“What happens when I can no longer care?”

Future Planning for Mental Health Carers Project

Literature Review:

Service Models for Ongoing Support

May 2025

A project by Arafmi and Mental Illness Caregivers Association of Canada (MICA)

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Background

Arafmi and Mental Illness Caregivers Association (MICA) believe more needs to be done to support caregivers' planning for when they are gone. Together, via the "What happens when I can no longer care?" Future Planning for Mental Health Carers Project, we are undertaking a collaborative effort to map out and develop solutions aimed at addressing this issue. This literature review (the review) is the first stage of this project. It has been completed as a rapid review, highlighting key service models rather than a comprehensive review due to the time available for this stage of the project. This review aims to identify and understand models of planning for ongoing support that already exist in Australia and overseas. The search criteria included programs that provide targeted support for people experiencing mental health challenges and disability more broadly. While the focus is existing models, some discontinued Australian programs that are well-supported in evaluations and continue to receive ongoing support from consumers during consultations have also been included. For each service model, this review seeks to identify:

- how they are structured,
- examples of the service and where they are located,
- how they are funded and managed; and
- what benefits or challenges are associated with the model, particularly when applied to people experiencing mental health challenges.

Overall, this review found that both in Australia and overseas, innovative service models exist that could address various dimensions of the challenge of planning for and providing long-term caregiving support for individuals with mental illness, when family caregivers are no longer able to provide care. These are outlined below.

Service Models

Future Planning Tools and Information Services

Future planning tools and information services help families to find future planning information and create sustainable plans for the person they care for. Plans often involve third-party organisations taking on a caregiving role.

Examples

The Arc

Who they work with: Individuals with intellectual and developmental disability (including those with mental illness), their family members and friends, professionals who support them and other members of the community.

Location: United States

Service description: The Arc is a not-for profit advocacy organisation with a large network comprised of 660 chapters across the United States. Through the online Center for Future Planning, The Arc aims to support and encourage adults with intellectual disability or developmental disability and their families to plan for the future. The Center provides reliable information and assistance in areas such as person-centered planning, decision-making, housing options, and financial planning[1]. Through the online Build Your Plan tool (explained further below) available on the Center website, families receive assistance with legal, financial, and care planning. They can also find and connect with local chapters of The Arc, which may be able to support ffamilies with legal, financial, and care planning, and connections to services and organisations that can assume caregiving responsibilities[2]. Families are encouraged to begin planning and consider all aspects of the planning process, including non-financial, regardless of the size of the estate and regardless of whether they have access to legal support[3]. The Center provides up-to-date links and guidance regarding public benefits and programs that are available. Guidance on how to access urgent support is also available for individuals who have an immediate need for temporary or permanent support because a parent or primary caregiver can no longer provide that help[4]. Individual local chapters of the Arc can provide information

[1] The Arc (2023) About the Centre for Future Planning. Accessed online 14/04/2025 at https://futureplanning.thearc.org/pages/learn/about

[2] The Arc (2023) About the Centre for Future Planning. Accessed online 14/04/2025 at https://futureplanning.thearc.org/pages/learn/about

[3] The Arc (2023) Future Planning. Accessed online 14/04/2025 at https://futureplanning.thearc.org/pages/learn/future-planning-101

[4] The Arc (2023) Urgent Need. Accessed online 14/04/2025 at https://futureplanning.thearc.org/pages/urgent-need

workshops or in-person support to navigate the planning process, however it is noted that individual chapters of The Arc vary in size and in the services they provide[5].

The *Build Your Plan* tool available online through the Center for Future Planning website helps people to think about and plan for their future. The interests, preferences, and skills of the person are the main focus. The tool guides people and their families through important topics, including:

- Expressing wishes for the future in writing
- Deciding where to live and how much support is needed
- Paying for basic and other needs
- Getting a job and other daily activities
- Making daily and major life decisions
- Making friends and having good relationships[6].

The Center encourages person-centred planning that reflects the wishes of the person with intellectual or developmental disability, as well as his or her parents, siblings, extended family members and friends, and other important people in his or her life. It is recommended that plans include information about all aspects of a person's life that would help them maintain their daily routines during a life transition, including:

- Daily routines, needs and supports
- Living arrangements
- Finances, including the family and person's public benefits, assets, incomes, trusts, insurance policies
- Doctors' contact information and information about the person's medical history (including any medications and food allergies)
- Decision-making support
- Education history

[5] The Arc (2023) Future Planning 101. Accessed online 14/04/2025 at https://futureplanning.thearc.org/pages/learn/future-planning-101
[6] The Arc (2023) Build Your Plan. Accessed online 14/04/2025 at https://futureplanning.thearc.org/landing

- Details about the person's employment, leisure activities, religious beliefs, behaviors, interests, friendships, and other important relationships[7].

The *Build Your Plan* tool allows users to create a live document that can be saved and returned to as needed by people and their families. The tool is designed this way in recognition of the fact that future planning is an ongoing process, rather than something that just happens once[8].

Funding and management: The Arc is funded through donations, government grants, and service fees, and partners with local agencies to provide tailored support[9].

National Alliance for Mental Illness (NAMI)

Who they work with: People living with mental illness, caregivers and educators.

Location: United States

Service description: NAMI is a not-for-profit grassroots mental health organisation made up of more than 600 state organisations and affiliates in local communities across the United States[10]. NAMI provides support and resources for families of individuals with mental illness, including guidance on long-term planning for future care needs. Though not directly offering third-party caregiving, NAMI provides support structures and connects families to relevant legal and social resources. The program offers peer-led support groups, educational resources, and a national helpline to advise families on finding care and services. For example:

- *Circle of Care Guidebook:* This guide – released in 2016 - emerged from the first national study on mental health caregiving in the United States, "*On Pins and Needles: Caregivers of Adults with Mental Illness*" which identified numerous challenges faced by caregivers[11]. Circle of Care is designed to guide unpaid friends, family and neighbours who care for someone with a mental health condition[12]. Fact sheets included in the guide assist

[7] The Arc (2023) Future Planning 101. Accessed online 14/04/2025 at https://futureplanning.thearc.org/pages/learn/future-planning-101
[8] The Arc (2023) Build Your Plan. Accessed online 14/04/2025 at https://futureplanning.thearc.org/landing
[9] The Arc (2025) Supporters. Accessed online 14/04/2025 at https://thearc.org/about-us/supporters/
[10] National Alliance for Mental Illness (2025) Who we are. Accessed 14/04/2025 at https://www.nami.org/about-nami/
[11] National Alliance for Mental Illness (2025) Circle of Care Guidebook. Accessed 14/04/2025 at https://www.nami.org/support-education/publications-reports/guides/circle-of-care-guidebook/
[12] National Alliance for Mental Illness (2025) Circle of Care Guidebook. Accessed 14/04/2025 at https://www.nami.org/support-education/publications-reports/guides/circle-of-care-guidebook/

caregivers with finding help for the specific challenges identified in the On Pins and Needles study. It includes topics such as Communicating with Health Professionals, Discharge Planning, Taking Care of Yourself and Planning for the Future. The Planning for the Future Fact Sheet (Factsheet 10) provides information on:
    - What is future planning?
    - What planning is needed? (e.g. benefits and financial planning, residential planning, support networks)
    - Taking the first step
    - Helpful websites[13]
- *NAMI Family Support Groups:* These peer-led support groups provide support for any adult with a loved one who has experienced symptoms of a mental health condition. NAMI's support groups follow a structured model to ensure everyone is heard. They are confidential, free of cost and 60-90 minutes long and meet weekly, biweekly or monthly depending on location.
- *NAMI Helpline:* The NAMI HelpLine is a free, confidential nationwide service that can provide one-on-one emotional support, mental health information and support to find resources and services[14] to help tackle challenges involved with future planning for people with mental illness and caregivers.

Funding and management: NAMI is funded through donations, grants, and partnerships with healthcare organisations[15].

Community Resource Unit (CRU)

Who they work with: People living with disability, their families, disability services and the community.

Location: Australia (Brisbane)

Service description: Community Resource Unit (CRU) emerged as an initiative of parent advocacy organisation, Queensland Parents of People with a Disability. CRU aims to create positive change so that people living with disability can belong to and actively contribute to social and economic

[13] National Alliance for Caregiving and National Alliance for Mental Illness (2016) Circle of Care: A guidebook for mental health caregivers. Accessed 14/04/2025 at https://www.nami.org/wp-content/uploads/2023/08/CircleOfCareReport.pdf
[14] National Alliance for Mental Illness (2025) NAMI Helpline. Accessed 14/04/2025 at https://www.nami.org/support-education/nami-helpline/
[15] National Alliance for Mental Illness (2025) Meet our Partners. Accessed 14/04/2025 at https://www.nami.org/about-nami/who-we-are/meet-our-partners/

life. They do this through their vision and research to assist people to shape and deliver helpful, relevant and responsive human services and support arrangements. CRU is not involved in direct service provision and is not considered an advocacy organisation. Instead, they influence and equip others to lead meaningful and sustainable change through four main strategies:

- Information provision through conversations, workshops, courses, conferences and online resources
- Fostering connections through workshops, events and small groups
- Exploring new initiatives and trialling grant-based pilot projects
- Tailored consulting services

CRU includes resources for succession planning as part of their "Why it Matters" booklet series. These resources were developed as part of the Anne Cross Leadership Initiative, a partnership between Uniting Care Queensland (UCQ) and CRU, which aims to contribute to strong, principled leadership amongst people with disability and families across Queensland to work towards better lives for people with disability. The *Why Succession Planning Matters* booklet provides information about succession planning and prompts families to consider what is needed, including developing a collective vision for the future, and building their person's support circle and capacity to engage in supported decision-making early.

The booklet includes these planning prompts for families considering what resources they need to implement the plan:

- *Wills*
- *Considering how to divide family resources among children in the will, considering the needs of person with disability*
- *For a person under 18 – appointing a testamentary guardian*
- *For a person over 18 – if they struggle with managing money, consider a managed trust*
- *Who to appoint as trustees*
- *Tax and social security*
- *Circumstances under which a guardian or administrator may be appointed*
- *Other legal decision making arrangements e.g. Statutory Health Attorney and Enduring Power of Attorney*

- *Memorandum of Wishes (i.e. how you want your chosen trustees to use the trust funds)*[16]

Funding and management: CRU are funded through a mix of government funding and fee-for-service (NDIS) offerings[17].

Benefits and challenges of the model for mental health carers

No formal evaluations of either The Arc or NAMI service model for future planning were identified within the literature. However, the NAMI Circle of Care Guidebook provides targeted information and support for mental health caregivers which is likely to be a useful starting point for future planning by mental health caregivers and the person they care for. While The Arc's online *Build Your Plan* tool is clearly a useful future planning resource for caregivers, mental health carers may face more complex future planning issues than those covered by The Arc service model example due to the additional complexities involved in decision making and support where mental illness is involved. Overall, while valuable, future planning tools and information services rely on the existence of third-party support networks to provide critical support, such as coordination support, which may not exist or be easily accessible, therefore potentially limiting the effectiveness of the model.

Circles of Support

The Circles of Support model "utilises an extended network of trusted people to help formulate, promote and support the goals of a 'person at the centre'"[18]. Members of the circle often include family, friends, acquaintances, teachers, colleagues, team and community members, neighbours, support workers and employers[19], although there is some debate within the literature as to whether paid support staff should be included in 'circles' or whether membership should be

[16] Community Resource Unit Ltd (2025) Our Work. Accessed 21/06/2025 at CRU_Why-Succession-Planning-Matters-1.pdf
[17] Community Resource Unit Ltd (2025) Our Work. Accessed 21/06/2025 at Our Work - CRU – Community Resource Unit Ltd.
[18] Mental Health Coordinating Council (2018) 'Circles of Support': Feasibility study. Accessed 16/04/2025 at https://mhcc.org.au/wp-content/uploads/2018/05/mhcc_cos_lit_review.pdf
[19]

entirely voluntary[20]. Overall, circles of support seek to provide a way to address the ongoing support needs that a person may have for practical support and decision-making once their primary caregiver is gone. In most cases, circles of support operate using person centred planning techniques that build on people's strengths and capacities and are usually underpinned by supported decision making approaches[21]. Trained facilitators were also found to be a key element of circles of support to ensure meetings are run ethically, follow a set agenda and remain fun and informal for participants[22].

Examples

Planned Lifetime Advocacy Network (PLAN)

Who they work with: People with disability (including those living with mental illness), their family and caregivers.

Location: Canada

Service description: PLAN is a Canadian not-for-profit organisation founded in 1989 that helps families establish lifelong networks of support for loved ones with disabilities, including those living with mental illness, to ensure ongoing care even after their primary caregiver passes away. Using an asset-based approach that focuses on the individual's gifts and interests, PLAN facilitates Personal Support Networks (i.e. 'Circles of Support') through connections to community networks of volunteers and friends and provides financial and legal planning assistance to ensure stability and continuity[23].

The PLAN 'Network Development Team' comprises mentors, advisors and advocates. This team collaborates with families and individuals to create and nurture networks that grow over time,

[20] The Circles Initiative (2015) Information Guide: Creating Circles of Friends for people who have disability. South Australia. Australia. Accessed 16/04/2025 at http://www.clp-sa.org.au/sites/default/files/Circles%20Booklet-5%20FINAL.pdf
[21] Mental Health Coordinating Council (2018) 'Circles of Support': Feasibility study. Accessed 16/04/2025 at https://mhcc.org.au/wp-content/uploads/2018/05/mhcc_cos_lit_review.pdf
[22] Marsh, S. (2007) Circles of Support, *Crucial Times*, vol. 38.
[23] Planned Lifetime Advocacy Network (PLAN) (2025) What We Do. Accessed 16/04/2025 at https://plan.ca/get-involved/family-network/

with the aim being to create and sustain networks that can adapt to evolving priorities and goals[24]. The team provides support that includes:

- Identifying caring individuals to include in the network;
- Strengthening relationships to ensure they are meaningful and reciprocal;
- Planning for the future by preparing network members to take on important roles, such as advocacy or decision-making; and
- Providing ongoing support to keep networks active and responsive over time[25].

The PLAN approach to developing circles of support aims to ensure that personal support networks are sustainable and able to provide a lasting source of connection, care, and security[26]. At a few times throughout the year, network members are brought together for formal gatherings. These meetings provide an opportunity to:

- Plan and take action on the person's goals and dreams.
- Learn as a group and share perspectives.
- Update priorities and refine the network's focus.

In 2016, in response to an increasing number of complex challenges faced by families, PLAN introduced 'Family Advocates'. Family Advocates support families by helping them mobilise both formal and informal networks to:

- Navigate government ministries, service providers, and legal systems
- Access funding, resources, and housing options
- Collaborate with health professionals and other community supports

In addition to support to build personal support networks, PLAN also provide information and seminars to assist with wills, trusts and estate planning and other important future planning

[24] Planned Lifetime Advocacy Network (PLAN) (2025) How Does PLAN Create Networks. Accessed 16/04/2025 at https://plan.ca/what-we-do/networks/how-does-plan-create-networks/
[25] Planned Lifetime Advocacy Network (PLAN) (2025) What We Do. Accessed 16/04/2025 at https://plan.ca/get-involved/family-network/
[26] Planned Lifetime Advocacy Network (PLAN) (2025) How Does PLAN Create Networks. Accessed 16/04/2025 at https://plan.ca/what-we-do/networks/how-does-plan-create-networks/

topics such as connecting with the Registered Disability Savings Plan (RDSP), a Canadian investment scheme for people with disability[27].

Funding and Management: PLAN is funded by membership fees and philanthropic contributions. Families pay a membership fee to access the network-building services, and additional funding is accessed through donations and grants[28].

Benefits and challenges of the model for mental health carers

In a large-scale 2018 review of the literature to investigate the feasibility of the model for people living with mental health conditions, the Mental Health Coordinating Council (MHCC) highlighted that circles of support often contribute positively to a person's life by providing practical advice, problem solving and generating creative ideas[29] [30]. The review found that circles of support have been shown, anecdotally and empirically, to lead to numerous benefits. These include:

- Bringing together people who care about the person and have different skills to those of the family
- Increased social participation and inclusion
- Providing help with the financial management of support packages (e.g. National Disability Insurance Scheme funding)
- Providing a safety net of support into the future
- Contributing to the emotional support network of families and supporters as well as person in centre
- Ensuring person at centre feels respected, empowered and supported to achieve their goals

[27] Planned Lifetime Advocacy Network (PLAN) (2025) Financial Security. Accessed 16/04/2025 at https://plan.ca/what-we-do/planning/financial-security/
[28] Planned Lifetime Advocacy Network (PLAN) (2025) Financial Reports. Accessed 16/04/2025 at https://plan.ca/about/financial-reports/
[29] Mental Health Coordinating Council (2018) 'Circles of Support': Feasibility study. Accessed 16/04/2025 at https://mhcc.org.au/wp-content/uploads/2018/05/mhcc_cos_lit_review.pdf
[30] Resourcing Families (2015) Circles of support fact sheet. Accessed 16/04/2025 at www.resourcingfamilies.org.au/assets/Uploads/.../Circles_of_Support_fact_sheet.pdf

- Enabling a cost-effective mechanism for drawing on community capacities, extending opportunities and positive outcomes to disadvantaged groups[31].

The review also identified service model challenges highlighted in the literature, including:

- Difficulty finding and engaging supporters
- Goals remaining unmet
- Goals being limited to options provided by the service
- Where paid facilitators are employed, funding and professional control issues can occur
- Issues regarding maintaining professional boundaries if support staff join on a voluntary basis
- Supporters failing to understand their role as 'supporter' not 'decision maker'[32].

In addition, MHCC noted it may be more difficult to establish effective 'Circles of Support' for people living with mental health conditions due to additional challenges and complexity that may exist such as extreme social isolation, complex co-existing conditions and negative side effects of medications[33].

Microboards

A Microboard is a small, person-centred group of committed people in unpaid relationships with a person with disability who come together regularly to support that person to live the life they choose. Microboards resemble Circles of Support in that their purpose is to help the person make decisions, plan for the future, maintain social inclusion, and safeguard their wellbeing. However, microboards differ in that they are incorporated as a not-for-profit association that exists solely to support the person at the centre. Incorporation provides a formal governance

[31] Mental Health Coordinating Council (2018) 'Circles of Support': Feasibility study. Accessed 16/04/2025 at https://mhcc.org.au/wp-content/uploads/2018/05/mhcc_cos_lit_review.pdf
[32] Mental Health Coordinating Council (2018) 'Circles of Support': Feasibility study. Accessed 16/04/2025 at https://mhcc.org.au/wp-content/uploads/2018/05/mhcc_cos_lit_review.pdf
[33] Mental Health Coordinating Council (2018) 'Circles of Support': Feasibility study. Accessed 16/04/2025 at https://mhcc.org.au/wp-content/uploads/2018/05/mhcc_cos_lit_review.pdf

structure, with a tailored constitution based on state requirements. It also encourages long-term continuity when parents or primary carers are no longer able to provide support, which is a key strength of the model[34]. Microboards are usually made up of between five to seven members who may be family, friends, former support workers, professionals, neighbours, or other trusted long-term community connections who work as a team around the individual. The role of a Microboard may include:

- Helping the person at the centre to set goals, plan and make decisions about day-to-day life
- Brainstorming ideas for how to get there and who to enlist to support
- Advocating for what the person needs
- Monitoring the person's wellbeing and the supports they are engaged with
- Helping the person to connect to their wider community and enjoy everyday life together
- Employing, training and managing support workers as part of their person's support network[35].

Overall, Microboards are recognised as a sustainable, relationship-based support model that can provide continuity, choice, and safeguards across the lifespan of a person with disability.

Examples

Microboards Australia

Who they work with: People with disability, their family and caregivers.

Location: Australia (endorsed by Vela Microboards Canada)

Service description: Microboards Australia is a family led, not for profit organisation supporting people with a disability and their networks of support to find ways to develop lasting

[34] Microboards Australia (2026) What is a Microboard? Accessed online 13/04/2026 at https://microboards.org.au/microboards-community/what-is-a-microboard/
[35] Microboards Australia (2026) What is a Microboard? Accessed online 13/04/2026 at https://microboards.org.au/microboards-community/what-is-a-microboard/

relationships, recruit support teams and plan for the future. Established in 2008 in Western Australia, Microboards Australia brought the Microboard model to Australia and is the only Australian organisation trained and endorsed by Vela Microboards Canada, who founded the original model.

Microboards Australia use a facilitation and capacity-building service model that helps people with disability and their families establish and sustain a personalised Microboard. The organisation works alongside the person and their supporters to identify trusted members, build a Circle of Support, develop governance arrangements, and incorporate the Microboard as a not-for-profit association tailored to the individual's needs.

Facilitators provide guidance through each stage, including person-centred planning, clarifying roles and responsibilities, creating constitutions, supporting compliance requirements, and strengthening decision-making processes. Once established, ongoing coaching and mentoring help the Microboard remain active, effective, and focused on the person's goals, wellbeing, inclusion, and long-term future. Microboards Australia currently support thirty-one Microboards with five active facilitators working on these[36]. All facilitators have personal lived experience of Microboards: as parents of people with disability whose children have Microboards, as Microboard members, or as support workers or other professionals who have been employed by Microboards[37]. While Microboards Australia do offer separate NDIS support coordination services, facilitators are not Support Co-ordinators and not experts in the NDIS or NDIS funding. They are about working with the support network to really listen to the person with a disability and what they want for their life[38].

Funding and Management: In the past, Microboards Australia services – including Microboards facilitation support – has been funded by individual NDIS support packages. However changes to

[36] Microboards Australia (2024) 2023/24 Microboards Australia Annual Report. Accessed online 13/04/2026 at MICROBOARDS AUSTRALIA ANNUAL REPORT JULY 2023 – JUNE 2024
[37] Microboards Australia (2026) What do faciltators do? Accessed online 13/04/2026 at What do facilitators do? – Microboards Australia
[38] Microboards Australia (2026) What do faciltators do? Accessed online 13/04/2026 at What do facilitators do? – Microboards Australia

the NDIS have made funding for Microboards more complex[39]. The 2023/24 Annual Report highlighted that Microboards Australia is working with the NDIS in the hope of finding an agreement as to how Microboards, and Circles of Support, can be sustainably funded.

Vela Canada

Who they work with: People with disability, their family and caregivers.

Location: Canada

Service description: Established in 1985, Vela Canada is a not-for-profit organisation based in British Columbia, Canada. Vela Canada assists people with disabilities to take greater control of their lives by exploring a range of customised, inclusive, and creative supports, including developing a Microboard, accessing Individualised Funding, or using a Person Centred Society[40]. There are over 1,500 Microboards in British Columbia[41].

Vela Canada developed the microboard model and was the first organisation in the world to deliver this focused service, which is offered free in British Columbia. They now provide consulting services to international family groups, organisations, and governments throughout Canada, Australia, the United States, Northern Ireland, Scotland, England, Norway, and the Republic of Ireland.

Funding and Management: Funding may come from a government agency such as the Ministry of Children and Family Development, Community Living BC, the Ministry of Health, a trust or a settlement (i.e. ICBC, WorkSafeBC). If the Microboard does not want to access funding and

[39] Microboards Australia (2024) 2023/24 Microboards Australia Annual Report. Accessed online 13/04/2026 at MICROBOARDS AUSTRALIA ANNUAL REPORT JULY 2023 – JUNE 2024

[40] A "Person Centred Society" is a small non-profit organisation that is created to provide a circle of support for a single person and governed by the BC Societies Act. It differs to Microboards which are a specific type of Person Centred Society that are created using Vela's processes and documents and upholds the guiding principles of Vela Microboards. Vela Canada (2026) What is a Person Centred Society. Accessed online 18/04/2026 at Person Centred Society - Vela Canada

[41] Vela Canada (2026) About Us. Accessed online 18/04/2026 at Microboard and Individualized Funding Supports for Disabled

deliver the services, the individual may still choose to access Individualised Funding. Individualised Funding (IF) is a payment option for people served by Community Living BC (CLBC). IF lets people use the money provided by CLBC to create new, different kinds of services that will support people in their community. With IF the person can be their own Agent or choose a trusted family member or friend to be the Agent.

Benefits and challenges of the model for mental health carers

The Microboard model may offer significant promise for people living with mental health challenges and their carers, especially where families worry about the future, fragmented systems, social isolation, or what happens when primary carers can no longer provide support. Key benefits include:

- Improving future planning and continuity by creating an enduring circle of trusted people who can continue advocacy, planning and support over time
- Sharing the care burden between several committed people so that one carer isn't responsible for everything, reducing the potential for carer burnout
- Encouraging person centred recovery support that focuses on housing stability, meaningful goals, relationships, education/work aspirations, health appointments and relapse prevention planning
- Improving safeguarding and advocacy by helping a person to navigate services, challenge poor treatment and noticing when someone is declining

While Microboards can provide lifelong relational scaffolding and shared care for people living with mental health challenges and their families and carers, they also require trust, facilitation, boundaries, and complementary clinical supports. Challenges associated with the model can include:

- Finding the right people as people's networks may be small or fractured

- Fluctuating capacity or consent where a person may want support, then reject it, then re-engage, requiring Microboards to balance autonomy, dignity of risk, safety and supported decision-making
- Boundaries and role confusion may occur if friends or family become over-involved or controlling and there is not clear governance
- Complex mental health crises still require clinical supports; Microboards do not replace this
- Risk of burnout or role confusion as unpaid board members can fatigue over time
- Mental health systems may not understand or formally engage with a Microboard as they are not well recognised.

Care Coordination and Recovery Support

Care Coordination and Recovery Support provide a collaborative, coordinated, and integrated model for supporting individuals with severe and persistent mental illness[42] [43]. The model builds on key features of Social Prescribing[44], and uses similar elements to general care coordination such as 'System Navigators' (Canada)[45] and 'NDIS Support Coordination' (Australia), however specialised for mental health. Care Coordination and Recovery Support emphasises community-based mental health recovery and aims to improve outcomes for people with mental illness, including their families and carers, by addressing complex needs and facilitating access to services[46]. Care Coordination and Recovery Support assists caregivers with understanding recovery and symptoms experienced by the person they care for, finding resources, navigating

[42] Trankle, S.A., Reath, J. (2019) Partners in Recovery: an early phase evaluation of an Australian mental health initiative using program logic and thematic analysis. *BMC Health Serv Res* **19**, 524. https://doi.org/10.1186/s12913-019-4360-2

[43] Obegu, P., Nicholls, K. and Alberti, M. (2025) Care coordination for people living with serious mental illness: understanding the caregiver's perspective. Frontiers in Health Services. Volume 4. https://www.frontiersin.org/journals/health-services/articles/10.3389/frhs.2024.1473235

[44] Obegu, P., Nicholls, K. and Alberti, M. (2025) Care coordination for people living with serious mental illness: understanding the caregiver's perspective. Frontiers in Health Services. Volume 4. https://www.frontiersin.org/journals/health-services/articles/10.3389/frhs.2024.1473235

[45] Pinecrest-Queensway Community Health Centre (2019) *System Navigators*. Accessed 07/05/2025 at https://www.pqchc.com/system-navigation

[46] Trankle, S.A., Reath, J. (2019) Partners in Recovery: an early phase evaluation of an Australian mental health initiative using program logic and thematic analysis. *BMC Health Serv Res* **19**, 524. https://doi.org/10.1186/s12913-019-4360-2

services, and providing referrals and linkages[47]. This helps caregivers manage stress, increases their knowledge about support services, helps them prepare and plan for the future and navigate the caregiving role more effectively, ultimately improving their well-being and the care provided[48]. The model focuses on recovery-oriented mental health practice – often delivered through peer support - that values workers with skills and capabilities to support people to recognise and take responsibility for their own recovery and wellbeing, leading to greater capacity to manage their own symptoms and lives[49] [50] .

Examples

NDIS Psychosocial Recovery Coaching (One Good Day)*

Who they work with: Australian National Disability Insurance Scheme (NDIS) participants who live with significant impairment from their mental health condition that is likely to be permanent[51]. Families, friends and peer supports can also receive support if the participant wants them to be part of their recovery journey[52].

Location: Australia

[47] Obegu, P., Nicholls, K. and Alberti, M. (2025) Care coordination for people living with serious mental illness: understanding the caregiver's perspective. Frontiers in Health Services. Volume 4. https://www.frontiersin.org/journals/health-services/articles/10.3389/frhs.2024.1473235

[48] Obegu, P., Nicholls, K. and Alberti, M. (2025) Care coordination for people living with serious mental illness: understanding the caregiver's perspective. Frontiers in Health Services. Volume 4. https://www.frontiersin.org/journals/health-services/articles/10.3389/frhs.2024.1473235

[49] Australian Health Minister's Advisory Council (2013) A national Framework for Recovery-Oriented Mental Health Services: Guide for practitioners and providers. Accessed 16/04/2025 at https://www.health.gov.au/sites/default/files/documents/2021/04/a-national-framework-for-recovery-oriented-mental-health-services-guide-for-practitioners-and-providers.pdf

[50] Trankle, S.A., Reath, J. (2019) Partners in Recovery: an early phase evaluation of an Australian mental health initiative using program logic and thematic analysis. *BMC Health Serv Res* **19**, 524. https://doi.org/10.1186/s12913-019-4360-2

[51] National Disability Insurance Scheme (2024) Psychosocial Disability Access Factsheet 3: Lifetime support and recovery for psychosocial disability in the NDIS. Accessed 16/04/2025 at file:///C:/Users/FarinaMurray/Downloads/PB%20Psychosocial%20Disability%20Access%20Factsheet%203%20(1).pdf

[52] National Disability Insurance Scheme (2024) Psychosocial Disability Access Factsheet 3: Lifetime support and recovery for psychosocial disability in the NDIS. Accessed 16/04/2025 at file:///C:/Users/FarinaMurray/Downloads/PB%20Psychosocial%20Disability%20Access%20Factsheet%203%20(1).pdf

Service description: Psychosocial Recovery Coaching (Recovery Coaching) was introduced under the NDIS in July 2020 as a 'Recovery Oriented' support intended for people with psychosocial disability (i.e. disability related to mental health)[53]. The aim of Recovery Coaching is to support people with psychosocial disability to work toward their own goals for wellbeing and life. While coordination of supports is part of what a Recovery Coach does, Psychosocial Recovery Coaches are different from NDIS Support Coordinators in that they bring knowledge and skills in psychosocial recovery, mental health and service navigation within the mental health system[54].

Recovery Coaches help people with psychosocial disability to increase independence as well as social and economic participation[55]. By helping people to take more control of their lives and better manage complex challenges of daily living, Recovery Coaching can reduce the need for ongoing caregiver support. A Psychosocial Recovery Coach also works with people to:

- build their capacity and resilience (including through times of grief, such as loss of a caregiver);
- identify, plan, design and coordinate different supports;
- plan and maintain engagement through times of increased support needs; and
- provide coaching that builds on people's strengths, knowledge, skills, resilience, and decision-making[56].

[53] Elmes, A., Campain, R., Wilson, E., Brown, C., Kelly, J. and Campbell, P. (2023). Psychosocial Recovery Coaching: Client outcomes and experiences, July 2023, Centre for Social Impact, Swinburne University of Technology, Hawthorn, Australia. https://doi.org/10.26185/apjw-6x94

[54] National Disability Insurance Agency (2020). Psychosocial Recovery Coach – Version 1.1 July 2020. Accessed from the Mental Health and the NDIS section of the NDIS website. https://www.ndis.gov.au/understanding/how-ndis-works/mental-health-andndis#psychosocial-recovery-coach

[55] National Disability Insurance Scheme (2024) *Psychosocial Disability Access Factsheet 3: Lifetime support and recovery for psychosocial disability in the NDIS*. Accessed 16/04/2025 at file:///C:/Users/FarinaMurray/Downloads/PB%20Psychosocial%20Disability%20Access%20Factsheet%203%20(1).pdf

[56] National Disability Insurance Scheme (2024) *Psychosocial Disability Access Factsheet 3: Lifetime support and recovery for psychosocial disability in the NDIS*. Accessed 16/04/2025 at file:///C:/Users/FarinaMurray/Downloads/PB%20Psychosocial%20Disability%20Access%20Factsheet%203%20(1).pdf

There are a wide range of psychosocial recovery coaching service providers across Australia who deliver their own version of recovery coaching support. One Good* Day is a registered provider of NDIS psychosocial recovery coaching nationally who utilise a hybrid online and face-to-face model to deliver services. The organisation's service delivery model was documented in a 2023 evaluation study conducted by Swinburne University[57]. Key service features identified by the study included:

- delivery of a dedicated Psychosocial Recovery Coaching service (rather than multiple supports), by a team who specialise in mental health
- use of an inclusive recruitment strategy that focuses on both learned expertise gained through professional experience in a mental health role and/or mental health qualifications *and* lived experience related to mental health (approximately 75 percent of One Good* Day team members were found to identify with lived experience of mental health and recovery);
- used of a Wellbeing Recovery Action Plan (WRAP) developed collaboratively with clients to identify goals and guide service provision
- proactive service provision approach with regular client check-ins, especially helpful during times where people may be unwell and hesitant to reach out for support[58].

Funding and Management: The National Disability Insurance Scheme (NDIS) is a government program in Australia that provides funding for eligible people with disabilities to support their needs and goals. Psychosocial Recovery Coaching is currently only available to NDIS participants with psychosocial disability who have funding allocated for this in their NDIS funding package. Since 2024, participants have been able to access NDIS funding for psychosocial recovery coaching either via the NDIS early intervention pathway which limits support to three years, or disability pathway, which is ongoing. However the NDIS Review completed in 2023

[57] Elmes, A., Campain, R., Wilson, E., Brown, C., Kelly, J. and Campbell, P. (2023). Psychosocial Recovery Coaching: Client outcomes and experiences, July 2023, Centre for Social Impact, Swinburne University of Technology, Hawthorn, Australia. https://doi.org/10.26185/apjw-6x94

[58] Elmes, A., Campain, R., Wilson, E., Brown, C., Kelly, J. and Campbell, P. (2023). *Psychosocial Recovery Coaching: Client outcomes and experiences*. Centre for Social Impact, Swinburne University of Technology, Hawthorn, Australia. https://doi.org/10.26185/apjw-6x94

recommended significant changes to the way psychosocial supports are delivered in Australia, including more equitable access to mental health services and psychosocial supports for people with severe mental illness outside the NDIS[59]. In particular, the Review recommended the creation of new 'Psychosocial Recovery Navigator' roles to replace Psychosocial Recovery Coaches and an expanded system of foundational supports – supported by dual funding from state and federal governments - for people who are not eligible for the NDIS. It also recommended that people with psychosocial disability should be able to continue receiving support from their Psychosocial Recovery Navigator even once they transition from the NDIS early intervention pathway into mainstream or foundational psychosocial supports[60], indicating the possibility of an ongoing support role outside the NDIS in the future.

Partners in Recovery (Nepean Blue Mountains Partners in Recovery)

Who they work with: People with severe [serious and persistent mental illness] with complex needs[61]. Importantly, the Partners in Recovery (PiR) program emphasised easy access to services and referral pathways via a 'no wrong door approach' to make it easier for people to access support no matter where they enter the system[62].

Location: Australia

Service description: Partners in Recovery (PIR) was a national program that was discontinued in 2019 with the introduction of the NDIS[63]. The PIR initiative aimed to improve coordination between services such as medical care, housing, income support, employment, education and

[59] Australian Government (2023) NDIS Review – Psychosocial Supports. Accessed 07/05/2025 at https://www.ndisreview.gov.au/resources/fact-sheet/psychosocial-supports
[60] Australian Government (2023) *NDIS Review – Psychosocial Supports*. Accessed 07/05/2025 at https://www.ndisreview.gov.au/resources/fact-sheet/psychosocial-supports
[61] Mental Health Australia and National Mental Health Consumer and Carer Forum (2024) *Advice to Governments: Evidence Informed and Good Practice Psychosocial Services. Psychosocial Services to Fund Outside the National Disability Insurance Scheme*. Accessed online 16/04/2025 at https://mhaustralia.org/submission/advice-governments-evidence-informed-and-good-practice-psychosocial-services
[62] Mental Health Coordinating Council (2020) *Programs and Initiatives – Partners in Recovery*. Accessed 16/04/2025 at https://mhcc.org.au/publication/partners-in-recovery/
[63] Mental Health Coordinating Council (2020) *Programs and Initiatives – Partners in Recovery*. Accessed 16/04/2025 at https://mhcc.org.au/publication/partners-in-recovery/

rehabilitation services that support people with mental health and complex needs[64]. Under the program, forty-eight regional PIR consortia were established in Medicare Local areas across Australia, with each drawing on the strengths and resources of the local consortium partners to provide services that aligned with local needs[65]. The PIR program specifically aimed to:

- Better support people with severe and persistent mental illness with complex needs, and their carers and families;
- Facilitate better coordination of clinical and non-clinical services to deliver 'wrap around' support to meet the full range of an individual's needs;
- Improve referral pathways and strengthen partnerships with existing services;
- Further embed a community based recovery model of support and service delivery throughout the mental health and related sectors; and
- Adopt a 'no wrong door' approach to service access and referral[66].

Recovery focused care facilitation was central to the PIR initiative[67]. Organisations delivering PIR services employed 'Support Facilitators' to help people navigate services, with the facilitation approach intentionally used to empower clients, rather than case management[68]. The primary responsibilities of Support Facilitators were to assess client needs, manage referrals and develop

[64] Mental Health Coordinating Council (2020) *Programs and Initiatives – Partners in Recovery*. Accessed 16/04/2025 at https://mhcc.org.au/publication/partners-in-recovery/
[65] Trankle, S.A., Reath, J. (2019) Partners in Recovery: an early phase evaluation of an Australian mental health initiative using program logic and thematic analysis. *BMC Health Serv Res* **19**, 524. https://doi.org/10.1186/s12913-019-4360-2
[66] Mental Health Coordinating Council (2020) *Programs and Initiatives – Partners in Recovery*. Accessed 16/04/2025 at https://mhcc.org.au/publication/partners-in-recovery/
[67] Trankle, S.A., Reath, J. (2019) Partners in Recovery: an early phase evaluation of an Australian mental health initiative using program logic and thematic analysis. *BMC Health Serv Res* **19**, 524. https://doi.org/10.1186/s12913-019-4360-2
[68] Trankle, S.A., Reath, J. (2019) Partners in Recovery: an early phase evaluation of an Australian mental health initiative using program logic and thematic analysis. *BMC Health Serv Res* **19**, 524. https://doi.org/10.1186/s12913-019-4360-2

partnerships for participants' recovery goals[69]. Program evaluation completed in 2018 describes the role of Support Facilitators:

> *"A client entering the PIR program underwent a detailed assessment of their specific needs such as access to stable housing; the Support Facilitator then located and facilitated access to services to ensure that people with mental illness were not lost to gaps between services[70].*

The PIR program also provided a small amount of 'flexible funding', which could be accessed as required for participants to access services and additional supports that could not be sought elsewhere[71]. This allowed services to address immediate needs such as crisis accommodation and medications, especially to assist clients in need at times where the service was already at capacity[72].

While Support Facilitators were not required to work from lived experience perspectives under the PIR program, evaluation of the Nepean Blue Mountains Partners in Recovery service highlights the use of peer mentoring as a recovery oriented initiative implemented within the NBMPIR service that was reported to be beneficial to clients in their recovery journey.

Funding and Management: The Partners in Recovery program received $549.8 million (over five years from 2011/12 to 2015/16) for the Partners in Recovery (PIR): Coordinated Support and Flexible Funding for People with Severe and Persistent Mental Illness with Complex initiative in the 2011/12 Federal Budget[73].

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[69] Banfield M, Forbes O. (2018) Health and social care coordination for severe and persistent mental illness in Australia: a mixed methods evaluation of experiences with the Partners in Recovery Program. Int J Ment Health Syst. Accessed 16/04/2025 at https://pmc.ncbi.nlm.nih.gov/articles/PMC5883333/

[70] Banfield M, Forbes O. (2018) Health and social care coordination for severe and persistent mental illness in Australia: a mixed methods evaluation of experiences with the Partners in Recovery Program. Int J Ment Health Syst. Accessed 16/04/2025 at https://pmc.ncbi.nlm.nih.gov/articles/PMC5883333/

[71] Banfield M, Forbes O. (2018) Health and social care coordination for severe and persistent mental illness in Australia: a mixed methods evaluation of experiences with the Partners in Recovery Program. Int J Ment Health Syst. Accessed 16/04/2025 at https://pmc.ncbi.nlm.nih.gov/articles/PMC5883333/

[72] Trankle, S.A., Reath, J. (2019) Partners in Recovery: an early phase evaluation of an Australian mental health initiative using program logic and thematic analysis. *BMC Health Serv Res* **19**, 524. https://doi.org/10.1186/s12913-019-4360-2

[73] Mental Health Coordinating Council (2020) *Programs and Initiatives – Partners in Recovery*. Accessed 16/04/2025 at https://mhcc.org.au/publication/partners-in-recovery/

Benefits and challenges of the model for mental health carers

Care coordinators help caregivers identify and access relevant community resources, including support groups, therapy services, and respite care, to build a network of assistance which may enable them to step away from their role as caregivers in the future. The Social Care Institute for Excellence in the United Kingdom, highlights that care coordination and recovery support assists mental health caregivers engage in shared decision making as caregivers can actively participate in developing care plans that address both immediate and long-term needs, alongside the person they support[74]. Recovery-oriented programs have also been shown to equip caregivers with practical skills to navigate challenges, address crises, improve their own wellbeing and promote positive interactions with the person they care for[75]. These benefits are likely to lead to improved long-term outcomes for both caregivers and the person they care for.

However, challenges associated with the model have also been identified, which may present concerns for caregivers. These include:

- the importance of relational trust and ensuring the right "fit" between support facilitators and clients, with lived experience (peer) support playing a useful role[76] [77]
- negative client experiences of continuity and coordination of care when workers move on or information is lost in the transition between service providers[78]
- limited contribution to long-term employment outcomes and self-care/resilience for recovery coaching clients[79].

[74] Social Care Institute for Excellence (2025) *MCA: Care Planning, Involvement and Person-Centred Care*. Accessed 08/05/2025 at https://www.scie.org.uk/mca/practice/care-planning/person-centred-care/
[75] Redublo T, Paul S, Joshi A, Arbour S, Murray R and Chiu M (2024) We-Care-Well: exploring the personal recovery of mental health caregivers through Participatory Action Research. *Frontiers in Public Health* 12:1366144. Accessed 08/05/2025 at http://frontiersin.org/journals/public-health/articles/10.3389/fpubh.2024.1366144/full
[76] Banfield M, Forbes O. (2018) Health and social care coordination for severe and persistent mental illness in Australia: a mixed methods evaluation of experiences with the Partners in Recovery Program. Int J Ment Health Syst. Accessed 16/04/2025 at https://pmc.ncbi.nlm.nih.gov/articles/PMC5883333/
[77] Trankle, S.A., Reath, J. (2019) Partners in Recovery: an early phase evaluation of an Australian mental health initiative using program logic and thematic analysis. *BMC Health Serv Res* **19**, 524. https://doi.org/10.1186/s12913-019-4360-2
[78] Banfield M, Forbes O. (2018) Health and social care coordination for severe and persistent mental illness in Australia: a mixed methods evaluation of experiences with the Partners in Recovery Program. Int J Ment Health Syst. Accessed 16/04/2025 at https://pmc.ncbi.nlm.nih.gov/articles/PMC5883333/
[79] Elmes, A., Campain, R., Wilson, E., Brown, C., Kelly, J. and Campbell, P. (2023). *Psychosocial Recovery Coaching: Client outcomes and experiences*. Centre for Social Impact, Swinburne University of Technology, Hawthorn, Australia. https://doi.org/10.26185/apjw-6x94

System Navigators

System navigation programs are based in a primary care setting and aim to link patients to appropriate community-based health and social services[80]. In Canada, "system navigators" are individuals or organisations that assist people in finding and understanding complex healthcare, social service, and community support systems. They are typically available to a wide range of people, including caregivers and community members, and help individuals identify and access appropriate programs and services, acting as guides through the multitude of available resources.

Examples

West Elgin Community Health Centre Systems Navigation

Who they work with: The Centre's Systems Navigation services are available to everyone who primarily resides in Dutton Dunwich or West Elgin Municipalities.

Location: Canada

Service description: The West Elgin Community Health Centre (the "Centre") are part of a network of community health centres (CHCs) across Ontario, Canada, who are committed to building healthy communities[81]. The Centre provides primary health care, a range of community programs, illness prevention services, and health promotion services via an interdisciplinary team, including Systems Navigators[82].

Systems Navigators assist people to understand and find their way through health care, community and social service systems, especially during times when they are facing life

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81 West Elgin Community Health Centre (2020) *About Us.* Accessed 08/06/2025 at https://www.wechc.on.ca/about-us/overview

82 West Elgin Community Health Centre (2020) *About Us.* Accessed 08/06/2025 at https://www.wechc.on.ca/about-us/overview

challenges[83]. Systems Navigators support individuals and families to discover and access appropriate programs and services, for example:

- Referrals to Home and Community Care
- Help finding a medical care provider
- Linking people to other health care services like mental health counseling or diabetes education
- Referrals to programs offered at the Health Centre
- Referrals to community support agencies in the community
- Referrals and help with forms for government programs such as Ontario Disability or Ontario Works
- Assistance with applications for Unemployment or medication coverage
- Connection to a social prescription[84]

The Centre also provides specialised system navigation support for people who are homeless, or at risk of homelessness[85].

Funding and management: In 2023-2024, the West Elgin Community Health Centre was primarily funded by government funding (91% of total funding), with a small percentage of funding from charitable funding and consumer contribution[86].

[83] West Elgin Community Health Centre (2020) *Systems Navigation.* Accessed 08/06/2025 at https://www.wechc.on.ca/programs-and-services/systems-navigation
[84] West Elgin Community Health Centre (2020) *Systems Navigation.* Accessed 08/06/2025 at https://www.wechc.on.ca/programs-and-services/systems-navigation
[85] West Elgin Community Health Centre (2020) *Systems Navigation.* Accessed 08/06/2025 at https://www.wechc.on.ca/programs-and-services/systems-navigation
[86] West Elgin Community Health Centre (2024) *2023-24 Annual Report*. Accessed 08/05/2025 at https://wechc.on.ca/userfiles/2023-24_Annual_Report.pdf

Benefits and challenges of the model for mental health carers

A large scale review of system navigation programs that link primary care with community-based health and social services conducted in 2023 demonstrated mixed results[87]. This review found that team-based system navigation may result in slight improvements in health service utilisation. It also identified that further research is needed to determine the effects on caregiver and cost-related outcomes[88].

Housing Based Support

Examples of housing-based support combine housing with personalised support, providing an alternative to institutionalised care.

Examples

Shared Lives Schemes (UK)

Who they work with: People aged 16+ (in England and Scotland) and 18+ (in Wales and Northern Ireland) who want to live independently in their community, with the support of a family and community network. Shared Lives schemes support adults with learning disabilities, mental health needs, or other disabilities that may make independent living challenging[89].

Location: United Kingdom (UK)

Service description: Shared Lives is a care and support service that provides an alternative to supported living or residential care. Over 10,000 Shared Lives carers share their own home and family life with someone who needs support around the UK. Carers earn between £350 – £650 a

[87] Teggart, K., Neil-Sztramko, S.E., Nadarajah, A. *et al.* (2023) Effectiveness of system navigation programs linking primary Accessed 08/05/2025 at https://bmchealthservres.biomedcentral.com/articles/10.1186/s12913-023-09424-5#:~:text=System%20navigation%20programs%20based%20in,other%20medical%20specialty%20care%20services.
[88] Teggart, K., Neil-Sztramko, S.E., Nadarajah, A. *et al.* (2023) Effectiveness of system navigation programs linking primary Accessed 08/05/2025 at https://bmchealthservres.biomedcentral.com/articles/10.1186/s12913-023-09424-5#:~:text=System%20navigation%20programs%20based%20in,other%20medical%20specialty%20care%20services.
[89] Shared Lives Plus (2025) *What is Shared Lives?* Accessed 08/05/2025 at https://sharedlivesplus.org.uk/what-is-shared-lives-care/

week with tax relief, training, regular breaks and a UK support network. Individuals who are interested in becoming Shared Lives carers must go through a thorough application and approval process to ensure they meet the necessary standards, before being approved by one of the regulated local schemes[90].

The program works by matching an adult or young person who needs long-term support with a carefully approved Shared Lives carer. Together, the person needing support and the Shared Lives carer share the carer's family and community life. According to the Shared Lives website, approximately half of the 10,000 people using Shared Lives move in with their chosen Shared Lives carer to live as part of their household while the rest use the scheme for day support or overnight breaks. People get safe, personal care and support, in a place which feels like home[91].

One hundred and fifty regulated local Shared Lives schemes exist across the UK, with each program individually managed or commissioned by local councils[92]. There is significant variation between local schemes, including their structure, funding, integration with local health and social care systems and the support needs of individuals. As such, there is no one single recommended model of delivery[93].

Overall, service evaluation suggests Shared Lives is successful, with the Care Quality Commission rating the sector as ninety-six percent good/outstanding[94]. The cost of supporting someone with mental health needs is also significantly lower – about half the cost – through the program, costing approximately £400 per week via Shared Lives care compared to around £800 per week in traditional care homes or services[95]. User satisfaction is high, with eighty-five percent of users reporting that they felt it had improved their social life and eighty-nine percent reporting that they feel involved with their community[96].

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[90] Shared Lives Plus (2025) *What is Shared Lives?* Accessed 08/05/2025 at https://sharedlivesplus.org.uk/what-is-shared-lives-care/
[91] Shared Lives Plus (2025) *What is Shared Lives?* Accessed 08/05/2025 at https://sharedlivesplus.org.uk/what-is-shared-lives-care/
[92] Shared Lives Plus (2025) *What is Shared Lives?* Accessed 08/05/2025 at https://sharedlivesplus.org.uk/what-is-shared-lives-care/
[93] Harflett, N. and Jennings, Y. (2016) *Evaluation of the Shared Lives Mental Health Project*. Accessed 08/05/2025 at https://www.ndti.org.uk/assets/files/Final_NDTi_Cabinet_Office_SLP_MH_Eval_Report.pdf
[94] Shared Lives Plus (2025) *What is Shared Lives?* Accessed 08/05/2025 at https://sharedlivesplus.org.uk/what-is-shared-lives-care/
[95] Shared Lives Plus (2025) Shared Lives for Mental Health. Accessed 08/05/2025 at https://sharedlivesplus.org.uk/our-work-and-campaigns/our-shared-lives-programmes/mental-ill-health/
[96] Shared Lives Plus (2025) *What is Shared Lives?* Accessed 08/05/2025 at https://sharedlivesplus.org.uk/what-is-shared-lives-care/

A 2016 evaluation[97] of Shared Lives, specifically focused on its ability to support people with mental ill health, identified a range of key factors to enable the further development of Shared Lives as a form of support for people with mental ill health. These include flexibility in how Shared Lives arrangements are offered, the existence of compatible funding mechanisms, good matching between the Shared Lives carer and the person being supported and ensuring that Shared Lives carers are well supported through careful recruitment, assessment, induction and ongoing support through placements so that they can fulfil their roles well[98].

Funding and management: Varies according to local scheme implementation.

Housing First (Doorway Program)

Who they work with: People experiencing or at risk of experiencing homelessness with mental health and substance use problems.

Location: Australia (Victoria)

Service description: The Housing First service model is a consumer-driven model that houses participants immediately to permanent housing in the community, without any preconditions, before collaborating with them to address health, mental health, addiction, employment, social, familial, spiritual, and other needs[99]. While there are many models of care which focus on ensuring stable housing for people with mental ill-health, the Housing First model was included in the 2024 publication by Mental Health Australia and the National Mental Health Carer and Consumer Forum "*Advice to governments: evidence-informed and good practice psychosocial services Psychosocial Services to fund outside the National Disability Insurance Scheme*" as a model that has a strong evidence base[100]. This advice includes the Victorian Doorway program as

[97] Harflett, N. and Jennings, Y. (2016) *Evaluation of the Shared Lives Mental Health Project*. Accessed 08/05/2025 at https://www.ndti.org.uk/assets/files/Final_NDTi_Cabinet_Office_SLP_MH_Eval_Report.pdf
[98] Harflett, N. and Jennings, Y. (2016) *Evaluation of the Shared Lives Mental Health Project*. Accessed 08/05/2025 at https://www.ndti.org.uk/assets/files/Final_NDTi_Cabinet_Office_SLP_MH_Eval_Report.pdf
[99] Ritsuko, K., Hamilton, B., Brophy, L., Minas, H. and Harvey, C. (2017) *Models of Care for people with severe and enduring mental illness: an Evidence Check rapid review*. Accessed 08/05/2025 at https://www.saxinstitute.org.au/wp-content/uploads/MoC-severe-and-enduring-mental-illness.pdf
[100] Mental Health Australia and National Mental Health Consumer and Carer Forum (2024) *Advice to Governments: Evidence Informed and Good Practice Psychosocial Services. Psychosocial Services to Fund Outside the National*

an example of the Housing First model in action. The program is targeted towards people at risk of/or homeless in Victoria's public mental health system. Participants in the program choose properties through the open rental market and receive rental subsidies, assistance, advocacy and brokerage support from a Housing and Recovery Worker[101]. The Doorway program has been shown to improve housing and health outcomes and reduce length of stay in hospital[102]. It also presents cost savings for governments, with a report by Mental Health Australia and KPMG estimating that "for every $1 spent on Housing First models, $3 is generated in the short term and $6.70 is generated in the longer term"[103].

Funding and management: The Victorian Doorway program is funded by the Victorian Department of Health (DoH). It is implemented by Mental Illness Fellowship Victoria (MI Fellowship)[104].

Benefits and challenges of the model for mental health carers

The challenge of housing is real, with at least 31,000 people across Australia living with mental ill-health experiencing or at risk of homelessness and having an unmet need for long-term housing, with a further 2,000 people are stuck in institutional care because other accommodation is not

Disability Insurance Scheme. Accessed online 16/04/2025 at https://mhaustralia.org/submission/advice-governments-evidence-informed-and-good-practice-psychosocial-services

[101] Mental Health Australia and National Mental Health Consumer and Carer Forum (2024) *Advice to Governments: Evidence Informed and Good Practice Psychosocial Services. Psychosocial Services to Fund Outside the National Disability Insurance Scheme*. Accessed online 16/04/2025 at https://mhaustralia.org/submission/advice-governments-evidence-informed-and-good-practice-psychosocial-services

[102] Mental Health Australia and National Mental Health Consumer and Carer Forum (2024) *Advice to Governments: Evidence Informed and Good Practice Psychosocial Services. Psychosocial Services to Fund Outside the National Disability Insurance Scheme*. Accessed online 16/04/2025 at https://mhaustralia.org/submission/advice-governments-evidence-informed-and-good-practice-psychosocial-services

[103] KPMG and Mental Health Australia, Investing to Save: The Economic Benefits of Investment in Mental Health Reform. Accessed 08/05/2025 at https://mhaustralia.org/sites/default/files/docs/investing_to_save_may_2018_-_kpmg_mental_health_australia.pdf

[104] Dunt, D.R., Benoy, A.W., Phillipou, A., Collister, L.L., Crowther, E.M., Freidin, J., Castle, D.J. (2017) Evaluation of an integrated housing and recovery model for people with severe and persistent mental illnesses: the Doorway program. *Australian Health Review* **41**, 573-581. Accessed 08/05/2025 at https://www.publish.csiro.au/ah/fulltext/ah16055#:~:text=The%20authors%20also%20thank%20David%20Carey%2C%20Kon,funded%20by%20the%20Department%20of%20Health%2C%20Victoria.

available[105]. Housing based support services can ease caregivers' concern that their loved ones may face these issues in the future.

Evaluation of the Shared Lives model for people with mental health needs identified that "it will not be right for everyone, but for the right person, at the right point in their mental health recovery, Shared Lives can offer an individualised, person-centred form of support at the heart of the community[106]". It is a service model that all caregivers can proactively plan for together with the person they support, and may give caregivers comfort in knowing that their loved ones' social and accommodation needs are likely to be looked after. By contrast, the Housing First Doorways Program – in its current form – provides a safety net and wrap around support in the community only for those who are eligible.

Neighbourhood Based Support

Neighbourhood Based Support services are delivered within the community, often in the person's own home. The model uses a community development approach to build local networks and capacity.

Examples

Buurtzorg - Dutch Model of Neighbourhood Community Workers

Who they work with: Local communities. This includes individuals who need support to live independently in their community, as well as general practitioners, other community healthcare providers, and social services. Since 2006, areas of care have expanded to include mental health and social work services for children and families[107].

Location: The Netherlands and Scotland

[105] Mental Health Australia and National Mental Health Consumer and Carer Forum (2024) *Advice to Governments: Evidence Informed and Good Practice Psychosocial Services. Psychosocial Services to Fund Outside the National Disability Insurance Scheme*. Accessed online 16/04/2025 at https://mhaustralia.org/submission/advice-governments-evidence-informed-and-good-practice-psychosocial-services

[106]

[107] Iriss (2020) The Buurtzorg Model. Accessed 08/05/2025 at https://www.iriss.org.uk/sites/default/files/2020-03/iriss_on.the_buurtzorg_model.pdf

Service description: The term Buurtzorg is Dutch for 'neighbourhood care'[108]. The Buurtzorg model is a nurse-led approach originating in the Netherlands, which offers a holistic, home-based care model focused on supporting independent living and recovery in the community, including for individuals experiencing mental health challenges. It emphasises building strong relationships between nurses, clients, and their families, and encourages self-management and recovery by connecting clients with their social networks[109].

The Buurtzorg model was documented by Iriss in 2020[110]. Under the model, a team (maximum 12 professionals) is based in a local area and supports and cares for people. This group of professionals is responsible for all services provided, including assessment, and developing and implementing care plans. The team has its own office in the area and spends time in the local community, getting to know GPs and other professionals. They work together to decide how to organise the work, share responsibilities and make decisions. Key features of the Buurtzorg model for mental health are:

- **Focus on Relationships:** The model emphasises building strong, trusting relationships between healthcare professionals, patients and families[111], which is crucial for effective mental health support.
- **Community-Based Care:** Services are delivered in the community, often in the patient's own home, fostering a sense of normalcy[112] and reducing the stigma associated with mental health care.
- **Continuity of Care:** Patients receive consistent support from the same team of healthcare professionals, which can improve adherence to treatment plans and reduce the risk of relapses[113].

[108] Iriss (2020) The Buurtzorg Model. Accessed 08/05/2025 at https://www.iriss.org.uk/sites/default/files/2020-03/iriss_on.the_buurtzorg_model.pdf
[109] Iriss (2020) The Buurtzorg Model. Accessed 08/05/2025 at https://www.iriss.org.uk/sites/default/files/2020-03/iriss_on.the_buurtzorg_model.pdf
[110] Iriss (2020) The Buurtzorg Model. Accessed 08/05/2025 at https://www.iriss.org.uk/sites/default/files/2020-03/iriss_on.the_buurtzorg_model.pdf
[111] Kreitzer MJ, Monsen KA, Nandram S, de Blok J. (2015) Buurtzorg nederland: a global model of social innovation, change, and whole-systems healing. Glob Adv Health Med. 2015 Jan;4(1):40-4. Accessed 08/05/2025 at https://pmc.ncbi.nlm.nih.gov/articles/PMC4311562/#:~:text=At%20Buurtzorg%2C%20encouraging%20the%20clients,by%20clients%20and%20their%20families.
[112] Iriss (2020) The Buurtzorg Model. Accessed 08/05/2025 at https://www.iriss.org.uk/sites/default/files/2020-03/iriss_on.the_buurtzorg_model.pdf
[113] Hegedüs A, Schürch A, Bischofberger I. (2022) Implementing Buurtzorg-derived models in the home care setting: a Scoping Review. Int J Nurs Stud Adv. 2022 Jan 12;4. Accessed 08/05/2025 at https://pmc.ncbi.nlm.nih.gov/articles/PMC11080323/#:~:text=Staff%20and%20patients'%20satisfaction%20Various%20studies%20have,delivered%20through%20the%20Buurtzorg%2Dteams%20(%20Brunnschweiler%2C%202019

- **Patient Empowerment:** Patients are actively involved in their care planning and decision-making, promoting autonomy and self-management of their health[114].
- **Access to Resources:** Buurtzorg teams connect patients with community resources, such as social support groups, employment opportunities, and other services, which can help them live full and meaningful lives[115]
- **Self-Managing Teams:** Nurses and other professionals work in small, self-governing teams with autonomy over their practice and service delivery[116].
- **Holistic Approach:** The model addresses both physical and mental health needs, recognising the interconnectedness of well-being[117].
- **Collaboration:** Buurtzorg teams work closely with general practitioners, other community healthcare providers, and social services to ensure a coordinated approach to care[118].

Funding and management: Buurtzorg are primarily funded through a combination of public funding and fee-for-service arrangements[119]. They receive government subsidies and reimbursements for the care they provide and supplement this with a commercially sustainable business model. Buurtzorg charge patients and their families for services via a flat per-hour payment method for its services with nurses deciding the amount of care needed for each patient[120].

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[114] Kreitzer MJ, Monsen KA, Nandram S, de Blok J. (2015) Buurtzorg nederland: a global model of social innovation, change, and whole-systems healing. Glob Adv Health Med. 2015 Jan;4(1):40-4. Accessed 08/05/2025 at https://pmc.ncbi.nlm.nih.gov/articles/PMC4311562/#:~:text=At%20Buurtzorg%2C%20encouraging%20the%20clients,by%20clients%20and%20their%20families.

[115] Kreitzer MJ, Monsen KA, Nandram S, de Blok J. (2015) Buurtzorg nederland: a global model of social innovation, change, and whole-systems healing. Glob Adv Health Med. 2015 Jan;4(1):40-4. Accessed 08/05/2025 at https://pmc.ncbi.nlm.nih.gov/articles/PMC4311562/#:~:text=At%20Buurtzorg%2C%20encouraging%20the%20clients,by%20clients%20and%20their%20families.

[116] Iriss (2020) The Buurtzorg Model. Accessed 08/05/2025 at https://www.iriss.org.uk/sites/default/files/2020-03/iriss_on.the_buurtzorg_model.pdf

[117] Kreitzer MJ, Monsen KA, Nandram S, de Blok J. (2015) Buurtzorg nederland: a global model of social innovation, change, and whole-systems healing. Glob Adv Health Med. 2015 Jan;4(1):40-4. Accessed 08/05/2025 at https://pmc.ncbi.nlm.nih.gov/articles/PMC4311562/#:~:text=At%20Buurtzorg%2C%20encouraging%20the%20clients,by%20clients%20and%20their%20families.

[118] Iriss (2020) The Buurtzorg Model. Accessed 08/05/2025 at https://www.iriss.org.uk/sites/default/files/2020-03/iriss_on.the_buurtzorg_model.pdf

[119] Hegedüs, A., Schürch, A. and Bischofberger, I. (2022) Implementing Buurtzorg-derived models in the home care setting: a Scoping Review, *International Journal of Nursing Studies Advances, Volume 4*. Accessed 08/05/2025 at https://www.sciencedirect.com/science/article/pii/S2666142X22000017#:~:text=The%20teams%20are%20supported%20by,care%20needed%20for%20each%20patient.

[120] Hegedüs, A., Schürch, A. and Bischofberger, I. (2022) Implementing Buurtzorg-derived models in the home care setting: a Scoping Review, *International Journal of Nursing Studies Advances, Volume 4*. Accessed 08/05/2025 at

[For another example of Neighbourhood Based Support (Australia) see the ACDC Project – Doorknocking for Mental Health a pilot project led by Community Mental Health Australia, and completed in 2024].

Benefits of the model for mental health carers

The Buurtzorg model has been widely studied and is recognised within the literature as having significant benefits for individuals, families and communities. For example, Kreitzer et al. (2015) found that by leveraging powerful client and team networks to cultivate the health and wellbeing of the client and community, the "positive outcomes of care have a ripple effect on the wellbeing of the neighborhood, community, and health system"[121]. Other benefits of the model include reduced bureaucracy, an emphasis on prevention and increased patient satisfaction compared to traditional mental health care[122]. While not directly mentioned in the literature, it can be inferred that where this model exists, it may give mental health caregivers comfort to know that community-based, relational support is available for their loved one if they are no longer able to provide care.

Social Prescribing via a Community Link Worker

Social prescribing via a community link worker is a holistic healthcare approach that connects individuals with community-based resources to address social, emotional, and health needs. A 'Link Worker', often a non-medical professional, helps individuals identify their needs, create personalised plans, and connects them with relevant activities and support groups. This model aims to improve well-being and reduce reliance on traditional healthcare services[123]. However

https://www.sciencedirect.com/science/article/pii/S2666142X22000017#:~:text=The%20teams%20are%20supported%20by,care%20needed%20for%20each%20patient.

[121] Kreitzer MJ, Monsen KA, Nandram S, de Blok J. (2015) Buurtzorg nederland: a global model of social innovation, change, and whole-systems healing. *Glob Adv Health Med.* 2015 Jan;4(1):40-4. Accessed 08/05/2025 at https://pmc.ncbi.nlm.nih.gov/articles/PMC4311562/#:~:text=At%20Buurtzorg%2C%20encouraging%20the%20clients,by%20clients%20and%20their%20families.

[122] Iriss (2020) The Buurtzorg Model. Accessed 08/05/2025 at https://www.iriss.org.uk/sites/default/files/2020-03/iriss_on.the_buurtzorg_model.pdf

[123]

general practitioners (GPs) can play a key role in the model by referring into or otherwise providing information about how to access social prescribing link workers.

Examples

Rotherham Mental Health Connectors and Social Prescribing Services

Who they work with: People living with Severe Mental Illness (SMI) across Rotherham, who are 18 years of age or older, and their families or carers[124] (Mental Health Connectors pathway) *or* people aged 18 years or older who are at risk of deteriorating health and wellbeing[125] (Rotherham Social Prescribing Service). Individuals must be referred via a Rotherham general practitioner for all services.

Location: United Kingdom (Rotherham)

Service description: Voluntary Action Rotherham is a not-for-profit organisation that is the lead body for supporting, developing and promoting the voluntary and community sector in the Rotherham borough, in the United Kingdom[126]. They offer three different social prescribing pathways, covering general social prescribing services for people at risk of worsening health and wellbeing, and a specialised Mental Health Community Connector program. Mental Health Community Connectors provide one-to-one support to people living with Severe Mental Illness (SMI) across Rotherham. Support may include:

- Supporting people to access funded physical health provisions
- Connecting people to community groups and activities
- Mental well-being support and resources
- Support to access vaccinations and medication reviews
- Employment and volunteering support

[124] Voluntary Action Rotherham (2025) *Mental Health Community Connectors*. Accessed 08/05/2025 at https://www.varotherham.org.uk/page/mental-health-community-connectors
[125] Voluntary Action Rotherham (2025) *Rotherham Social Prescribing Service*. Accessed 08/05/2025 at https://www.varotherham.org.uk/page/rotherham-social-prescribing-service
[126] Voluntary Action Rotherham (2025) *About Us*. Accessed 08/05/2025 at https://www.varotherham.org.uk/about

- Support to access statutory services[127]

By contrast, the The Rotherham Social Prescribing Service (RSPS) is a service targeted at adults in Rotherham aged 18 plus who are identified as needing additional non-medical support to maintain and improve health and wellbeing. The service has an early intervention focus, and aims to "improve patient outcomes by engaging with people before they experience significant health deterioration or crisis point is reached"[128]. According to the Voluntary Action Rotherham website, the Social Prescribers in the RSPS team offer services that include:

- advice on a wide range of community, statutory and public services in Rotherham and contact services on people's behalf when needed
- supported referrals to a range of voluntary and community services, commissioned by the service to deliver direct support where people need it most[129].

Social Prescribing Link Workers may assist to commission services – often delivered in people's homes – that may include:

- practical help such as advocacy and help to check benefits and claim benefits;
- social support may include befrienders and enablers who can spend time with people taking them out or to join social groups or light exercise opportunities;
- emotional support may include lower-level counselling or bereavement support groups[130].

Funding and management: The Voluntary Action Rotherham website states that the Rotherham Social Prescribing Service pathway is commissioned and funded by NHS South Yorkshire Integrated Care Board[131]. It is unclear whether the other social prescribing pathways are funded in the same way or differently.

[127] Voluntary Action Rotherham (2025) *Mental Health Community Connectors*. Accessed 08/05/2025 at https://www.varotherham.org.uk/page/mental-health-community-connectors
[128] Voluntary Action Rotherham (2025) *Rotherham Social Prescribing Service*. Accessed 08/05/2025 at https://www.varotherham.org.uk/page/rotherham-social-prescribing-service
[129] Voluntary Action Rotherham (2025) *Rotherham Social Prescribing Service*. Accessed 08/05/2025 at https://www.varotherham.org.uk/page/rotherham-social-prescribing-service
[130] Voluntary Action Rotherham (2025) *Rotherham Social Prescribing Service*. Accessed 08/05/2025 at https://www.varotherham.org.uk/page/rotherham-social-prescribing-service
[131] Voluntary Action Rotherham (2025) *Rotherham Social Prescribing Service*. Accessed 08/05/2025 at https://www.varotherham.org.uk/page/rotherham-social-prescribing-service

Footprints Social Prescribing

Who they work with: People over 18 years old with ongoing health conditions or unmet social needs negatively impacting on their health and wellbeing who live in the service catchment areas within South East Queensland[132].

Location: Australia

Service description: Footprints Community is a not-for-profit community organisation based in South East Queensland, Australia. Established in 1991, Footprints has a long history of working with vulnerable people residing in South East Queensland[133]. Footprints Community offer two social prescribing programs:

- the Care Coordination Service (CCS); and
- Social Health Connect (SHC).

According to the Footprints Community website, these programs provide holistic health care that connects people to local community supports with the aim of improving their health and wellbeing in a way that is meaningful to them[134]. This can include linking to supports for healthy living, social groups, activities and can provide personalised support and service navigation[135]. Footprints Community Link Workers can work with people to understand what matters to them and what's missing to help build a support plan to work on their goals. Key features of both programs include:

- providing support to develop personalised goal plans
- linking participants to personalised health services and community supports

[132] Footprints Community (2025) What is Social Prescribing? Accessed 08/05/2025 at https://www.footprintscommunity.org.au/what-is-social-prescribing/
[133] Footprints Community (2025) What is Social Prescribing? Accessed 08/05/2025 at https://www.footprintscommunity.org.au/what-is-social-prescribing/
[134] Footprints Community (2025) *What is Social Prescribing?* Accessed 08/05/2025 at https://www.footprintscommunity.org.au/what-is-social-prescribing/
[135] Footprints Community (2025) *What is Social Prescribing?* Accessed 08/05/2025 at https://www.footprintscommunity.org.au/what-is-social-prescribing/

- providing information and advice about how to manage barriers
- ongoing communication between individuals and their health care providers[136].

The Footprints Community Care Coordination Service links people with organisations and health services to manage their health and improve their overall wellbeing. The Care Coordination Service provides information to find local finance groups, cultural, mental health and/or community groups. It also provides a support person to "walk program participants through the steps to build strong local connections for participants to confidently manage their health"[137].

Footprints Community share that participants in the program often report:

- Improved ability to manage personal health
- Increase in knowledge about health care options available
- Motivation and confidence to manage their health[138].

The Footprints Community Social Health Connect (SHC) social prescribing service is for adults who are over 18 years old and have unmet social needs negatively impacting on their health and wellbeing, and who live in the Redcliffe, Caboolture or Kilcoy hospital catchments[139]. SHC strives to build meaningful relationships and build community, in recognition of the fact that supporting social health can positively impact physical, mental and emotional health and wellbeing. The program aims to:

- Develop person-centred goal plans to address loneliness and social isolation
- Explore local groups and social activities/opportunities people might be interested in

[136] Footprints Community (2025) *What is Social Prescribing?* Accessed 08/05/2025 at https://www.footprintscommunity.org.au/what-is-social-prescribing/
[137] Footprints Community (2025) *Care Coordination Service*. Accessed 08/05/2025 at https://www.footprintscommunity.org.au/services/care-coordination-service/
[138] Footprints Community (2025) *Care Coordination Service.* Accessed 08/05/2025 at https://www.footprintscommunity.org.au/services/care-coordination-service/
[139] Footprints Community (2025) *Health Connect Service*. Accessed 08/05/2025 at https://www.footprintscommunity.org.au/services/social-health-connect/

- Build capacity and address barriers that prevent social inclusion[140].

Funding and management: Footprints Community partner with primary health care, health and hospital services, government agencies, other service providers and the private sector to deliver services[141].

Benefits and challenges of the model for mental health carers

Social prescribing has been attracting increasing attention both in Australia and internationally as an evidence-based, affordable, and complimentary solution to more conventional treatments such as prescription medications and referrals to psychologists (see for example [142] [143] [144] [145]). Social prescribing via a community link worker reduces pressure on acute health systems and has been shown to be a cost-effective approach with significant social return[146]. A recent 2024 evaluation of social prescribing outcomes across nine local health systems in England found:

1. *a 42% reduction in GP appointments*
2. *a 23% reduction in emergency department attendances*
3. *a 9% decrease in secondary care costs*
4. *up to a 39% cost reduction for frequent emergency department users*[147]

[140] Footprints Community (2025) *Health Connect Service*. Accessed 08/05/2025 at https://www.footprintscommunity.org.au/services/social-health-connect/
[141] Footprints Community (2025) About Us. Accessed 08/05/2025 at https://footprintscommunity.org.au/about-us/#ourApproach
[142] World Health Organisation. (2014). *Social Determinants of Mental Health*. Available at https://iris.who.int/bitstream/handle/10665/112828/9789241506809_eng.pdf?sequence=1
[143] Community Support and Services Committee. (2021). *Inquiry into Social Isolation and Loneliness in Queensland: Report No. 14, 57th Parliament Community Support and Services Committee*.
[144] Fancourt D, Finn S. (2019). *What is the evidence on the role of the arts in improving health and well-being? A scoping review*. Copenhagen: WHO Regional Office for Europe.
[145] Dingle, G. (2023). *Report on the 18-Month Evaluation of Social Prescribing in Queensland*. Available at https://www.researchgate.net/publication/373653337_Report_on_the_18-month_evaluation_of_social_prescribing_in_Queensland_2
[146] O'Connell Francischetto, E., Bradly, J. and Knight K. (2024). *The Impact of Social Prescribing on Health Service Use and Costs: Examples of Local Evaluations in Practice*. Available at The Impact of Social Prescribing on Health Service Use and Costs- Examples of Local Evaluations in Practice – Social Prescribing Tools and Resources
[147] O'Connell Francischetto, E., Bradly, J. and Knight K. (2024). *The Impact of Social Prescribing on Health Service Use and Costs: Examples of Local Evaluations in Practice*. Available at The Impact of Social Prescribing on Health Service Use and Costs- Examples of Local Evaluations in Practice – Social Prescribing Tools and Resources

The benefit for individuals appears harder to evaluate, with early systematic reviews of the literature showing mixed results for the benefits of social prescribing. For example, a 2018 review of sixteen navigator-based social prescribing evaluations found that the evidence base is mixed, with some studies finding improvements in health and wellbeing, health-related behaviours, self-concepts, feelings, social contacts and day-to-day functioning post-social prescribing, whereas others have not[148]. This review also showed that the evaluation methodologies used in these studies were variable in quality, with qualitative studies providing stronger evidence of the benefits of social prescribing than those relying on quantitative evidence alone. However, a much larger and more recent 2022 systematic review of 68 reports from 53 different projects, including three controlled studies, found that social prescribing holds benefits in relation to mental health and wellbeing, loneliness, quality of life, general health, self-efficacy, and health care utilisation[149]. This same study identified that uncontrolled studies with shorter time frames were found to show mostly positive effects, while effects reported from studies with control groups or longer follow-up periods were smaller or inconsistent[150].

For mental health caregivers specifically, social prescribing may hold benefits by increasing knowledge, support and resources available to them in a caregiving role[151]. However in terms of being a viable model for future planning for mental health caregivers, the effectiveness of this model is likely to be contingent on whether additional support or follow up care is provided to access services, as some people are likely to need more support to access groups and services than navigation support alone. Like other navigation-based models, social prescribing is also

[148] Pescheny, J.V., G. Randhawa, and Y. Pappas, (2019) The impact of social prescribing services on service users: a systematic review of the evidence. *European journal of public health*., 2019. 14. Accessed 08/05/2025 at https://academic.oup.com/eurpub/article/30/4/664/5519001?login=true

[149] Napierala H, Krüger K, Kuschick D, Heintze C, Herrmann WJ, Holzinger F. (2022) Social Prescribing: Systematic Review of the Effectiveness of Psychosocial Community Referral Interventions in Primary Care. *Int J Integr Care.* 2022 Aug 19;22(3):11. Accessed 08/05/2025 at https://pmc.ncbi.nlm.nih.gov/articles/PMC9389950/

[150] Napierala H, Krüger K, Kuschick D, Heintze C, Herrmann WJ, Holzinger F. (2022) Social Prescribing: Systematic Review of the Effectiveness of Psychosocial Community Referral Interventions in Primary Care. *Int J Integr Care.* 2022 Aug 19;22(3):11. Accessed 08/05/2025 at https://pmc.ncbi.nlm.nih.gov/articles/PMC9389950/

[151] Dayson C, Bashir N, Bennett E, Sanderson E. (2016) The Rotherham Social Prescribing Service for People with Long-Term Health Conditions: Annual Evaluation Report [Internet], 2016, Accessed 08/05/2025 at file:///C:/Users/FarinaMurray/Downloads/eval-rotherham-social-prescribing-long-term-conditions-17-18.pdf

highly dependent on the resources and services that exist in the "service ecosystem" for social prescribing link workers to refer into[152].

Nonetheless, a review of Australian link worker social prescribing programs has recently recommended that policy makers and funders explore social prescribing across funding models in Australia, including NDIS[153]. In particular, social prescribing may hold benefit as a population-level early intervention support with the Queensland Alliance for Mental Health (QAMH) suggesting that there is an opportunity for the Australian Government to incorporate social prescribing "Wellbeing Connectors" within its General Foundational Supports model to meet information, advice, referral and capacity building needs for all people with foundational support needs[154].

Mental Health Hubs

Mental health hubs provide "drop-in" support services from a team of mental health professionals in accessible community-based locations.

Examples

Medicare Mental Health Centres

Who they work with: Anyone. No referral or appointment is needed, nor is a previous history of accessing mental health support.

Location: Australia

Service description: The Australian Government is currently working with state and territory governments and Primary Health Networks to establish 61 Medicare Mental Health Centres

[152] World Health Organisation. (2014). *Social Determinants of Mental Health.* Accessed 08/05/2025 at https://iris.who.int/bitstream/handle/10665/112828/9789241506809_eng.pdf?sequence=1

[153] Baker JR, Bissett M, Freak-Poli R, Dingle GA, Zurynski Y, Astell-Burt T, et al. (2024) *Australian Link Worker Social Prescribing Programs: An integrative review*. PLoS ONE 19(11): e0309783. Available at https://doi.org/10.1371/journal.pone.0309783

[154] Queensland Alliance for Mental Health. (2024). General Foundational Supports Submission. https://www.qamh.org.au/works/general-foundational-supports/

across Australia by mid-2026[155]. According the National Service Model (2025) the Centres are designed to provide "a welcoming, low stigma, soft entry point to engagement, assessment and treatment for people who may be experiencing distress or crisis, including people with conditions too complex for many current primary care services but who are not eligible for or who need more timely care than that available from state or territory public community mental health[156]". They provide immediate, short and medium-term support to anyone who needs it, over extended operating hours. Medicare Mental Health Centres are staffed by teams of qualified mental health professionals, including a combination of Peer Workers with their own lived experience of mental health challenges, and clinicians like psychologists, nurses, social workers and occupational therapists[157]. Centres help to connect individuals with other services to support them into the future, from health to mental health, and social supports like housing and employment[158]. Overall, the Centres aim to assist adults seeking help in times of crisis, or as needs emerge, to have access to on-the-spot care, advice and support provided by mental health professionals without needing a prior appointment[159].

The Medicare Mental Health Centres National Service Model (2025)[160] identifies that the model seeks to address key gaps in the system by:

- Providing a highly visible and accessible entry point to services for people experiencing psychological distress, where all feel safe and welcomed
- Offering assessment to match people to the services they need
- Providing on-the-spot support, care and advice without needing referral, prior appointments or out-of-pocket cost. Every interaction should be with the intention of therapeutic benefit

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[155] Australian Government Department of Health (2025) *Medicare Mental Health Centres*. Accessed 08/05/2025 at https://www.health.gov.au/our-work/medicare-mental-health-centres

[156] Australian Government Department of Health (2025) *Medicare Mental Health Centres: National Service Model*. Accessed 08/05/2025 at https://www.health.gov.au/resources/publications/national-service-model-medicare-mental-health-centres

[157] Neami National (2025) *Early implementation findings from co-evaluation research of Medicare Mental Health Centres delivered by Neami*. Accessed 08/05/2025 at https://www.neaminational.org.au/news-and-stories/early-implementation-findings-from-co-evaluation-research-of-medicare-mental-health-centres-delivered-by-neami/

[158] Australian Government Department of Health (2025) *Medicare Mental Health Centres*. Accessed 08/05/2025 at https://www.health.gov.au/our-work/medicare-mental-health-centres

[159] Australian Government Department of Health (2025) *Medicare Mental Health Centres*. Accessed 08/05/2025 at https://www.health.gov.au/our-work/medicare-mental-health-centres

[160] Australian Government Department of Health (2025) *Medicare Mental Health Centres: National Service Model*. Accessed 08/05/2025 at https://www.health.gov.au/resources/publications/national-service-model-medicare-mental-health-centres

- Offering an episode of care model based on short to medium term multidisciplinary collaborative care, aimed at improving psychological wellbeing for people with moderate to high levels of mental health need, whose needs are not being met through other services[161].

The service model aims to address the following four service elements at individual Medicare Mental Health Centre sites[162]:

- Respond to people in significant distress, including people at heightened risk of suicide, providing support that may reduce the need for emergency department attendance
- Provide a central point to connect people to other services in the region, including through offering information and advice about mental health and alcohol and other drug use, service navigation and warm referral pathways for individuals, and their carers and family
- Provide in-house assessment, including information and support to access services
- Provide evidence-based and evidence-informed immediate, and short to medium term episodes of care, including utilisation of digital mental health platforms[163].

Funding and management: Medicare Mental Health Centres are funded through a joint effort between the Australian government and state or territory governments. The Australian government provides funding to establish the centres, while state and territory governments may contribute to the ongoing operations and delivery of services[164]. Additionally, Primary Health Networks (PHNs) play a role in commissioning services at these centres[165].

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[161] Australian Government Department of Health (2025) *Medicare Mental Health Centres: National Service Model*. Accessed 08/05/2025 at https://www.health.gov.au/resources/publications/national-service-model-medicare-mental-health-centres

[162] Australian Government Department of Health (2025) *Medicare Mental Health Centres: National Service Model*. Accessed 08/05/2025 at https://www.health.gov.au/resources/publications/national-service-model-medicare-mental-health-centres

[163] Australian Government Department of Health (2025) *Medicare Mental Health Centres: National Service Model*. Accessed 08/05/2025 at https://www.health.gov.au/resources/publications/national-service-model-medicare-mental-health-centres

[164] Australian Government Department of Health (2025) *Medicare Mental Health Centres: National Service Model*. Accessed 08/05/2025 at https://www.health.gov.au/resources/publications/national-service-model-medicare-mental-health-centres

[165] Mind (2025) *Mind to Deliver Free Centre Based Mental Health and Wellbeing Support in Cairns*. Accessed 08/05/2025 at https://mindaustralia.org.au/news/mind-deliver-free-centre-based-mental-health-and-wellbeing-support-cairns

Benefits and challenges of the model for mental health carers

Early implementation research into the Medicare Mental Health Centre model conducted by Neami in partnership with The ALIVE National Centre for Mental Health Research Translation project[166] in 2024 found that:

- The consumer experience is positive, with people valuing the compassionate, non-judgemental approach offered by centres as well as having access to a multi-disciplinary team of Peer Workers and clinicians. Services were also found to provide an enduring sense of care and connection with guests over time[167].
- The services are increasing access and filling a gap in the system with services reaching people who may not have otherwise accessed support. It also found that 65 – 85% of guests are self-referred[168].

The impact of the model on caregivers is currently missing from the literature. In terms of a model for future planning for mental health caregivers however, this model's focus on crisis support and the time-limited nature of support available through this model may not be enough to reassure caregivers that the holistic needs of the person they care for will be looked after.

Public Trustee

Public Trustees are government-appointed agencies or officers that provide financial, legal, and trustee services, especially to people who are vulnerable, unable to manage their own affairs, or who need help with estate or future planning. They exist in most Australian states and territories

[166] Neami National (2025) *Early implementation findings from co-evaluation research of Medicare Mental Health Centres delivered by Neami*. Accessed 08/05/2025 at https://www.neaminational.org.au/news-and-stories/early-implementation-findings-from-co-evaluation-research-of-medicare-mental-health-centres-delivered-by-neami/
[167] Neami National (2025) *Early implementation findings from co-evaluation research of Medicare Mental Health Centres delivered by Neami*. Accessed 08/05/2025 at https://www.neaminational.org.au/news-and-stories/early-implementation-findings-from-co-evaluation-research-of-medicare-mental-health-centres-delivered-by-neami/
[168] Neami National (2025) *Early implementation findings from co-evaluation research of Medicare Mental Health Centres delivered by Neami*. Accessed 08/05/2025 at https://www.neaminational.org.au/news-and-stories/early-implementation-findings-from-co-evaluation-research-of-medicare-mental-health-centres-delivered-by-neami/

(and internationally in some jurisdictions), and while the exact scope varies by region, the core functions are broadly similar.

Examples

Queensland Public Trustee

Who they work with: Individuals with impaired decision-making capacity, including those with serious mental health conditions, their families, carers and services.

Location: Australia (Queensland)

Service description: The Queensland Public Trustee (QPT) provides essential support, services and information for Queensland families in financial administration, life planning, trusts and deceased estate management. Caregivers can access the following services:

- **Wills:** QPT provides a free will-making service to all Queensland adults. Wills can include provisions for testamentary trusts (see below) to protect assets for a person with mental illness after the carer's death.
- **Enduring Powers of Attorney (EPA):** QPT can help caregivers draft EPAs and act as attorney for financial matters, but not personal/health matters. Carers can encourage their loved one to complete an EPA while they still have capacity and may appoint a backup plan in their own EPA to ensure someone can continue caring if they are unable.
- **Trusts:** QPT can manage protective trusts, such as testamentary trusts (set up in a will to distribute and manage funds as specified by the deceased person) or compensation trusts (from personal injury or insurance settlements). These trusts:
    - Safeguard funds for people with impaired decision-making,
    - Prevent financial exploitation,
    - Provide structured income and ongoing management.
- **Financial Administration:** If someone loses capacity and has not appointed an EPA, a carer or health professional can apply to QCAT to appoint the Public Trustee as financial administrator. While this is more of a reactive than a planning tool, it provides a safety net if a crisis occurs. Carers can initiate conversations early about this pathway if they foresee a future need.

- **Education Sessions:** QPT provides community education sessions and online tools to help families and carers:
    - Understand EPAs and wills.
    - Prepare for substitute decision-making roles.
    - Navigate planning for someone with a mental illness or cognitive impairment[169].

Funding and management: The Public Trustee operates as a commercial, self-funding statutory authority under the *Public Trustee Act 1978*. Although it may receive occasional one-off government grants, it is primarily self-funded through a combination of fee-for-service and investment earnings[170].

Benefits and challenges of the model for mental health carers

Overall, the Public Trustee model can provide caregivers with a level of reassurance and a crisis safety net for their person where needed. In particular, it ensures financial safety when a person is unable to manage their own affairs, can reduce the burden of complex financial management responsibilities on carers, and offers professional and consistent financial administration in long-term or recurring episodes of mental ill-health.

Nonetheless, the model has faced significant criticism, particularly in Queensland. A 2021 report by Queensland's Public Advocate, *Preserving the financial futures of vulnerable Queenslanders*, highlighted issues with fee transparency, customer communications, and administrative consistency[171]. For carers, specific issues such as limited collaboration or consultation with Carers, frequent report delays, poor updates, mismanagement of funds, overly bureaucratic processes and high and often complex fee arrangements which can significantly erode client

[169] Queensland Public Trustee (2025) Information and our Services. Accessed online 21/06/2025 at Queensland Public Trustee
[170] Queensland Public Trustee (2025) *Fees and Charges*. Accessed online 21/06/2025 at Fees and charges | Queensland Public Trustee
[171] The Public Advocate (2023*) Implementation Update: Preserving the financial futures of vulnerable Queenslanders: A review of Public Trustee fees, charges and practices, 10 March 2023*. Accessed online 21/06/2025 at 20230314-PT-implementation-update-FINAL-website-COMBINED.pdf

funds have been reported in the media[172] [173]. In addition, Public Trustee arrangements can feel disempowering, especially where clients (or the carer) are partially capable of managing some aspects of their finances. Indigenous, CALD, or neurodivergent clients may also face systemic barriers or lack of culturally safe service delivery. Since the 2021 report into its operations, QPT has undertaken significant reforms, including review of its fees and charges and introduction of a Customer Advocate Office[174].

[172] ABC News (2023) *The Stories of Vulnerable People Under Public Trustees are Putting the Little Known System Under Scrutiny.* Accessed 21/06/2025 at The stories of vulnerable people under public trustees are putting the little-known system under scrutiny — but change may be coming - ABC News

[173] ABC News (2024) *Queensland's Public Trustee said complaints were 'not substantiated'. Refunds tell a different story.* Accessed 21/06/2025 at Queensland's Public Trustee said complaints were 'not substantiated'. Refunds tell a different story - ABC News

[174] The Public Advocate (2023*) Implementation Update: Preserving the financial futures of vulnerable Queenslanders: A review of Public Trustee fees, charges and practices, 10 March 2023*. Accessed online 21/06/2025 at 20230314-PT-implementation-update-FINAL-website-COMBINED.pdf