatively new term, and conceptually it sits across four interconnected frames of reference, namely:

i) Organisations and their relationships, e.g. local authorities and community organisations and their links to NHS mental health systems, as well as interactions with other systems, such as housing.
ii) Professional identities and roles, e.g. social workers and other professionals working in the sector and/or with similar values, and underpinning models of practice (see fourth frame). This also extends to other MHSC practitioners including support and peer workers. In addition, those in the social networks of people living with mental health problems, including family members/carers, are central to MHSC perspectives and might also be considered here.
iii) Legislation and statutory guidance, which define some of the roles and responsibilities of organisations and staff working in MHSC.
iv) Values and models of care, which are especially grounded in a social model of disability and understanding and working with people and their particular circumstances (personalisation).

These roles, identities, organisations and values are all essential elements of good mental health care systems, but they are often overlooked or downplayed in national and local policy and system planning compared to their value to people's lives. The concept of MHSC helps bring a clarity and more unified identity with the intention of thereby raising the profile and understanding of the value of the work of people and organisations in the field.

Current evidence and theory

Whilst the research evidence base for MHSC interventions and models may be weaker than more established fields in some regards, clear approaches do exist (Appleton 2023; Barnett et al. 2022). These are grounded in the values discussed above, and often on strong theoretical foundations. Martin Webber and colleagues (2021), for example, developed the Connecting People model on the concept of social capital, i.e. the various resources available to people through their networks, and its potential as a foundation for working with people to help them live good lives. Clark (2024), meanwhile, has articulated the need for a relational understanding of mental health, e.g. conceptualising how mental health emerges from a network of our interactions rather than being intrinsically part of a person's "essence" and/or their identity. Similarly, Duff and Hill (2022) argue from an understanding of wellness as a continuous process of assemblages of social forces and resources.

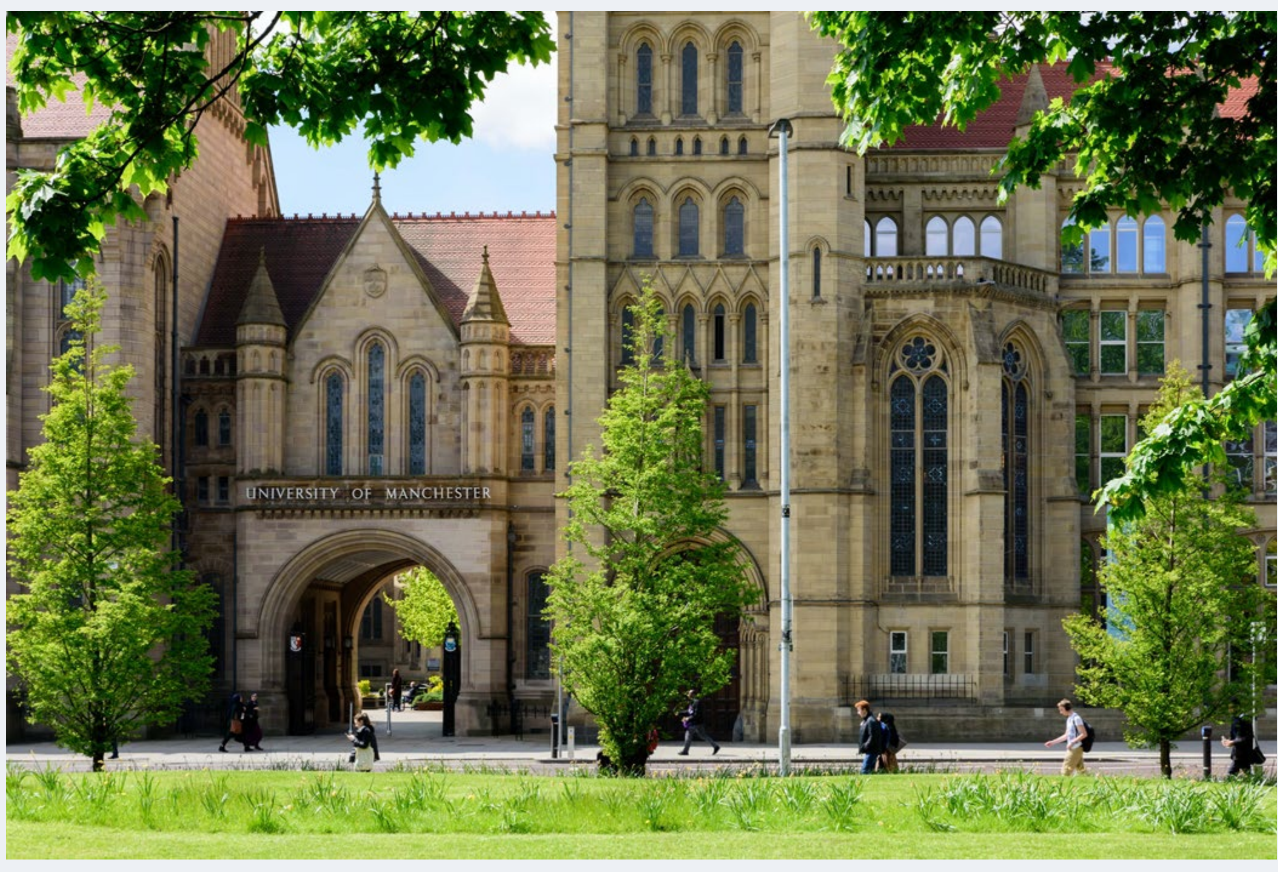


Together, these perspectives show that people's lives and relationships are constantly in flux, and that building and maintaining a "good life" takes ongoing effort. For people with mental health problems, this can be especially challenging. MHSC organisations should play a central role by supporting people, sharing that burden, and helping sustain hope. Whilst they diverge in some ways, these perspectives emphasise that people's social relationships and environments are central to understanding mental health. Supporting people means understanding all aspects of their lives and identities and being alongside them as they manage and maintain their wellbeing over time. These are the strengths that MHSC can bring to developing good neighbourhood care, the theme of our third summit.

The third summit

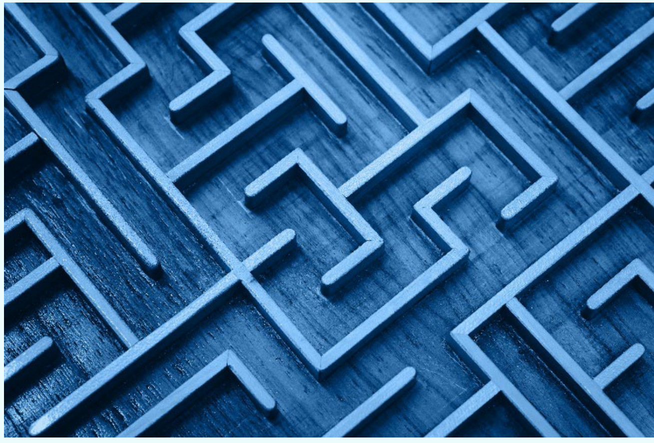
Our first summit (MHSCI 2024a) was an opportunity for stakeholders to come together to articulate a shared understanding of MHSC, its potential, as well as the research and other priorities needed to nurture it. The second summit (MHSCI 2024b) provided space to examine in more detail the priorities for building research capacity in MHSC. Being an emergent area of understanding, there is a need to urgently invest in developing the research capacity to generate the evidence needed to make most effective investments in and use of MHSC expertise (O'Neill et al. 2025).

This third summit, held at the University of Manchester, was organised in the light of the UK government publishing its 10-year strategy for the NHS in England, Fit for the Future. This envisages three major strategic shifts for the NHS, namely from hospital-based care to neighbourhood care, to more prevention of illness, and to more organisation of care through digital technologies. For the first two, neighbourhood and prevention, MHSC has considerable experience to contribute to achieve these and most effectively support individuals, communities, and their mental health. This summit was an opportunity to explore this experience and through this report to articulate it to other audiences.



“You really are on your own. There is nobody there to support you”

Chris Frederick, expert by experience, 2025 (State of community mental health services by the Health and Social Care Committee)



Summit III: situating the summit

A recent overview of the state of community mental health services by the Health and Social Care Committee (2025) opens with the following quotation from Chris Frederick, an expert by experience on mental health challenges:

“I think about an analogy of walking through a maze [...]. You are trying to figure out where you turn left or right. Do you go straight? Despite some of the referrals, recommendations and lots of content on social media — “You should try these different techniques” — you really are on your own. There is nobody there to support you.” (page 2)

Yet, we have a sector in local mental health systems, MHSC, whose very ethos is summarised as ‘being alongside people’. Implicit in Chris’s description of his experience, nonetheless, is that local systems are not utilising MHSC to stop people feeling they are on their own.

Reasons for this are no doubt complex, but the titular reference to ‘service’ points towards a particular way of thinking: specifically, the idea that community mental health support is predominantly about NHS services. Plausibly, this might influence decision makers to consider the role of MHSC as afterthought or fringe activity, rather than as something central to effective, person-centered mental health support.

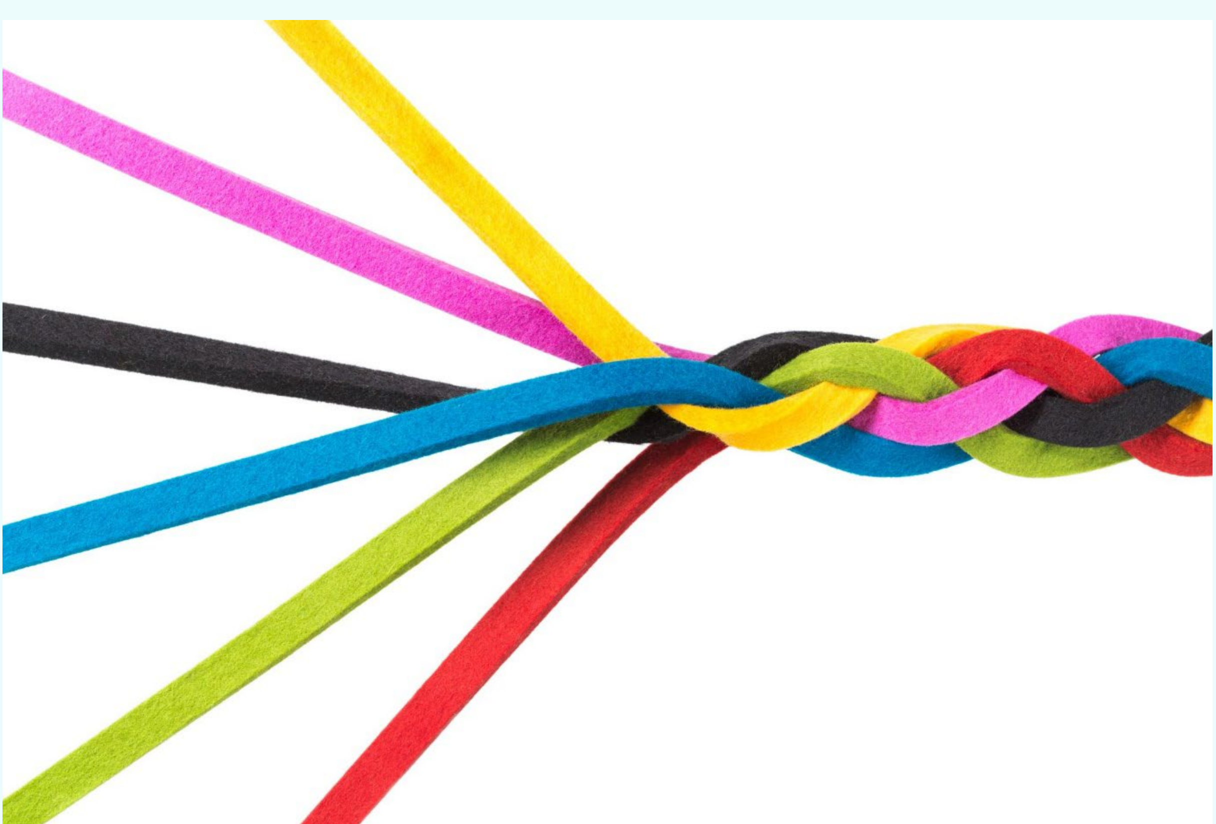
In the same Health and Social Care Committee report (2025) there is a further, particularly powerful lived experience testament to guide how we need to think about mental health support for people:

> “[W]e need to be talking about how people can stay well in their communities and how we can keep people well within their communities. Once you come out of statutory care, how do you stay well? We need to be working on this integrated model.”
>
> *Jake Mills, expert by experience, and CEO and Founder of Chasing the Stigma and the Hub of Hope* (page 5).

This potentially aligns with the shift to neighbourhood care in the NHS’s Fit for the Future plan, which puts communities at the centre of supporting people’s lives. However, we should not treat “community” as a simple and standalone solution. Communities are complex and cannot be easily influenced by policy to improve their member’s wellbeing. Research on social networks and health shows that outcomes depend heavily on context (Shiell, Hawe & Kavanagh 2020). If we look at how people, relationships, and systems are all interconnected, it becomes clearer why this happens: because both social networks and health are complex, influenced by society, and constantly evolving.

We also know that for many ‘community’ is an experience of stigma and exclusion. It is therefore important to help people find and build connections where they feel supported and included. In some cases, this means actively helping to create those positive environments, especially for people living with mental health problems. Crucially, MHSC organisations have strong experience working with communities, particularly those underserved by statutory services: often by establishing trust with groups who are less likely to engage. This trust, closely tied to people’s identity and sense of hope, is essential for both individual recovery and community wellbeing.

A trap to avoid in thinking about neighbourhood, though, is not to think of it as a fixed entity such as boundaries on maps, or as specific institutions like a place of worship or community venue. Rather, neighbourhoods, and related concepts such as place and community, are lived experiences that are fluid and dynamic. They are continually shaped and reshaped through people’s interactions with one another, with institutions, with the built environment, and with broader social processes (Massey 2005).



By working closely with people and within communities, MHSC organisations understand these perspectives and the challenges of supporting people with mental health problems to live well in their communities. In particular, connectedness, hope and optimism, identity, meaning and purpose, and empowerment (the CHIME Framework; Leamy, et al. 2011) align with MHSC’s ethos of supporting people by being alongside them in supportive community environments.

As a knowledge base, MHSC and its proponents bring significant experience and expertise to developing neighbourhood support for mental health. This summit brought together expertise from research and MHSC practice, including social workers, peer workers, key organisations (particularly charities and community groups working with underserved and marginalised populations), and people with lived experience, to articulate MHSC’s contribution to shaping neighbourhood support.

Summit III: Presentations

The programme for the summit contained the following presentations

- **Robert Lewis, Mental Health Social Work Lead, DHSC,** who provided an overview of the national policy developments in mental health.
- **Liam Gilfellon, Director, Everyturn Mental Health**, who presented on the longer-term local perspective and the MHSC contribution to neighbourhood care and support and prevention.
- **Carey Bamber and Becky Gill** from the Mental Health, Learning Disability and Autism Programme at NHS England, who gave another national perspective, this time on learning from the Mental Health Neighbourhood 24/7 Mental Health Centres programme.

Copies of their presentations are attached as appendices to this report.

In summary, there is complex landscape of changes in mental health, including new legislation and policy developments. Central to the latter appear to be a commitment to extend the learning from the pilots of the Mental Health Neighbourhood 24/7 Mental Health Centres. Liam provided an in-depth review of lessons from one such centre, Hope Haven in Whitehaven and Copeland, Cumbria, where initial reports indicate a very promising future for support for individuals and the local community. Carey and Becky provided a national overview of the Mental Health Neighbourhood 24/7 Mental Health Centres programme. Central to each of the 6 pilot sites in the programme has been the input of MHSC organisations and staff, particularly alliances across local community organisations. The Incubator and the Association of Mental Health Providers are providing support to colleagues in the programme to collate learning about the MHSC input into these pilots and how a MHSC ethos is fundamental to the development of these Centres.

Summit III: group discussions

During the Summit presentations, participants undertook two separate group discussions. Each focused on:

- What do we know about the impact of MHSC on delivering neighbourhood and prevention support? What evidence base do we have?
- What is the contribution of MHSC to inclusive neighbourhood and prevention support?

The following summarises the discussions in these workshops.

It was clear from participants that neighbourhood care and support need to commence from understanding local communities, in all their diversity, with their richness and strengths, and their specific experiences and challenges. This includes racism, stigma, marginalisation, and a related sense of hopelessness and mistrust of statutory organisations. Working with communities is the starting point to this, which may mean firstly nurturing safe spaces within which people can gradually feel they are involved in a sincere dialogue. Building the social and relational capital for this to happen takes time and is not a one-off event. Engaging with and involving diverse communities continues to be a challenge for the establishment of good, equitable mental health care, but one that many MHSC organisations are well placed to help take on.

Participants emphasised that there is a huge body of evidence on MHSC to support good neighbourhood mental health care and thereby support the prevention imperative. The fact that MHSC organisations are at the forefront of the 6-pilot neighbourhood 24/7 centres testifies to this. Participants also pointed to the Wigan Deal programme as an example of the community empowerment to support better health, to shift to a prevention approach, and to operationalise the MHSC ethos. Similarly, the Preston Community Wealth Building Programme demonstrates the positive impacts for people of a coordinated economic, health, and social approach to community development, including on mental health (Rose et al., 2023). Lastly, recovery colleges were another example discussed, including the economic evidence of significant savings to statutory mental health services through the colleges (Thériault et al. 2020).

However, the evidence base for MHSC is not as well recognised as medical and psychological evidence. It is harder to work with because it is scattered and lacks a single, organised body of knowledge. Much of it is not written and published but is in the experience of many actors in MHSC across the country. What evidence has been formally written is spread across a very diverse literature. Nonetheless, this evidence does not offer formulaic solutions. As noted in the introduction, working with people and neighbourhoods, issues of identity and wellbeing, means operating within complex, ongoing processes which are highly dependent on context. The evidence from practice and research for MHSC is a guide to practice and policy in this undertaking, however, it is not a simple recipe.

Some participants argued that MHSC and the medical model were complementary in the context of a holistic, supportive system. They emphasised the potential in seeking common ground in perspectives to improve systems. There continues, for example, to be a strong strain in psychiatry arguing for a social perspective (e.g. Priebe et al., 2023; Bonsack et al. 2025; Ventriglio et al. 2025). More widely, understanding the impact of social determinants on all aspects of health provides a strong basis for building alliances and strengthening the role of MHSC within neighbourhood care.

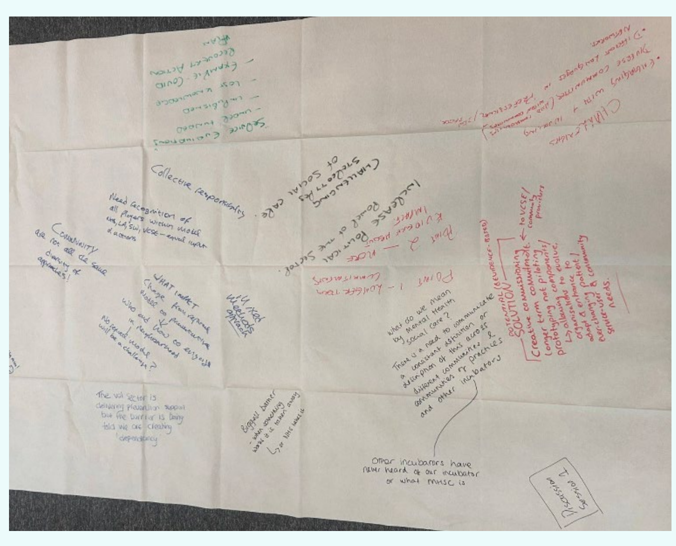
Nonetheless, attendees highlighted the potential challenges around workforce dynamics this may bring. One is the often lower status of MHSC colleagues compared to other health professions. If people are to work alongside each other, there needs to be a change in the power dynamics and the often hierarchical practices found in current multidisciplinary teams. Core care values, such as recovery and person-centred support, provide a strong basis for recognising and valuing a workforce that can put these principles into practice.

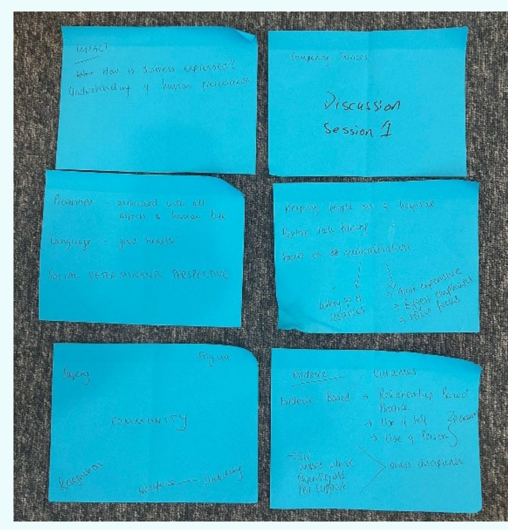
There is a need to continue to aggregate and share the existing evidence base to support an understanding of and commitment to MHSC amongst national and local decision makers. There is also an urgent need to invest in developing evidence to strategically grow MHSC in mental health systems. Participants, however, foresaw significant challenges in growing the research evidence base, not least in nurturing the capacity to do the work. The Incubator has made significant steps forward in this, but the work of the Incubator needs to be sustained, and further investment in MHSC capacity building is required. The group suggested people with lived experience and communities should be more at the forefront of capacity building, but research systems place significant structural barriers in the way of doing this. This and other themes from previous summits about building capacity and demystifying research to make it more inclusive were repeated.

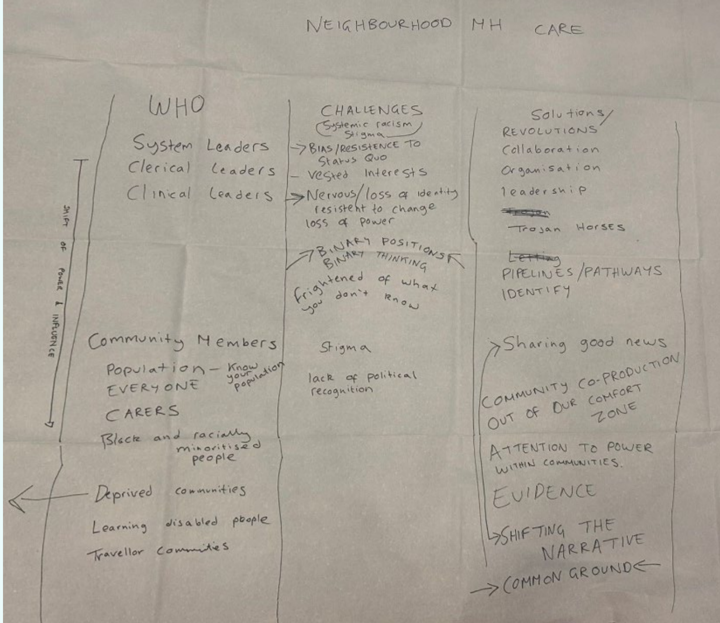
Another challenge attendees foresaw was in committing to changing from narrow, often symptom-based outcome measures to measures more relevant to MHSC and its wider perspective on a “good life”. Prevention and supporting good self-care for people and communities means understanding the “good life” is socially embedded. The shift in considering evidence might be underpinned by increasing recognition of the importance of narratives of change from individuals and communities in influencing policy developments. Distress and developing an understanding of the ‘human presentation’ in people and communities was one example of the need to shift from narrow measures. Some argued this is vital if research is to focus on providing the evidence to inform future system improvements and the centrality of MHSC in this as opposed to justifying the existence of the system.

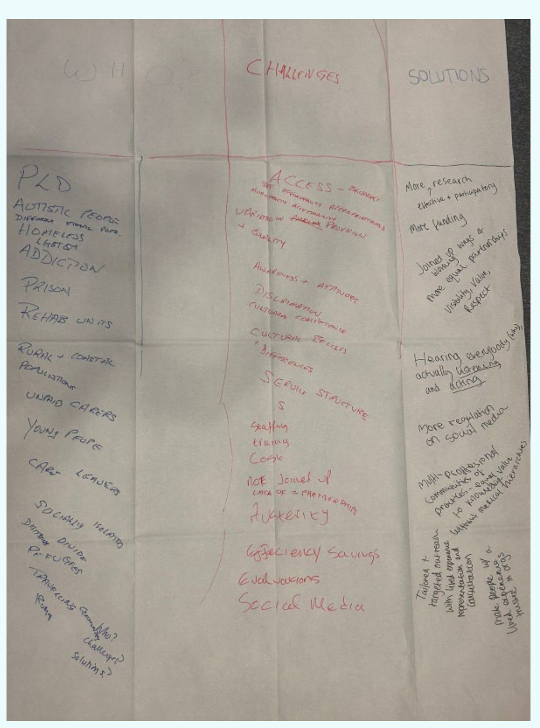
Participants further thought that better creative commissioning could play a more engaged role in helping to develop the evidence base for MHSC and its place in neighbourhood and preventative care and support. Often, MHSC initiatives are too tied to short-term commissioning processes which do not easily fit with research cycles. Attendees noted that local evaluations are often undertaken, but they are rarely widely shared and aggregated in any meaningful way. Long-term commissioning is essential to support a process of piloting and refining services. This should include evaluation and critical reflection by stakeholders, feeding into ongoing development of the service model through an action research cycle. In combination, this would make a valuable contribution to the evidence base. This might even be approached across several related services and/or different localities in a programme of evidence development to better support neighbourhood and preventative care.

Tablecloths and Post-it Notes









Conclusion

Participants at the summit agreed that neighbourhood models of mental health support are a positive policy direction. However, their implementation must place MHSC experience at the centre, rather than relying solely on the clinical perspective. Different languages and outlooks between actors in local mental health systems may hinder collaboration to deliver this holistic model of neighbourhood care, but, as the neighbourhood pilot sites have shown, this can be overcome when focused on starting from what communities and people want and need.

For some at the summit there is a need to change the image of MHSC, to develop a more coherent narrative of its potential and, thereby, improve its political impact to shape systems. This is a developing agenda. We are continuing to communicate what MHSC is, its ethos and evidence base to stakeholders at all levels of mental health systems. The collective identity of MHSC is still relatively new. Whilst significant progress has been made to raise its profile, particularly through the Incubator, further work is needed to consolidate and develop it. This will be essential if the sector is to fulfil its potential in shaping policy shifts towards neighbourhood and preventative mental health systems.

Acknowledgements

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Appendices: presentations

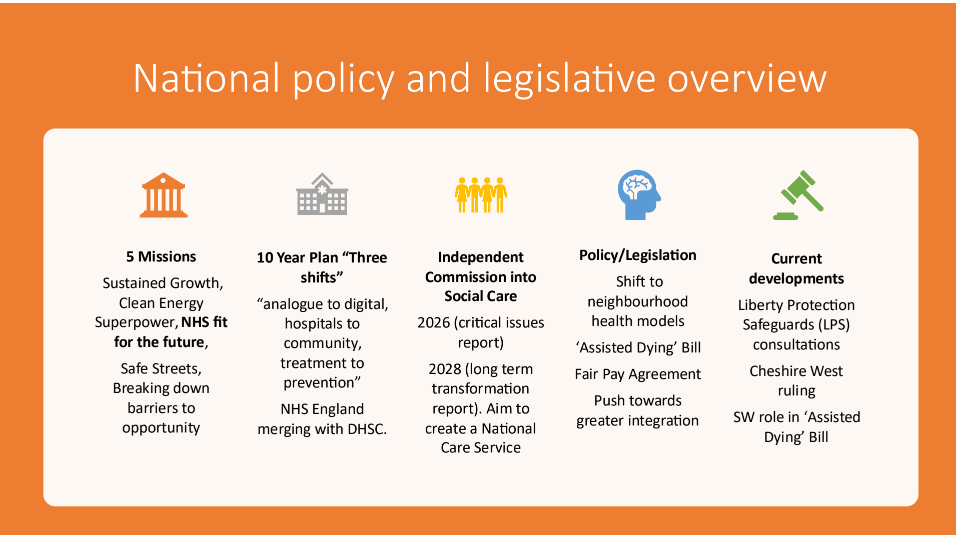
1. **Robert Lewis, Mental Health Social Work Lead, DHSC**

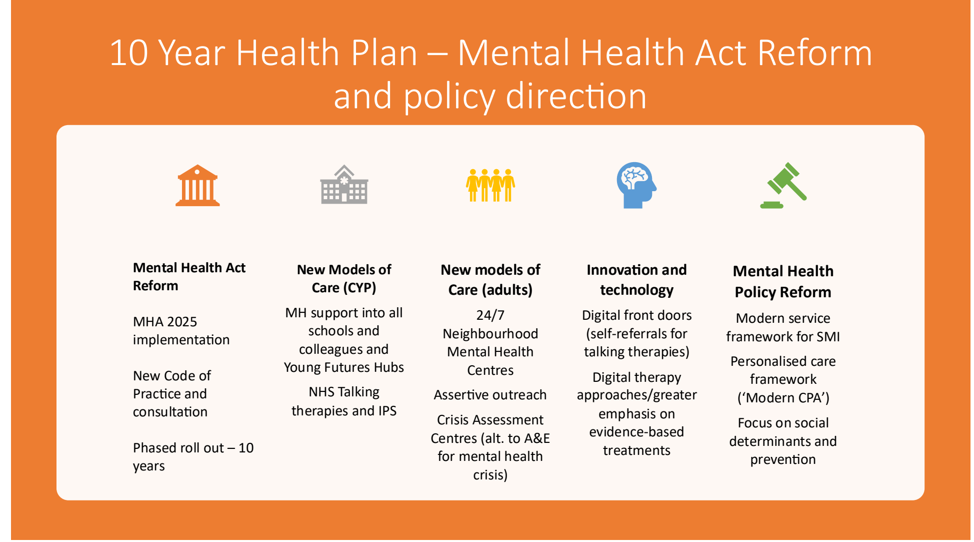
Mental Health Social Work Lead
Office of Chief Social Worker for Adults

Robert Lewis

Mental Health Social Care Incubator – Manchester University

20th and 21st January 2026





Mental Health Social Work

Regulator/Social Work Workforce

Social Work England consultation

Adult Social Work Workforce Steering Group (SWE/SfC)

Impacts for LAs, AMHPs and the sector

Training for the amended MHA

Nominated Person

Advanced Choice Documents

Statutory Care and Treatment Plans

s.117

Upcoming Consultations

MCA/LPS Code of Practice

MHA Code of Practice

Emergency Powers consultation (linked to RCRP)

Network Development and support

AMHP Leads

NHS SW Leaders Network

Principal SWs

Perinatal, forensic, CAMHS

AMHP Partnership Group

AMHP workforce

National AMHP Dataset

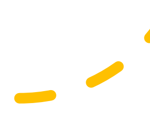
Section 13/System Support

Code of Practice Development

Neighbourhood Health Centres

In November 2025, the UK Government announced plans to deliver **250 Neighbourhood Health Centres** across England as part of its "NHS Neighbourhood Rebuild" programme and 10YP.

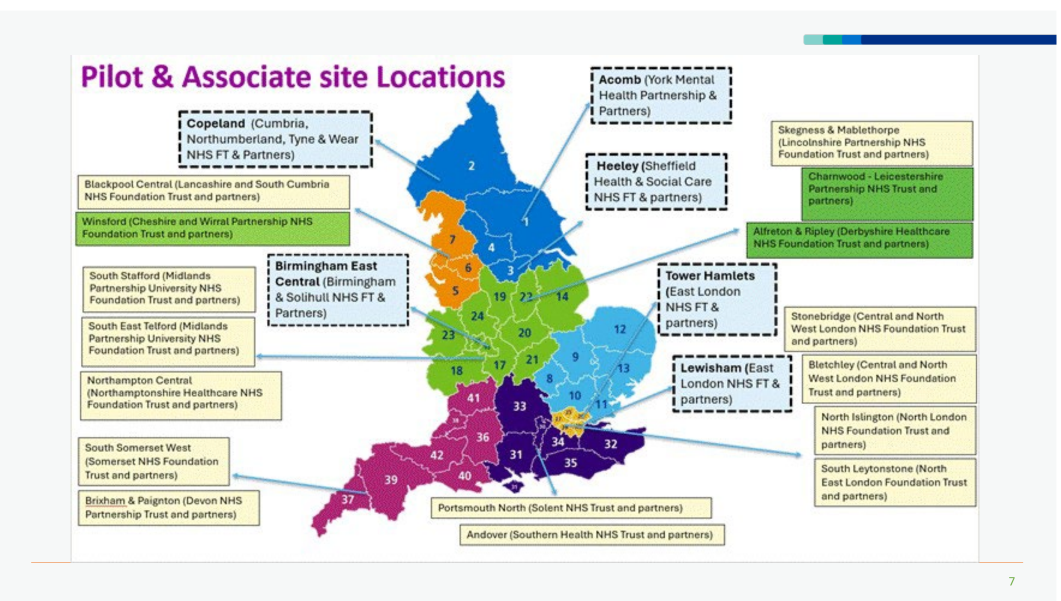
Joint guidance from DHSC and NHSE on neighbourhoods to follow. No date yet but was expected before Christmas so not too far away hopefully.



Neighbourhood Health Centres

Key milestones for this rollout include:

- **Initial Wave: 43 pilot areas** to begin testing the neighbourhood health service model. "One-stop shops" bringing together GPs, nurses, dentists, pharmacists, and mental health specialists.
- **2030 Target:** The Government aims to have **over 100** centres (estimates range from 100 to 120) operational by 2030.
- **2035 Long-term Goal:** The full target of 250 (and potentially up to 300) centres is expected to be completed by the end of the 10-year plan in 2035.
- They will be established through a combination of **repurposing existing NHS buildings** and new modular construction supported by public-private partnerships.



6 Aims of the Community Mental Health Framework

1. Promote mental and physical health and prevent ill health.
2. Treat mental health problems effectively, using evidence-based interventions
3. Improve quality of life, including supporting individuals to contribute to and participate in their communities
4. Maximise continuity of care and ensure no 'cliff edge' of lost care.
5. Work collaboratively across statutory and non-statutory commissioners and providers to address health inequalities
6. Build a model of care based on inclusivity, particularly for people with coexisting needs

10 principles of Neighbourhood Mental Health Centres

1. Trusted Relationships
2. Continuity of Care
3. Open Access
4. All Means All
5. Co-Produced
6. Promote belonging and citizenship
7. Close to Primary Care and System Partners
8. Neighbourhood Based
9. Promote Freedom, Autonomy and choice
10. Do no Harm

6 Core components of Neighbourhood health

1. **Population health management**
2. **Modern general practice**
3. **Standardising community health services:** address physical, mental health and social care needs to provide seamless, joined-up care.
4. **Neighbourhood multi-disciplinary teams (MDTs): proactive, planned and responsive care**
5. **Integrated intermediate care with a 'home first' approach**.
6. **Urgent neighbourhood services:** coordination through a single point of access

Adult social care priorities for local authorities: 2026 to 2027 - GOV.UK

Policy paper

Adult social care priorities for local authorities: 2026 to 2027

Published 18 December 2025

Annex A - list of priority outcomes and expectations for local authorities: 2026 to 2027 - GOV.UK

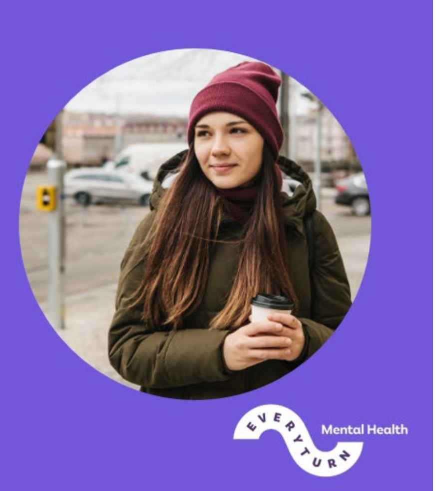
Priority outcome 1 - People who draw on care and support, and their carers, experience high-quality adult social care provided by a skilled workforce

Priority outcome 2 - People who draw on care and support are supported to promote their independence, where possible, and have choice and control over their support

Priority outcome 3 - People who draw on care and support experience joined-up health and social care services at a neighbourhood level

2. Liam Gilfellon, Director, Everyturn Mental Health

Mental Health Social Care in Neighbourhood Care



EVERYTURN Mental Health

Mental health is all embodying, it is not always borne from a medical state but is usually a product of our surroundings and experiences

Mental health is a societal issue

We all have our part to play

Taken from Hope Haven

Neighbourhood models of care should allow us to get a **greater understanding of the person.**

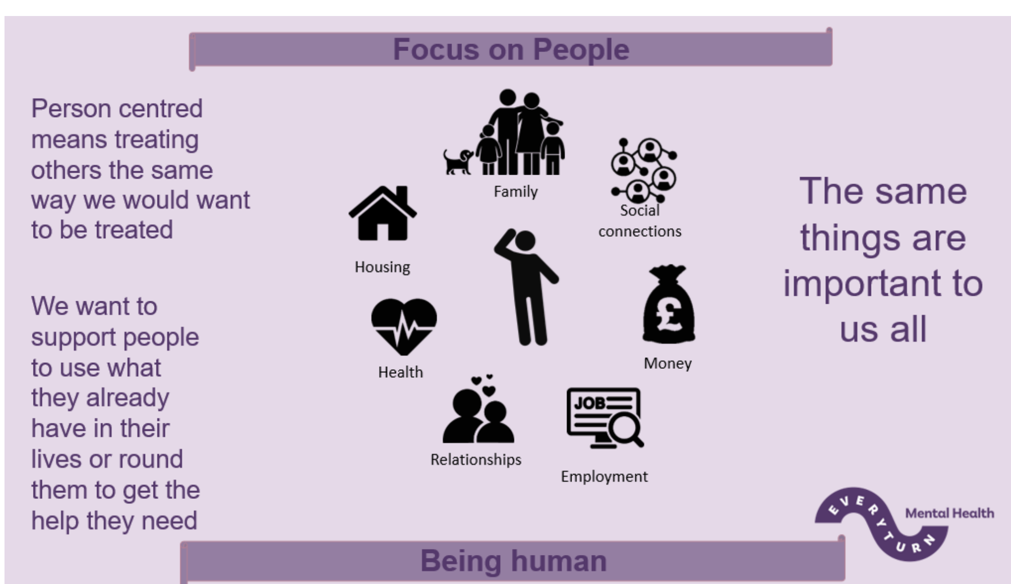
Not only their needs but also their **interests** and **aspirations.**

The neighbourhood model of care

- A multi agency collaborative system-wide solution which will support the community by promoting mental wellbeing 24/7.
- People will be able to access support for mental health experiences which will help them to identify what may trigger or drive their mental health distress.

The neighbourhood model of care

- The offer will be based on a model of trauma informed; recovery focussed, person-centred care.
- This places the person and their family at the centre of a collective approach to listen and understand their needs and help to support, build strength, value and wellbeing as part of their daily life.



Key Principles

- Open access, removing 'referral and discharge' and Work without 'criteria'.
- Enable services to work collaboratively around the person's needs- 'designing teams around the person' and not fitting the person to teams.
- Utilise skills, expertise and access to support from across services.
- Develop a true multi-disciplinary team approach.
- Connect to local partners and services.
- Change the power balance to empower people's choices and autonomy.
- Rich in peer and carer support.

Connecting the Community

We will move away from traditional models of 'silo', organisation-based working, to support mental health and wellbeing differently and in the heart of our community.

The offer will…..

- be delivered without traditional team and service boundaries
- be individually tailored around the person's needs and priorities, acknowledging risk, choice, ownership
- aim to connect the person within their community to achieve improved mental wellbeing and citizenship

Community partners are key to the successful delivery of this model.

Partners offer a wide range of recovery and evidence-based support, interventions and

Lived Experience

- Lived experience is unique, person-centred knowledge, insight and expertise. It brings important and often overlooked perspectives to the field of mental health.
- At the centre of neighbourhood care should be a lived experience offer which aims to support greater involvement, and empowerment as well as access to lived experience support across services.
- These models should inclue dedicated Peer Supporters, Senior Peer Supporter and Carers to embed, highlight and enhance this culture.

Learning from 'Hope Haven'

Presenting issues

- Over half of people seen at Hope Haven have experienced suicidal thoughts.
- A high portion have also experienced anxiety, depression or low mood and self-harm.
- Regarding practical issues, people have presented with issues with housing, alcohol and drug problems and advice needed for financial, benefit and debt issues.
- High numbers of people experiencing relationship issues and bereavement.

The data gathered shows most people have their needs met and their self-rated mental health scores improve.

Learning from 'Hope Haven'

System effect

Notable reductions in crisis caseload and in particular, a significant reduction in informal admissions needing a hospital bed.

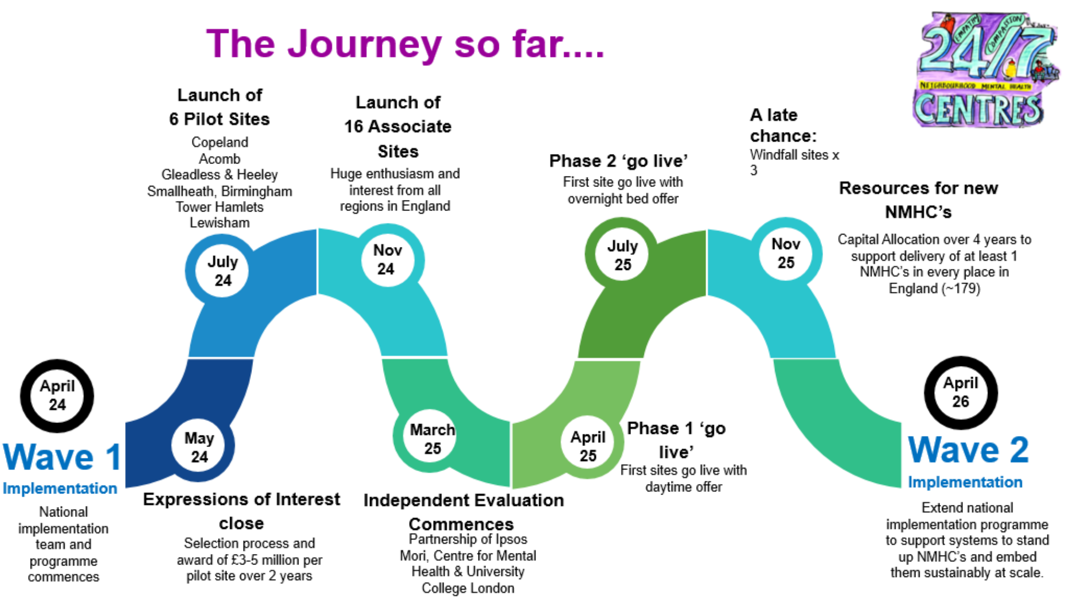
- **Informal admissions reduced from 12 to 1**
  when comparing the 3 month period (18/08/2025 – 03/11/2025) to the same period a year previously

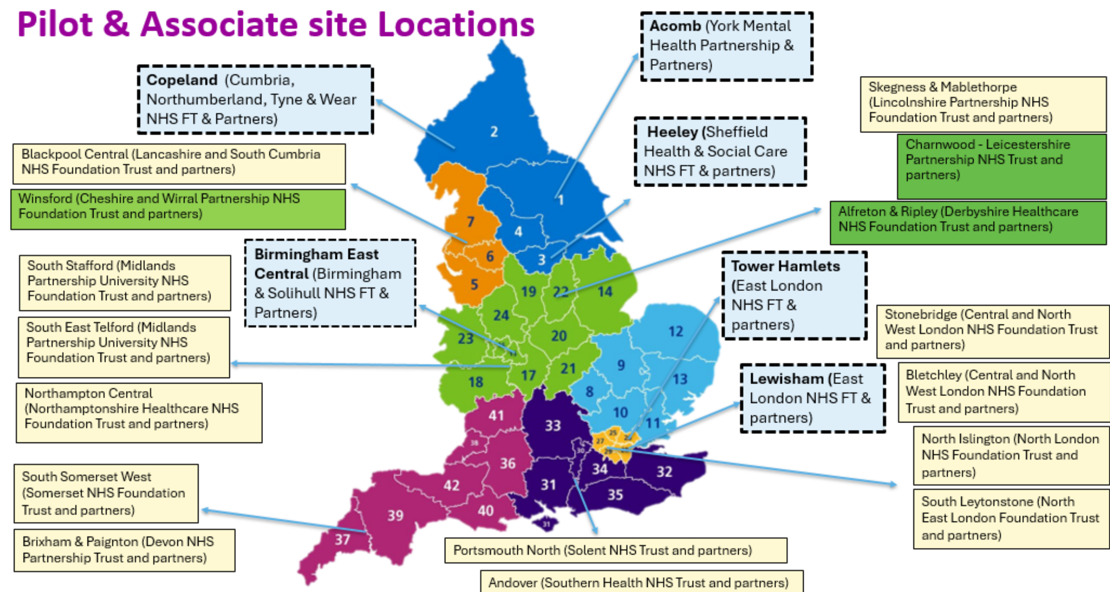
- **average caseloads of the Crisis Team in West Cumbria reduced by 24%,** from 33.22 in 2024 to 25.24 in 2025
  Comparison taken between Sep/Oct 24 to Sep/Oct 25

3. Carey Bamber and Becky Gill, NHS England

24/7 Neighbourhood Mental Health Centres

Carey Bamber and Becky Gill, NHS England





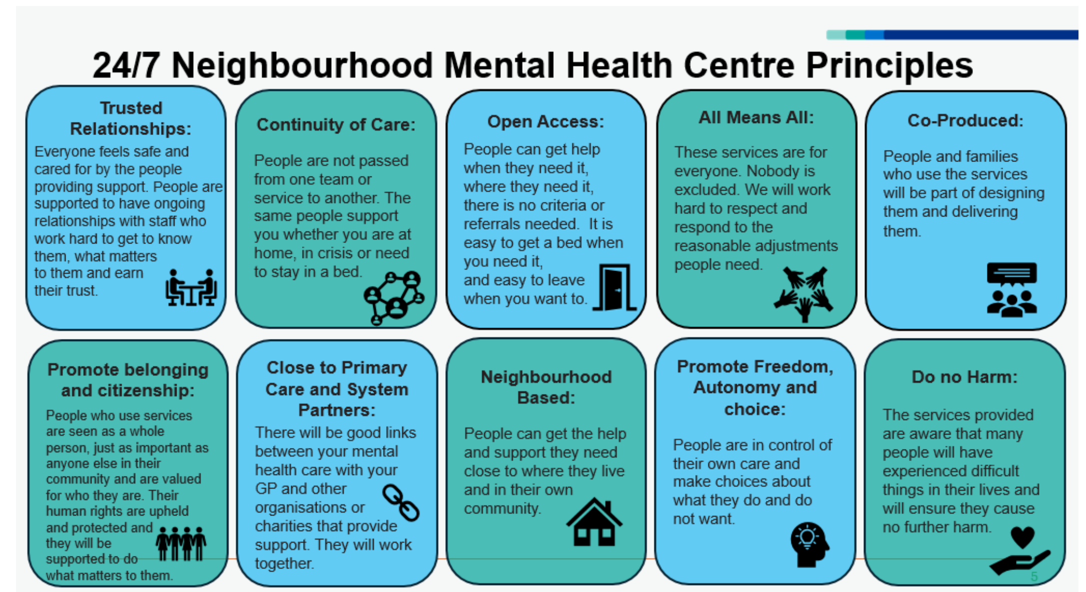
What is a Neighbourhood Mental Health Centre and who is it for?

A NMHC is:

- **A place:** Visible, welcoming building that feels familiar, safe and ordinary, closely connected to local spaces and partners. "*An ordinary building on an ordinary street*"
- **A team:** Multi-disciplinary, multi-agency, bringing together clinicians, peer workers, VCFSE, social care and primary care practitioners, IPS, housing, benefits etc.
- **A function:** Open access, neighbourhood-based mental health service, ensuring continuity, from everyday help to periods of crisis, delivering relational, whole person care.
- **An ethos:** Person centred, rights affirming, rooted in ordinary community life, fostering belonging and citizenship, prioritising prevention and early help and the conditions that enable people to thrive.

A NMHC is for:

- **Anyone** who has a mental health need -but targeting people experiencing severe mental illness who need consistent, neighbourhood-based support and rapid response when required.



Why Neighbourhood Mental Health Centres – international evidence

Improved Patient Safety
- In Trieste, the transformation of services has resulted in a 30-40% reduced suicide rate

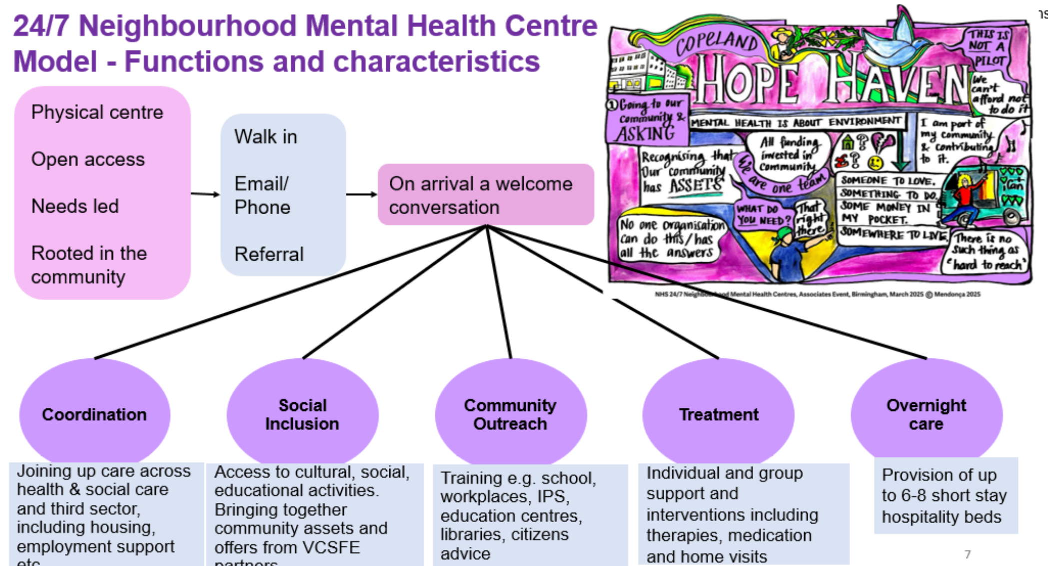
Reduced Hospitalisation
- In East Lille average length of stay in hospital reduced between 26 days in 2002 to 7 days in 2019

Improved efficacy
- Crisis care provided by 24/7 Community Mental Health Centres is more effective in crisis resolution than alternatives at 2yr follow up

Reduced Restriction
- In Brazil, evaluation found no reports of violent or disrespectful incidents in the previous year; seclusion and restraint were not accepted practices in the service

Clinical Outcomes
- In a sample of high priority users a 5 year follow up showed a high rate of social recovery, reduction of symptoms and increased social functioning

Timely Access
- East Lille data indicates 80% of people who access mental health services receive their initial assessment within 48 hours



What have we learned so far?

- Clear core principles and evidence informed design paired with local flexibility in delivery, ensuring fidelity to the model while adapting to neighbourhood need
- Strong multi-professional/multi-agency broad partnerships are critical to the model
- **Open access** – promoting early intervention, preventing crisis driven responses, 'hand-offs' and gaps – simpler routing for primary care etc.
- **Co-production**: people with lived experience and wider community – design and delivery
- Flexible workforce: utilising 'all the talents'
- Shared data, records and outcomes
- Ability to pool/blend budgets & having flexibility & sustainability to support the inclusion of VCFSE esp. grass roots and community led organisations
- Estates – use of local neighbourhood assets and flex in leasing etc.

These factors can be barriers to successful implementation when not in place.

Next Steps

- NHS Capital bid funding process for 2026-2030 - happening now
- Pilot work ongoing, windfall sites
- Close alignment with National Neighbourhood Centres programme
- Association of Mental Health Providers* to publish VCFSE reflection paper March / April
- Guidance materials to support implementation now in development
- Evaluation -Publication in Summer 2026

* To be confirmed

Thanks for listening

- For more information:
- NHS England » Mental Health, Learning Disability and Autism Inpatient Quality Transformation programme
- 24/7 Neighbourhood Mental Health Centres - Mental Health, Learning Disabilities and Autism Quality Transformation Programme (MHLDAQT) – Futures

- Email: england.neighbourhoodmh@nhs.net