Association of Mental Health Providers

MENTAL HEALTH SOCIAL CARE: THE MISSING PIECE IN POLICY REFORM

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Understanding Mental Health Social Care

A definition of mental health social care

Mental health social care is not merely an adjunct to health services. It is a distinct and foundational part of how society supports people living with mental illness, deep distress or complex psychosocial needs. Rooted in a social model of wellbeing, it seeks to enable people to live full and meaningful lives in their communities, not just to treat symptoms but to sustain agency, dignity and belonging.

To understand mental health social care properly, we must first challenge a persistent misconception: that social care is primarily about older people and residential care homes. In reality, **social care spans the life course**. It supports working-age adults, families and communities, including many people living with enduring mental health conditions who require practical, relational and community-based support to thrive. Reframing social care in this way is critical. When we see it only through the lens of ageing, we overlook its central role in enabling people with poor mental health to participate in society, sustain relationships, and exercise choice and control in their daily lives.

At its core, mental health social care embraces the idea that recovery from mental health challenges is a biopsychosocial process - one in which social, economic and relational factors matter as much as clinical diagnosis or therapeutic intervention.

It recognises that people's experiences of mental illness are shaped by their housing, income, relationships, culture, discrimination, trauma histories and opportunities for participation in community life. These dimensions must be addressed if people are to live safely, independently and with purpose.

How social care operates

These dimensions are reflected in the delivery of social care - it offers **practical, personalised support** with everyday activities; providing information and advice; helping people navigate complex systems; and forging connections to community supports that bolster resilience and reduce isolation. Social care professionals - including social workers and a wide range of support roles across statutory and voluntary sectors - prioritise relational, long-term engagement with people, learning about the whole of a person's life and building trust over time.

That relationship-centred approach contrasts with more transactional aspects of care and emphasises empowering individuals to exercise choice and control over how they live. It respects human rights and social justice principles, reminding us that wellbeing cannot be managed purely through clinical diagnosis - it must be co-created with people in the contexts where they live and aspire to thrive.

Mental health social care's place in policy

Mental health social care is also increasingly being discussed in policy terms as part of a broader reform moment: delivering tangible change in the short term while preparing for deeper reform over the longer term. This creates a particular urgency. The system is being asked to improve outcomes "now" while also getting ready for the next phase of reform thinking - and that readiness depends on understanding what is already happening in communities, what the provider market looks like in reality, and what the lived experience of support feels like to the people who rely on it.

In that context, mental health social care is not an optional layer around clinical services: it is part of the infrastructure that makes a shift toward community-based support possible.

Until recently, this visibility has been limited. Mental health social care has often been poorly represented in national datasets, fragmented across commissioning routes, and difficult to quantify in a way that informs system planning. Through the development of the Association of Mental Health Providers' Mental Health Data Observatory, we are beginning to address that gap.

Our national mental health sector mapping tool brings together regulatory, NHS and VCSE data to provide an interactive picture of service provision across England - showing not only where services exist, but where they do not. This is critical for reform: systems cannot plan equitably if they cannot see the full landscape of provision.

Mental health social care in practice

Together for Mental Wellbeing provides 24-hour accommodation services across the country to support people to build the foundations for them to recover and eventually live independently. Their **Progression Together** model supports people with complex mental distress to achieve greater independence by equipping the individual to lead their own support. The **Clinical and Recovery-Focused Accommodation Service** provides step-down social care to people moving from inpatient settings to the community, focused on building more responsibility and life skills.

"They told me at 18 that I was not safe to be out in the community, and I spent much of my life in and out of hospital. Together helped me to move into a wonderful flat of my own."

What This Means for People with Mental Ill-Health

The day-to-day experience of social care

For individuals navigating mental health challenges, social care can make the difference between surviving and living well. Where clinical mental health services focus predominantly on treating symptoms and managing risk, social care attends to the broader life circumstances that make recovery - or a good quality of life - possible.

Social care can mean practical support with daily living - from maintaining a tenancy to managing money, connecting with education or employment opportunities, and reducing social isolation. It can mean advocacy and voice, particularly where people struggle to make themselves heard within complex systems or face discrimination and marginalisation. It includes support for carers and families, many of whom provide unpaid care under intense strain; their wellbeing is integral to the wellbeing of the person they support. And it means community integration, ensuring people are part of supportive networks rather than confined to institutional settings.

Crucially, mental health social care recognises recovery as non-linear and deeply personal. It cannot be standardised into uniform pathways or short episodes of intervention. It requires time, continuity and a holistic view of the person's life. Social care often remains alongside people as they navigate the ebbs and flows of their wellbeing, not just at moments of acute medical need.

For many, the presence of consistent relational support prevents escalation into crisis. For others, it provides the scaffolding needed after discharge from hospital, reducing the likelihood of readmission. For families and carers, it provides reassurance that support extends beyond clinical appointments. In all cases, it affirms that people are citizens first, not patients.

Who mental health social care is for

And because mental health social care is rooted in ordinary life - in homes, neighbourhoods, relationships, and the day-to-day work of coping - it often reaches people who do not experience themselves as "patients" at all. Some of the most marginalised people, including those facing multiple disadvantage, may not be connected to primary care or may actively avoid statutory services due to mistrust, stigma, trauma, or previous experiences of exclusion. For these individuals, community-based social care and VCSE provision can be the route into support - often long before a crisis becomes visible to the health system.

Mental health social care in practice

Natalie is living in **KeyRing**'s Newburn Street project in Lambeth, South London. Natalie lives on her own in a self-contained apartment. She experienced mental ill-health around the birth of her son and talks about debilitating postnatal depression.

KeyRing has been supporting Natalie with financial management to pay off her debts after having rent arrears due to an extended stay in hospital. She also has support with her mail and healthy relationships. Natalie knows that she can call KeyRing when she has a problem and that she can reschedule her support around her availability. KeyRing knows that without this layer of support Natalie's needs can escalate with consequences that impact both her mental and physical wellbeing.

Aaron is living in **Servol Community Services'** Phoenix Project after serving his prison sentence. The Phoenix Project provides specialist supported accommodation for prison leavers with complex mental health needs.

Since living at the Phoenix Project, Aaron feels like he has been given the opportunity to build a positive future and is committed to making a positive change in his life. He supports with keeping the household clean and tidy, and spends time discussing ways to support and manage mental health with the staff and other residents. He's seeing early signs of improvement in his physical and mental health and will continue to work with staff towards meeting his goals, managing his health, maintaining his family relationships and building a stable crime-free future.

The Policy and Reform Context

Social care reform vows significant change – with the UK's first Fair Pay Agreement promising minimum standards for employment and equal pay within the social care workforce, and an independent review by Baroness Casey expected in 2027 set to determine next steps towards a new National Care Service. At the same time, political change in the UK presents a renewed opportunity to accelerate progress. As of August 2026, the UK's Prime Minister, Andy Burnham, has made commitments to fix the social care system, bidding to expedite the Casey Commission and assigning a cross-government ministerial team to lead reform plans.

Making mental health a priority in social care reform

These discussions have reinforced the need to recognise mental health as central to social care policy. Leaders across government and the voluntary and community sector have recently emphasised that social care reform must include - not marginalise - people living with poor mental health.

An important lesson emerging from reform engagement is that **policy change must be informed by those with lived experience of mental health challenges,** as well as providers delivering services on the ground.

Listening to people who use services, their families and frontline practitioners is not an optional extra - it is foundational to designing systems that work. Reform is not solely structural; it is relational. It requires time, resource and sustained dialogue across government, statutory services and the VCSE sector, as well as lived-experience networks.

This collaborative approach reflects a broader truth: mental health social care cannot be designed from organisational silos. It requires co-production and partnership, ensuring that people's voices shape commissioning decisions, workforce planning and service transformation.

Yet this is also where ambition meets the hard realities of pace and power. The speed of policy change can outstrip the time needed to involve people meaningfully - and too often the people purchasing services are not the people using them.

If mental health social care is to be more than a technical annex to reform, then lived experience must shape not only service design but also the way priorities are set, what outcomes are valued, and how trade-offs are made. That is particularly important for the voices that are least often heard: people who are not currently engaged with statutory services, people living with multiple disadvantages, and those whose needs only become visible when systems have already failed them.

The state of integrated care

Effective mental health social care does not exist in a vacuum; it is shaped by broader reforms in how health and social care are planned, funded and delivered. Integrated Care Systems (ICSs) aim to bring health services, local authorities, voluntary organisations and communities together to plan and deliver joined-up services. The aspiration is to break down long-standing silos between mental health services, primary care, adult social care, public health, housing and community supports, so that people receive coordinated support that matches their complex needs.

Yet integration is far from automatic in practice. Commissioning arrangements - how services are planned and funded - often remain fragmented, reflecting historical divides between the NHS, local authorities and the voluntary sector.

Without deliberate alignment, people experience transitions between services as disjointed, confusing or even adversarial.

For people with mental health needs, better integration means fewer gaps in support, smoother transitions between hospital and community, and an experience of care that feels coherent rather than fragmented. It means that housing, employment support and social networks are treated as essential components of recovery rather than secondary considerations.

There is also a particular risk in how "integration" is interpreted when systems talk about shifting care from hospital to community. If that shift is framed primarily as the NHS redeploying its own workforce into community settings, rather than building a broader partnership across social care, housing and community-based support, the reforms may reproduce the very silos they claim to dissolve. True neighbourhood and community models require a wider and more diverse set of partners than the NHS alone - including VCSE organisations with deep roots in local communities and experience supporting people whose needs sit across multiple domains.

Commissioning Challenges and Their Impact

Commissioning profoundly shapes what support is available to people. But, mental health social care providers experience a range of challenges, as detailed in the Association's Charity Commissioning Charter. Traditional commissioning models have too often been transactional, focusing on narrow outputs rather than meaningful outcomes. Contracts may be short-term, inflexible or designed around organisational convenience rather than people's lives.

When commissioning is overly rigid or constrained by short funding cycles, services that depend on trust and long-term engagement struggle to flourish. Preventative community-based supports may be under-funded despite their potential to reduce crisis admissions and long-term costs.

There remains a persistent imbalance between investment in clinical services and investment in social care and community infrastructure. Much of mental health social care is delivered by the voluntary, community and social enterprise sector, yet funding flows are often insecure. Without sustainable commissioning models, relational services - which take time to demonstrate impact - can be vulnerable.

One reason this imbalance has persisted is that mental health social care has not always been clearly mapped or understood at system level. Our national sector mapping now provides commissioners and Integrated Care Systems with the ability to identify geographical variation, service clustering and areas of unmet need. When combined with local intelligence, this enables more strategic commissioning decisions - moving beyond assumptions toward evidence-informed planning. If reform is to succeed, such tools must be actively used to align investment with community need.

The practical consequences of short-term commissioning show up quickly. Annual negotiations, uncertainty about future funding, and differences in approach between funding routes can make it difficult for organisations to plan strategically, retain staff, or invest in service development. Even where the evidence of impact is strong, it can take time to capture and demonstrate outcomes - and that work becomes harder when services are repeatedly destabilised by changing contract conditions.

When funding does not keep pace with cost pressures, providers absorb increases until they cannot, and smaller organisations with limited infrastructure are often the first to be forced to scale back or exit.

The result is a quieter form of service erosion that can reduce community capacity precisely when national policy is asking systems to shift support away from hospitals.

There is also a recurring commissioning pattern that unintentionally undermines what works: a preference for funding framed as "innovation", even when services are already delivering effective, community-based support. When short-term pilot funding ends, there may be no route to sustain what has been built - and what is lost is not only a service but also the local relationships, trust and continuity that made it effective. This is particularly damaging in mental health social care, where continuity is often the mechanism of change.

Best practice commissioning increasingly involves pooled budgets, alliance contracting, co-production with lived experience partners, and outcomes frameworks that capture social as well as clinical impact. These approaches recognise that social care is not peripheral to mental health systems; it is a core component of sustainable recovery.

Mental health social care in practice

Certitude provides mental health social care through their **Short-Term Intensive Support** service. In the last 4 years, they have supported 650 people with supported living after an inpatient stay at hospital. Working with Ward Home Treatment and Community teams, they provide the support for people to develop the confidence and skills they need to move on to a more permanent home.

Their **Solidarity in Crisis** service provides a crisis alternative through peer-led support for people experiencing a mental health crisis in South London, with lived experience peer supporters preventing people from reaching crisis point and promoting recovery and feelings of belonging to people in distress.

Workforce: The Heart of Social Care Provision

At the centre of mental health social care is the workforce - a diverse group of social workers, support workers, peer practitioners, advocates, community connectors and leaders across statutory and VCSE sectors.

This workforce carries significant expertise in relational practice, rights-based advocacy, safeguarding, community development and trauma-informed approaches. Yet it faces profound pressures. Recruitment and retention challenges persist. Pay disparities between sectors create instability. Workforce planning often remains divided between health and social care systems, limiting integrated development.

Understanding workforce capacity is equally essential. Through our mental health workforce mapping tool - integrating Skills for Care data with Census and provider insight - we now have a clearer national picture of who delivers mental health social care, where workforce pressures are most acute, and how patterns vary regionally.

This exposes disparities in workforce density and highlights areas where recruitment, retention and pay pressures pose systemic risk. Without such insight, ambitions to shift care into communities risk being disconnected from workforce reality.

Reform discussions have underscored that workforce change requires listening - not only to professionals but to people using services.

Building capacity and capability is not simply about numbers; it is about culture, diversity, lived experience representation and sustained professional development.

For people with mental illness, workforce instability translates directly into inconsistent relationships, longer waits and fragmented support. Because social care is inherently relational, continuity of staffing is not a luxury - it is foundational. Trust, once broken through staff turnover or service closure, can take years to rebuild.

And the workforce challenge cannot be separated from commissioning and funding practice. When contracts are short, when uplifts do not match rising costs, and when providers must repeatedly renegotiate year-on-year, the burden falls directly on workforce stability. People delivering care absorb uncertainty alongside their workload; organisations become cautious about development; and retention becomes harder even when roles are meaningful and staff are deeply committed to the work.

If national ambitions include fair pay and improved workforce outcomes, then funding mechanisms must make that ambition real across the system - including for VCSE providers whose contribution is central to community-based mental health support.

Investing in the workforce means valuing relational time, supporting peer roles, strengthening supervision and career pathways, and ensuring parity of esteem between health and social care professionals.

Mental health social care in practice

Hammersley Homes provides permanent support for adults living with mental illness in Hampshire, who have been referred by the NHS. Providing social care outreach support to people within their own homes, they offer a sense of safety, security and community through help with daily tasks, such as cooking, internet use, finances, mail, benefits, social engagement and hobbies.

The demand for Hammersley's services in Hampshire has continued to grow – from supporting 20 members in 2021, to 104 members in 2024. This equated to 1,872 hours of support to people with severe mental illness. Hammersley has recognised the need for mental health social care services more broadly, and are aiming to expand the service nationwide, with a network of fully supported homes for life, where residents can live among friends, with 24/7 support on hand.

Turning Point provides **Residential Rehabilitation, Supported Accommodation** and **Crisis Support** mental health social care services, as well as **Drugs and Alcohol Residential Rehabilitation** to provide wrap-around support for lasting recovery from substance use.

Turning Point's mental health residential rehabilitation is focused on developing a person-centred recovery pathway for people with severe and enduring mental health needs. While every service user has a goal of developing practical skills to live independently, Turning Point works with people to identify their individual needs, goals and aspirations and build coping strategies and self-management techniques for their mental health. While, group activities provide service users with creative and social opportunities.

Implications for Policy and Integrated Care Leadership

If mental health social care is to fulfil its promise, it cannot sit at the margins of reform. It must be explicitly recognised as a core component of the mental health system and embedded in the way policy, commissioning and system design are undertaken.

Reform now can move beyond principle toward precision. The existence of national service and workforce mapping means that decision-makers can no longer argue that the sector is invisible or unknowable. The data exists. The question is whether it will be used to shape commissioning, workforce planning and neighbourhood design in a way that genuinely embeds mental health social care at the heart of the system.

First, **integration must move beyond rhetoric**. Shifting care from hospital to community is not achieved simply by relocating NHS activity into community settings. It requires a broader rebalancing of power, resource and design - one that brings social care, housing, employment support and community-based provision into the centre of planning conversations. Integrated Care Systems must ensure that mental health social care expertise is present not only at delivery level but at the strategic commissioning table, shaping priorities upstream rather than responding downstream.

Second, **commissioning practice must align with the relational nature of the work**. Short-term, annually renegotiated contracts undermine precisely the stability and continuity that effective mental health social care depends upon. If the system wishes to prioritise prevention, recovery and community resilience, it must create commissioning and funding models that enable providers to plan over multiple years, invest in workforce development and build sustained relationships with local communities. Innovation should not be conflated with novelty; sustaining what works can be as important as piloting something new.

Third, **workforce reform must encompass the full ecology of support.** Mental health social care is delivered by a diverse workforce that spans statutory and voluntary sectors, includes peer roles and lived experience leadership, and often operates at the boundaries of formal services. Workforce strategies that focus solely on clinical roles will miss a substantial part of what keeps people well. Parity of esteem must extend beyond rhetoric about mental and physical health to include parity between health and social care workforces in terms of recognition, investment and voice.

Fourth, **lived experience must shape reform at a structural level.** There is growing commitment to placing people's experiences at the heart of system design, but this requires more than consultation. It requires time, skill and cultural change within institutions, as well as recognition that some of the most important voices belong to people who are not currently engaged in services. Community-based mental health social care providers are often uniquely placed to reach and amplify those voices; reform should treat that capacity as an asset, not an afterthought.

Finally, **national reform efforts - whether through long-term reviews, neighbourhood health initiatives or changes in departmental operating models - must avoid narrowing social care to its most visible pressures**. While issues of hospital flow and residential provision are urgent and politically salient, mental health social care encompasses a much broader set of supports that prevent crisis in the first place. If reform focuses only on beds and bottlenecks, it risks overlooking the everyday relational work that sustains independence, connection and dignity.

Mental health social care sits at the intersection of personal lived experience, community life, policy systems and professional practice. It offers a vision of support that is human-centred, relational and deeply social - recognising that people are more than their diagnoses and that wellbeing is woven through everyday life. Effective mental health social care can mean the difference between isolation and engagement, crisis and stability, fragmentation and continuity.

Mental health social care is already delivering for thousands of people across England. The challenge now is not whether it works - but whether the system will fully recognise and sustain it. Realising this vision at scale requires political will, adequate funding and genuine partnership across sectors. It means valuing not just clinical interventions but the social scaffolding that enables people to live with dignity, autonomy and connection.

The opportunity now is to align ambition with reality: to match the language of community and prevention with the structural conditions that allow them to thrive. Mental health social care is not an accessory to clinical care; it is the connective tissue that enables people to live well beyond the boundaries of the hospital. **Ensuring it is visible, valued and sustainably supported is therefore not a peripheral task in reform - it is central to whether reform succeeds at all.**


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