

Community Mental Health Navigation  
Pilot Evaluation final report:  
**Executive Summary**



# 1. Introduction

The final evaluation report for the Community Mental Health Navigator Pilot Programme (CMHN Pilot) presents insights and learning from programme delivery between April 2020 and December 2022. It follows on from the scoping report (March 2021) and interim report (April 2022). After giving an overview of the project and its evaluation, the report explores how the Pilot was delivered, what outcomes were achieved, and identifies challenges and success factors. It ends with recommendations to support ongoing delivery of CMHN services within healthcare settings.

## 1.1 The project

The CMHN Pilot was delivered by Mental Health UK, a partnership of four charities: Rethink Mental Illness (England); Hafal/Adferiad Recovery (Wales); Mindwise (Northern Ireland); and Support in Mind/Change Mental Health (Scotland). With funding from Johnson & Johnson in the UK and the Johnson & Johnson Foundation, the pilot established four new navigator posts, one in each nation, within a local healthcare setting. The two main aims of the pilot were to:

- Support the non-clinical needs of people experiencing mental illness (e.g., with housing, social integration, or employment).
- Reduce demands on the capacity of GPs, Mental Health Nurses, A&E, and other frontline health and care professionals.

Navigators in England and Wales were due to begin in April 2020, in Scotland and Wales in early 2021, with each service lasting two years. The navigation service was designed as an early intervention for up to 240 people, for approximately six months each. It aimed to help prevent patients from escalating into crisis, giving clinicians more time to better address their patients' clinical needs. It was anticipated that there would be mental health and wellbeing benefits for patients and for their family members and carers, greater job satisfaction and wellbeing of healthcare staff, and economic benefits for the healthcare system.

## 1.2 The evaluation

The Tavistock Institute of Human Relations was commissioned to undertake an external, mixed methods evaluation, designed to help answer whether and how it met the aims listed above. The evaluation began with scoping work including creating a Theory of Change and gaining NHS ethics approval. Evaluation activity included:

- Interviews with key project stakeholders, navigators, people supported by navigators (service users), and health service staff at up to two timepoints each.
- Surveys completed by service users (at up to three timepoints) and health service staff (at up to two timepoints). Surveys for service users included two standard health and wellbeing scales: the Short Warwick Edinburgh Mental Health and Wellbeing Scale (SWEMWBS) and the EQ-5D to measure health-related quality of life.
- Analysing monitoring and diversity data collected by navigators on a quarterly basis (though there were inconsistencies in this reporting).

In total, 43 interviews were undertaken and 107 people completed surveys (including from service users: 95 baseline surveys, 47 follow up surveys, and eight surveys completed three months after support ended). Monitoring data analysed covers the period from April 2021 to September 2022.

COVID-19, increasing economic pressures and other project-specific challenges contributed to difficulties with engaging people in the evaluation and gathering data from sites. Therefore, caution is advised when drawing conclusions from the data presented.

## 2. How was the CMHN Pilot delivered?

Four navigator posts were created in partnership with local primary healthcare services and managed by the respective Mental Health UK partner organisation.

The England Navigator was based in the Meridien Primary Care Network in North-east Lincolnshire, hosted by NAViGO Health and Social Care CIC. The Wales Navigator was based in The Princess of Wales Hospital in Bridgend, and the Royal Glamorgan Hospital in Rhondda Cynon Taf, hosted by Cwm Taf Morgannwg University Health Board. The Scotland Navigator was based in GP surgeries serving Stranraer, hosted by NHS Dumfries and Galloway. The Northern Ireland Navigator was based in a GP surgery in Belfast, hosted by the West Belfast Federation of Family Practices CIC. Table 1 summarises the actual pilot timeline, reflecting adjustments due to the onset of COVID-19 and the Northern Ireland Navigator post becoming vacant. COVID-19, increasing economic pressures and other project-specific challenges contributed to difficulties with engaging people in the evaluation and gathering data from sites. Therefore, caution is advised when drawing conclusions from the data presented.

**Table 1: Actual CMHN Pilot timeline**

Date	Milestone
June to October 2020	England and Wales deliver a COVID-19 Navigator service
October 2020 onwards	England and Wales begin delivering the CMHN Pilot
June 2021	Scotland and NI begin delivering the CMHN Pilot
July 2022	NI Service ends prematurely when navigator leaves post
December 2022	CMHN Pilot completes in England and Wales.
Summer 2023	Scotland Navigator service is due to complete.

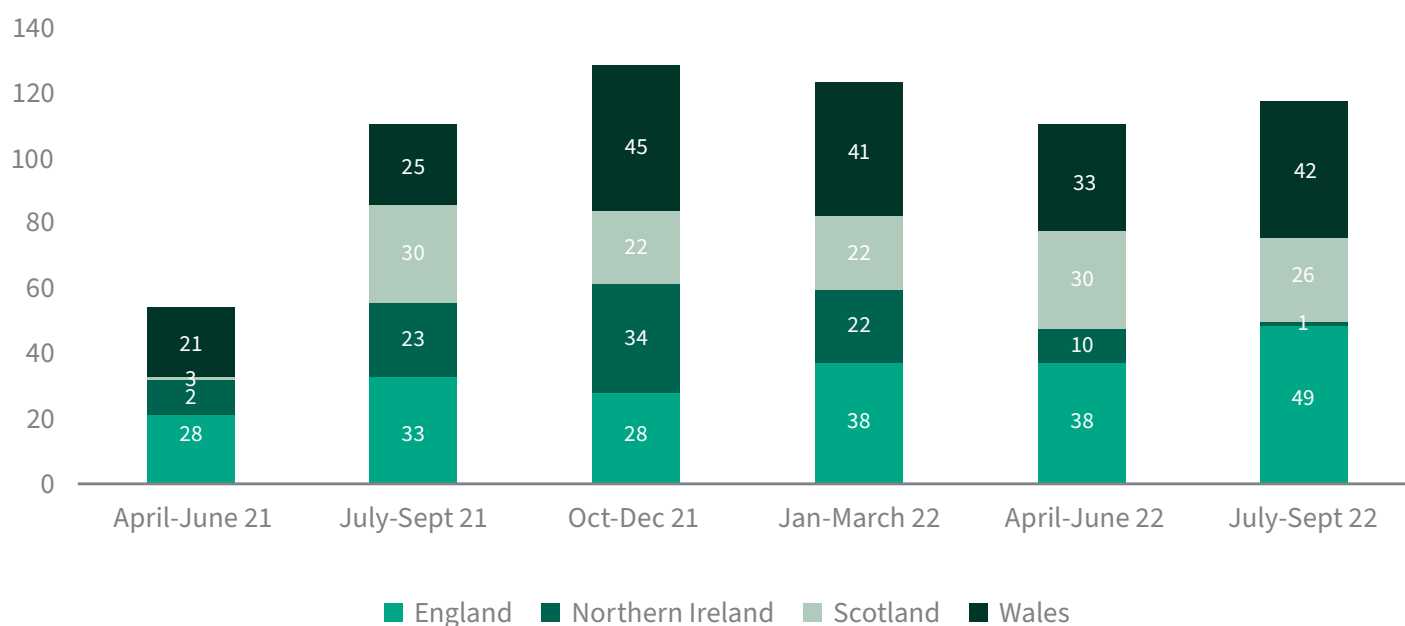
During the period April 2021 to September 2022, 647 referrals were logged by navigators, a 270% overperformance on the anticipated number. Referrals increased from, on average, 34 referrals per month between April 2021 and January 2022, to 38 referrals per month between February and September 2022. Although a relatively small rise overall, this increase is inclusive of four months without monitoring data from Northern Ireland. Figure 1 illustrates referral numbers by site and quarter, which indicates the popularity of the service.

Referrals from healthcare professionals, such as GPs, were either triaged by a Mental Health clinician or came to navigators via email, telephone or in team meetings. People being referred, some of whom had a pre-existing mental health diagnosis, were experiencing deterioration in

their mental health and needed help with non-clinical issues. These included difficulties with finances, housing, accessing social and community activities, and often a need for ongoing emotional support. In some cases, people might be awaiting further clinical attention, including assessments for ADHD or Autism. As the pilot progressed, people being referred were presenting with worse mental health and wellbeing than at earlier stages. This perhaps reflects the effects of the pandemic and cost-of-living crisis.



**Figure 1 Number of referrals by site and quarter between April 2021 and September 2022**



Note. N=647; Source: Monitoring data provided by each site.

Monitoring data did not report length of appointments nor of how long navigation support lasted for clients. However, from interviews, it seemed that people might see a navigator for anything from a couple of weeks to over a year, depending on need. Between April 2021 and September 2022, there were 5785 appointments offered, of which 85% were attended. On average, people had four appointments each and navigators held caseloads of 31 people per month. However, these rates varied greatly at different times and across sites. For instance, Scotland held an average of 23, and Wales and England held an average of 40 people per month.

Navigators helped people in accessing further support, such as financial or housing advice, completing benefits applications, accessing food banks, making appointments, attending groups, taking up volunteering or applying for jobs. Many people interviewed highlighted how navigators were proactive when needed, whether by meeting someone at their home, actively going with someone to a new place, or supporting with other activities that could be anxiety provoking.

**“She actually came, bless her, and sat beside me while I put on the laptop and while I made phone calls and I needed that level of support at that time.”**

This approach, different from social prescribers or care coordinators, was important. This is because people experiencing mental ill health are more likely to struggle doing such tasks alone, without additional emotional and motivational support.

### 3. What outcomes did the CMHN Pilot achieve?

A range of outcomes were reported via interviews and surveys, that were attributed to the CMHN roles. It was also possible to identify potential economic benefits from implementing a CMHN service within healthcare settings.

#### For people supported by navigators, there were reports of:

- Non-clinical needs being better met: interviewees reported that the CMHN model was effective in helping people address non-clinical issues or access further help. This proactive, specialist support had not been previously available.
- Decreased anxiety/exacerbation of health or mental health conditions: people reported improvements in confidence, self-worth, purpose and in physical health. Reports were supported by statistically significant improvements in SWEMWBS and EQ-5D scores over the period of the CHMN support. There was limited evidence of improved wellbeing continuing three months after engagement.
- Better engagement in and maintenance of positive health behaviours: linked to other outcomes, people reported increased physical activity and healthy eating behaviours, including cooking healthier meals.
- Better adherence to clinical and non-clinical treatments: navigators supported people to get medication reviews and there were some reports of people feeling better able to engage with other professionals.
- Access to and engagement in social/ community activities: interviews and survey responses suggested people felt better connected and less isolated because of navigator support.

**“The navigation service has helped me because I am going out during the week when I can to go to a couple of places to do some voluntary work.”**

Data from health service staff interviews and surveys supported these reports. Together, this evidence suggests that the support of a CMHN role can effectively support people with their non-clinical needs and help prevent escalation into a crisis.

**“It probably saved my life. If not for [navigator] I don’t know what I would have done or where I would be.”**

Whilst evidence was limited, and the pilot took place at a time of increasing demand on frontline services, it seemed that having a navigator helped relieve some burden **for healthcare professionals**. For instance, where patients did not meet secondary care thresholds, it made a positive difference to staff to know that the navigators could offer some support. Likewise, the navigator had capacity to identify services available in the community, relieving pressures from health service staff to do this work. There were isolated reports of benefits for wider family members and carers, but further research is needed in this area.



### **3.1 Can these outcomes be sustained?**

England and Wales partners have successfully identified further funding, and now have four CMHN posts in England and 12 'Social Navigator' posts in Wales (that are reported to follow the CMHN model). There is therefore a greater likelihood of outcomes being sustained for individuals with ongoing provision. Unfortunately, the CMHN Pilot in Northern Ireland did not continue due to staffing challenges, with further plans not yet known. At the time of writing, partners involved in the Scotland CMHN Pilot were working to identify funding for continued CMHN roles. Further research is needed to identify how well changes might be sustained for individuals, following navigator support. However, it is important to recognise the continuing difficult social and economic contexts that people are living in, which could impact the potential for lasting benefits without some ongoing support.

### **3.2 What are the potential cost benefits from implementing a CMHN service?**

A cost utility analysis was undertaken using EQ-5D scores and calculating quality-adjusted life years (QALYs). QALYs combine the quality of life with the quantity of life years of people supported by a CMHN service. Comparing the change in QALYs with the financial cost of support indicated that there was an increase in QALYs from the CMHN service, and that it was well within the accepted cost threshold for England and Wales. It is likely that the cost-utility benefit recorded was a conservative calculation, as it did not take account of potential time saved for healthcare professionals, nor savings made by people not presenting at A&E or needing secondary healthcare. For instance, there was one report of a person who had previously persistently called their ambulance service, and because of the Navigator's support, no longer did so. If further data can be gathered and analysed from the ongoing navigation services in England and Wales, it is likely to demonstrate increased financial benefits than recorded in this evaluation.

## 4. What challenges did the CMHN Pilot meet?

There were a range of challenges faced in delivering the CMHN Pilot, some overlapping with success factors. For instance, the popularity of the service, the ability and commitment shown, and trust generated, by the individuals employed as navigators was a success and a challenge, with the potential for navigator overwhelm and burnout. Therefore, context needs considering when addressing challenges and building on success factors. In summary, three types of challenge were reported:

### Healthcare system challenges:

- The different working styles and processes between different nations, NHS structures, settings, and organisations, making some coordination and communications difficult.
- Navigators each had various levels of access to the local NHS IT systems. This could present communication challenges, particularly around sharing referral information and recording progress of work with clients.
- Some perceptions of overlap between the navigator and other local services.
- A lack of clarity and understanding from some within the healthcare system (including patients) as to what was unique about the navigator role and therefore when it was best to refer to a CMHN, rather than, for instance, a social prescriber.
- Workload and service demand pressures increasingly felt by healthcare services. Whilst a factor in helping create the argument for CMHN roles, it was also a challenge in that some healthcare staff struggled to find time and energy to engage with the role.

### Navigator capacity and pilot set up:

- The success of the role is reliant to a large degree on the approach, profile, aptitudes, and autonomy of the individuals fulfilling the role.
- The high workload of and demand for support from navigators.
- The administrative and reporting burden faced by navigators.

### External factors:

- Immediate and ongoing impacts of the COVID-19 pandemic.
- The cost-of-living crisis.
- The availability and capacity of local services for onward referrals.
- An increasing diversity and complexity of needs faced by people.



## 5. Key success factors of the CMHN Pilot

Figure 2 illustrates contributing factors to the success of the CMHN Pilot. Whilst more learning is needed around what works best in different settings and for different population groups, there were ways in which this model was innovative.

For instance, being based within primary care, but with specialist mental health knowledge and skills seemed to work particularly well, distinguishing the role from other types of primary care navigation and social prescriber roles. Unlike other services, navigators were able to work with:

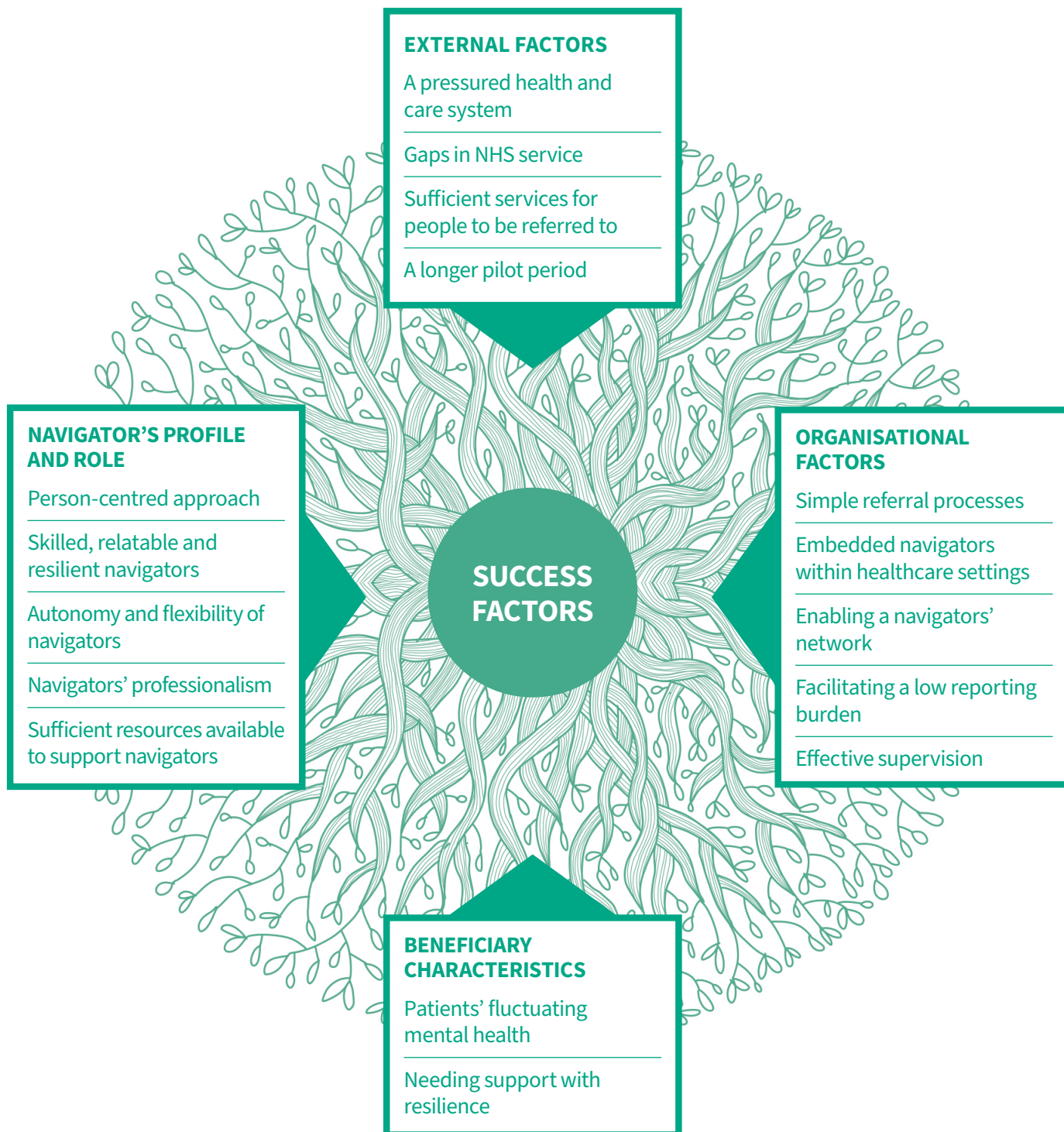
- A range of mental health needs, from mild to severe and enduring.
- Someone for as long as they needed.
- A person's fluctuating mental health, offering light-touch signposting through to proactive, ongoing support, together with check in calls following discharge.

A key aspect was the ongoing emotional support people received. Navigators would sometimes 'hold' a client, within a caring, nurturing relationship, supporting self-management of mental health, alongside giving support to access other services and support. This was a unique feature of the role.

Finally, the CMHN role seems scalable to a variety of primary care settings. In addition to innovative aspects, other scalable components include the simple, quick referral processes, the person-centred focus and navigators working between potential referring professionals and wider health, social and community services for onward referrals. Finding the right people to fulfil the role, alongside ensuring appropriate supervision support to avoid burnout, may be the biggest challenges to scalability.



Figure 2 Success factors identified for the CMHN Pilot



## 6. Conclusion

There is evidence from a variety of sources that a CMHN role is a much-needed service within primary care settings. It can work well in supporting people emotionally and with their non-clinical needs, whilst relieving pressures on clinical services. It both complements and is different from existing roles such as care coordinators and social prescribers. And it provides a cost-effective way of supporting people, which could help prevent deteriorating mental health, escalating of crises, and therefore the need for more expensive healthcare.

Both health service staff and people receiving support reported valuing the navigators working on the pilot. The continued investment in and expansion of the service in England and Wales indicates the popularity of and need for such a service. Attention to ensuring the development of and appropriate support for a CMHN workforce will be key to the success of scaling up, and further research will help better understanding about what works and why in a CMHN service.

A range of recommendations, building on the successes and challenges of delivering the CMHN Pilot include:

- Clarify and agree referral routes into navigation services, ideally with triaging by a clinician.
- Improve access to IT systems for navigators.
- Review induction processes for navigators and develop peer networking/forums for navigators to learn and share best practice together.
- Review and monitor navigator caseloads, perhaps evaluating a cut-off point of no more than 30 people being 'held' at one point, and avoiding a single navigator in one service, to protect against burnout.
- Supervisory oversight that helps check that navigators work within their competencies and capacity, whilst protecting their autonomy and flexibility. As CMHN services grow, opportunities for senior navigator roles may develop.
- Implement administrative support for navigation services, to assist with communications and reporting work.
- Streamline monitoring and evaluation reporting processes, to minimise burden.
- Continue quantitative and qualitative evaluation activity to further explore what type and length of support works best for different population groups, and the difference it makes to individuals and clinical services. This will help increase the building of evidence, to support continuing scaling up of the model.



[www.tavinstitute.org](http://www.tavinstitute.org)