Community Navigator Project
Evaluation Report

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ASSOCIATION CANADIENNE POUR LA SANTÉ MENTALE

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A Tribute to Dr. Nancy Hall (1950–2011)

By Trevor Hancock

This evaluation report was largely developed by Nancy Hall. Sadly, Nancy did not live to see the report published; she succumbed to breast cancer on March 24, 2011. Nancy was a remarkable woman and is deeply missed by the many people whose lives she touched, and who were helped and enriched by knowing her. She was a pioneer in health promotion, with a particular interest in the health and wellness of seniors, and was committed to improving the health and wellbeing of everyone she met and worked with, so she could be quite intense—yet at the same time Nancy was a warm, funny and engaging person and a wonderful friend and colleague. She was, as I said at her memorial service, a force of nature, and it is still hard to believe that force has been stilled.

Nancy had a particular affinity for people with mental health problems, doubtless a consequence of her own experience with a family member with a serious mental health condition. That experience would have strengthened her resolve in her work as British Columbia's first—and sadly, only—Mental Health Advocate. She brought to that work, as she brought to all she did, a passionate commitment, a keen intellect, impatience with any effort that was less than full and less than honest—and the integrity to speak out for what she believed in and to criticize what she saw as wrong. She cared very much for the people on whose behalf she worked, and she expected the politicians and public servants with whom she worked—and with whom she sometimes fought—to care as much and to do what was right.

In many ways this report bears witness to all these aspects of Nancy. It is well written and well-researched; it is focused on what is best for people with complex mental health problems, and it expects the best for them. A true and fitting memorial to Nancy would be to see the Community Navigator program become a permanent program in BC—and for that matter

across Canada—something I am confident the Canadian Mental Health Association (CMHA) will champion.

Trevor was a long time friend and colleague of Nancy, whom he greatly admired and respected, and whose friendship he cherished. He is Professor and Senior Scholar at the School of Public Health and Social Policy, University of Victoria.

Dr. Nancy Hall acted as a key advisor, consultant, and friend to CMHA BC for more than 15 years and passed away in 2011 after a battle with cancer. That year, The Dr. Nancy Hall Public Policy Leadership Award was established to annually recognize an individual who has influenced mental health policy and designate a $500 gift for the recipient's charity of choice. In addition, the Dr. Nancy Hall Speaking Up Speaking Out Fund was created with an initial investment of $50,000. Currently containing $100,000, the fund will support CMHA's continued work in public policy and systemic advocacy at the provincial level and provide an informed independent voice on the impact of the public mental health system on the lives of people with mental illness and substance use problems and their families.

Executive Summary

There is growing consensus among health care workers and policy makers that Canada's current model of health care delivery is not adequately serving the needs of people with complex health issues such as mental illness, addictions or developmental disabilities. The current patchwork of services often leaves individuals and families feeling confused, frustrated and unable to access the care they need. The current system can also be costly, as it does not adequately support people to access the services they need on an ongoing basis. This ultimately leads to an increased need for costly emergency care, hospitalization and crisis intervention.

In response to these problems new models of care are being developed to help create a more patient centered and integrative approach to mental health issues. One program that has recently been piloted in British Columbia by the Ministry of Housing and Social Development in partnership with the Canadian Mental Health Association (CMHA) BC Division, is the Community Navigator Project. This project provides individualized support to clients with complex mental health issues, addictions and disabilities and assists them in navigating the care they need. The specific goals of the program are:

1. To provide direct support to individuals with mental illness to access income assistance, including Persons with Disabilities (PWD) and Persons with Persistent Multiple Barriers (PPMB) benefits as well as other income benefits available through all levels of government.
2. To assist individuals to access health care services, to facilitate their application process and to provide the necessary medical services to maintain and enhance their health.
3. To support individuals in the development of stronger personal support networks, which in turn may assist them in their community participation and in securing and/or maintaining housing, employment and volunteer opportunities.

Findings from the evaluation indicate that this project offers an excellent opportunity to improve client outcomes including improved access to health services, income assistance and social support for people with complex mental health issues. More importantly, the project was found to bridge the current patchwork of services offering a more user friendly and client-centered model of care. This is a client centered and flexible project that responds to the unique needs of individual clients and communities. Navigator work does not replicate other services in the community, but rather enables clients to understand and access existing services while supporting clients to reconnect with their communities and become more active and engaged citizens. Overall, responses from community partners, clients and navigators suggest that this is a very valuable program. Of particular note, **100% of community partners who responded to the survey indicated that this was a valuable program.**

The findings from the evaluation are supported by evidence within the academic literature which indicates that navigators can significantly improve patient satisfaction and health outcomes in a number of different health care settings and can lead to improved patient satisfaction, quality of care, and sustained use of services. Navigators provide a consistent point of access that helps build trust between the client and provider. This trust greatly contributes to the client's successful use of health services and to their positive experiences with the health care system. This is particularly important in the case of patients with complex mental health issues, who often experience prejudice and discrimination.

A few recommendations were also made. Most importantly, it is recommended that program continuity be maintained by securing future funding for an ongoing navigator role either within CMHA or other funding opportunities in the province such as the new Family Practice Divisions currently being established throughout the province. It is also recommended that a formal partnership between the navigator and the homeless outreach worker be established at each site.

Key Quotes from the Evaluation

"This has been an amazing program and it has been a lifesaver for our clients and other programs that are overwhelmed or unable to deal with the issues our clients have. Our clients have reaped the benefits and would be the first ones to tell you how much having a program like this has assisted and supported them and still does".
—Community Navigator

"For people who have become disconnected, frustration is high and trust in the system is very low. It's helpful to have an advocate to walk with them through a system that presents barrier after barrier."
—Community Partner

"I consistently received positive feedback from clients regarding the program. I found the program worked collaboratively with our services as needed."
—Community Partner

Introduction

There is growing evidence that the complex needs of people with mental health issues in Canada are not adequately being met by the current health system [1,2,3]. The majority of people with mental illness in Canada experience two or more concurrent conditions which range from substance abuse to physical, mental and developmental disabilities, all of which may challenge in one way or another their ability to manage tasks of daily living and lead healthy and fulfilling lives [2,3]. The challenges of living with multiple disabilities can often lead to poor living conditions including inadequate housing, lack of social connectedness and lack of meaningful daily activities [3]. Increasingly, there is recognition that the current patchwork of services for mental health and addictions is not adequately meeting these complex needs [4]. Life expectancy for this population is significantly less than that of the general population [29], indicating the need to better connect this population to the services they need in a timely and cost effective manner. In Ontario, the Select Committee on Mental Health and Addictions describes *"a troubling situation in which there are hundreds of services yet individuals are still unable to access care, leaving Ontarians confused and frustrated when beginning their search for help".* The Kirby report (2006) emphasizes that in order to adequately address complex health issues like mental illness, disabilities and addictions it will be essential that there is increased client focused care and coordination amongst a variety of services and health professionals. This position is supported by the *2010 BC Ministry of Health Services Policy Paper* that calls for a coordinated network of community-based health professionals supporting patients as partners in the management of their health.

In 2009, the National Coalition on Dual Diagnosis recommended that there is a need for developing new approaches to service delivery in order to provide better integration, coordination and support to patients navigating a complex system. As part of their recommendations, the coalition suggested that a community navigator role be developed to provide individualized support and advocacy to people with complex mental health issues. This recommendation has been echoed by other policy papers including the *2010 Final Report of the Ontario Select Committee on Mental Health and Addictions* and the 2005 dialogue paper developed by the Ontario Office of Child and Family Service Advocacy. These papers have highlighted the potential for community navigators to help improve continuity of care and the quality of the patient experience within mental health and addictions.

About the Navigator Project

The Community Navigator Project was piloted in 2008, by the Ministry of Housing and Social Development in partnership with CMHA BC Division with the objective of making it easier for people with mental illness to access government services and supports. The program has supported people with mental illness to access health services, income assistance and other supports that enable them to participate more fully in their communities, and experience an improved quality of life.

The program hired and trained community navigators to work in five sites throughout BC. The participating sites are listed below. The navigators came from a range of different professional backgrounds and work experiences but were selected based on the following criteria: knowledge of the community and the local programs and services available; knowledge or experience working with people with mental health and addictions issues; ability to be empathetic and connect people with the appropriate services; ability to set boundaries; advocacy and mediation skills.

Upon being hired the navigators were provided additional training, in order to orient them to the job, improve their advocacy skills, improve their knowledge of PWD and PPMB forms, increase their understanding of local services, and prepare them for the kinds of client situations they should expect to be working with. Navigators were also trained to be flexible to the needs of clients, build trusting relationships, facilitate the development of clients' personal support networks and provide support in a variety of ways depending on the client's individual needs and challenges. They received an initial month long training, as well as other training sessions throughout the pilot program. Some examples of specific training sessions that the navigators attended are PLAN and Wrap Canada's WrapAround, both of which focus on training participants how to create caring personal support networks for their clients. Once they started working, further on the job training was provided by the homeless outreach worker at each site. In addition, the navigators would all meet regularly for conference calls to share experiences and learn from one another.

The navigators were paid a yearly salary of $40,000 for full time work. This is the largest component of the base budget of $64,800 annually per site, which is broken down as follows:

1. **Training**—$3000
2. **Salary**—$40,000
3. **Expenses**—$1,200 monthly x 12 months = $14,400 annually (supervision, rent, telephone, etc.)
4. **Client support expenses**—$5,000
5. **Transportation**—$200 monthly x 12 months = $2400 annually

Participating Locations

- Kootenays Branch, including Cranbrook district
- South Cariboo Branch including 100 Mile House/Chilcotin/Williams Lake
- Prince George Branch
- Kelowna Branch
- North and West Vancouver Branch

Examples of Navigator Activities

- **Individualized client-driven support:** Navigators connect with clients through the Homeless Outreach Program and other referral sources to provide one-on-one support for client-defined goals beyond housing.
- **Income support:** Navigators assist clients to access the income support to which they are entitled: Income Assistance, Persons with Disability (PWD), Persons with Persistent Multiple Barriers (PPMB) Canada Pension Plan disability benefits (CPP), GST rebates, income tax rebates, Climate Action Dividend, Shelter Aid for Elderly Renters (SAFER).
- **Health referral and advocacy:** Navigators connect clients with services for physical and mental health, as well as addictions. They provide support for clients at doctor appointments including supporting them with health literacy issues, finding a physician, completing PWD forms, making appointments and arriving at appointments.
- **Reconnect families:** Navigators facilitate supervised access visits with children in care of the Ministry of Children and Family Development and help redevelop family networks.
- **Community contribution:** Navigators recognize client skills and work to connect them with community volunteer opportunities or employment.
- **Social connection:** Navigators facilitate client involvement in leisure and recreation activities. They support clients to develop personal support networks.
- **Life skills:** Navigators help clients build basic life skills including money management, banking, grocery shopping, and meal preparation.
- **Housing security:** Navigators liaise with landlords where necessary to assist clients in retaining housing.

Stories From The Field

Bob

"I was introduced to Bob by a homeless outreach worker. He is 45 years old and First Nations. Bob was on income assistance, but continued to end up on the streets, as he could not afford rent and food. When I started working with Bob, I called his band office and spoke to a native counselor who knew his background.

I learned he was a residential school survivor who had an undiagnosed learning disability and/or fetal alcohol syndrome. I found he was kind, simple, quiet, nonassertive and very vulnerable. Bob had spent his whole life falling through the cracks. I assisted Bob with his PWD application. We started this journey with a visit to his doctor, who did not diagnose Bob as having a disability. So, I researched where we could get an assessment done, requested a referral to the physiatrist and accompanied Bob to this appointment (It must be noted that it is often very difficult to find our clients for these appointments, as most do not have phones). The psychiatrist suggested Bob's IQ was 70, indicating disability. I completed a 'mock' copy of a PWD application detailing all of the daily assistance that Bob will require to move forward in his life. The PWD application was approved.

Now, Bob has enough income to have his own home and is living alone successfully. I have also hooked Bob up with our Clubhouse for people with mental illness, where they enjoy social activities such as playing bingo, going bowling and having lunches."

Sheila

"In March 2009, I received a referral from the homeless outreach worker at CMHA. The concern at the time was that Sheila and 19 year old daughter, Lindsey, both on PWD pensions, were living in an apartment they could not afford. Sheila had fled abuse, had recently had a mastectomy, needed hip surgery, and had breathing problems at the time. Lindsey had developmental delays and was legally blind, with a small amount of vision. She was working in a supported work environment, hanging clothes and working the till at a Thrift Shop, and enjoyed it.

Too tired, too much work to pack, too many changes for her daughter. After I assured her we would do the packing and moving, she agreed if anything came up, she would consider it. Within a month, a two bedroom social housing unit modified for disabled access and living became available and both Sheila and Lindsey agreed to move. I arranged the move, and did all the packing with direction from Sheila. A washer and dryer were purchased second hand, as Lindsey cannot see well enough to walk to the common laundry room, and Sheila walks with a cane, very slowly, unable to carry laundry basket."

About the Evaluation Process

This evaluation consisted of four main components:

- **A literature review** of navigator roles within the health care sector (the full review is an appendix to this report);
- **A policy scan** involving interviews with key stakeholders and policy makers in BC;
- **Community-level feedback** from each site involving surveys and interviews with Navigators, community partners, referral sources and clients;
- **An analysis of key indicators** from the Community Navigator Project database.

The project was evaluated based on the three primary goals of the project:

1. To provide direct support to individuals with mental illness to access income support including Persons with Disabilities (PWD) and Persons with Persistent Multiple Barriers (PPMB) benefits as well as other income benefits available through all levels of government.
2. To assist individuals to access health care services, to facilitate their application process and to provide the necessary medical services to maintain and enhance their health.
3. To support individuals in the development of stronger personal support networks, which in turn may assist them in their community participation and in securing and/or maintaining housing, employment and volunteer opportunities.

In addition to these primary project goals, the evaluation explored other key successes and challenges, site-specific variations, and overall recommendations.

Methodology

1. The Navigator Project evaluation was carried out between September 2010 and January 2011 by Be Well Consultants (Nancy Hall, PhD and Alisa Stanton, MPH). Through the policy scan phase of the project Nancy Hall conducted interviews with the following key informants:

- **Mariann Burka**
  Executive Director
  Aboriginal Relations and Reconciliation
  Intergovernmental and Community Relations Branch
- **Heather Davidson**
  Assistant Deputy Minister
  Health Authorities Division
- **Kelly McQuillen**
  Director
  Patients as Partners
- **Allison Bond**
  Assistant Deputy Minister
  Housing and Social Development
  Employment and Labour Market Services Division
- **Sharon Moysey**
  Assistant Deputy Minister
  Housing and Social Development
  Regional Services Division
- **Andrew Wharton**
  Special Advisor
  Disability Services Division

These interviews were primarily held over the phone between October and December 2010. Any key policy documents recommended through the key informant interviews were subsequently reviewed.

In addition to the policy scan, a literature review of both academic and gray literature was conducted by Alisa Stanton in October, 2010. The literature search explored previous applications of a navigator role within the health care sector and the benefits and limitations of these roles. The review also explored previous recommendations with regard to training of navigators, effectiveness of navigator projects, and level of innovation achieved by previous projects.

The interview and survey phase of the project involved the development of two survey tools: one for community navigators at each of the 5 BC sites, and one for community partners at each site. The community partners consisted of referral agencies, organizations that worked with the navigator clients in other capacities and organizations that navigators collaborated with in some other respect through their work in the community. All community partners were identified and recruited for participation by the navigator at each site. In total the survey was sent to all five navigators (one from each site) and 40 community partners (16 from Kelowna, seven from South Cariboo, two from North Vancouver, two from Prince George and 13 from the Kootenays). The response rate from the navigators was 100% and from the community partners the response rate was 75%. The survey data provided both qualitative and quantitative information with regard to the strengths and challenges of the project overall and the site-specific variations that occurred. A copy of the survey questions for both surveys are included in Appendix 2.

Within each survey there was an opportunity for participants to request a follow-up interview. All participants who requested an interview were subsequently contacted. In total 3 navigators (Kelowna, Kootenays and South Cariboo) and two community partners (South Cariboo and North Vancouver) were contacted for follow up interviews. These interviews followed up on points of interest that emerged through the survey and provided an opportunity for participants to provide more in depth information, and/or clarify anything that they did not feel was adequately covered in the surveys. In addition to the follow-up interviews with navigators and community partners, two program clients were contacted and provided input on their experience with the project.

Summary of Literature Review

A number of lessons about the role and function of navigators can be learned from the literature review. The key lessons are summarized here, the full literature review is included as an appendix.

- Navigator roles have been found to be cost-beneficial, particularly when navigators are not over professionalized.
- It is beneficial to hire navigators who have lived experience, cultural connections or community connections. This is more important than academic credentials.
- Navigator models have been found to reduce access barriers, increase patient satisfaction and provider satisfaction.
- Family centered models are recommended, and support should be offered to both patients and caregivers.
- It is important that navigators have the flexibility to respond to a variety of individual patient needs.
- Navigators have been successfully used within cancer care, mental health and addictions and chronic disease prevention/management.

Policy Scan

Community navigator roles have been increasingly considered and adopted over the last 20 years throughout Canada and the US. In Canada a variety of different navigator roles have been developed within Ontario, Nova Scotia, British Columbia, Quebec and Alberta. The navigator role was first used in cancer care in the early 1990s, and has since been adapted for a number of diverse settings [6]. Currently the role is widely used in cancer care, particularly to support underserved populations such as Aboriginal people, African American's and Hispanic populations [5, 10, 11]. Paid and volunteer cancer patient navigators are currently working for a variety of organizations including health authorities and community cancer support centers [5, 11, 12]. Because of the navigator model's success at improving access to care and quality of care, the model has recently been adapted for other settings including mental health and addictions and chronic disease prevention [8, 14, 15]. In 2006 the US government passed the Patient Navigator Outreach and Chronic Disease Prevention Act, which supports the demonstration of the use of navigators to support individualized patient education and access to services to support chronic disease prevention [13]. In the area of mental health and addictions, both the Mental Health Commission of Canada's new framework for a mental health strategy in Canada and the Ontario Legislatures Select Committee on MHA recommend the adoption of a navigator role within mental health and addictions services in Canada [1, 3]. This view is also supported by the Canadian Coalition on Dual Diagnosis, and Ontario's Office of Child and Family Service Advocacy [2,4]. Recommendations suggest that navigators within mental health and addictions could help fill the gaps within the current mental health system and contribute to improved coordination, patient satisfaction and effectiveness of mental health services [1, 2, 3]. This would support the recommendations of leading mental health policy papers including the Kirby Report (2006) which advocates for increased client centered and collaborative approaches to mental health service delivery [21].

Even where navigator roles have not been specifically recommended, there is significant potential for navigators to contribute to various mental health agendas in Canada. The Canadian Medical Association's 2010 policy paper on health reform suggests that there is a need to focus attention towards improving the continuity of care, improving access and quality of care, focusing on patient centered and family based approaches, as well as tailoring to the needs of diverse Canadians [18]. Although the paper doesn't specifically recommend the navigator role, this role is certainly well positioned to contribute to several of the stated objectives. Because of the navigators direct involvement with patients, families and providers they are able to support increased access and continuity of care and coordination within the system. They are also able to provide support, advocacy, referrals, and education to both patients and their families and thus contribute towards more family centered care. Similar models have been developed including the Assertive Community Treatment Teams model recommended in the Ministry of Health Services policy paper entitled *Delivering Effective, Integrated Systems of Primary and Community Care* [22]. This model uses a collaborative team of professionals to support patients with complex health conditions. Although this model has been found to be effective, it is unclear whether it will be financially feasible to take this program to scale throughout BC. The navigator model provides a similar client centered and collaborative approach but because it uses a somewhat less professionalized model, it may be more financially feasible to take to scale.

The navigator role also has potential to break down barriers for traditionally underserved populations. In British Columbia, the Aboriginal Mental Health and Addictions Forum, hosted by Vancouver Coastal Health and The Aboriginal Health Strategic Initiative have identified the need for improved outreach and access to mental health services, support in overcoming transportation barriers, improved cultural continuity and increased community-based prevention and risk reduction strategies [19]. Again, although they did not specifically recommend the navigator role, navigators could greatly contribute to their stated objectives.

In terms of mental health and addictions policy in BC, there is a growing shift towards more community-based, client centered and coordinated care which emphasizes the need for increased integration of services [20, 24]. These goals would be well supported through the further development of a Community Navigator Project. The Ministry of Health's 2004 publication entitled *Every Door is the Right Door*, emphasizes the need for community based and patient centered models of care in the management of substance use and addictions [20]. This view is echoed by the 2010 Ministry of Health Services policy paper entitled Healthy Minds, Healthy People which recommends a ten year action plan to improve integrated and collaborative care for mental health and addictions in BC. Included in these recommendations is the call to improve coordinated responses for people with complex health challenges, and implement integrated evidence-based primary and community care practices for people with severe and complex mental disorders and/or substance dependence [24]. All of these policy recommendations support the development of a community navigator position. The Navigator would ultimately offer an opportunity to provide more client-centered, community-based and coordinated care for people with complex mental health issues.

Findings

Database and Demographic Analysis

The following information about the navigator clients and the program outcomes was retrieved from the Navigator Project database. The database was created by an independent consultant during the initiation of the Navigator Project. At each site, the navigators were responsible for inputting information into the database on a regular basis and monitoring the database.

Who Are The Clients of the Community Navigator Project?

In total, approximately 394 clients were served by the project. There was one navigator located at each site, and the number of clients served by each site over the duration of the pilot project is estimated below.

Site Location	Number of Clients Served*	Number of Months
South Cariboo	65	20
Kelowna	63	23
North/West Vancouver	126	22
Kootenays	62	19
Prince George	78	22

*These numbers are based on the information available from the Navigator Project database at the time of the evaluation.

The project had an open referral policy, and welcomed drop-in clients. Each site had numerous referral agencies including: the BC Housing Homeless Outreach Program, various community disability services, Mental Health and Addictions Services, the Salvation Army and numerous other community service groups.

The clients were split more or less evenly between males and females with a small proportion being transgendered (see Chart 2 on the next page).

Table 1. Average Client Age

Navigator Site	Average Client Age
100 Mile House	57
Kelowna	47
Kootenays	42
North and West Vancouver	43
Prince George	36
Williams Lake	44

Chart 2. Client Gender Breakdown

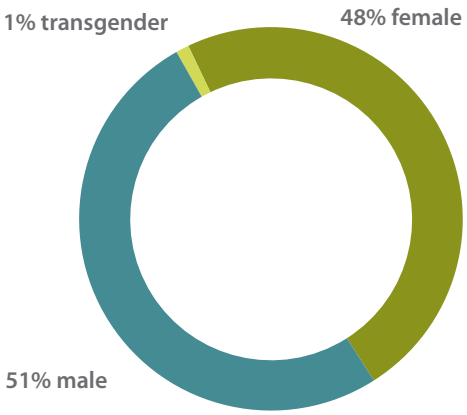
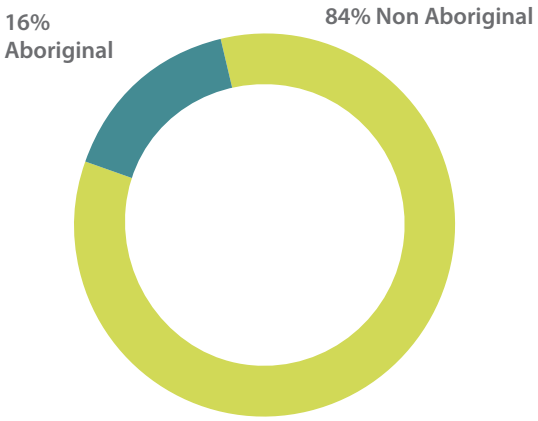


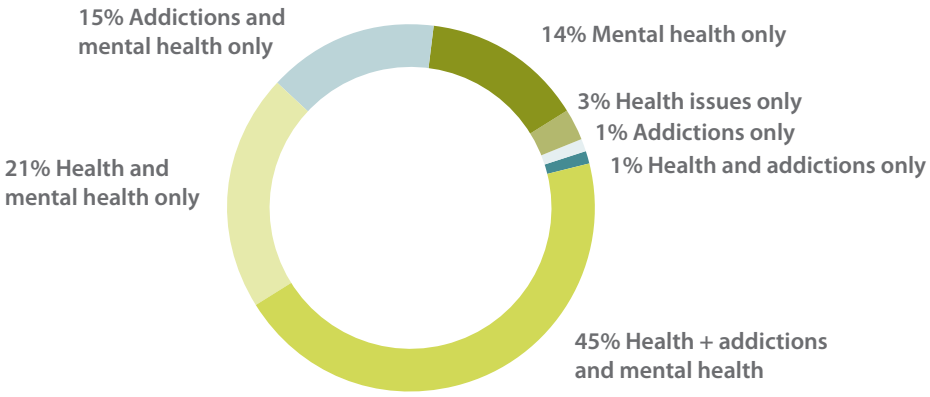
Chart 3. % Aboriginal Clients



Overall, 16% of navigator clients were Aboriginal, but the percentage was much higher at specific sites. For example, in Williams Lake 45% of clients were Aboriginal.

The clients experienced a range of different health issues, and the vast majority of clients experienced at least two or more concurrent conditions (see Chart 4 below).

Chart 4. Clients with Concurrent Health Conditions



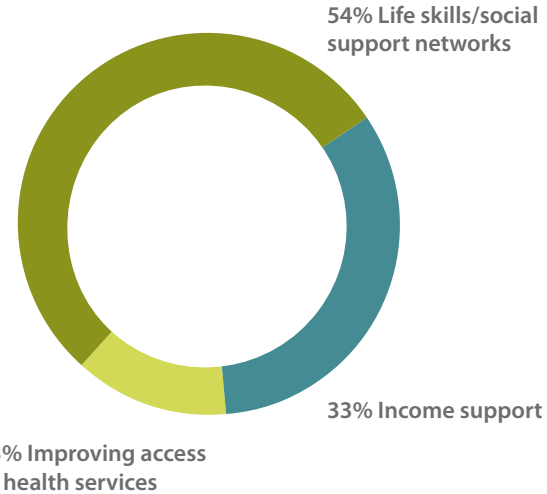
Findings from Interview and Survey Responses

Community Response to the Program

Overall, responses regarding the Community Navigator Project were extremely positive. 100% of the community partners who filled out the survey for the evaluation said that the program was valuable in their community. Quotes and stories from the sites are included throughout this report to highlight the key experiences and perceptions of the program from those involved at the community level.

Progress towards Primary Project Goals

The Navigator Project established three primary goals: to increase access to PWD, PPMB and other income support; to increase access to health services and to increase personal skills and support networks. The chart below highlights the percentage of navigator time spent on each of these goals. The following sections outline the key findings from the interview and survey data with regard to these program goals.



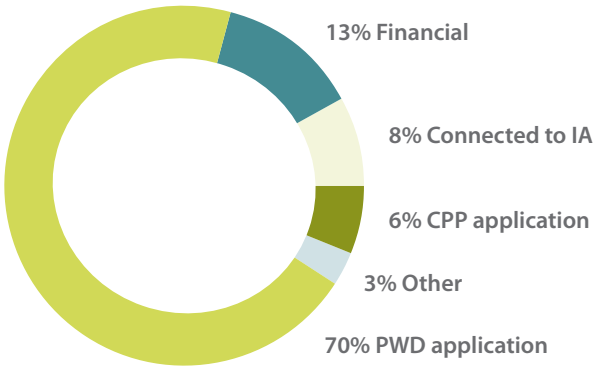
Goal 1: Increase Access to PWD, PPMB and Other Income Supports

Supporting improved access to PWD, PPMB and other income support was an important responsibility of the community navigators, and progress towards this goal was achieved at all sites. A strong collaboration with the homeless outreach worker was important in terms of improving client access to income support. While the outreach worker was responsible for supporting clients in their basic application process, the community navigator supported those with more complex applications, and followed up with clients and physicians to ensure the applications were complete. The navigators also followed up on other income support opportunities. The Navigator Project had a wider inclusion criteria than the Homeless Outreach Program allowing navigators to provide income support to clients who were housed but still struggling with multiple concurrent health conditions.

- Overall, 80% of survey respondents said that the Navigator Project improved client access to PWD/PPMB income support either a lot or quite a lot.
- The navigator provided needed support to both the client and their physicians with regard to filling in lengthy income assistance application forms, and ensuring that the client was able to access a physician for this purpose.

- The navigators' ability to provide support at medical appointments regarding PWD/PPMB forms was considered an important benefit of this program. This support was made possible by the fact that the program was designed to be client focused, allowing the navigators the flexibility to respond to the various complex needs of clients, and support them through the various steps required to secure income support.
- For 80% of clients, the navigator played a needed role in supporting them with income assistance applications.
- The collaboration with the outreach worker was also reported to be beneficial in terms of worker productivity and safety as it allowed both employees to communicate regularly and support one another in dealing with complex clients.

Chart 5. Income Assistance Breakdown



Note: In the chart above, PWD application refers to the work that the navigators contributed to support the PWD application process. The majority of these cases were complex applications that required more in depth support than could be provided by the homeless outreach worker alone.

Key Quotes and Responses

"Many clients were unsure about the medical information provided to them, having someone help clarify something or fill out the paperwork they were given proved to be an invaluable resource for many navigator clients. Advocacy with explaining PWD applications to a new physician was a huge help for the client as well as physician."
—Community Partner

"Much of the success of the Community Navigator Project is due to its connection to the Homeless Outreach Program. The two services are a natural fit."
—Community Partner

"It's scary work at the beginning, it's not something that's appropriate for just one person. The collaboration with Outreach is very important".
—Community Navigator

Stories from the Field

Les

Les was referred to me by another non-profit organization in January 2009. Les had been couch surfing on and off for a year and considered his housing arrangement temporary. Les wanted to apply for Persons with Disability (PWD) status and needed assistance with gathering the appropriate information as well as someone to advocate for him during the appointments needed to have the application filled out. Les and I encountered many hurdles while trying to get his PWD application filled out correctly. It took numerous doctor's appointments and supporting documents from specialists to include in his application. Les was approved for PWD benefits in July 2009. Les seemingly disappeared for many months but returned in November 2009 to ask for assistance with securing housing. He had a roommate and wanted to find a bachelor suite for himself. I assisted Les with finding housing and he secured housing in December 2009.

Goal 2: Increase Access to Health Services

The majority of community navigator clients live with two or more concurrent conditions (see chart 4 in the previous section) and efficient access to health services is extremely important in terms of their overall health. The navigator helped clients to understand what care they needed, supported them to make an appointment, supported them to get to the appointment, and advocated on their behalf at the appointment. This advocacy component was extremely valuable as many clients faced many barriers and frustrations in their daily interactions.

- 80% of survey respondents said that the Navigator Program improved client access to health services by either a lot or quite a lot.
- The navigators provided a single, trusted contact person for clients, who face complex mental health and physical health challenges, and often become very confused and frustrated in their attempts to understand where they can go for help. It was invaluable for clients to have access to someone whom they trusted and could ask to assist them in accessing whatever care they needed without judgment or criticism.
- The flexibility of the navigator to respond to individual client's needs was very valuable.
- The program facilitated access to health services including access to a family physician as well as treatment for physical health conditions such as diabetes, emphysema, physical disabilities, arthritis and blindness.

- The program facilitated access to mental health and addictions services needed by clients with schizophrenia, depression, addictions, developmental disabilities and other mental health issues.
- The navigator's role in supporting clients at medical appointments made a huge difference in terms of clients being willing to see a doctor and in terms of the positive outcomes resulting from visiting a doctor. Providing transportation and accompaniment support to and from doctor appointments was an essential component of this work, as was assisting clients to overcome literacy barriers.
- The importance of providing transportation support to clients should also not be overlooked, as many clients do not have the life skills competency to make such arrangements on their own, leaving them extremely isolated without support that they can trust.
- In theory, improving client access to preventive health services has the potential to reduce the need for costly emergency response.

Key Quotes and Responses

"I find it a highly needed service for individuals in the community to have a person to help navigate them to the health services that they are needing."
—Community Partner

"Many clients did not access doctors/mental health as often as they should have. My accompanying them to these services reduced client anxiety."
—Community Navigator

"One of the reasons clients become disengaged is because they get frustrated with being sent from agency to agency with little result, or can't access services like medical appointments or cope with all of the pieces involved with getting help—having one central person who can help is invaluable."
—Community Partner

Goal 3: Increase Personal Support Networks

Improving clients' personal support networks was a highly valued component of the navigators' work. Navigators received extensive training in how to support the development of personal support networks for their clients and used a variety of strategies to enhance social networks. For example navigators supported clients to: engage in positive leisure opportunities; return to work; reconnect with families; navigate the justice system; access housing; connect with friends or family over a hot meal; and become involved in cultural services. Navigators brainstormed potential volunteer opportunities with clients and helped them to become aware of the services available to them. They also supported clients to develop important life skills and advocated on their behalf with landlords and at the MHSD office. Together, these supports greatly increased clients' ability to become connected and engaged in their communities, increased clients' awareness of the supports and services available to them and helped them to feel they had a network of caring supports upon which they could rely.

- 100% of survey respondents said that the Navigator Project improved client personal support networks either a lot or quite a lot.
- Overall 54% of navigator activities logged were related to supporting clients to achieve improved social support networks and improved life skills.

Stories from the Field

John

John is an elderly gentleman with terminal lung cancer, living 5 miles out of town. He is new to the community and he cares for an adult mentally and physically challenged daughter. There was a considerable amount of assistance needed to get the family connected to both medical services and social support service. The Navigator supported them in terms of transportation, advocacy and arranging appointments. The services they have been able to access through the Navigator Project have greatly contributed to their physical and mental wellbeing.

Paul

Paul has been housed for several years and therefore is not eligible for outreach service. However, he became unable to work and had run out of savings. Paul had become very isolated due to mental health problems and was referred by a neighbor who knew of CMHA's services. Since then, Paul has become eligible for income assistance, has secured a family doctor, become involved with the ArtWorks Studio at CMHA, paired up with an advocate from Inn Home Support program, has expanded his social network, applied for PWD status. He also took part in the MACS outpatient program and was introduced to other Mental Health services. This particular client needed the one-on-one support that the Community Navigator was able to provide to improve his quality of life. The job of the Community Navigator required an intricate knowledge of the community resources available for clients in the local area.

- The development of a trusting relationship with the Navigator was a key strength of the project. The navigators' ability to meet clients in the community and support them in their individual progress enhanced the clients' sense of support and ability to connect to their communities.
- There was substantial variation in terms of the ways in which navigators supported clients to improve their personal support networks. This variation reflected the flexibility that navigators were given in terms of responding to individual clients' needs, and was one of the key strengths of this program.
- The navigators' intricate knowledge of community programs and services enabled them to act as an advocate for clients and help them connect to needed supports as well as community engagement opportunities.
- The navigators provided intergenerational and family focused assistance that was highly valued.
- The work of supporting clients to engage in community activities enabled navigators to liaise with other agencies and programs in the community resulting in improved interagency awareness and service efficiency.

Key Quotes and Responses

"The community navigator position has been a huge asset to our community—connecting people that have not found the "trusted entry point" to community support in more normal intake processes. The web of supports that the navigator position has built is based on the solid trusting relationship with the navigator and has paved the road for increased referrals out into other community supports."
—Community Partner

"The navigator was able to refer clients to new programs/services in the community they didn't know about before, this allowed them to meet new people and increase their support network. The community navigator was also able to help clients recognize the healthy supports they had already and expand on those. Getting clients involved in other CMHA and community activities was a great way to increase personal support networks."
—Community Partner

"Many clients were not aware of all the possible personal supports available to them until brainstorming with me."
—Community Navigator

Site Specific Variations

Kelowna

The collaboration with the homeless outreach worker was very strong in Kelowna and was a strength of the program there. The outreach worker was the primary referral source for the navigators in Kelowna, and this collaboration worked well.

It was considered very important to help clients in Kelowna recognize their own strengths and to offer them opportunities to get involved at CMHA or other community activities.

The Meals Matter Program was a great compliment to the Navigator Program in Kelowna. The Meals Matter Program not only provided an opportunity for clients to learn about healthy eating and access healthy foods but it also provided them with opportunities for social networking and building connections and personal skills. Meals Matter also provided the navigator with opportunities to engage other agencies in the navigator work, and educate them about navigator activities.

Almost 50% of the navigator activities logged for the Kelowna site were either directly or indirectly related to increasing clients' personal support networks. This reflects the fact that there was a very strong collaboration with outreach workers in Kelowna, and there was a high number of outreach workers employed in the area. The navigator was therefore able to complement this work by providing more ongoing support for clients after they were housed and assisting them to develop improved social support networks and community engagement opportunities.

The Kelowna also site had a higher percentage of drop in activities then some of the other sites (almost 20% of all activities).

Stories from the Field

Mary

I met Mary through another client about five months ago. She was isolated, depressed, and suicidal. Mary was on PWD, but having difficulty making ends meet. I connected Mary to the Salvation Army where she began to volunteer as a cashier. Her volunteer work has given her job skills, which in turn has led to a part-time job at a local convenience store. This whole experience has really put a positive spin in Mary's life. She has made some new friends, is better able to financially support herself, continues to volunteer in her community, and is no longer feeling suicidal. GO MARY!

Kootenays

In the Kootenays a strong working partnership was formed with income assistance staff and this relationship was considered beneficial to both programs.

The Kootenays program also developed a good working relationship with the Achieve Employment Program for People with Disabilities. This partnership was important in terms of supporting clients with disabilities to access health services, manage daily activities and participate fully in their communities.

Brainstorming with clients about their social support networks and how they might expand these was considered a strength of the program in the Kootenays. For example, one client began to work at the Salvation Army through the support he received from the navigator and then began to refer people to the navigator program through his own work at the Salvation Army.

Support in accessing medical care was a highly valued component of the program in the Kootenays. Clients were supported to develop better relationships with physicians and access the care they needed.

Transportation support was considered very important in the Kootenays as many clients did not have access to their own means of transportation and were therefore challenged in terms of making it to appointments and health services. This is especially relevant in more rural communities where there are large distances between services.

Stories from the Field

Julie

Julie was housed, on disability and having extreme difficulties getting her Blue Cross medical claims filled out and sent in. She would get very overwhelmed, confused and anxious when attempting to fill in the paperwork on her own and could not seem to get it done. Julie came to CMHA as a last resort as she had run out of options. The community navigator was able to assist with explaining and filling out the forms as well as advocating for Julie with Blue Cross to attain specific information that she did not understand.

Prince George

In Prince George the navigator's direct role in supporting clients to find housing was higher than at other sites with over 20% of activities dedicated to this. This reflects the fact that the navigator in Prince George did not have the same degree of support from the Homeless Outreach Program as did other sites and the navigator in Prince George therefore adapted her work to fill in this gap. Based on survey and interview feedback it was determined that a stronger connection to an outreach worker based at CMHA would have been a welcomed asset to the program in Prince George.

Support in terms of helping clients connect with medical services was another important aspect of the project in Prince George, as was helping clients find housing and stay connected to the community. The CMHA clubhouse was an easily accessible and friendly place for clients to build social connections in Prince George and this was considered an asset to the project.

Stories from the Field

Lorne

Lorne is 62 years old. He has been in recovery from alcohol addiction for the past sixteen months. He had been having difficulty getting his doctor to fill out the PWD application for his many physical ailments and depression. Through the assistance and advocacy of the Navigator Project, Lorne now volunteers at the Salvation Army, has PWD status, and is also on medication to help treat some of the symptoms of depression. Through his work at the Salvation Army, Lorne has recently begun referring new clients to the Navigator Program. With these positive additions to his life, Lorne is now enjoying a healthier, better quality life.

North/West Vancouver

The collaboration with the My Circle Project in North/West Vancouver was a unique and successful aspect of the program at this site. The My Circle Project provided 3-1 volunteer support to clients with complex needs and assisted them to build social support networks and community connections. The navigator acted as a resource to the My Circle Project and supported the circle volunteers by telling them about resources and services that their clients could access. The My Circle Project would also refer clients to the Navigator Project and vice versa. This collaboration likely contributed to the high number of clients seen in North/West Vancouver.

Multiple community connections were made at this site including connections with churches, recreation programs, doctors, the legal system and the Ministries. These connections greatly facilitated and enriched the navigator's work.

In North/West Vancouver it was considered important to advocate on behalf of clients at medical appointments in order to help build good relationships between clients and physicians. Navigator activities in North Vancouver also focused on supporting clients to obtain PWD and PPMB income support more than other sites (over 60% of activities).

South Cariboo

Williams Lake and 100 Mile House provided a unique challenge for the project because of being small communities with relatively high poverty and low access to transportation. The navigator was able to adapt to the unique needs of the communities and provide flexible and client centered support.

The caseload felt very high in South Cariboo. It was recommended that in the future a separate navigator should be employed at both 100 Mile House and Williams Lake.

South Cariboo had a 100% success rate with PWD applications, and there was a close collaboration with the homeless outreach worker at this site, which worked very well. The navigator worked to provide ongoing support for income assistance applications once clients were housed and also supported clients with more complex applications.

Developing social support networks was also a primary focus of the project in South Cariboo with over 60% of client activities dedicated to this goal. Life skills development was a stronger emphasis here than at some of the other sites, and there were also many opportunities to help clients reconnect with the community and provide intergenerational and family support.

Stories from the Field

Tony

I met Tony last year when he was referred to me by the BC Employment Program. We worked together completing his PWD application. I was able to locate a doctor that was willing to work with us to complete this application, and arranged for a psychotherapist to complete the last section. His PWD application was approved and he is now receiving his PWD. Tony is now part of the Achieve program and is currently looking for employment.

Tony has been gradually putting together a binder of information on various credits, benefits and resources, including instruction sheets, from a client's perspective, on how to apply for each and in what particular order. He thought others might find the binder helpful so contacted our Executive Director to discuss it. When I met with him I thought his ideas were great. We brainstormed together about adding in other resources and building on the categories he already had. We agreed that at the end of November the final product would be completed and our organization would purchase the resource binder from him.

Conclusions and Recommendations

There is ample evidence that the current mental health system in BC is not adequately meeting the needs of people with complex mental health and addictions issues. The current patchwork of services leaves many people with complex health challenges feeling frustrated and unable to access the care they need. We have to change this situation and build on the momentum that currently exists in BC to move forward a more progressive, integrated and community based mental health agenda. The Community Navigator Project provides an opportunity to contribute to this agenda by providing client-centered and flexible support to a vulnerable segment of the population. This model has been used in a variety of settings and has been demonstrated to lead to improved patient satisfaction, quality of care, and sustained use of services.

Based on the community feedback and survey data collected through the evaluation, it is evident that this project was highly valued and beneficial in each of the communities where it was piloted. Although quantitative outcome analysis was limited by the data available through the database, qualitative accounts of progress towards each of the three main project goals provides compelling evidence of the benefits of this program.

The Navigator Project does not replicate services, but fills in the gaps by providing a consistent point of support to people with complex needs who are otherwise unable to access the care they require. This role complements that of the homeless outreach worker, with the key strength of the navigator role being that the navigator has the flexibility to meet the client in the community and support them on an ongoing basis through a variety of complex challenges. The navigators need to have a strong understanding of the services available within their community so that they can connect clients to the supports they need. The navigator offers a trusted and consistent point of entry into a complex system. This is invaluable in building client confidence in utilizing services as well as their awareness of services available.

A few primary recommendations and points for improvement were also found. These include the need for continuity, which would require expanding the program into an ongoing model. This program is extremely popular to a highly at risk population, and **it is important to make it available to those in need**. This would likely involve increasing the number of navigators employed. It is also recommended that in the future, more funding be provided for daily expenses. Because of the complexities and challenges associated with this population, navigator support was highly valued in terms of rebuilding trust and community connectedness. A key aspect of this, was rebuilding a relationship with a family physician. In March 2010, a plain language summary of the navigator role was created. This kind of document facilitates the navigators ability to engage local physicians as well other service providers, families, and the community at large.

This project offers a significant opportunity to contribute to better health outcomes, improved access to income support, better community involvement and improved overall wellbeing for this vulnerable population. It also provides a relatively low cost intervention, which supports clients to access the services they need in a timely fashion.

Stories from the Field

Carl

Carl was referred to me by the Community Response Unit in April of 2009. He was in need of housing and income. Carl is a 19-year-old who many professionals, including his physician, felt was "slipping through the cracks."

Carl has unique behavioural issues that make it difficult for him to develop relationships within his family, as well as succeed in school or obtain employment. He had spent some time at the Children's Hospital as well as had numerous school psychological assessments. Unfortunately, Carl has never received a formal diagnosis from any of the many psychologists and psychiatrists involved in these assessments. When being assessed Carl had a tendency to speak very little, making it difficult to make any clinical conclusions.

Carl would come to see me sporadically as I sought out an agency within our community that could assess him so that he could apply for Persons with Disability status. It took six months of being turned down by agencies and referred to others before Carl was formally assessed in December of 2009. During the six months of trying to secure an assessment, Carl began to speak more with myself and pulled the hood of his shirt back from his face. This was an incredible change in his behaviour, as he consistently used one word answers with me and would always have his hood pulled right over his face. Carl received a thorough assessment that required two appointments. He was given a diagnosis that will adequately illustrate to the Ministry of Housing and Social Development his need for assistance.

While I assisted Carl with obtaining Income Assistance, Carl sought out housing with a family member. Carl did not live with his mother as their relationship was strained. Although she is quite concerned with Carl's well-being she has two smaller children that consume much of her time. Carl managed to stay out of shelters throughout this time and maintained contact with his family members. He attended his required meetings for his assessment and, although he lives in a notoriously "bad" area of town, he has not used any drugs or alcohol this entire time.

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Appendix 1: Literature Review

Summary of Navigator Models Used in Different Settings

Community or patient navigators are paid or volunteer workers who provide individualized support to underserved populations and assist them in accessing quality care. Over the last 20 years, community or patient navigator roles have been developed and applied in a variety of settings across Canada and the US. The navigator role originated in the early 1990s in cancer care where a patient navigator model was used to help underprivileged patients to overcome barriers to cancer screening, diagnosis and treatment [5]. In this model, the navigators were laypersons from the community who provided patients with support in navigating complex barriers in the health system [6]. The evaluation of this initial navigator project found that it reduced time to follow-up and increased the 5-year survival rate for the cancer patients who used the navigator service [6]. Since 1990 the navigator role has been adapted by a number of different organizations and institutions to improve patient experience and access to services in a number of different settings. Across Canada and the US, the role has been increasingly applied in a range of community and clinical settings including mental health and addictions, youth outreach, aboriginal patient care, chronic disease management and cancer care.

Navigator positions have been adapted as both paid and volunteer positions depending on the context. In contexts where patients are dealing with cultural barriers or stigma, a peer navigator model has proved very useful [7,8,9]. In these models, navigators have been selected who have ties to the cultural community or lived experience of the stigmatized condition and therefore have an increased ability to provide relevant and acceptable support and guidance to the patients [10,11].

Roles and Responsibilities of Navigators

The roles of the navigator vary from setting to setting and include helping patients navigate barriers to accessing services, improving quality of patient care, providing emotional support to patients and families, explaining terminology, referring patients to additional services, patient advocacy, transportation, conducting intake assessments, coordinating with health providers, supporting benefit applications and providing health education. The level of training provided to navigators varies with the level of responsibility, but some on the job training is recommended. It is important to note that navigators do not need a professional degree in order to be effective in their work. Often, peer navigators are better able to relate to their clients and provide them with professional yet understanding support [8,11].

Level of Innovation of Programs

The level of innovation of navigator programs have ranged from pilot projects to permanent programs, with the latter being most commonly found in clinical settings and cancer care where the navigator role has been more thoroughly developed and evaluated [11]. In mental health and addictions settings, pilot projects are currently being used to explore and evaluate the potential benefits of such roles [14]. Similarly, in other contexts such as chronic disease prevention settings where the navigator role has only been developed more recently, demonstration projects form the majority of projects and are contributing to an initial understanding of how these new roles could fit within the array of existing services [8,13].

Chronic Disease Prevention and Cancer Care: Roles of Patient Navigators

The navigator model has been successfully used within a variety of cancer care and chronic disease management settings, often with a specific focus on underserved or vulnerable populations.

Within cancer care, the patient navigators have been used to improve patient experience, reduce barriers to care and improve quality of care [6]. In Canada the nurse-navigator model has been piloted in several provinces including Ontario, Nova Scotia, British Columbia and Quebec. In Nova Scotia, a 2004 evaluation of the nurse-navigator model found that it *"significantly benefited cancer patients and their families in dealing with the emotional turmoil, informational needs and logistical challenges associated with having cancer. It resulted in more efficient use of clinical time for physicians and more appropriate use of community health professionals"* [11]. The program also contributed to improved integration, coordination and continuity of care within the cancer care system. Following the evaluation, it was recommended that the program be adopted in all health districts in Nova Scotia [11]. Some of the key strengths of this program include that it was patient focused, and Navigators had the flexibility to address both individual client needs and provide support to the family [11]. Navigators were considered an integral component of the cancer care system in the districts where they worked. They contributed to improved communication, coordination of care, and increased overall efficiency of care [11].

"Patient Navigation is fostering collaboration and communication among health professionals and reducing duplication of services, which is attributed with more efficient and cost effective care." [11]

The navigator role has often been used to specifically target improved access and quality of care for underserved populations [5, 6, 10, 12]. In Ontario, an aboriginal patient navigator program was piloted from 2006 to 2007 at the Juravinski Cancer Center in Hamilton, and has since become a permanent program within the Ontario cancer care system [10]. Through this program navigators support First Nations, Inuit and Metis clients to access cancer care in a way which meets their physical, emotional, spiritual and mental needs. Aboriginal patients using the program value having an Aboriginal helper who understands their specific cultural needs [10]. Some of the supportive roles provided by the navigators include educating, supporting and preparing patients for cancer care and treatment, explaining terminology, helping clients fill out benefit forms and referring patients to traditional healers [10]. Similarly, an Aboriginal patient navigator role has been developed in several settings within BC including Vancouver Coastal Health and by the Ktunaxa Nation in the Kootenay region [9,12]. These navigators work in the clinical setting and the community to provide continuity of culturally appropriate care to Aboriginal patients. In the US, a patient navigator model has been used to provide increased support for African American, Native American and Hispanic communities in accessing cancer care [5,6]. The roles of these navigators have included scheduling appointments, coordinating insurance, providing patient education and outreach and encouraging clinical trials participation [5,6].

In the US, the government is beginning to explore the potential application of the navigator model within chronic disease management and has recently signed the Patient Navigator Outreach and Chronic Disease Prevention Act which authorizes funding for a demonstration program to pilot the use of patient navigators to improve access to services and patient education related to chronic disease prevention [13]. Six projects have been funded for the pilot over a two year period beginning in September 2008. The patient navigators are non-medical staff who help underserved populations learn about chronic disease, access chronic disease support services in the community and access screening and treatment as needed [13]. The Promotores program in California's Latino communities is another example of how navigator models have been successfully used to support clients in both chronic disease management and mental health management [8].

Navigator Roles in Mental Health and Addictions

As a result of the successful outcomes of the navigator role within the cancer care and clinical contexts, other applications of the model have been explored in both Canada and the US. In the context of mental health and additions the navigator role has potential to contribute to improved continuity of care, quality of care and access to services for patients navigating a complex mental health system [1, 2, 3].

Several mental health navigator models have been developed throughout Canada and the US. In Sooke, BC, a community supported navigator model was used to improve mental health service access in a rural community where overburdened family physicians have traditionally been the main access point for people with mental health and addictions problems [14]. In this model, the navigator role was embedded within a local family service organization, and a community steering committee met to develop the role of the navigator. The community-based navigators were mobile and able to meet clients at various locations in the community. The navigator role was found to improve access to services and improve assessment by helping to link a range of community services for a more effective network of care [14].

Case managers within mental health and addictions services have also often be used to deliver similar functions. Case managers are traditionally professionals (social workers or nurses) who assess client needs, identify mutual goals and develop service plans [15, 16]. Roles include advocacy, referral, assessment, system navigation, treatment and emotional support. Assertive community treatment (ACT) teams have also been found to be effective at helping patients with complex needs to access the care they need [22]. These are teams made up of various professionals who work collaboratively to support patient care. Similarly, peer and community advocacy programs can be used to support access to services. For example, in Greater Victoria three agencies (the CoolAid Society, Together Against Poverty Society (TAPS) and Community Living BC) provide differing models of peer and community advocacy support. These programs emphasize flexibility, experience and training rather than academic credentials, which enables them to provide excellent service in a highly cost effective manner. In BC, homeless outreach workers play a role similar to that of a navigator and provide housing support and referrals to people with severe and persistent mental illness [17]. This program is a result of collaboration between BC Housing and CMHA BC Division.

The development of mental health navigator roles in Canada is supported by current trends in the US where the National Federation of Families for Children's Mental Health offers a peer navigator program to support children with mental illness and their families. The program began in 2008 and supports both children and parents to understand the services available to them, manage recovery and wellness, and be advocates for mental wellness. Some of the roles of the navigator include listening to experiences, explaining terminology, accompanying children to meetings with health professionals, and building skills related to managing recovery and wellness [7].

In California, the longstanding Promotores program in Latino American communities has also begun to incorporate a mental health component. Promotores, who are members of the communities they serve, have been shown to be effective at increasing access to health services and promoting health knowledge and healthy behaviors related to chronic disease prevention [8]. Promotores take on a navigator style role, supporting individual patients to become partners in the management of their overall health and wellbeing. Recently, there has been increased exploration of the roles that Promotores may play in promoting mental health and access to mental health services. Promotores, who can be either paid and volunteer workers, are well positioned to provide mental health support, because of their connections to the communities serve and their experience working with families, individuals and service providers [8]. In 2008 a policy paper prepared by Center for Multicultural Development at the California Institute for Mental Health recommended increased functions for Promotores within mental health and addictions and highlighted how they are well positioned to provide peer support to help people with mental health and addictions navigate complex mental health services [8].

Appendix 2: Surveys

Community Partner Survery

Introduction

Thank you very much for your participation in this survey!

This survey is part of the formal evaluation of the Community Navigator Project, a project piloted in 2008 by the Ministry of Housing and Social Development in partnership with CMHA BC Division. The purpose of this survey is to get your feedback on the Navigator Project and its impacts in your community. Your candid answers are very much appreciated and will contribute to the future success of this project.

Thank you again for your time.

Key Strengths of the Navigator Program

Please let us know what you thought about this program.

1. Did you like this program?
   ☐ Yes ☐ No

2. If so what did you like about it?

Points for Improvement

This is a prototype and we'd like to make the next version as best as possible.

3. Were there challenges?
   ☐ Yes ☐ No

4. If yes, please describe.

5. If you like, please offer suggestions for how these challenges could be overcome in the future.

Primary outcomes

To get your feedback on the diverse outcomes of the Navigator Project.

6. Please rate the degree to which you observed the following outcomes

	Not at all	some-what	quite a lot	a lot
Increased access to disability benefits (PWD or PPMB)				
Increased access to other income support				
Increased access to primary care				
Increased access to mental health and addictions services				
Increased family reconnections				
Improved social support networks				
Increased access to housing				
Improved life skills				
Increased vocational opportunities				

Other (please specify any other outcomes you observed and the degree to which you observed them)

7. Were there any unanticipated or negative outcomes?
☐ Yes ☐ No

8. If yes, please describe.

Anything else to add? Please feel free to write as short or long a comment as you would like.

9. Please write any additional comments here.

Thank you!

Thank you again for your time and participation. We appreciate this is the busiest time of the year and we have given you an added task to complete. Thanks so much for your efforts in giving us feedback. We will ensure you receive our final report to CMHA and BC Housing and Social Development.
—Nancy Hall Ph.D.
—Alisa Stanton M.P.H

Happy Holidays!

10. Would you like to be contacted to follow up on this survey with a telephone conversation?
☐ Yes ☐ No

11. If yes, please enter your contact information here, and any preferred dates for us to contact you in the coming weeks. Thank you!

Community Navigator Survery

Introduction

Thank you very much for your participation in this survey!

This survey is part of the formal evaluation of the Community Navigator Project, a project piloted in 2008 by the Ministry of Housing and Social Development in partnership with CMHA BC Division. The purpose of this survey is to get your feedback on the Navigator Project and it's impacts in your community. Your candid answers are very much appreciated and will contribute to the future success of this project.

Thank you again for your time.

RE: PWD and PPMB Benefits—Project Goal #1

To understand how the Navigator Project contributed to increased access to PWD and PPMB benefits for clients.

1. To what degree did the Navigator Project contribute to increased access to PWD and/or PPMB for clients at your site?
   ☐ Not at all ☐ Somewhat
   ☐ Quite a lot ☐ Very much

2. Please describe successes you had in this regard. You are welcome to give examples of success stories from your site.

3. Please describe any challenges you experienced with regard to increasing access to PWD and PPMB.

RE: Access to Health Services—Project Goal #2

To get your feedback on how the Navigator Project increased access to health services.

4. To what degree did the Navigator Project increase access to health services for clients at your site?
   ☐ Not at all ☐ Somewhat
   ☐ Quite a lot ☐ Very much

5. Please describe successes you had in this regard. You are welcome to give examples of success stories from your site.

6. Please describe any challenges you experienced in terms of assisting clients to access health care.

RE: Personal Support Networks—Project Goal #3

To understand how the Navigator Project contributed to increased personal support networks for clients.

7. To what degree did the Navigator Project contribute to improved personal support networks for clients at your site?
   ☐ Not at all ☐ Somewhat
   ☐ Quite a lot ☐ Very much

8. Please describe successes you had in this regard. You are welcome to give examples of success stories from your site.

9. Please describe any challenges you experienced with regard to increasing clients' personal support networks.

Other Project Outcomes

To understand any other outcomes you observed as a result of the Community Navigator Project.

10. Please rate the degree to which you observed the following outcomes for clients at your site.

	Not at all	some-what	quite a lot	a lot
Improved vocational skills				
Improved personal skills				
Increased access to other income support (other than PWD and PPMB)				
Increased access to housing				
Increased opportunities for family reconnections				
Increased access to mental health and addictions services				
Others (please specify any other outcomes you observed, and the degree to which you observed them)				

11. Please feel free to give any other examples or success stories you think will help highlight the outcomes of the project.

12. Were there any negative outcomes of the project?
☐ Yes ☐ No

13. If yes, please describe.

14. Please describe the key element required to ensure positive outcomes for clients.

Anything else to add?

Please feel free to write as short or long a comment as you would like.

15. Please write any additional comments here.

Thank you!

Thank you again for your time and participation. We appreciate this is the busiest time of the year and we have given you an added task to complete. Thanks so much for your efforts in giving us feedback. We will ensure you receive our final report to CMHA and BC Housing and Social Development.

—Nancy Hall Ph.D.
—Alisa Stanton M.P.H

Happy Holidays!

16. Would you like to be contacted to follow up on this survey with a telephone conversation?
☐ Yes ☐ No

17. If yes, please enter your contact information here, and any preferred dates for us to contact you in the coming weeks. Thank you!

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