Association of Mental Health Providers

NEIGHBOURHOOD MENTAL HEALTH CENTRES PILOT PROGRAMME

LEARNINGS FROM THE VCFSE SECTOR TO INFORM NEIGHBOURHOOD HEALTH DEVELOPMENT

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Executive Summary

The NHS 10-Year Plan, Fit for the Future, sets out three priority strategic shifts for health and care in England: **towards neighbourhood-based care, prevention, and digitisation**. The Neighbourhood Mental Health Centre pilot programme (also known as Community Mental Health Centres) sits squarely within this reform agenda, testing how mental health support can be redesigned around communities, relationships, and social determinants rather than crisis-led, clinically dominated responses.

National evidence indicates that mental health inequalities are not evenly distributed across populations. Racialised communities, particularly Black African and Caribbean groups, experience disproportionate use of coercive pathways, including detention under the Mental Health Act, alongside reduced access to early and preventative support. Migrants, refugees, people experiencing poverty, and disabled and neurodivergent individuals also face systemic barriers linked to language, exclusion, discrimination, and mistrust of statutory systems.

For all communities, neighbourhood health is a new model of delivering support. This presents challenges to all partners, but especially when working to better support marginalised communities.

These patterns highlight that neighbourhood models cannot rely on universal design alone to achieve equitable outcomes. **Delivering on the ambition of "all means all" requires explicit attention to structural inequality, culturally informed practice, and the removal of barriers to access,** embedded from the outset in how centres are designed, delivered, and evaluated. Frameworks to help decision makers and communities do this, such as core principles for Neighbourhood Centres, will help in this. Without explicit design for equity, there is a significant risk that Neighbourhood Mental Health Centres will improve access for some while leaving the most marginalised communities experiencing the same patterns of exclusion and coercion within a redesigned system.

Executive Summary

This document provides a framework to help strengthen the rollout of neighbourhood support, so it works for all communities. Drawing on cross-site learning from Voluntary, Community, Faith, and Social Enterprise (VCFSE) organisations working within pilot centres, convened through a **national network co-chaired by NHS England and the Association of Mental Health Providers,** supported by the London School of Economics and Political Science and the NIHR-supported Mental Health Social Care Incubator, this paper explores what it takes to deliver neighbourhood mental health models in practice and the system conditions required for them to succeed.

It highlights the foundational role of Mental Health Social Care (MHSC) and VCFSE partners within neighbourhood health, in building trusted, accessible, and preventative support, and surfaces critical tensions around outcomes, risk, workforce culture, and system structures that risk undermining impact if left unaddressed. Together, these insights provide timely learning for policymakers, system leaders, commissioners, and providers as neighbourhood health models continue to develop and scale nationally.

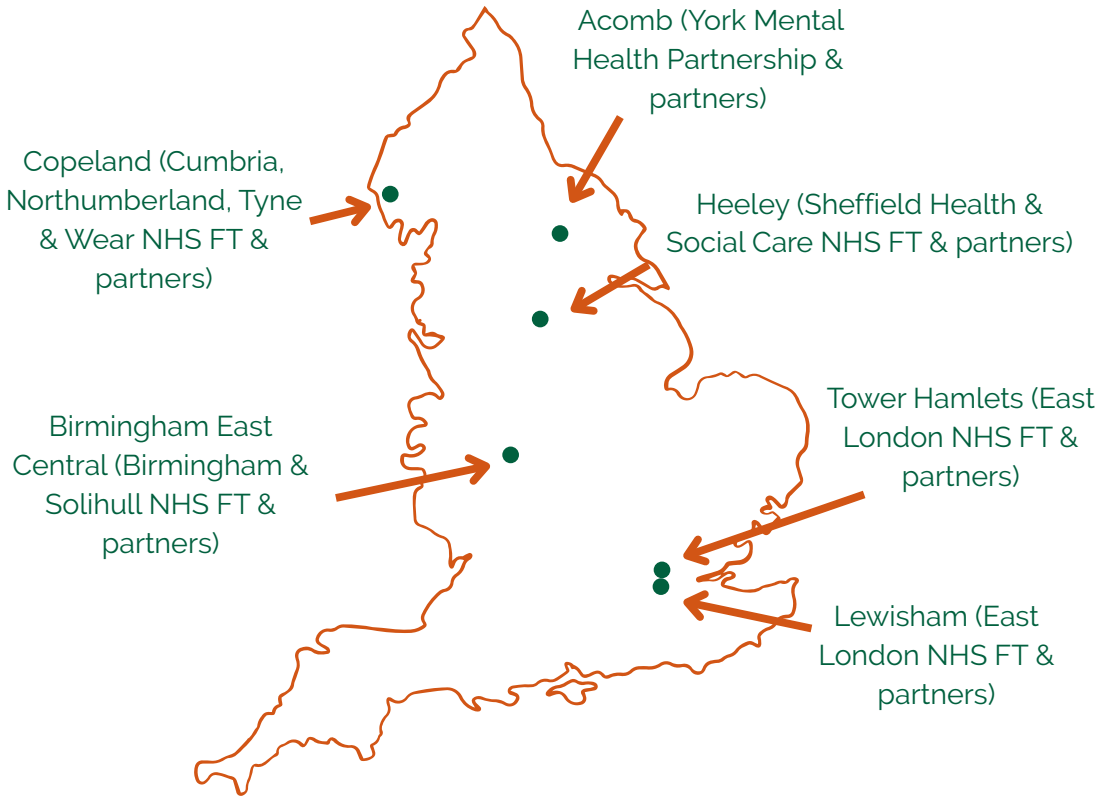


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Introduction

How This Paper Was Developed

Between mid-2025 and February 2026, a series of meetings was convened, bringing together VCFSE organisations engaged in the pilot sites in a national VCFSE network. In these discussions, participants shared experiences of designing and implementing Neighbourhood Mental Health Centres, focusing on how an MHSC ethos and VCFSE partnership have shaped practice and learning.
The distilled insights have been organised into a set of **key lessons**, framed through a Communities, Aims, People, and Structures (CAPS) lens, emphasising their interdependence and implications for systems and policy.

Why This Learning Matters Now

Neighbourhood-based care is rapidly becoming a central organising principle for health and care reform in England. Integrated Care Systems (ICSs) are expected to deliver prevention, reduce inequalities, and shift demand away from acute services, with neighbourhood models positioned as a key mechanism for achieving these aims.

Mental health presents a particular test for neighbourhood approaches. Experiences of stigma, exclusion, poverty, trauma, and mistrust of statutory systems mean that access, experience, and outcomes cannot be achieved through service redesign alone. They depend on **trusted relationships, flexible responses, and community-rooted practice** - all core features of Mental Health Social Care and VCFSE delivery.

The Neighbourhood Mental Health Centre pilots are therefore not standalone initiatives. They are live system experiments that reveal how neighbourhood models operate in practice when applied to mental health. The learning comes at a formative moment, while neighbourhood health policy and implementation frameworks are still evolving, offering a timely opportunity to embed MHSC principles and VCFSE partnership at the heart of reform, before neighbourhood models become fixed through policy, commissioning, and performance frameworks.

About the Neighbourhood Mental Health Centre Pilots

The Neighbourhood Mental Health Centre pilot programme comprises sites across diverse urban and regional contexts in England: Sheffield, Birmingham, York, Tower Hamlets, Lewisham, and Cumbria. These pilots are partnerships between VCFSE providers, NHS organisations, and local authorities, and are testing open-access, community-embedded alternatives to traditional support and crisis pathways that are often dominated by clinical approaches and settings.



The centres aim to provide non-clinical, place-based support at all hours, address social determinants of mental health, and reduce reliance on hospital and emergency services.

Many pilots are co-designed and co-delivered with lived experience leadership and VCFSE partners at the core of their models, reflecting a biopsychosocial understanding of recovery and community wellbeing. This variation in geography, partnership arrangements, and stage of implementation offers a rich evidence base for learning about neighbourhood mental health models in practice.

About Mental Health Social Care

Mental Health Social Care[i,ii] empowers people living with mental illness or experiencing mental distress, their unpaid carers, and their communities, enabling them to lead fulfilling, independent lives through personalised information, advice, and practical support.

[i] Association of Mental Health Providers (2022) Mental Health Social Care: What it is, why and how it matters for Integrated Care. Available at: https://amhp.org.uk/mental-health-social-care-what-it-is-why-and-how-it-matters-for-integrated-care/

[ii] NIHR School for Social Care Research (2025) Conceptualising Mental Health Social Care in England. Available at: https://sscr.nihr.ac.uk/wp-content/uploads/2025/04/210.-Conceptualising-Mental-Health-Social-Care-in-England.pdf

MHSC emphasises relational, rights-enhancing, whole-life support that works holistically with individuals' social, economic, and community contexts. MHSC is foundational for recovery because it helps people develop agency, identity, and a sense of belonging, and supports communities to be supportive, resilient, and emotionally healthy.

The VCFSE mental health sector is a major source of MHSC expertise, particularly through relationship-centred and strengths-based[iii] practice, community engagement, and flexible response to need. This paper reflects how MHSC principles are being interpreted and enacted within the pilots and what that reveals about neighbourhood models more broadly.

Key Lessons from the Centres

The pilot centres represent diverse approaches and local contexts, yet an overriding theme was widespread positivity about the direction of support they embody. Participants agreed that successful models must be grounded in shared principles that are co-owned, actively reflected upon, and embedded in everyday practice.

Principles co-developed by the pilot sites include:

- Trusted relationships
- Continuity of care
- Open access
- "All means all"
- Co-produced practice
- Promoting belonging and citizenship
- Close alignment with primary care and system partners
- Neighbourhood grounding
- Promoting freedom, autonomy, and choice
- Doing no harm

The CAPS Framework: Detailed Learning from Practice

The Communities, Aims, People, and Structures (CAPS) framework captures how Neighbourhood Mental Health Centres function as dynamic systems rather than static service models. Communities are the starting point, but each element interacts continuously with the others – this means the centres and the support they provide to communities are always evolving. Learning from the pilots suggests that an action-learning approach, grounded in the shared principles, is therefore essential.

[iii] see Clark et al. (2025) A relational understanding of strengths-based practice in social work. Available at: https://academic.oup.com/bjsw/advance-article/doi/10.1093/bjsw/bcaf178/8262453?guestAccessKey=

Lesson 1: Communities

Pilot experience emphasises that communities are complex, dynamic, and relational[iv]. They are not simply administrative or geographical units, but **networks of relationships, identities, power, inclusion, and exclusion**. Centres that engaged deeply with this understanding were better able to build trust, reduce stigma, and reach people who might otherwise avoid statutory services, and to continue to respond to evolving needs and opportunities.

VCFSE partners played a central role in connecting centres to community assets, including grassroots organisations, faith groups, peer networks, and informal supports. These assets were not treated as peripheral, but as integral to how centres functioned. However, participants also stressed that communities are not inherently benign: they can exclude, stigmatise, or marginalise. **Centres therefore need flexibility in their approaches**, including in hours and patterns of working, locations, and modes of engagement, embracing outreach beyond a single physical site.

This learning highlights the importance of explicitly addressing inequality, culture, and identity within neighbourhood models. Understanding communities requires attention not only to relationships and place, but also to the ways in which race, ethnicity, faith, migration status, disability, and socioeconomic conditions shape access, experience, and trust.

Participants identified the need for culturally-informed approaches that recognise the disproportionate use of coercive pathways for some racialised communities, and the role of culturally specific VCFSE organisations in building trust and providing appropriate support. This includes **strengthening partnerships with organisations rooted in Black, Asian, and other minoritised communities,** and embedding anti-racist practice within service design and delivery.



[v] see Clark (2024) Relationships and a relational understanding in mental health research. Available at: https://journals.whitingbirch.net/index.php/SWSSR/article/view/2292

Faith and spirituality emerged as important but underdeveloped areas within current models. While faith groups are often recognised as community assets, participants noted the absence of structured approaches to faith-sensitive care, including partnerships with faith leaders and recognition of spiritual distress within mental health support.

Participants also identified significant gaps in relation to migrants, refugees, and people seeking asylum, particularly those with No Recourse to Public Funds or concerns about immigration enforcement. Learnings from the pilot sites tell us that **neighbourhood models must ensure safe, inclusive access for these groups, recognising the impact of trauma, displacement, and mistrust of statutory services**.

Consideration of neurodivergence and disability was also seen as essential. This includes creating **sensory-aware environments, adapting communication approaches, and ensuring physical accessibility and inclusive design.**

Finally, digital inclusion was identified as an emerging issue. As systems increasingly adopt digital approaches, **neighbourhood models must ensure that people without access to devices, data, or digital literacy are not excluded from support.** Digital has to add to the support provided, and not as a simple substitution.

Without explicit attention to these dimensions, there is a risk that neighbourhood models remain relational in intent but do not fully address the structural and cultural barriers that shape inequality in mental health access and outcomes.

Learning from the pilots reframes centres not primarily as buildings, but as configurations of relationships, resources, and responses, embedded within and working with communities and evolving over time.

System Implication

Neighbourhood health policy must move beyond map-based definitions of community and support flexible, relational models that recognise community dynamism, diversity, emergence and inequality.

Lesson 2: Aims

Once communities are engaged and understood, Centres must articulate clear aims grounded in MHSC principles. Pilot sites highlighted the importance of defining success in terms that make sense to people and communities, not solely to systems. **Aims commonly included improving people's sense of identity, safety, belonging, stability, and hope, alongside reductions in crisis escalation**.

Participants repeatedly raised tensions between these aims and existing outcome and data requirements. Systems often prioritise outputs and activity measures, while people using services describe success in narrative and relationship terms ***("I feel better," "I feel more connected," "I know where to go for support")***. Pilots reported that misaligned metrics can distort practice, pulling staff towards what is measurable and achievable in the short-term rather than what is meaningful for communities.

The learning suggests a need for **outcome approaches that combine quantitative data with qualitative, person-defined evidence**, supporting reflection and improvement rather than just compliance.

Participants also highlighted the importance of understanding outcomes through an equity lens. This includes examining who is accessing support, who is not, and how experiences and outcomes differ across groups. The absence of disaggregated data by ethnicity, deprivation, disability, gender, and migration status limits the ability of systems to identify and address inequalities.

Without this level of analysis, neighbourhood models will reproduce existing disparities in access and outcomes, regardless of overall improvements in service availability.

System Implication

Outcome frameworks must evolve to support prevention, relational practice, and learning, or they risk undermining the core aims of neighbourhood mental health models.

Lesson 3: People

Neighbourhood Mental Health Centres bring together people from different organisations, professions, and lived experience backgrounds. This diversity is a strength, but it also introduces challenges around culture, identity, power, and expectations - including differing approaches to risk, governance, and ways of working.

Pilot sites described the importance of deliberate work to **help staff feel a sense of belonging to the centre, rather than to their parent organisation alone**. Often this was an ongoing process, rather than a single administrative fix. Lived experience leadership emerged as particularly influential in shaping non-hierarchical cultures and keeping practice grounded in what matters to people. At the same time, participants noted that culture change is slow and ongoing, especially when statutory norms exert strong gravitational pull.

Supporting people to work differently requires sustained attention to emotional labour, reflective practice, and adaptation in a rapidly changing environment. An action research approach to underpin the work of the centres would support this ongoing evolution.

Delivering culturally responsive neighbourhood models also requires a **workforce that reflects and understands the diversity of the communities it serves**. Participants noted the importance of recruiting staff with a range of cultural, linguistic, and lived experience backgrounds, alongside providing training in anti-racist, trauma-informed, and culturally informed practice.

Recognising intersectionality - the ways in which race, poverty, gender, disability, and migration status interact - is essential to ensuring that support is responsive to the complexity of people's lives.

System Implication

Workforce strategies must invest in cultural alignment, lived experience leadership, and reflective practice, recognising that integration is as much relational as it is structural.

Lesson 4: Structures

Structures - including governance, risk management, reporting, IT, and resourcing - were consistently identified as either enabling or constraining delivery. Participants described how **misaligned structures can unintentionally undermine the principles of neighbourhood working**, for example by prioritising compliance over connection or risk aversion over access.

VCFSE partners highlighted disproportionate reporting burdens, limited infrastructure, and assumptions that flexibility would sit primarily with the voluntary sector. Risk governance was a particular tension, with concern that statutory approaches to "known risk" could erode VCFSE strengths in holding "unknown risk" within open-access models, potentially creating new barriers for people seeking support.

Participants raised concerns that, without explicit structural commitments, neighbourhood models may replicate existing inequalities within new settings.

There was limited clarity on how models would actively reduce the use of coercive pathways, including detention under the Mental Health Act and police involvement in crisis response, despite well-established inequalities in these areas.

There was also concern that open-access centres could, over time, become aligned with traditional risk management approaches, potentially functioning as gateways into existing crisis systems rather than alternatives to them. Without clear system-level intent to reduce reliance on these pathways, inequalities in experience and outcomes may remain unchanged.

Lesson 4: Structures

More broadly, participants highlighted the need to balance relationship-focused approaches with structural interventions. While relational practice is central to the model, there is a risk that, without structural interventions Neighbourhood Centres become strong in terms of their interpersonal relationships but structurally limited, unable to influence the underlying drivers of mental distress such as poverty, insecure housing, and exclusion.

Sustainability of VCFSE provision was also identified as a key issue, particularly in the context of short-term funding and unequal resourcing. Without **long-term investment in VCFSE infrastructure**, there is a risk that neighbourhood models cannot be sustained or scaled in a way that maintains trust and continuity within communities.

Learning from the pilots emphasises the importance of shared responsibility for risk at system level and structures that enable, rather than stifle, flexible, relational practice.

System Implication

Neighbourhood models require aligned governance, proportionate reporting, shared risk frameworks, and infrastructure that supports equitable partnership and MHSC principles.



Implications for policy and practice

The Role of VCFSE and Mental Health Social Care

Across the pilot sites, VCFSE organisations and MHSC partners have been central to shaping how neighbourhood mental health models work in practice. Their contributions include:

- Providing **open access, non-clinical** support that meets people where they are, including those disengaged from statutory services.
- Building and sustaining **trusted relationships** with communities, particularly those facing marginalisation or stigma.
- Embedding **lived experience leadership** to enhance accessibility, relevance, and responsiveness of services.
- Enabling **flexibility** in response and delivery that statutory frameworks often struggle to accommodate.
- Acting as **relational connectors** across sectors and community assets.

Pilot experience suggests that models without strong VCFSE and MHSC involvement struggle to achieve accessibility, inclusion, and preventative impact, underlining that such involvement is foundational rather than optional.

Structural tensions identified - including infrastructure, reporting burden, and risk governance - highlight system risks that must be addressed to sustain VCFSE contribution and MHSC principles at scale.

This reflects the Association of Mental Health Providers' long-standing articulation of MHSC as a core enabler of prevention, recovery, and population mental health within integrated care systems.

Implications for policy and practice

System Implications from the Pilots

The pilot learning underscores that neighbourhood mental health models are as much about system transformation as they are about service redesign. The experiences from multiple sites suggest:

- **VCFSE and MHSC partners are essential** to delivering neighbourhood models that are accessible, preventative, and trusted.
- **Shared risk** approaches and **joint governance** are critical; risk cannot be safely held in isolation by any single partner.
- **Outcome frameworks** significantly shape practice and require evolution to capture what matters to people and communities.
- **Infrastructure** (governance, data, workforce, and administration) either enables or undermines relational, community-rooted practice.

These implications extend beyond mental health and contribute to broader neighbourhood health reform.

Implications for Neighbourhood Health Policy and Implementation

The Neighbourhood Mental Health Centre pilots provide early evidence on what enables neighbourhood approaches to achieve their intended impact, and what risks arise when system conditions do not align with MHSC principles. Key implications for policy and practice include:

- Embedding **mental health and MHSC** within neighbourhood health models from the outset is crucial for achieving integration and community relevance.
- Recognition and resourcing of **VCFSE organisations** as equal system partners should be codified in commissioning, governance, and evaluation frameworks.
- **Outcome measurement and reporting systems** should support learning, adaptation, and person-defined outcomes, avoiding over-reliance on throughput and narrow process metrics.

Implications for policy and practice

- Integrated **workforce strategies** should support cultural alignment, reflective practice, and shared leadership across statutory and VCFSE partners.

- **Infrastructure investments** in data, IT, governance, and shared risk mechanisms are needed to ensure that structures support, rather than constrain, neighbourhood working.

This learning aligns with broader policy directions for integrated care systems and neighbourhood health reform, where authentic partnership, equity, and community engagement are core to effective, sustainable transformation.

The learning also underscores the need for explicit **system-level commitment to equity.** This requires embedding anti-racist and culturally responsive practice within neighbourhood models, developing data frameworks that enable disaggregated analysis of access and outcomes, and taking active steps to reduce reliance on coercive pathways.

It also requires recognising the role of **structural determinants, including housing, poverty, and exclusion**, and ensuring that neighbourhood models are equipped to respond to these factors in practice.

Finally, **meaningful co-production** must extend beyond engagement to include shared decision-making, resource allocation, and governance power, enabling communities - particularly those most affected by inequality - to shape how neighbourhood mental health support is designed and delivered.

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