Article

The Sooke Navigator project: using community resources and research to improve local service for mental health and addictions

J Ellen Anderson MD MHSc
Sooke Community Health Initiative and University of British Columbia, Department of Family Practice, Sooke BC, Canada

Susan C Larke MSc
Sooke Community Health Initiative, Sooke BC, Canada

ABSTRACT

Our rural BC community engaged in an innovative action research project to improve access to mental health and addiction (MHA) services for citizens and increase connections and communication between primary care, community-based providers, and the formal mental health service system. Developed by a community-based steering committee, our Navigator model is aimed at anyone with mental health and addictions issues seeking help in our region. The model includes the following services: timely needs assessment, collaborative assistance with need-based care planning, appropriate information, referral, and linkage facilitation. Key features of the Navigator model are discussed, including community engagement, guiding principles, and a description of the service is provided. In our rural and remote community, a community-supported Navigator model was effective in increasing access to comprehensive, strengths-based assessment, planning and referral facilitation.

Keywords: community-based participatory research, community mental health service, mental health service access, primary mental health care

Introduction

Providing straightforward, timely access to appropriate care for all citizens seeking assistance with mental illness and substance misuse or addiction poses significant challenges for both urban and rural communities in Canada.[1] Connecting primary care, community-based providers and the formal mental health service system into a seamless network that is responsive to changing community and client needs requires flexible adaptive models of service focused on patient centred care, clear communication and effective connection.[2]

One such approach is outlined in this review of a community-based action research project which focused on defining and implementing the elements of an effective and responsive service model at a community level. The Sooke Navigator service model was adapted from models used in outpatient cancer care,[3,4] and developed by a community-based steering committee as part of an action research project undertaken in the community of Sooke, BC. Securing sufficient monetary and research support for the duration of the two-year project required partnerships with a variety of research networks and funding bodies. (Funders included: the BC College of Family Physicians, the Michael Smith Foundation for Health Research, the Vancouver Island Health Authority, the Vancouver Foundation, the BC Ministry of Children and Family Development, the Sutherland

Foundation, the Victoria Foundation and the District of Sooke.) The pilot project research activities were supported by the University of British Columbia, Simon Fraser University, the Vancouver Island Health Authority, and the University of Victoria; each of these institutions provided ethical review to ensure the project met ethical guidelines. Navigator service has been in place since July 2005, and currently offers any person with mental health and addictions issues who seeks help in our region the following services: timely needs assessment, collaborative assistance with need-based care planning, appropriate information, referral, and linkage facilitation.

Figure 1 provides a detailed logic model iteratively developed to describe and evaluate the navigator role and the community-based participatory research.

The key features of the Navigator model discussed in this review are:

- **community engagement and involvement**: a community-based steering committee designs, directs and supports service, meets regularly, evaluates programme data, and advocates for necessary service improvements
- **community guiding principles**: low-threshold access, client-centred service, service flexibility, timely transparent ethical communication, data collection and analysis at a local level
- N**avigator service activities**: collaborative needs assessment and planning (including strengths and existing supports), support, connection to agreed-upon services, assistance that may be therapeutic but is not psychotherapeutic, education of clients and service providers, knowledge exchange, communication and co-ordination, and follow-up.

The Sooke Navigator service model

The Navigator service model developed in this pilot project reflected the priorities that our community members and service providers felt were most crucial for effective engagement with community members in need. Facilitation of communication and connection between community organisations, primary care and the health authority were important to its overall success. The application of this inherently flexible service model will and should continue to evolve over time to respond to changes in community demographics and demand, service reorganisation and availability. Other communities applying this model will identify additional components or differing organisational priorities to meet their own unique needs. Our experience with this Navigator service project demonstrated that locally responsive service adaptations grounded in fundamental guiding principles can sustain an effective yet flexible service that meets community, client and service provider priorities.

Community engagement and involvement

The Navigator project and the service model arose from a strongly felt sense of frustration in the community that many citizens were unable to access necessary services, and that community members without mental health training needed to help clients with the many challenges to negotiate their way through an opaque and confusing process in order to find help. Primary care physicians were overwhelmed by patient needs for a mental health and addictions service and were unable to meet those needs effectively in the fee-for-service system with the available matrix of community and health authority resources. This common frustration was the rallying point around which community service providers coalesced into an action group to investigate the problem. Together the group learned about action research, and they designed and implemented a plan to begin to address the problem.

The other driving force behind the development of the model was the complete unavailability of local data on mental health and addictions service need. Most regional services were planned elsewhere, using a utilisation-based formula. If an individual had not previously been able to access or connect with any formal mental health and addiction (MHA) service, then they didn't count as needing service, and planning for future service occurred in the absence of that information.

The community-based Navigator steering committee (hereafter the steering committee) was integral to both the development and success of the Navigator model and service. Together, over a two-year period, the key partners in the project met monthly and engaged in a variety of activities together (see Table 1). The community charter and monthly meetings of the steering committee supported the partners in nurturing collaboration within the community and the primary healthcare system, and in carefully and thoughtfully planning, developing and maintaining a service model that would be responsive to community service needs and the desire for locally relevant data.

Monthly steering committee meetings were held for a year prior to the start of the project, and continue as the project has moved to become an ongoing programme. At monthly meetings, steering committee

Table 1 Sooke Navigator steering committee members and activities

Steering committee members	Steering committee activities
Sooke Family Resource Society	Brainstormed the problem
Sookeworks Employment Centre	Sought information and advice from stakeholders, key informants
Royal Canadian Mounted Police Victim Services	Reviewed the literature
Sooke Crisis Centre	Applied for funding
Ministry for Children and Family Development	Learned about action research
Sooke Family Physicians	Secured ethical approval
BC Ambulance – Sooke	Built a network of external and internal relationships
Edward Milne Community School	Developed and signed a community charter that defines the nature of their service partnerships
Center for Applied Research in Mental Health and Addiction at Simon Fraser University (CARMHA)	Participated in education about MHA service and available services
Vancouver Island Health Authority	Reviewed anonymised cases together
Sooke Transition House	Responded to changing community circumstances by advocating as a group for improved services when needed (and continue to do so)
Pacific Centre for the Family	
University of Victoria	
T'Sou-ke First Nation	
Shoppers Drug Mart Pharmacy	
Sooke Seniors Centre	
RCMP Sooke Detachment Port Renfrew Health and Social Service Society	
Community Volunteers	

members participate in reviews of service data, anonymised case reviews, development of Navigator policy and practice, problem solving around inter-agency communication and understanding, and training opportunities. Consistent attendance and input are attributed to agency and individual experience of steering committee meetings as a useful and engaging forum for sharing information and problem solving across disciplines and domains. As one steering committee member put it:

'I get a positive sense that there are professionals talking across disciplines ... I feel like there is ... education that happens ... I was able to go to one committee meeting and suddenly fourteen different pockets of the community, professional and not professional, all knew more about what was going on' (quote drawn from anonymised interviews with community service providers).

Each steering committee member was offered an opportunity and administrative support to chair the steering committee meetings for a three-month period, and most chose to do so. Despite numerous attempts, we were only intermittently successful in engaging community members who were consumers of MHA services to attend meetings. We continue to see this as an important priority and continue to develop novel ways to meet this objective.

Although the Navigator action research project has come to its planned conclusion, steering committee members continue to engage in research activities related to the project and to attend monthly steering committee meetings and provide input to the ongoing Navigator programme. We are reviewing the publication protocol that we have developed to ensure that the collaborative and participatory
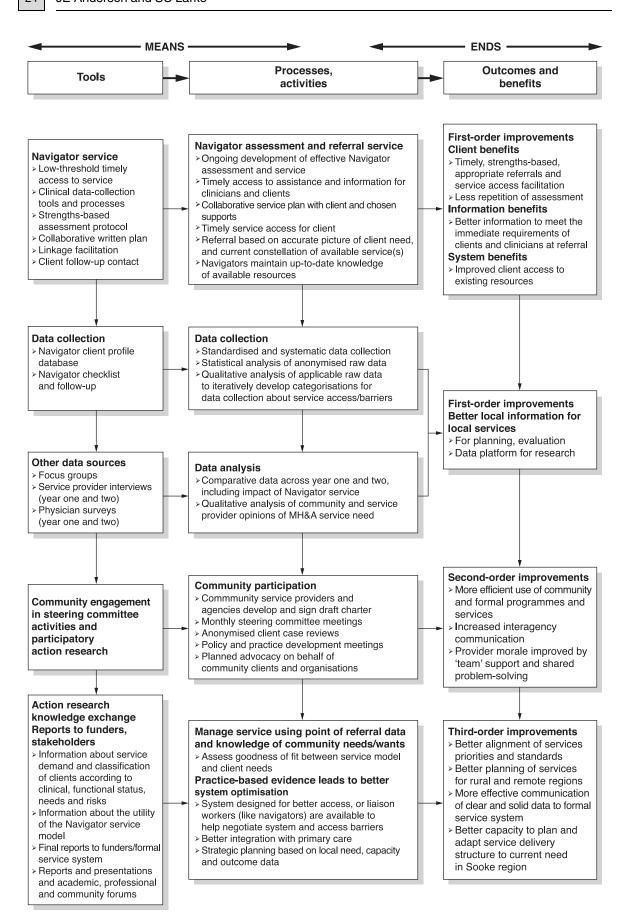
MEANS →   ← ENDS

| Tools | Processes, activities | Outcomes and benefits |

Navigator service
➤ Low-threshold timely access to service
➤ Clinical data-collection tools and processes
➤ Strengths-based assessment protocol
➤ Collaborative written plan
➤ Linkage facilitation
➤ Client follow-up contact

Navigator assessment and referral service
➤ Ongoing development of effective Navigator assessment and service
➤ Timely access to assistance and information for clinicians and clients
➤ Collaborative service plan with client and chosen supports
➤ Timely service access for client
➤ Referral based on accurate picture of client need, and current constellation of available service(s)
➤ Navigators maintain up-to-date knowledge of available resources

First-order improvements
Client benefits
➤ Timely, strengths-based, appropriate referrals and service access facilitation
➤ Less repetition of assessment
Information benefits
➤ Better information to meet the immediate requirements of clients and clinicians at referral
System benefits
➤ Improved client access to existing resources

Data collection
➤ Navigator client profile database
➤ Navigator checklist and follow-up

Data collection
➤ Standardised and systematic data collection
➤ Statistical analysis of anonymised raw data
➤ Qualitative analysis of applicable raw data to iteratively develop categorisations for data collection about service access/barriers

First-order improvements
Better local information for local services
➤ For planning, evaluation
➤ Data platform for research

Other data sources
➤ Focus groups
➤ Service provider interviews (year one and two)
➤ Physician surveys (year one and two)

Data analysis
➤ Comparative data across year one and two, including impact of Navigator service
➤ Qualitative analysis of community and service provider opinions of MH&A service need

Community engagement in steering committee activities and participatory action research

Community participation
➤ Commmunity service providers and agencies develop and sign draft charter
➤ Monthly steering committee meetings
➤ Anonymised client case reviews
➤ Policy and practice development meetings
➤ Planned advocacy on behalf of community clients and organisations

Second-order improvements
➤ More efficient use of community and formal programmes and services
➤ Increased interagency communication
➤ Provider morale improved by 'team' support and shared problem-solving

Action research knowledge exchange Reports to funders, stakeholders
➤ Information about service demand and classification of clients according to clinical, functional status, needs and risks
➤ Information about the utility of the Navigator service model
➤ Final reports to funders/formal service system
➤ Reports and presentations and academic, professional and community forums

Manage service using point of referral data and knowledge of community needs/wants
➤ Assess goodness of fit between service model and client needs
Practice-based evidence leads to better system optimisation
➤ System designed for better access, or liaison workers (like navigators) are available to help negotiate system and access barriers
➤ Better integration with primary care
➤ Strategic planning based on local need, capacity and outcome data

Third-order improvements
➤ Better alignment of services priorities and standards
➤ Better planning of services for rural and remote regions
➤ More effective communication of clear and solid data to formal service system
➤ Better capacity to plan and adapt service delivery structure to current need in Sooke region

Figure 1 Sooke Navigator project: causal logic model (Sue Larke and Ellen Anderson July 2006; model designed by Ken Moselle VIHA, 2006)

nature of our research is sustained through the writing and publication process. The role of steering committee participation in continuing Navigator service and in continued advocacy to support community services is always under discussion by the Navigator steering committee.

Having a community-based steering committee allowed us to effectively collect, analyse and use the knowledge gained from the community process and client service in a variety of ways. It allowed us to collectively support the most effective use of the Navigator service, and to share information from the project with community members. The steering committee provided a strong community voice, and a base from which project staff could advocate for service improvements to meet community needs.

Our experience at the steering committee table was that thorough and respectful interagency and interdisciplinary discussion of contentious issues and challenges ultimately supported consensus decision making. This required very careful attention by project staff and the principal investigator to ensuring that all voices were heard, that all perspectives were aired, and open discussions about inter-agency tensions and power differentials in relationships were encouraged. Inevitably, there were background conversations and community pressures that found their way into the steering committee process. Our major challenges have been securing regular health authority engagement and participation, and ensuring that consumers and lay community members have a voice at the table.

Community guiding principles

The Navigator service model was developed by the community-based steering committee to address local priorities. The service currently offers any person with mental health and addictions issues in our region a more effective way to find and connect with help. These principles were developed after extensive community discussion and review of other service models. These are:

- *access*: 'Every door is the right door' is a phrase used to guide Navigator practice. Timely, easily accessible service is highly valued by community members and service providers. Interested individuals may be referred by a healthcare provider, other community service provider, family or friend, or they may self-refer. Advanced access scheduling by the navigators ('do today's work today, and always leave some space for urgent clients') allows the navigators to avoid waiting lists, and

manage high caseload times without reducing service. If a client is successfully navigated to a service and then enters another crisis period, they may return to the navigator for reassessment and re-referral as needed

- *client-centred service*: navigators are client centred, respectful, non-judgemental and culturally sensitive. A key aspect of Navigator service is the ability to meet and work with a client or family at whatever level of functioning they are currently at. Navigator service adapts service planning to fit existing resources, natural supports and client strengths and challenges. Clients are encouraged to hold a copy of their own service plan. We recognise the importance of assessing client strengths as well as problems, and the necessity of working with families as the identified client

- *service flexibility*: navigators recognise that individuals with mental health and addictions issues are a heterogeneous group with widely varying needs. Some clients may require flexibility in location and hours of service, duration of service and extent of involvement. Some clients may require brief intermittent visits over a period of months before they are ready to be navigated to a mental health or addiction service. Other clients may simply require information or self-management tools. The navigator is both grounded in community and the informal service system, and knowledgeable and up to date about the formal health authority service systems

- *timely ethical and transparent communication*: respecting client privacy and using an ethical consent process, navigators communicate necessary information honestly with their client, and service providers, on a need to know basis. Our goal is for each client to hold a copy of their assessment and service plan and to identify the care providers or personal supports they choose to inform of their plan

- *timely ethical and transparent data collection*: in order to advocate for appropriate service enhancement and organisation, high-quality locally generated summary data are essential. We remain unable to access such community-level data at the health authority level, so are engaged in an ongoing process to define, collect and report the data elements that are essential to providing responsive service. The amount of clinician time involved in data collection and analysis in the original Navigator research project was substantial. Despite a full-time project manager and part-time research assistant support, there was a considerable clinician burden in order acquire more than basic administrative data. We have now completed electronic database development to

streamline data collection and reporting to reflect staff resources and allow timely reporting of relevant administrative information to the steering committee.

Navigator service activities

Our model utilised the service of two navigators with complementary skills in social work and psychiatric rehabilitation. One navigator focused primarily on youth under age 19 years and one navigator worked primarily with adults. One navigator was female and one was male. However, it was very important for both of them to be able to work with clients of any age and either sex.

Based on client need, the Navigator service encompassed the following activities:

- *strength-based assessment and planning*: navigators perform a formal strength-based assessment which includes identification of client priorities, capacities and needs, therefore maximising the appropriateness of referrals and connections. In some cases, a standardised resiliency assessment tool was used
  - 2006 Resiliency Initiatives (www.resiliency canada.ca/index.php?option=com_content& task=view&id=25&Itcmid=45): the resiliency assessment questionnaires CR:ADS – Child Resiliency: Assessing Developmental Strengths; YR:ADS – Youth Resiliency: Assessing Developmental Strengths; AR: ADS – Adult Resiliency: Assessing Developmental Strengths) were used by the navigators
  - when preparing the written needs assessment and plan, we found it was important to balance a discussion of client strengths (important for client and for effective service planning) with the need to emphasise client deficits, which was necessary to in order to access the formal MH service system
- *connection*: connecting clients to formal and informal community and regional services as appropriate is the *key* Navigator activity. Connecting community service providers into a local network of care is also an essential part of the navigator role. Navigators effectively link primary care and community services with the formal mental health service system
- *therapeutic but not 'psychotherapeutic'*: navigators are not counsellors, diagnosticians, or therapists, although their work may ultimately be experienced as therapeutic for individual clients and families. Navigators support the process of personal change in their clients with clearly defined service boundaries – they do not engage in

ongoing therapy. The navigator's job is not to label, diagnose, or provide therapy or advocacy. However, elements of all of these activities can become part of the assessment and linkage process. The steering committee oversight and direct clinical supervision are useful in helping to identify 'clinical drift' or 'service drift' in response to the pressure of client needs and service system demands (or to change the scope of the service in a measured and thoughtful response to community need)

- *education*: navigators educate clients and other community service providers about mental health and addiction symptoms, how the service system works, potential treatment modalities, and habilitative treatment approaches. Navigators provide education at the client, service provider and community level
- *knowledge*: the navigators have thorough, up-to date knowledge of mental health and addictions diagnostic categories, current treatment modalities, the harm-reduction model of addictions treatment, developmental issues across the lifespan, the trans-theoretical model of change, and motivational interviewing techniques. In addition, navigators maintain up-to-date knowledge of the existing formal and informal service system, and the capacity to work within both the adult and child and youth service systems. Navigators regularly 'tend' referral lines (i.e. foster relationships with the individual people at the other end of the referral process)
- *collaboration*: client service plans are developed collaboratively with the client and each client is encouraged to hold a copy of their service plan. Navigators regularly collaborate with other community service providers to support shared clients
- *communication*: navigators assume responsibility for ensuring effective, ethical and timely communication on behalf of their clients to ensure that all of a client's included supports are up to date with the service plan
- *linkage facilitation*: navigators may in some instances need to support the service plan and client connection with activities such as a reminder phone call, transportation planning, or attending an appointment with the client to bridge the connection
- *follow-up*: the Navigator model includes follow-up contact 4–12 weeks post referral, to determine if the client was able to successfully connect to the service. If necessary, the navigator may re-engage with the client to facilitate linkage or to identify a more appropriate plan. It is important for the navigators to iteratively evaluate the success of their collaborative service planning to ensure they stay current with changing services.

Challenges faced with the Navigator service model

As an under-served community, insufficient local services were a limitation to effective navigation in some cases, and some transportation barriers remain. Ensuring individual steering committee members were supported to attend was a challenge, as was engaging with consumers or community members to sit on the steering committee.

Inadequate or non-existent local services can prevent effective navigation. The steering committee and the navigators were frequently faced with the challenge of *navigating to nowhere*. Using the data we collected on unmet need for service, applying persistent community pressure to formal service systems has resulted in some improvement in locally available services. However, not all needed services are currently provided by the formal service system, and issues such as poverty and the absence of available or affordable housing can also prevent effective navigation of individuals in need.

Even with a navigator in place, it was challenging to meet some of the needs of rural, remote, isolated or disenfranchised clients. Transportation and geographic barriers can be difficult to overcome, particularly when regular and ongoing travel for treatment is required. Addressing transportation infrastructure improvements was beyond the scope of this particular project. Clients with unstable housing or no telephone often require outreach from a variety of services, and may not be ready for formal navigation until other needs have been addressed.

Participation in the community-based steering committee was generally experienced as useful (based on feedback from members, and on the consistently large number of attendees). However, participation in the steering committee was not necessarily supported by participating non-government organisations (NGOs) or by formal service organisations (even after signing a charter of understanding). One steering committee member volunteered time to attend meetings because there were no funds in their contract to cover their participation. Initially it was also difficult to get regular attendance from formal MH service providers. Local family physicians were reluctant to attend steering committee meetings because of the time commitment and lost income. (This changed after local services were increased. The new MH service providers attend monthly steering committee meetings, so the formal service system is now communicating regularly with community agencies and accurate local information is regularly shared.)

We were not as successful as we wished in engaging client and consumer voices. Stigma and a fear of inappropriate information sharing were reasons cited by consumers of the service who declined to participate in focus groups and/or steering committee discussion. Future evaluation of this Navigator service should include anonymised client interviews to ensure that client experiences are included in steering committee deliberations and ongoing service planning.

Conclusions

In our rural and remote communities, challenged by MHA service access issues, a community-supported Navigator model was designed to increase access to comprehensive, strengths-based assessment, planning and referral facilitation.

Facilitating and supporting a steering committee comprising community members and primary care service providers contributed to the delivery of successful service, community engagement, and building local capacity.

Data collection in a participatory action research model can become a useful knowledge translation and advocacy tool. It is important to ensure sufficient support, both financial and technical, when such research is taking place in a community NGO. The sources of data and amount of data to be collected should be carefully considered in conjunction with the work load and work flow of the data collectors.

A Navigator model may also have application in urban settings where complex and multi-jurisdictional services need to co-ordinate care. This will require an urban pilot and evaluation.

A more seamless system of community-based mental health care for clients can be supported when primary care providers and community service providers engage together in MHA service planning and evaluation. However, infrastructure and support is necessary to help community members and care providers to engage in these activities, which all take time, energy and financial resources to complete. In order to investigate client experiences, and to increase understanding of the Navigator service model, a next step is to regularly and iteratively evaluate the subjective experiences of clients using the Navigator service.

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ADDRESS FOR CORRESPONDENCE

Dr JE Anderson, 6625B Sooke Road, Sooke BC V9Z 0A3, British Columbia, Canada. Email: jeanderson@telus.net