Mental Health Navigators in Housing

Implementation and Evaluation Toolkit

Begin interactive content

Acknowledgments

We would like to thank the many individuals and organisations who gave up their time to support the production of this Toolkit and in carrying out the wider evaluation of the Wakefield District Housing Mental Health Navigator scheme. In particular, we would like to thank the staff at Wakefield District Housing and South West Yorkshire Partnership NHS Foundation Trust for their valuable contributions, alongside members of our implementation advisory group:

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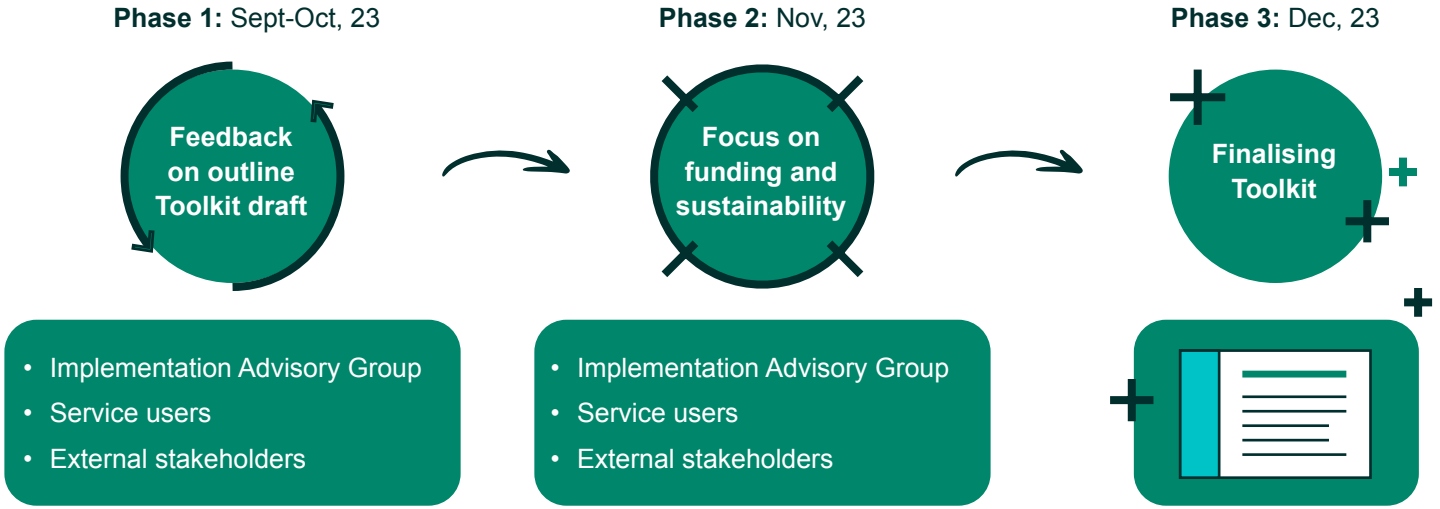
About this Toolkit

The universities of York, Manchester and Newcastle received funding from the **National Institute for Health and Care Research (NIHR) National Priority Area Research Programme 2020–23 (Health and Care Inequalities)** to evaluate the **Wakefield District Housing (WDH) Mental Health Navigator (MHN) scheme**. As part of this evaluation, a key objective was to produce a Toolkit that could support other housing organisations to implement similar schemes.

In this Toolkit, we aim to provide a package of information, advice and resources to guide you through the steps involved in implementing an MHN scheme in your housing organisation, along with the tools to help you to monitor and evaluate a scheme. The Toolkit draws on existing best practice [1], as well as information gathered during the evaluation that helped us understand what worked well in WDH and which aspects of the scheme proved more challenging to deliver. We also spoke to organisations which were interested in implementing an MHN scheme in their area to find out about their specific support needs. We have incorporated their views where possible.

The content of this Toolkit was developed in close consultation with members of our Implementation Advisory Group (IAG) which included **representatives from WDH, Thirteen Group, Tyne Housing, Gravesham Borough Council, Housing Associations' Charitable Trust (HACT), Teesside University** and **the evaluation team.** We also held Toolkit development workshops with **practitioners, third-sector representatives, policymakers, researchers** and **service users** including **people with lived experience of mental ill-health.**
An overview of the timeline for this development work is shown below in Figure 1.

Figure 1: Toolkit development workshops



The Toolkit covers **five key topics**

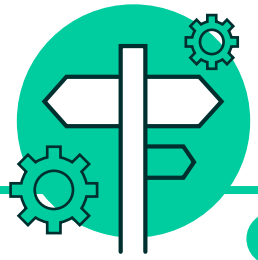
These are highlighted in the left navigation panel with the following icon ⚙

Background to the scheme

Information about the evidence for and background to MHN roles in housing settings, including an overview of the range of support WDH usually offers tenants.

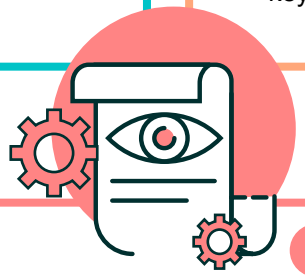
Preparing the ground

Advice and resources to help you assess whether your organisation is currently ready to introduce Navigators, and what you can do to address any key implementation barriers.



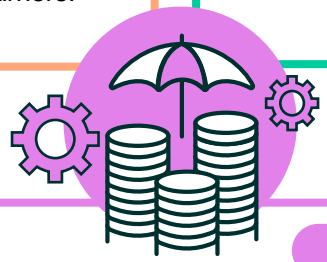
Developing a mental health navigator scheme

Practical information about how to set-up and manage a new MHN scheme in your organisation.



Monitoring and evaluation

Advice on how to monitor the implementation and understand the impact of your MHN scheme.



Funding and sustainability

Guidance on assessing cost and benefits of your scheme alongside suggestions about long-term sustainability.

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Mental health and housing

Evidence shows there is a clear link between mental ill-health and housing insecurity. People with mental ill-health are 1.5 times more likely to live in rented housing compared to the general population [2]. This means they face greater uncertainty about how long they can remain in their current home and are subject to more regulations or restrictions than homeowners. At the same time, poor mental health can make it harder to cope with housing problems, while being homeless or experiencing housing instability can make a person's existing mental health worse [3, 4]. Housing support officers can struggle to deal with mental health related tenancy problems, which can quickly escalate to clinical crisis or terminated tenancies.

High-quality, stable housing is key to maintaining good mental health and is also important for recovery from mental ill-health [5]. Stable housing helps people access formal support services and maintain their independence. It can also aid people to build good relationships with their neighbours. In doing so, it improves access to informal support networks and helps build social capital [6, 7]. Helping to improve the stability and quality of housing is key in efforts to improve mental health outcomes and may even prevent premature deaths and suicide [8].

Today, four million households in England live in rented social housing [4]. As social landlords prioritise vulnerable people, over half of these households include someone with a long-term illness or disability, a third have mental health problems [9], and most are living on comparatively low incomes [4]. Although social housing tenancies are mostly secure or assured which usually provides a higher level of protection for tenants and makes it harder for a landlord or housing provider to evict them, assured tenancies can still be terminated for anti-social behaviour or rent arrears. Additionally, some landlords issue 'assured short-hold tenancies' which provide even less security for tenants who can be evicted without landlords needing to give a reason.

The COVID-19 pandemic has further served to highlight the vulnerability of low-income renters. Private and social renters were more than twice as likely as people with mortgages to have lost their jobs during the pandemic [10]. Although some additional protections were provided to tenants during the COVID-19 pandemic, such as the eviction ban, these ended in May 2021 [11]. By January 2021, the Joseph Rowntree Foundation estimated that there was an extra 450,000 families in rental arrears, with 400,000 families at risk of eviction in May 2021 [12]. With increased levels of mental ill-health during COVID-19, particularly amongst more deprived households [13-15], there are concerns that pandemic-related income and mental health pressures will soon result in a large number of tenancy breakdowns [16].

This means we need better support for people in rented housing experiencing poor mental health to help them maintain their tenancies and secure housing stability.

Evidence to support use of navigator roles

Service navigation roles have emerged as a promising approach to reducing barriers to accessing care in increasingly complex health systems, particularly for people with multiple health and social support needs [17–23].

However, although a range of different types of navigator roles and programmes exist, there is limited evidence on whether and how they actually work [13, 20]. You might see different labels used to describe navigator roles, such as a trained lay person, healthcare professional or link worker; their scope of practice also varies [17, 24].

We provide a standard working definition below, but this may vary based on the needs of the organisation where they work:

Definition:

Navigators are trained professionals, often with relevant clinical or practitioner experience, who help people to identify and access appropriate support or care. They do this by raising awareness of appropriate services, aiding with self- or supported-referrals to these services, and where necessary, assisting people to attend appointments with these services.

Mental health service navigation has been introduced in a range of settings, with some evidence from small-scale studies that this leads to positive outcomes for service users [20, 25].

For example, one study introduced a workplace MHN scheme for employees with serious mental illness and reported improvements in general health and wellbeing, increased access to care, increased employment and reduced financial stresses [21].

However, to date there have been no studies evaluating the impact of MHN schemes designed to support people experiencing mental health difficulties and housing instability [21].

Wakefield Mental Health Navigator scheme

The Wakefield MHN scheme began in 2015 with the aims of:

- helping people with mental health issues to maintain their tenancies; and
- preventing inappropriate use of local healthcare services.

Jointly funded by the local NHS commissioning body (initially the Clinical Commissioning Group (CCG), since replaced by the Integrated Care System) and WDH, the pilot scheme comprised three NHS employed mental health practitioners who were embedded within WDH as part of their wellbeing team. As of December 2023, there were three navigators in post: two mental health nurses and one occupational therapist.

We conducted an evalaution which aimed to provide a comprehensive assessment of the Wakefield MHN scheme that could inform wider roll-out of the scheme to other organisations.

We used routine administrative data gathered by WDH as well as from local and regional health and care providers to understand the impact of the scheme on the tenants and the wider care system.

We also interviewed people involved in designing and delivering the MHN scheme in Wakefield as well as tenants themselves to find out their views and experiences.

Throughout the study, we also worked with a range of public stakeholders, including people with lived experience of poor mental health, to guide our study and help us make sense of the findings.

The following sub-sections provide some highlights of what we found.

How the Mental Health Navigators work

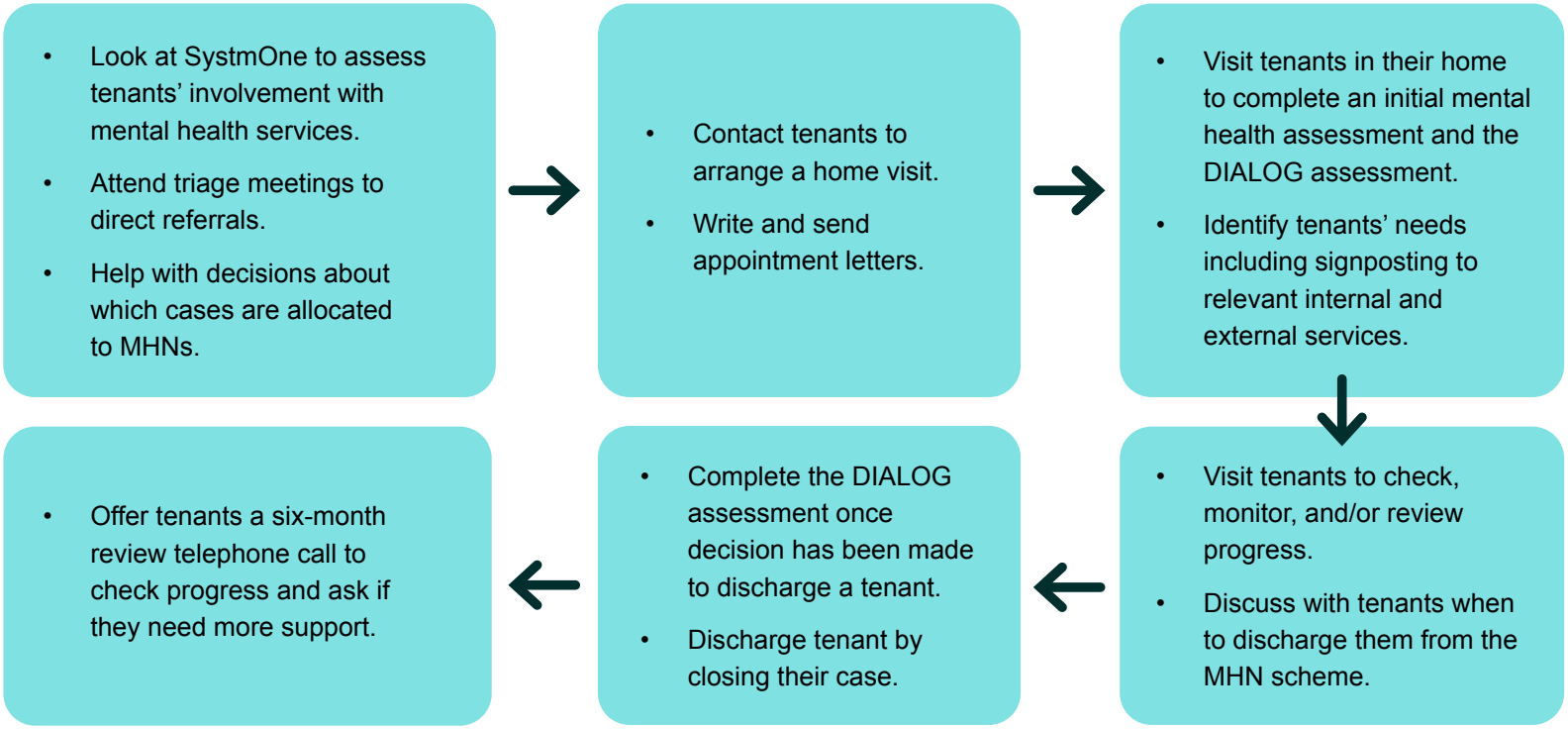
Theory of change

Evidence of impact

How the Mental Health Navigators work

WDH navigators are either Band 6 registered mental health nurses, social workers or occupational therapists employed by the local mental health trust (South West Yorkshire Partnership NHS Foundation Trust (SWYPFT)). Navigators draw on previous clinical experience to work as autonomous practitioners with tenants needing mental health support. However, navigators are expected to build and maintain effective links with WDH housing officers and to work as an integrated part of the WDH wellbeing team. Navigators are responsible for conducting a mental health assessment with WDH tenants, determining what tenants' mental health needs are and identifying the most appropriate services/agencies to meet those needs. They may engage with therapeutic work with tenants, refer them to another service/agency or advise them of other sources of support that they could access (see Figure 2 for key tasks and responsibilities).

Figure 2: Overview of navigator role and responsibilities



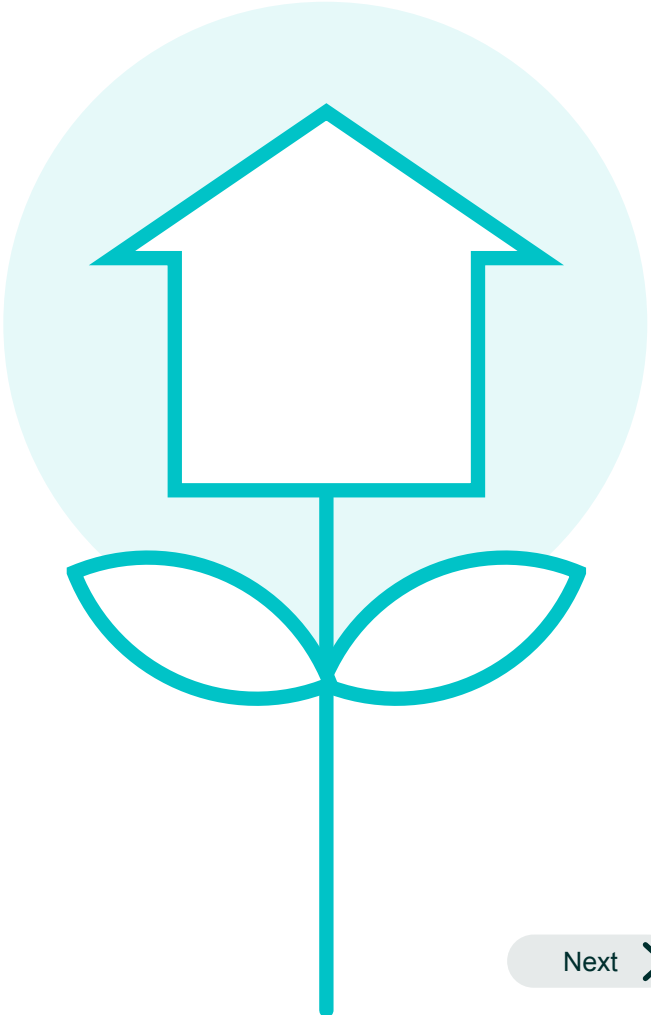
Referral and triage

Tenants can be referred into the MHN scheme through three main routes:

1. **WDH referrals**
2. **Self-referrals**
3. **Other/external referrals**

Most referrals to the MHN scheme are made by other teams within WDH (route 1) who visit tenants whilst carrying out other housing or health-related duties. These personnel are well placed to identify people who might benefit from a referral to the wellbeing team (or indeed any other WDH team). With the tenant's consent, the staff member uses a tablet device to complete an electronic referral to the relevant team in WDH. WDH tenants (route 2) and external local organisations (route 3) can also make referrals using a form located on the WDH website. Referrals made by the local NHS primary care mental health service are sent to WDH via SystmOne.

Once a referral has been received, it is discussed during a weekly triage meeting attended by the wellbeing team leader, the wellbeing coordinator, a navigator and a wellbeing caseworker (WBCW). A decision is then made as to whether the tenant is allocated to the caseload of a navigator or a WBCW.



Tenant journey

1. Needs assessment

If a tenant is allocated to the caseload of a navigator, an appointment letter is sent out and the first visit is conducted. This visit can be carried out face to face or via telephone. The first appointment with a new tenant is an opportunity to get to know them and conduct an assessment on their needs from a whole-person perspective. To help with this process, where appropriate, the navigator completes a primary mental health risk assessment with the tenant alongside the DIALOG tool. DIALOG is a validated scale that consists of **11 questions** to help assess tenants' satisfaction with their mental health, physical health, job situation, accommodation, leisure activities, relationship with their partner/family, friendships, personal safety, medication, any practical help that they receive and their meetings with mental health professionals. The information gathered at this stage enables the navigator to put together a tailored support plan for the tenant. Establishing a trusting relationship between the navigator and tenant at this point is essential to promote positive engagement with the support plan going forward.

3. Intervention duration

The MHN scheme is intended to provide tenants with support for up to three months, although this can vary according to an individual's needs. At a minimum, support is provided either face to face in the tenant's home, at a WDH hub, by telephone or video using Microsoft Teams in fortnightly planned contacts lasting around one hour. However, if a tenant's need is greater, these contacts could be more frequent. Contact may also take place in other convenient community locations (e.g., community centres).

2. Signposting and support

Once the navigator has a comprehensive understanding of a tenant's support needs, they can signpost the person to appropriate external services whilst also working directly with tenants using low-intensity therapeutic interventions focusing on coping strategies, anxiety management, building confidence and empowering tenants. Navigators can also advocate for tenants in relation to accessing and leveraging support from other WDH services (e.g., financial support, benefits advice, home adaptations, employment advice, moving to a new property) and being referred to other services (e.g., third-sector organisations, psychological therapy services, secondary mental health services). The preference is for tenants to self-refer to external services to help empower them to manage their mental health, but there is the potential for direct or supported referrals.

4. Case closure

Tenants are discharged from the MHN scheme (case closure) when tenants feel they no longer require support, or they have alternative support in place (e.g., if they are on the waiting list for additional support or engaging with support). Case closure is a mutual decision between the navigator and the tenant. At this point, the tenant completes the DIALOG tool again, and is informed that they can contact the wellbeing team/MHN scheme at any point in the future should they require further support. Tenants are also offered a six-month review. At this stage, the navigator contacts the tenant to check their progress and identify whether there are any support needs, and the tenant once again completes the DIALOG tool. If there are any new support needs identified, then the tenant can be re-referred into the wellbeing team/MHN scheme.

Addressing lack of engagement

Despite a navigator's best efforts, on occasion a tenant may choose not to engage with the offer of support. In this situation, the navigator will attempt contact on several occasions and may also get in contact with other internal WDH teams to obtain any additional information that may be beneficial as to how to approach the tenant.

If the tenant still does not wish to engage, the navigator will contact them in writing to let them know that they are being discharged from the service.

Within the letter will be details on how to access the service if they want to engage in the future, as well as contact information for mental health crisis support should this be needed.

Theory of change

One aspect of our evaluation was to develop a Theory of Change to understand the MHN scheme. To do this we worked with key stakeholders in Wakefield, including people with relevant lived experience.

We wanted the ToC to help us understand:

- **The need that the MHN scheme is trying to address (context)**
- **The changes it wants to make (outcomes)**
- **What the navigators do to bring about this change (activities)**
- **The underlying factors that cause this change to happen (mechanisms)**

We held a workshop with a range of key stakeholders at WDH, including two members of the management team delivering the service and one navigator to help us develop a ToC diagram for the service. We did this by working with workshop attendees to map out the MHN scheme from start to finish, to build our understanding why the service was needed and to agree the ultimate goal of the scheme.

We also discussed stakeholders' experiences of barriers and enablers that affected the delivery of the work, as well as whether there had been any unexpected outcomes.

We also developed a more detailed narrative or description of the ToC to sit alongside the diagram, using information from our evaluation plan as well as the workshop discussions, with guidance from the New Philanthropy Capital practical guide to creating a ToC [26]. This narrative allowed us to fully explain the thinking behind the MHN scheme, identify any missing elements and think about which aspects were needed to deliver the short-term, when compared with the long-term, outcomes.

After this, we held another workshop with members of the study's Public and Community Involvement, Engagement and Participation (PCIEP) group to sense check our draft diagram and narrative. Here, we asked additional stakeholders for their thoughts. The final ToC diagram (Figure 3) incorporated all this feedback.

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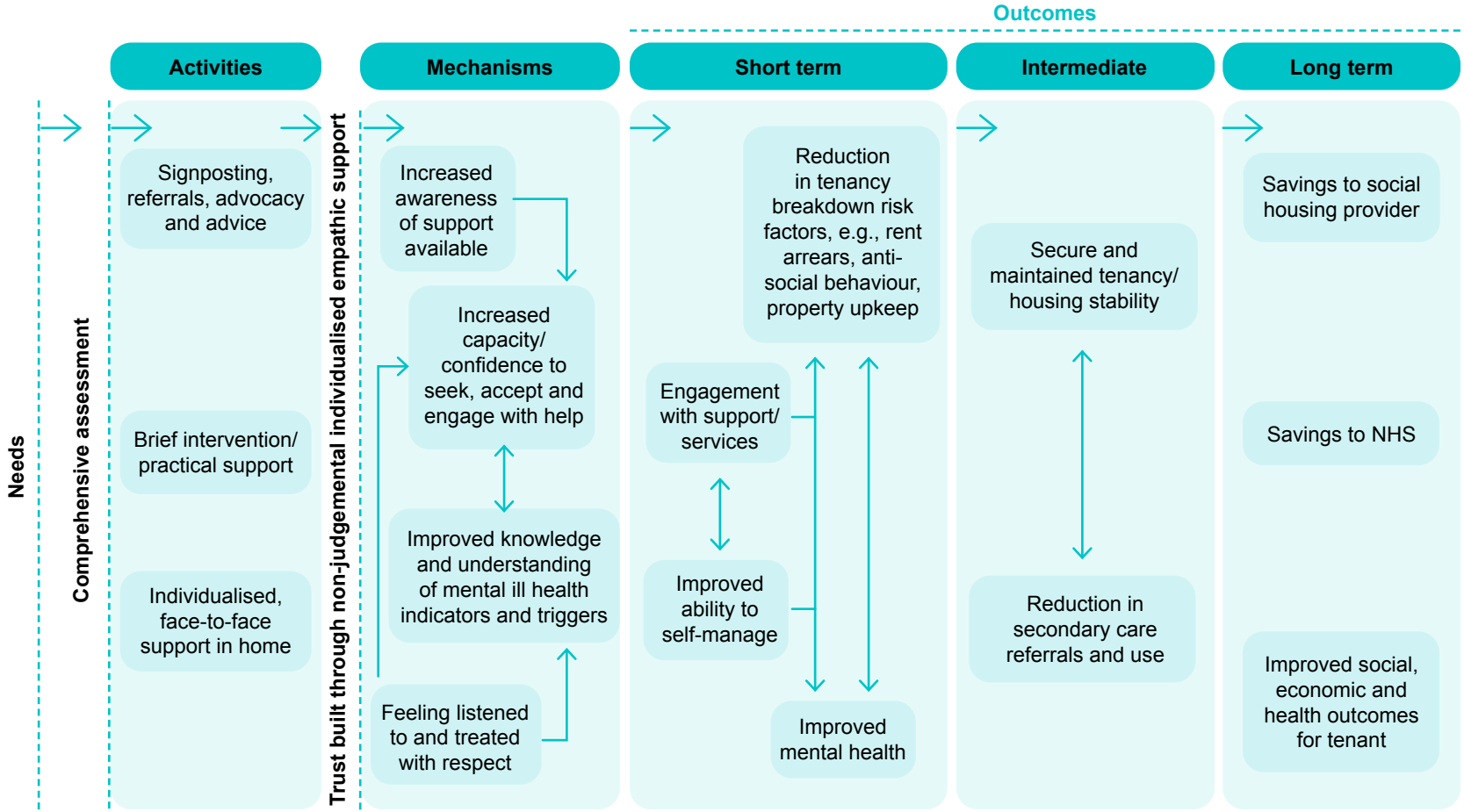
Figure 3: Theory of Change of the Wakefield Mental Health Navigator scheme



Internal enablers:

- Navigator has appropriate knowledge and skills to support tenant and has access to NHS records
- Employed by the NHS, Navigator has independence from housing provider

External enablers:

- Availability of appropriate and effective local services and tenant is eligible for timely support
- Navigator receives adequate clinical and operational supervision
- Housing provider delivers in-house services for wraparound tenant support
- Socially responsible housing provider with a strong cultural ethos and pride in supporting tenants

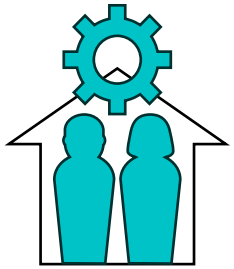
[1] For a copy of the detailed ToC text that accompanies the above diagram, please contact Dr Sarah Blower, sarah.blower@york.ac.uk.

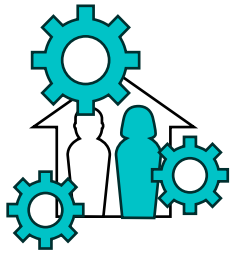
Evidence of impact

Which tenants received support and how did they benefit?

Routine WDH administrative data showed that the MHN scheme received 2,024 tenant referrals between 2015 and mid-October 2022.

This included 1,381 referrals relating to 1,381 unique individual tenants who had accessed the scheme just once;





the remaining 643 referrals related to 290 tenants who accessed the scheme on more than one occasion.

We do not know for certain why some tenants were re-referred into the scheme; it is possible that the services that tenants were being 'navigated' into were either not available or were not suitable to their needs. Alternatively, tenants may have been re-referred into the service due to changed needs or new triggers.

Receiving this volume of referrals within an eight-year period indicates that the MHN scheme is a high-volume intervention with referrals being received consistently each year of delivery, even during the COVID-19 pandemic. Despite this, however, **average waiting lists at WDH remained low, with tenants having a mean wait of just over a month (38 days) for an appointment with a navigator.**

Why were tenants referred?

Most referrals included a reason relating to 'emotional wellbeing' (n=1,909, 94%), followed by 'housing issue' referrals (n=394, 19%) and 'health issues' (n=304, 15%). This shows that the scheme is reaching those with mental health issues, which aligns with its aim of preventing the onset of housing issues and tenancy breakdown by addressing tenants' mental health needs.

Did these tenants engage with the MHN scheme?

Almost half of those referred (n=964, 48%) were recording as having 'engaged' with the scheme, with nearly one third (n=571, 28%) 'disengaged/did not engage'. For the remaining tenants (n=489, 24%), it was not clear if they had engaged or disengaged based on the available data. On average, tenants worked with the navigators for just over two months (67 days).

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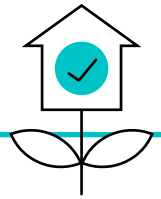
What was the impact of the scheme on key outcomes of interest?

We looked at data on tenancy issues, the amount of rent arrears across tenants and their quality of life before and after the scheme to understand this. We found that:



Of the tenants who were reported to have tenancy issues when they started being supported by the MHN scheme, 33% of these no longer had tenancy issues at the end.

For those who had no tenancy issues at the start, 70% still had no tenancy issues at the end and 9% had tenancy issues at the end.

These figures suggest that overall, **the MHN scheme is helping to maintain, or even reduce, tenancy risk.**

The total amount of rent arrears at the start of the MHN scheme was £402,450, which rose slightly to £407,450 at the end.

However, it is important to stress that **a rise in rent arrears does not necessarily indicate that the MHN scheme failed to prevent debt increase; it is possible that this figure would be even higher without the intervention.**

Total tenant scores on the DIALOG scale were higher at the end of the intervention (indicating a better quality of life), as were scores for each individual item on the scale.

There was a statistically significant improvement in scores for mental health, job situation, leisure activities, personal safety, medications and meetings, which may indicate that the MHN scheme worked particularly well for these areas.

The difference was not significant for physical health, accommodation, relationships and practical help, suggesting that the scheme may have worked less well for these areas.

What did key stakeholders think about the scheme?

Tenants that we interviewed valued working with the navigators as it increased both their awareness of available mental health support and boosted their confidence to reach out for help.

> It has made me realise that there are people out there that I never realised were out there that I can reach out to get help."
>
> ***Tenant 4***

Tenants really liked the fact that support from the MHN scheme was offered to them face to face in their own home. Tenants felt that these home visits helped to build trust with their navigator, encouraging them to speak more freely and they preferred this to receiving support via telephone. Tenants also thought the scheme benefited their wider family members, including giving them more confidence to speak openly about their mental health.

> They come to my house, and that was a lot easier for me. I would rather chat face to face rather than on the phone, do you know what I mean?"
>
> ***Tenant 4***

WDH staff who were interviewed as part of the evaluation were also positive about their experience. They saw the MHN scheme as an essential component of the organisation, which helps them to achieve their own goals such as reducing rent arrears and/or anti-social behaviour and maintaining property standards.

> I can't imagine life without them now, to be honest, I think it'd be really difficult."
>
> ***Estate Manager***

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Like the tenants, WDH staff saw the provision of face to face support in tenants' homes as a unique selling point which helps break down barriers to accessing appropriate support.

WDH staff felt that the scheme helps reduce the need for tenants to access primary health care and/or more acute services such as emergency services and crisis teams, describing the scheme as a 'really good preventative service'. Importantly, whilst tenants need to be registered with a GP to access support, they can be allocated to a WBCW to assist with this process.

Once registered, the WBCW can ensure that an internal referral is submitted so the tenant can be referred to a navigator. As such, the scheme was viewed as being more accessible to some individuals who were less engaged with standard healthcare services.

Local NHS staff also recognised the positive impact of the scheme in helping to reduce demand for mental health services and improving their understanding of local tenants' needs: Another member of WDH staff described how the scheme had helped boost their reputation as a social housing provider.

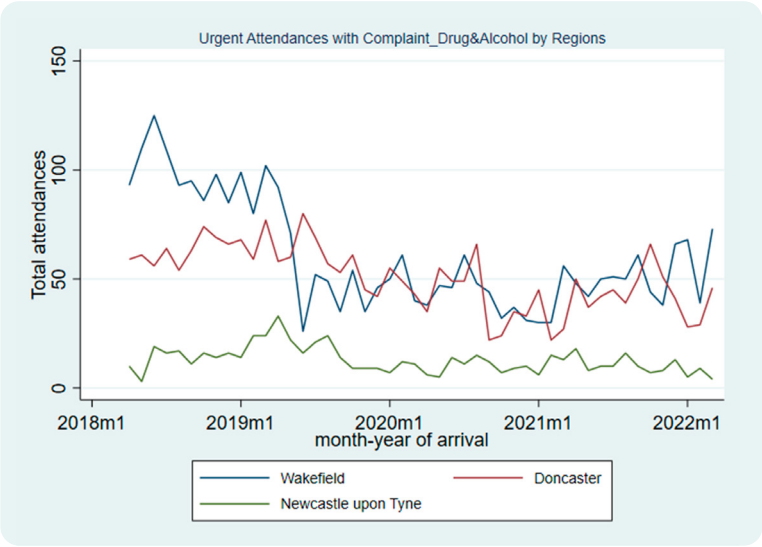
> I think the value that it adds to our customers is amazing. It really helps to support our tenants with that tenancy sustainment as tenancy breakdown can be quite costly…in terms of void turnaround and rental loss it can be quite cost…so it just makes business sense for us…It really is a true partnership in terms of like reducing the health purse and the costs associated with someone going through a GP appointment, attending at A&E, or having to access crisis services in."
>
> ***Care and Health Manager (Wellbeing)***

What were the wider benefits of the scheme?

We used routine electronic health records (Accident and Emergency and Emergency Care Data Set within Hospital Episode Statistics) to assess the impact of the MHN scheme on local emergency departments by comparing data from Wakefield to two other areas of England, namely Doncaster and Newcastle upon Tyne.

We found that in Wakefield, **since 2018, there has been a decrease in drug and alcohol-related attendances in emergency departments, particularly amongst younger people and the more deprived**. As shown in Figure 4, this trend was not reflected in comparable data from Doncaster and Newcastle upon Tyne.

Figure 4: Drug and alcohol-related emergency department attendance by region



This might mean that the supportive interventions provided by WDH via the MHN scheme to address problematic alcohol and other drug use could have had a positive impact on their tenants.

We also found that since 2017, there has been a reduction in attendances relating to self-harm at the local emergency department. This might suggest a potential positive influence of the MHN scheme in preventing self-harm amongst tenants, leading to reduced emergency department visits.

Note: We can't draw direct causal links between the scheme and the decreased emergency department attendances we found in Wakefield, as other factors that we did not measure could have contributed to these trends. It is also important to stress that even though we found reductions in key areas of local emergency department attendances, other data do not show changes in numbers of psycho-social complaints and mental health diagnoses in Wakefield during this period.

Designing a mental health navigator scheme

The first – and critical – step in designing a MHN scheme is for you to decide the scope and shape of scheme you would like to implement in your organisation. In the previous section of this Toolkit, we described the WDH model, but this might not be entirely appropriate for your specific organisation and/or wider delivery setting.

Whether you design your scheme from scratch or adapt the WDH model, we recommend that you start by developing a MHN scheme logic model.

Developing a logic model >>

What is a logic model? >> | How to develop a logic model | Logic model resources >>

Developing a logic model

What is a logic model?

A logic model is a graphic representation or blueprint of how an intervention (e.g., a MHN scheme) produces outcomes for the people it hopes to benefit.

It is a simplified version of the ToC underpinning an intervention. It translates the 'theory' into a plan of action. Usually, logic models contain a summary of the following key components: need, inputs, activities, outputs, outcomes and impact.

Generally, the graphic will present each of the components in a sequence of steps or a flowchart. Each of the components are defined in Table 1. We have provided a template (Appendix 1). Further resources for developing logic models and alternative approaches are provided at the end of the section.

Table 1: Key components of logic models

Component	Definition
Need	At the start of the logic model, you will set out the 'problem(s)' you are trying to solve. Here, you should summarise an answer to the basic question: 'Why is the intervention needed?'
Inputs	Inputs refer to the human and financial resources and infrastructure needed to implement the intervention. Examples include money, staff, time, equipment, technology, materials and partnerships.
Activities	The essential actions required to produce outputs and outcomes should be listed under activities. It is helpful to be specific here about the techniques and methods that are involved in the intervention and the frequency and intensity of these activities.
Outputs	Outputs refer to indicators that can be used to monitor whether activities have been delivered as planned. This might include the number of beneficiaries (over a specified period of time), duration and type of support delivered, number of staff trained and so on.
Outcomes	Outcomes are the expected changes, results, consequences or benefits for service users and organisations that you expect to achieve in the short term (e.g., at the end of the intervention). For example, outcomes might include improved confidence or self-esteem.
Impact	Impact refers to longer term 'downstream' outcomes, such as population level changes (e.g., reduced number of overall referrals to crisis services) or longer-term outcomes for individual service users (e.g., improved mental health for those navigated into appropriate care).
Context	For all interventions, there are contextual factors, external to the intervention and outside of its control, that act as barriers or facilitators to successful implementation. For example, you might wish to consider regulatory environments, policy, strategic priorities, commissioning arrangements, availability of funding schemes, organisational values and ethos.

How to develop a logic model

We recommend that you adopt a team approach to building a logic model.

Working with, or at the very least consulting with, representatives of relevant stakeholder groups can help ensure that your logic model is plausible, implementable and, ultimately, effective. Ideally you would involve a range of stakeholders when building your model including those who might be involved in frontline delivery, supporting administrative functions, service managers, supervisors, commissioners and potential service users. For an MHN scheme you would also want to consult with representatives of the complex care systems you will be navigating, that could be representatives of housing and health agencies as well as providers in the voluntary and community sector.

Working as a team could take different formats depending on the resources available to you. One approach would be to get your stakeholders together in a group and, during a number of meetings, co-create the logic model. This approach can be resource and time intensive and is often best undertaken when you can nominate the facilitator to be someone experienced with service design.

Another approach would be for one individual, e.g., a commissioner or service manager, to develop a first draft of the model that can then be shared and discussed with other stakeholders. But regardless of approach, it really helps to gather a set of 'critical friends' to play devil's advocate and try to pick the model apart. This scrutiny will produce a robust logic model.

When developing a logic model there are some guiding principles to have in mind. We have set these out below and framed them as a series of questions to ask yourself as you develop the logic model and to pose to your critical friends/stakeholders.

- Do the connections between inputs, activities and outcomes ring true and are they logical?
- Does the available evidence support the connections?
- Given your professional experience working with your target population, is the logic model plausible?
- Are there any circumstances under which the intervention might not work?
- What are the likely unintended (good and bad) consequences of the intervention and how serious are they?

Continued on next page

Logic models as living documents

We recommend that you periodically review and update your logic model to reflect any notable new developments. For example, you might update the model in response to changes in local commissioning arrangements, staff training requirements and composition, or new insights wabout outcomes and impact.

We provide more guidance on this in the monitoring and evaluation section of this Toolkit.

The benefits of logic models

- ✓ Highlight gaps in thinking or missing parts of the service
- ✓ Build a shared understanding with key stakeholders
- ✓ Provide a brief visual summary that can be easily shared
- ✓ Serve as a blueprint for implementation planning
- ✓ Support the design of monitoring and evaluation plans
- ✓ Useful for explaining your approach to funders and commissioners

Logic model resources

There are lots of resources available to help you develop logic models. We have curated some of our go-to resources and listed them here. Academics are often interested and able to support services to develop logic models. They may have access to funding to support the translation of their research into practice which may mean that they can facilitate the development process for you. See our advice in the monitoring and evaluation section about contacting academic researchers based in UK universities.

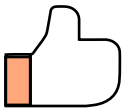
- BetterEvaluation
- Office for Health Improvement and Disparities (2018). 'Creating a logic model for an intervention: evaluation in health and wellbeing'.
- Medical Research Council (2021). 'Framework for the development and evaluation of complex interventions'.
- University of Wisconsin Extension Program Development and Evaluation: logic models (2016).
- WK Kellog Foundation (2004). 'Logic model development guide: using logic models to bring together planning, evaluation and action'.
- You might also find this podcast useful: Matt Egan (2018). 'Evaluation in Public Health Series – Creating a logic model to guide an evaluation'.

Assessing readiness to change

Once you have the blueprint (logic model) for your scheme, you need to understand the extent to which your organisation is currently 'ready' to introduce a MHN scheme.

There are various definitions of 'organisational readiness' described in the academic literature [28–30], but they tend to talk about the following key factors as being important:

Figure 5: Assessing organisational readiness



1. Do your key stakeholders (staff, service users, wider partners and collaborators) value and agree with the proposed change?

The more organisational members value the change, the more they will want to implement the change, or, in other words, the more resolve they will feel to engage in the courses of action involved in change implementation.

2. Are your staff ready and able to deliver the proposed change?

This concerns the extent to which your employees (and any other relevant stakeholders) have the relevant knowledge, skills and ability to do their job once the change is implemented.

3. Does your organisation have the resources to implement this change effectively?

This means you need to consider both human and physical/finanical resources, as well as whether you have adequate communication channels and appropriate policies in place.

4. Is the wider implementation context supportive of change?

For example, an organisational culture that embraces innovation, risk-taking and learning might better support the introduciton of new practices. Likewise, having local or regional support from policymakers, practitioners anwd service commissioners for the change is likely to positively affect adoption.

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Assessing readiness to change

You may already feel you have a good understanding of which of these types of issues are likely to hold back implementation efforts in your organisation. You might want to consider holding informal discussions or focus groups with relevant staff and local stakeholders to ensure you fully grasp their needs and/or concerns. You could also consider using tools that have been developed specifically for this purpose.

Existing tools and checklists

For example, one key tool developed by implementation science experts to help organisations assess potential factors shaping the adoption of a new practice is the **Consolidated Framework for Implementation Research** (CFIR) [31]. The CFIR lists a wide range of factors (or constructs) organised into five broad categories:

- Innovation (or practice)
- Characteristics (e.g., complexity, strength of the evidence)
- Outer Setting (e.g., external policy context and incentives)
- Inner Setting (e.g., organisational culture, leadership engagement)
- Characteristics of Individuals Involved (e.g., self-efficacy, knowledge and skills)
- Process (e.g., planning and engaging key stakeholders)

The CFIR website (The Consolidated Framework for Implementation Research – Technical Assistance for users of the CFIR framework) provides a detailed description of the content of the framework and a number of adaptable tools you can use to evaluate your organisation in advance of implementation.

Experts at the University of Toronto have developed a decision support tool that is designed to help organisations interested in implementing a new practice or intervention to select an appropriate readiness assessment measure for their setting [32].

You can access the 'Ready, Set, Change!' decision support tool here: Ready, Set, Change! A readiness for change decision support tool. To learn more about how the Ready, Set, Change! tool was developed, you can read the full academic paper here.

Devising an implementation plan

Once you have a solid grasp of the factors that are likely to support – or complicate – the introduction of a MHN scheme in your organisation, you can start to put together a more detailed implementation plan.

There are a variety of evidence- and theory-based strategies you can draw on to help you address any barriers to change you have identified. These strategies could focus on the individual level (e.g., actions to improve the knowledge, attitudes and skills of staff directly involved in delivery of the new service), or at the organisational level (e.g., actions to boost institutional commitment and leadership). You will also need to consider factors outside your organisation that could affect implementation, such as whether local policymakers and service commissioners are likely to prioritise support for your new service, and whether you need to foster collaborations with key external stakeholders to enable successful delivery.

Expert Recommendations for Implementing Change (ERIC) is one particularly comprehensive compilation of implementation strategies. ERIC includes 73 different implementation strategies than can be used alone or in combination as part of a wider reaching plan [33, 34]; see Appendix 2 for the full list. If you have used the CFIR to identify potential barriers to implementation, an online tool is available to help you 'match' these to ERIC strategies: Strategy Design – The Consolidated Framework for Implementation Research.

For example, if your assessment had identified key potential barriers to implementation of a MHN scheme as a combination of lack of skills, knowledge and interest amongst frontline staff, disengaged leadership, and limited awareness or support at local policy level, the tool would suggest an implementation plan along the following lines:

1. Unsupportive local policy environment

- Active networking to involve relevant decision makers
- Build a coalition of local/regional stakeholders

2. Leadership not receptive to change

- Identify and prepare organisational champions
- Identify and promote early adopters of the new practice

3. Poor staff knowledge or negative attitudes

- Hold training and education sessions with staff
- Develop and disseminate educational materials

Lessons from the frontline

Reflections on implementing the scheme in a new area

Lessons from the frontline

The positives

Active networking to build support amongst local decision makers and potential funders was a critical factor in the successful implementation of the WDH MHN scheme.

Senior management at WDH invested time meeting with NHS partners to raise awareness of the potential value of the scheme. Key to this process were discussions with a local primary care trust (PCT) manager who was interested in understanding more about the links between housing and health, why certain groups were not engaging with appropriate health services, and how people could be better supported to boost use of available support services.

These discussions highlighted both the barriers that people faced in accessing support services, including third-sector organisations, particularly as a result of long waiting lists, as well as the value of early intervention to address tenants' mental health issues and prevent tenancy breakdown.

As a result, the first iteration of the MHN scheme was funded by the local PCT, delivered by health inequality officers who were embedded within WDH but operated across the Wakefield District in its entirety.

> …the real foundation of everyone maintaining a reasonable standard of health and wellbeing; it starts with accommodation"
>
> ***Service Director (Housing & Neighbourhoods)***

However, the WDH experience demonstrates the continued need for organisations to engage in these types of **stakeholder relationship building** activities if MHN schemes are to be maintained. In 2013, the PCT was disbanded, meaning that WDH lost their link with the PCT manager, as well as the funding for the health inequality officer role. In the immediate term, WDH decided to fund a WBCW role which would only support WDH tenants.

However, they continued to work with the PCT's replacement body, the clinical commissioning group (CCG). This fostered a shared understanding of the value of having the two organisations work together to achieve their strategic objectives and the opportunity to 'do things differently' via the introduction of the MHN scheme. This concept of joint working was the basis of the business case that WDH put to the CCG, with the aim of preventing tenant mental health issues escalating. This helped to support stable tenancies and reduce avoidable use of crisis services. As a result, in 2015, the CCG and WDH decided to jointly fund a pilot of the MHN scheme.

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Positive working relationships between WDH and their local NHS partners continues to underpin delivery of the MHN scheme. Now jointly funded by WDH and the Integrated Care Board (which replaced the CCG as commissioning body), the MHN scheme remains highly valued by local NHS stakeholders. Additional initiatives have also been implemented as a result of this partnership between WDH and the NHS.

> I think in terms of what SWYPFT get, if you like, is an increased understanding and really good working relationship with WDH because we are working so closely together with the navigators… I don't think the links would be that close if we didn't have the navigator service."
>
> *Associate Director of Operations*

For example, the introduction of housing co-ordinators to support hospital discharge. These are based in two local hospitals.

Buy-in from the NHS trust has also been crucial to the effective day-to-day operation of the MHN scheme. From the outset, WDH were keen that the navigators would be employed by the local mental health NHS trust. This was felt to be important for a variety of reasons. Importantly, being employed by the NHS trust allows each navigator to contribute to the access of relevant clinical and line management supervision, appropriate human resources functions, occupational health and continuing professional development opportunities. It also allows them to maintain their professional registration.

Additionally, being employed by the local mental health NHS trust enables the navigators to directly access tenants' medical records, which would not be possible if the navigators were employed by WDH. To do this, the navigators are issued with a SWYPFT smartcard and laptop. This means that they can identify a tenants' current or previous involvement with mental health services.

This informs the triage process to determine if a referral will be accepted by the wellbeing team/MHN scheme or not (e.g., if someone was already receiving support from secondary mental health services). As only the navigators have access to tenants' medical records, this still means that WDH relies on their assistance with preparation for triage meetings. However, despite this, this access to records enables navigators to add a note to SystmOne to indicate to other health care professionals that they are providing support to a tenant.

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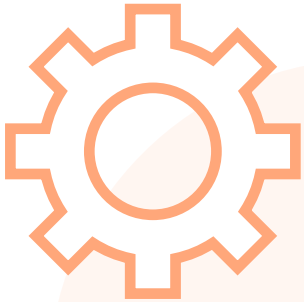
> There's not many providers that I know that do what we do in terms of providing specialist mental health related support for its customers… I suppose as a landlord the key function is very bricks and mortar, in terms of repairs, rent collection and estate management services. Our focus is on the value-added services that go above and beyond traditional housing management."
>
> *Care and Health Manager (Wellbeing)*

Interviews also highlighted the role played by having a **positive organisational culture and supportive infrastructure** at WDH in helping to set up and maintain the MHN scheme.

The existing departmental set-up meant it was reasonably straightforward to incorporate the navigator role within WDH. Also, the navigators could use established processes such as tenant referrals and home visits.

Employees value the holistic approach to housing offered by WDH and feel they see positive impacts in terms of tenant outcomes. Staff buy-in to this approach is established from the outset as part of induction arrangements and job-shadowing opportunities, with employees encouraged to share ideas of how to potentially innovate and adapt the scheme on a regular basis.



The challenges

> A key risk for any navigator scheme is "where they can refer onto for further ongoing support because there's either a lack of it due to funding or there being cuts or just services being saturated and just exhausted with waiting lists post COVID."
>
> ***Care and Health Manager (Wellbeing)***

A recurring issue highlighted by WDH staff is that whilst there are some areas that tenants can be helped with directly, the work of the navigators is in part reliant on **having access to available external support services and organisations**.

Staff reported that it was proving harder and harder to find appropriate support due to services being under-resourced or over-subscribed.

> When I started…I think we felt sometimes that we hadn't really got anybody to speak to from an NHS point of view… So one of the biggest changes is now we have actually got somebody that's responsible and that we can go to and we can bounce ideas off, who sits within the NHS, which to me, has been a massive improvement. It's just brilliant that we've got that support from that side."
>
> ***Mental Health Navigator***

As healthcare professionals, there was a strong sense that the navigators brought valuable skills and knowledge to WDH in relation to mental health support, and they were supported to maintain their professional registration and take part in NHS personal development activities.

However, this 'dual role' (housing and healthcare) also came with some challenges in terms of training and development. In particular, staff highlighted the importance of having ongoing clinical line management and to consider appropriate long-term career opportunities for the navigators.

Reflections on implementing the scheme in a new area

Members of the evaluation team attended an event organised by North Kent Mind for local voluntary and community sector organisations plus attendees from Gravesham Borough Council and Gravesend Housing. This provided an opportunity to discuss the WDH MHN scheme and consider the implications for implementing a similar scheme in the Kent area.

Gravesham Council has 5,700 council homes (as of September 2023) with each housing officer managing approximately 700 tenants.

Additionally, there are 17 estate care workers, five income officers, and 70 craft workers for repairs.

Council attendees told us they have noted an increase in anti-social behaviour in recent years, which they attributed to people being at home more since the COVID-19 pandemic.

At the same time, there has been an increase in rental arrears, demand for repairs and uninhabitable properties due to hoarding and vandalism.

Participants such as Gravesend Housing recognised the potential benefits of introducing a MHN scheme to tenants who are struggling by offering support and advocacy from trained specialists and helping to bridge gaps between services. There was a perception that through early intervention, navigators could help reduce pressure on other services, including emergency care and unplanned hospital admissions, leading to longer-term cost savings.

At the same time, participants at the event felt there were several key challenges facing the area that could make implementation of a MHN scheme difficult. In particular, the local population includes many immigrant and traveller communities, and attendees at the event perceived that some people form these groups could experience cultural stigma around disclosing when mental health help is needed. Additionally, non-English speaking individuals could experience increased isolation due to translation and language barriers.

Participants also highlighted a lack of job opportunities in the local area meaning that people from these marginalised communities are also struggling with unemployment. Alongside these specific population issues, there was a perceived lack of relevant services and support in the area, particularly specialist mental health supported housing. Accessible information about what sort of support is available in the area was also limited.

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In discussions with participants at the event, we explored potential solutions to the various challenges identified, and have summarised the key points made in Table 2 below:

Table 2: Challenges and solutions to implementing a new Mental Health Navigator scheme

Challenges	Solutions
Tenant level	
• Stigma attached to mental health issues. • Previous negative experiences of help-seeking. • Lack of awareness of the scheme.	• Consider potential and appropriate access points to the scheme. • Utilise existing trusted community spaces (libraries, children's centres, multi-use hubs, GP practices).
Skills and capacity	
• Lack of appropriately trained people to deliver the scheme.	• Upskill housing officers in mental health first aid. • Consider how to sustainably recruit, train and retain enough navigators to meet demand for the scheme.
• Need available services to signpost tenants to. Current system lacks capacity/relies on volunteers to meet demand.	• Ensure resources identified to collate a list of local available services and keep that list up to date.
• Referral pathways are overly complex.	• Raising awareness of community hub services that people can attend for support.
Funding and partnership working	
• Need for cross-system funding from local authority to statutory services and the voluntary sector. • Need for cross-system partnership working (NHS, local authority and voluntary sector). • Lack of buy-in from key local stakeholders.	• Set up sustainable partnerships underpinned by strong communication. • Build business case to demonstrate economic and health benefits of scheme.

Role and responsibilities

The role and responsibilities of your navigators should be adapted to the needs of your specific service users and the local implementation context.

In Wakefield, navigators must be a qualified registered mental health nurse, a social worker or an occupational therapist. They are responsible for conducting a mental health assessment with tenants referred to the service, determining what the individual's mental health needs are and identifying the most appropriate service or agency to meet those needs. They are expected to be able to engage in brief therapeutic work with the tenant directly, refer them to another service/ agency or advise them of other sources of support that they could access.

As such, Wakefield navigators must have direct experience of working in a community setting and of delivering mental health services on a one-to-one basis with service users, ideally, including brief therapeutic work. In other settings or organisations, there may be less need for navigators to be clinically trained. For example, it might be possible for existing clinically trained members of staff to provide day-to-day oversight and advise/support to the navigators as needed.

In addition to these specific qualifications, other key skills and qualities highlighted as important for navigators in WDH include:

Ability to build trust: The capacity to build trusting relationships with tenants is viewed as essential to the work of the navigators. WDH navigators are required to show that they are trustworthy, reliable, engaging and open prior to appointment. Competency-based interviews are used to provide applicants with an opportunity to demonstrate these fundamental qualities.

Independent and adaptable: navigators should be willing and able to operate autonomously and flexibly, due to the often-unpredictable nature of the work. Linked to this, navigators are required to have a current driving licence and access to a car during the working day.

Risk aware: navigators must be ready to manage the risks, to self and others, associated with unpredictable client groups in settings where there may be no other mental health professional support. This includes conducting relevant risk assessments and management plans and ensuring appropriate risk documentation is available to appropriate individuals and agencies.

Networking and communication: navigators need to be able to build and maintain effective links with key internal staff as well as local specialist mental health services and associated agencies including social care and voluntary agencies. They need to be able to communicate with referring teams as appropriate about tenant outcomes, as well as with the colleagues, carers and, where appropriate, relatives of tenants.

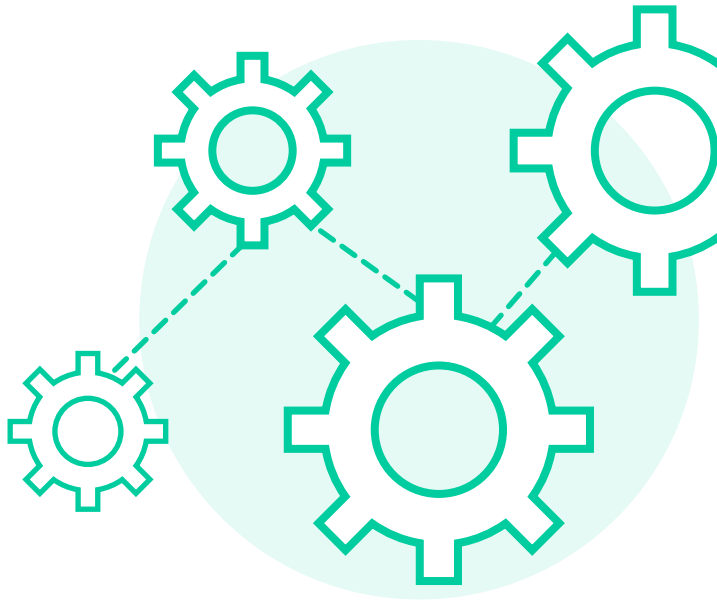
This list of skills and qualities should be adapted to suit the needs and priorities of your organisation. To do this, you might find it helpful to consider your core values and think about how these are reflected in both your recruitment materials and in the formal role and responsibilities outlined for the navigators.

Training and development

In addition to working with tenants, navigators at WDH are also responsible for providing mental health-related advice for staff at the organisation and helping to identify and support the delivery of any staff training needs on mental health issues. To do this, they need to have a solid grasp of relevant mental health-related legislation and guidelines, for example the Mental Health Act 1983, Care programme Approach, Clinical Governance, Risk Assessment and Child Protection Legislation and the National Institute for Health and Care Excellence (NICE) guidelines, as well as up-to-date evidence-based practices.

Navigators at WHD are encouraged to take responsibility for their own continuing professional development (CPD), and to attend relevant course, seminars and conferences. They are also encouraged to meet with the local Connecting Care Hubs[2] for peer-to-peer support for supervision, to allow best practice to be adopted, and to facilitate more integrated care provision across Wakefield.

Looking forward, one area highlighted as challenging for the navigators employed at WDH was around career development as there are limited promotion opportunities beyond Band 6 within the WDH organisational structure.



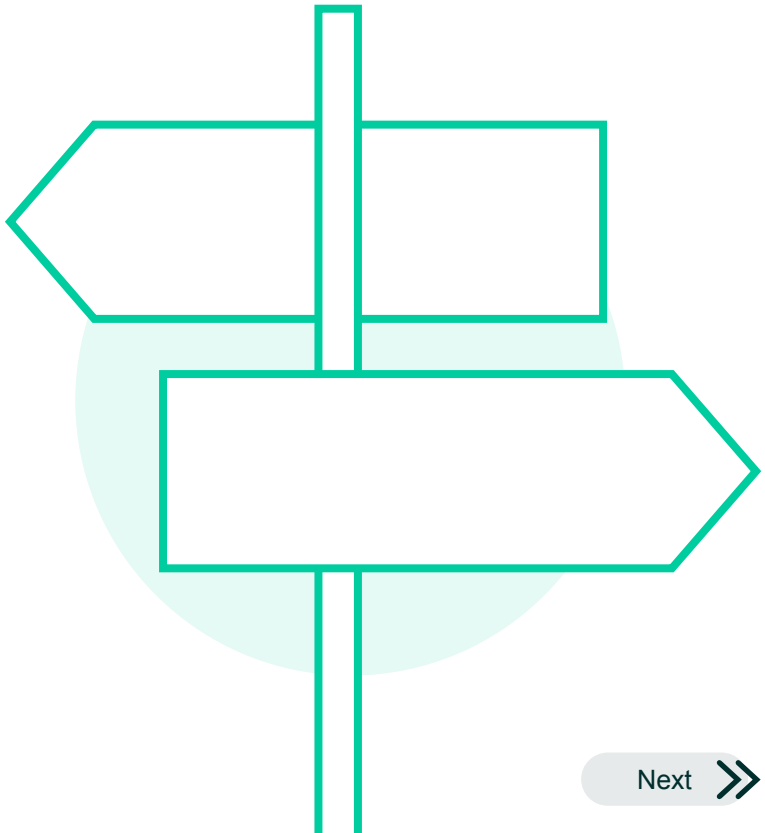
[2] Connecting Care Hubs include a mental health team as well as occupational therapists, physiotherapists, dietetics, general health, neurology and third-sector agencies who can offer health-related support.

Directory of local services and support

A critical component of any MHN scheme is **having access to up-to-date information** about which services and organisations are available to support your tenants in the area. Each service works differently and has their own criteria and referral processes. These need to be taken into consideration when looking at their appropriateness for tenants.

At WDH, they have developed a **'supporting agency folder'** which holds all the information about services within the area, including relevant referrals forms and processes. The folder covers a range of areas including finance, mental health, exercise and alcohol and other drug use. Whilst navigators can draw on their existing knowledge about the local care infrastructure, given services change frequently (e.g., new ones start, existing services close or change their remit), they must ensure they continue to map and update this knowledge as part of their everyday role meaning that the information is regularly reviewed and updated by the team. In addition, staff receive regular updates and bulletins from various services and organisations and ensure news is cascaded throughout the team.

Some healthcare professionals working outside WDH expressed an interest in having a **closer relationship** with the MHN scheme and the wellbeing team to enhance knowledge exchange and prevent inappropriate referrals. The organisation ReThink have set up a system where representatives of external organisations are invited to join their meetings and supervisions so they can tell navigators about their services at the same time as having the opportunity to hear about what ReThink offers. They commented that this helps to both strengthen external working partnerships as well as raising awareness for service referrals.



Management and support

In Wakefield, the navigators are employed by the local mental health trust (SWYPFT) but are fully embedded within WDH as part of the wellbeing team (see organisational chart - Figure 6). To ensure the navigators are effectively managed and supported on a day-to-day basis, WDH and SWYPFT provide:

Regular meetings

These take place with both with SWYPFT and WDH. Monthly meetings with SWYPFT managers help ensure clinical line management support is in place. This is an opportunity to discuss current caseload and is a space for support with capacity and the administrative elements of the role. This is also used as a space to identify development goals and any ongoing training needs.

Additionally, WDH provides monthly team meetings with guest speakers and quarterly performance meetings with the wider care and health team.

Guest speakers are generally from services that the navigators may refer tenants onto, such as new services in the area or refresher sessions about existing services. This helps maintain skills and knowledge to enhance the service provision to tenants. It is also a valuable tool to showcase the navigator role to external service providers that may refer tenants into the WDH wellbeing team.

Peer support

This has been identified as valuable by existing navigators. Peer support can take a few different forms, but the navigators have found it works best when there are informal networks of peers. This can be people who work in the same location, or it can be people in the same role in other settings.

Allowing for time and space to discuss current work presentations and pressures is important for the navigators. This can be via informal channels such as WhatsApp groups, catching up over coffee or through a dedicated time. The navigators rely on this form of support on at least a weekly basis.

Reflective practice

This is another key element of the package. The navigators all complete reflective practice as part of their CPD. Various models are used for CPD depending on their profession (mental health nurse, mental health occupational therapist or mental health social worker).

Reflective practice looks at achievements, challenges and lesson learnt. This then feeds into the navigator's personal development plan and objectives that are set going forwards.

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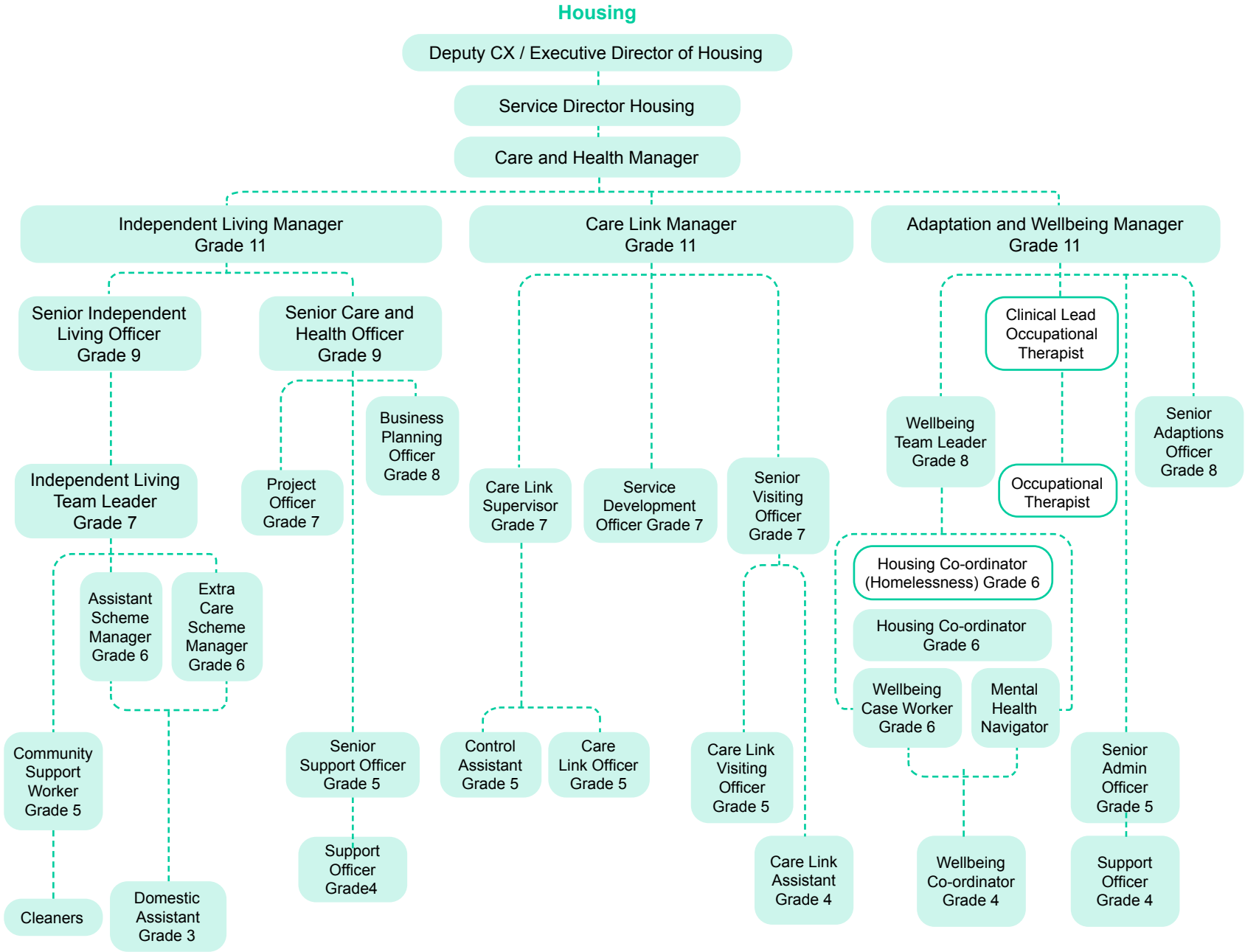
Management and support

Figure 6: Example WDH Organisational Chart



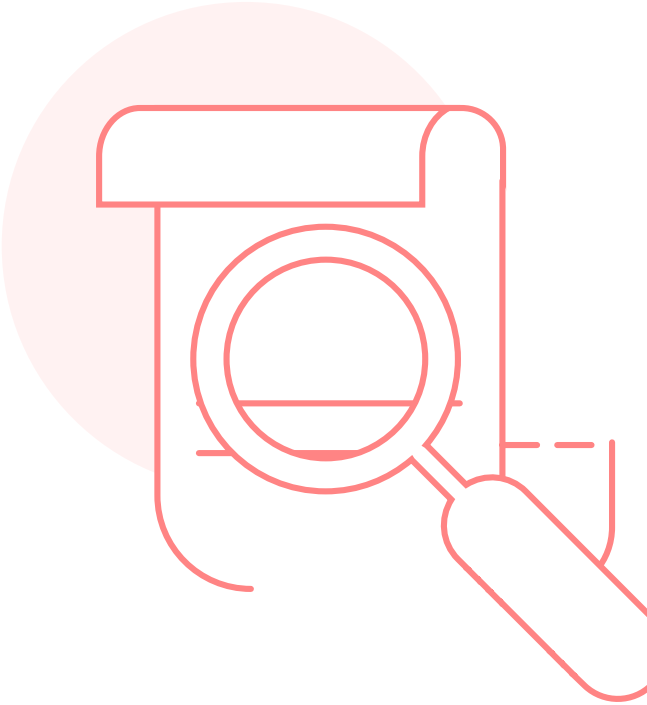
Monitoring and evaluation

You will find lots of guidance about monitoring and evaluation available in the public domain. We have curated some of these resources for you at the end of this section. Here we summarise some of the key differences between monitoring and evaluation and provide specific guidance for tracking the progress of MHN schemes.

Successful monitoring and evaluation efforts are guided by logic models, if your scheme doesn't have a logic model, please see the relevant section of this Toolkit for further guidance.

Reasons why monitoring and evaluating your MHN scheme is important

- **Allows you to track progress.**
- **Supports ongoing learning and improvement.**
- **Ensures people take accountability for their work.**
- **Supports evidence-based decision-making, including informing future business cases and commissioning decisions.**
- **Address the lack of research more generally on the impact of an MHN scheme.**
- **Helps you to evaluate the costs, benefits and economic sustainability of the scheme.**



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Differences between monitoring and evaluation

We would always recommend that any monitoring or evaluation plans for your MHN scheme are guided by your logic model. Monitoring typically focuses on measuring the inputs, activities and outputs specified in your logic model, whereas an evaluation assesses outcomes and impact. We have summarised some of the key differences between monitoring and evaluation in Table 3 below.

Table 3: Key differences between monitoring and evaluation

	Monitoring	Evaluation
Purpose	Track scheme progress and performance in real-time to inform decision-making and practice improvement.	Assess impact or effectiveness of the scheme over time as well as quality, relevance and sustainability.
Timing	Ongoing and throughout the MHN scheme lifecycle.	At specific intervals or time periods, or at the end of the scheme.
Methods	Data from key performance indicators (KPIs), often aggregated from individual data in case management systems are analysed.	Research techniques such as surveys and questionnaires, interviews, case studies, observations are carried out and analysed.
Scope	Inputs, activities and outputs specified in logic model.	Outcomes and impacts specified in logic model.
Audience	Usually, this means internal stakeholders and commissioners.	Wide range of internal and external stakeholders including funders, the public and policymakers.
Outputs	Regular internal reports.	Comprehensive reports and recommendations for future planning and decision-making, sometimes also other formats such as journal articles, blogs and videos.

Adapted from: Evalcommunity

First, monitoring

Before carrying out an evaluation, it is important that monitoring plans have been put into practice and the resulting data has been gathered and analysed. Monitoring provides essential data on real-world service delivery that forms the basis of decisions about whether evaluation is possible and what form the evaluation should take (more on this later). In some cases, monitoring data can actually be used in an evaluation study to provide insight into service user outcomes, so it is worth investing time in developing a robust and efficient monitoring plan.

Guidance on monitoring

In selecting data items to monitor, you will need to be guided by your logic model and any internal and commissioning reporting requirements. Your organisation or funder may have pre-set KPIs and targets you should account for. Local policymakers and service commissioners may have specific priorities that you need to provide evidence of impact for.

At a minimum, in order to develop insights into scheme implementation and progress, and to maximise the potential for future evaluability assessments, we recommend that you consider monitoring the following key aspects of project performance/delivery:

- referrals
- reach
- needs
- intervention activities
- implementation
- completion
- tenant satisfaction/user experience
- basic outcome data

In Appendix 3 you will find a suggested monitoring framework for a navigator and housing navigation scheme. You could adapt the framework and exact data requirements in line with your own service. To ensure the framework meets the full needs of local stakeholders, you could consider involving tenants and/or others with relevant lived experience in decisions around which outcomes to monitor and how.

Other key considerations for designing a monitoring plan, include the need for a system to support data capture; procedures to support the consistent and routine recording/data inputting; and identifying an individual or team responsible for collating, analysing and reporting monitoring data (or building systems to automate this). Monitoring reports are only as good as the quality and consistency of data recorded in case management systems.

MHN schemes are likely to serve tenants with wide ranging needs and circumstances. Paperwork associated with a scheme, such as referral forms and need assessments forms are likely to involve long lists of potential needs and risk/protective factors (reflecting the range of circumstances in the target population). In order to support a meaningful interpretation of monitoring data, it's important to ensure that data capture systems are set up to record all of this information, not just a selection.

Continued on next page

In order to streamline efforts required for monitoring, it is helpful to ensure that case recording involves tick boxes or drop-down boxes that convert to numerical scores behind the scenes.

Free text boxes are important for providing context and for case management purposes but are impossible to analyse in aggregate form.

You could consider supplementing some drop-down lists with free text boxes as appropriate. You should also consider the timing and frequency of monitoring reports.

A combination of quarterly and annual reports provides opportunity for the quick identification of successes and shortcomings or challenges in implementation.

Monitoring allows you to see how your MHN scheme is functioning, but it doesn't tell you anything about the difference the scheme is making for tenants. Monitoring can't tell you whether the scheme is effective or why it is or isn't progressing as expected, to find this out you would need to undertake an evaluation.

Data Quality and Completeness and UK Housing Data Standards

Goodquality data is essential in allowing housing providers to accurately assess the effectiveness of the services that they provide. Through carefully monitoring, providers can critically appraise outcomes for tenants ensuring that services meet the needs of all users regardless of their unique situations and backgrounds. Highquality data standards make good economic sense, enabling housing providers to make informed decisions that not only improve outcomes for tenants, but save the organisation money through improved tenancy stability and increased social returns of investment.

In 2018, HACT in collaboration with over 70 housing associations and industry partners developed the UK Housing Data Standards. These encompass ten modules that cover all elements of the business, including care and support, customer data and planned maintenance. The UK Housing Data Standards provide a framework for housing providers to format, define, structure, use and manage their data. Standardising data in this way not only allows housing providers to share information consistently and safely across their organisation but can also establish industry benchmarks that support the sharing of data with other partners including health service providers.

The UK Housing Data Standards can be downloaded by housing providers free of charge from HACT's website. If you would like more information on the UK Housing Data Standards and other data and digital services, please contact HACT at www.hact.org.uk/digital-form/.

Next, evaluation

Evaluation design options

Before-and-after study

Effectiveness evaluation

Engaging with academic partners

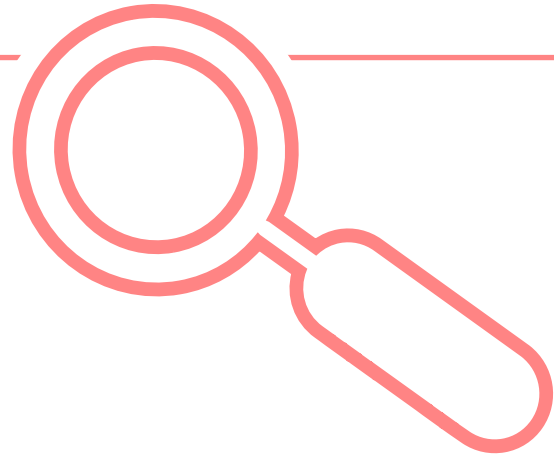
Evaluation is primarily concerned with understanding and evidencing the potential impact of an MHN scheme on the outcome for those who have received support. An important component of any evaluation is the implementation of outcome measures at the start and end of support. (See appendices 4, 5 and 6 for example outcome measures).

Outcome measures enable service users to have a voice and have their views heard. They also allow you to generate data that can be used to celebrate success as well as identify areas that require improvement. Data from outcome measures can be used to demonstrate impact to support tendering for funding as well as sustainability through recommissioning processes.

Outcome measures are an important tool for accountability. However, it is critical that services are clear on intended outcomes for service users in order to select appropriate measures and that wherever possible services implement valid and reliable measures. Note that formalising your ToC and logic model is an incredibly helpful process to guide the selection of outcome measures.

What do we mean when we say a measure is valid and reliable?

When using an outcome measure, it is important to ensure that the tool has previously been tested and found to be both valid and reliable. If an outcome measure is valid, this means that a tool actually measures what it claims to measure. A reliable measure is one which produces similar results when used under consistent conditions.



Evaluation design options

Before-and-after study

When evaluating interventions, researchers adopt different approaches depending on how established an intervention is and how much research has already been done. Two of those approaches are **before-and-after studies** and **effectiveness evaluations**.

Before-and-after studies estimate the change in outcome(s) at the end of the intervention. The analysis looks at change of time in a measure that has been completed at the start and end of the intervention. Findings can be compared to the logic model to determine if outcomes are moving in the direction expected.

You should aim to have complete data (e.g., completed measures at both start and end of intervention) for 90% of all service users. If you only have a small number of service users with complete data, the results will not give you an accurate picture of the impact of your scheme.

Some measures have cut-off scores that tell you something about the severity of difficulties, for example severe, moderate, mild or no depression. Exploring movement in and out of these categories over the course of the intervention can help interpret scores. Some measures also have benchmarks that can be used to compare scores from your scheme participants to national averages.

It's really important to bear in mind that whilst before-and-after studies are often a first step in testing logic models and gathering impact evidence, this type of study cannot tell you anything about whether the scheme you are evaluating caused the changes in outcomes that you have observed.

To be certain that any change in outcome is down to the scheme, an effectiveness evaluation would be needed.

Effectiveness evaluation

Effectiveness evaluations involve comparing outcomes for service users in your scheme to outcome for people who have not received support from your scheme. This allows researchers to account for any change that may have occurred naturally and measure precisely how much change in outcomes has been caused by the scheme itself.

We recommend that you consider conducting an evaluability assessment before embarking on an effectiveness evaluation. Checklists have been developed to support evaluability assessment and they typically consider factors such as intervention data availability and quality, use of reliable outcome measures, the existing evidence base, intervention uptake, scope for additional data collection and resources available to support the evaluation.

Examples of checklists can be found in 'Planning evaluability assessments' produced by the Department for International Development and in the Better Start Bradford Innovation Hub.

Engaging with academic partners

If you are interested in conducting an effectiveness evaluation, we strongly recommend that you partner with an academic institution. Many universities and academic institutions are keen to support local initiatives but don't always know about them. Make contact with your local university. You could start by looking for relevant departments such as health sciences, midwifery/nursing/medicine and policy, etc. Your organisation may already have links with universities, and you could also try emailing researchers directly.

NIHR has local research networks including public health, who will have research contacts that might be relevant to you. For example, through your regional NIHR Applied Research Collaborations: https://www.nihr.ac.uk/explore-nihr/support/collaborating-in-applied-health-research.htm.

Other useful links for NIHR are:

- https://www.nihr.ac.uk/explore-nihr/support/clinical-research-network.htm
- https://www.nihr.ac.uk/researchers/i-need-help-to-deliver-my-research/study-support-service

We have also invited our partners at WDH to share their experience of working with academic partners on different phases of the evaluation of their MHN scheme. The scheme manager at WDH shares their reflections in Table 4.

Continued on next page

Table 4: WDH reflections on the evaluation (continued on the next page)

What worked well	What didn't work so well
Project planning: early stages of the project with all aspects of the business	
✓ Involvement of key stakeholders from the beginning of the process. ✓ Commitment from representatives of WDH and the research team. ✓ Holding regular meetings and providing frequent updates on evaluation plans and objectives.	× Staff changes impacted slightly on the evaluation when promotions at WDH saw the movement of individuals into other roles within the organisation (although fortunately the majority stayed in the Care and Health Directorate).
Data extraction: compiling and sharing data	
✓ Having documentation stored and filed correctly meant it was readily available to the evaluators when needed.	× Combining two very sizeable documents containing a large amount of data for one of the work packages was challenging, particularly for IT. It is important to liaise with IT prior to starting an evaluation to see if they can provide the support required. × Difficult for some staff who joined the evaluation at a later stage to grasp the process. The provision of clear and concise documentation describing who was responsible for what and broken down into a process map would have been helpful.

Continued on next page

What worked well

What didn't work so well

Recruitment: approaching customers to participate in the project

- ✓ Having the recruitment packs available to provide tenants with complete information.
- ✓ Meeting with the navigators prior to the recruitment process to ensure all aspects are understood.
- ✓ Weekly recruitment updates between WDH and the evaluators.
- ✓ Regular weekly completion of recruitment paperwork for navigators.

- × Understanding the challenges facing the client group and how this affected their capacity to take part in interviews. There needs to be an appreciation that some clients are going through their hardest times and that getting them engaged in this project at the same time as getting them engaged in direct MNH support can be very difficult.

Managing staff workloads: impact throughout the project

- ✓ Evaluators' visits to WDH sites to complete data extraction.
- ✓ Input from colleagues in IT to enable secure data extraction.

- × The time needed for evaluation tasks on top of regular day-to-day commitments was challenging for navigators and their managers.
- × In particular from a management perspective, collating the data required was time consuming.
- × More forward planning and an understanding of the time required to dedicate to the project is essential.

Overall cost–benefit of evaluation

- ✓ Evaluators built on the findings from the previous evaluation to focus on tenant outcomes.
- ✓ From initial discussions in November 2020, the project gathered pace with a scope produced in December.

- × Impact of the COVID-19 pandemic and the ability to complete data mining exercises.

Building your business case

A key message highlighted throughout this Toolkit is the need to build meaningful relationships with people and organisations that might have an interest in funding your MHN scheme. Effective partnership working between WDH and the local mental health trust, SWYPFT, over time enabled the organisation to agree to a joint funding model for the MHN scheme. Interviews stressed how this was critical in terms of several key factors. Click here to see a short infographic summarising the scheme and the impact it has had.

1. Helps to foster shared awareness of the added value provided by navigators across different organisations. This ensured that the scope and focus reflected the needs of both housing and healthcare providers.

> …we started having conversations with our mental health provider… [about] the issues that we have if we evict people and how that impacts then on their services… we started talking about trying to plug that gap and having the mental health navigators working alongside our wellbeing caseworkers… [our mental health] provider said, Absolutely, we need this in the system but we don't have any money…So we started to build up the relationship then with the Wakefield CCG and the person there who led on the mental health commissioning…she got it and saw it as a great opportunity to try something different and understood that there was a gap there. So, we offered to fund 50% if the CCG would fund 50%we've continued with that arrangement ever since, since 2015."
>
> ***Service Director (Housing & Health)***

2. Supports co-production of a set of meaningful outcome measures for the scheme that reflect the different goals that different organisations might have for their investment and allow ongoing assessment of 'performance'.

> I think as well having those relationships really with provider commissioner and just building up those relationships and making sure that, you know, there's a mutual trust around the table, what people are wanting to achieve and get out of any such commission and that the performance dashboard that's associated meets and ticks everyone's boxes really so everyone's getting something for that investment."
>
> ***Care and Health Manager (Wellbeing)***

3. Ensures schemes are based on a realistic and current understanding of the wider health and care system. As well as potential commissioners, partnership working needs to include organisations providing other services across the local and regional care infrastructure. In particular, there is a need to consider the capacity of the local third sector when establishing a new scheme.

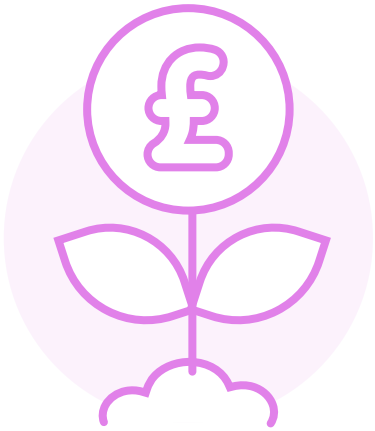
Evidencing the cost and impact of your scheme

When setting up an MHN scheme in your organisation, you will first need to think about how you will finance the scheme. This will mean identifying either 'new' funding or reorganising existing ('old') funding to finance the scheme. In economic terms, this is referred to as an 'opportunity cost'.

Essentially, this means that by choosing to spend money on an MHN scheme, that money cannot be spent on other areas of work or services. Therefore, any potential benefits of the other area(s) of work are forgone in favour of any of the benefits of the MHN scheme.

As an organisation, it is therefore important to ensure that you fund schemes that are likely to deliver the best return on your investment.

You can do this by assessing the cost and benefits of a scheme and by getting a clear understanding of the minimum amount you need to spend to deliver a minimum level of effectiveness or success.



As the care and health manager at WDH told us:

> "I think it's just having a good evidence base and dataset, so the business case and any potential cost benefit analysis really…public and health purses are really squeezed…so a robust business case is really fundamental to its success."
>
> ***Care and Health Manager (Wellbeing)***

WDH have conducted their own analysis of social return on investment indicating that for every £1 spent, £6.73 is saved (WDH, 2020–21).

Our independent economic evaluation of the scheme had significant methodological limitations that mean we are unable to pinpoint a precise figure, though it did also suggest potential financial savings linked to positive benefits from the scheme.

[3] NICE, an organisation set up to help practitioners and service commissioners get the best care to patients, fast, while ensuring value for the taxpayer. See more here www.nice.org.uk.

Maintaining your scheme over the long term

Once up and running, regular assessment of the costs and consequences (or impact) of your scheme was viewed as essential to fostering sustained commissioning buy-in. In addition, WDH staff told us that it was critical to continue to invest time and effort in partnerships with local and regional stakeholders. The positive relationship built between WDH and the local mental health trust was viewed as essential to ensuring continued funding for the scheme:

> "I think the partnerships and the relationships that we have with the NHS and commissioners has been, is good, relationships have positively developed over recent years, so I think it's important that that relationships are sustained, especially with the changes in commissioning, the shift to regional commissioning services."
>
> ***Adaptations and Wellbeing Manager***

These messages were emphasised again in a workshop we held with our IAG members to talk about funding and sustainability of MHN schemes. More than Minutes helped capture these discussions which have also informed how this Toolkit was put together and presented.

This is the impactful visual they produced:

Useful contacts and sources of support

Figure 7: How to fund, sustain and build engagement for MHN schemes in housing

Housing Associations' Charitable Trust

Address: 7–14 Great Dover Street, London SE1 4YR
Email: info@hact.org.uk
X/Twitter: @HACTHousing
Website: hact.org.uk

More than Minutes

Email: info@morethanminutes.co.uk
X/Twitter: @visualminutes
Website: www.morethanminutes.co.uk

Rethink

Address: PO Box 18252, Solihull B91 9BA
Email: advice@rethink.org
X/Twitter: @Rethink_
Website: www.rethink.org

David Thorpe, Wakefield District Housing

Address: Merefield House, Whistler Drive, Castleford WF10 5HX
Email: dthorpe@wdh.co.uk
X/Twitter: @WDHupdate
Website: wdh.co.uk

Thank you for reading this Toolkit.
We wish you all the best for implementing a MHN scheme in your area.

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Glossary

Term	Definition
Care and health manager	Oversees the overall management of teams responsible for customer health and wellbeing.
CCG (Wakefield Clinical Commissioning Group)	A clinically led statutory body responsible for the planning and commissioning of local healthcare services.
DIALOG	DIALOG is a scale comprising of 11 questions. It is administered to people with mental illness asking them to rate their satisfaction and care needs on eight life domains and three treatment aspects. It can be used as a patient reported outcome measure (PROM) and can evaluate the patient's treatment journey.
IAG (Implementation advisory group)	A group of external stakeholders who provide feedback on emerging findings from the evaluation, with a specific focus on implementation and sustainability.
Mental Health Navigator (MHN) scheme	Part of the wider wellbeing service, the scheme jointly commissioned by WDH and Wakefield CCG, seconds three navigators from SWYPFT to support WDH tenants struggling with their mental health to overcome the difficulties they face as a result of their mental ill health and to stay securely in their homes without risk of eviction.
Navigator	A Grade 6 NHS worker with professional experience as a mental health nurse, occupation therapist or social worker, seconded from SWYPFT to work in the WDH wellbeing team. Navigators carry out clinical assessments of tenants needs, create personalised action plans and deliver therapeutic interventions.
PCIEP (Public and Community Involvement, Engagement and Participation)	Where research is carried out 'with' or 'by' members of the public rather than 'to', 'about' or 'for' them. It involves researchers sharing information and knowledge with the public and vice versa.
Primary care services	Provide the first point of contact for people experiencing mental health difficulties, often supporting them in the primary care or community setting.

Continued on next page

Glossary

Term	Definition
PCT (Primary care trust)	A Primary Care Trust (PCT) is a legal entity, set up by order of the Secretary of State. It is a free-standing NHS body, performance managed by a Strategic Health Authority. Primary Care Trusts work with Local Authorities and other agencies that provide health and social care locally to make sure that local community's needs are being met [35]
Secondary mental health services	Provide specialist mental health care and support for patients who have been referred to them for specific expert care, often taking place in hospitals.
Social housing provider	For example, housing associations and local authorities, provide secure housing at rental prices that are affordable for tenants on low incomes. Social housing providers operate a waiting list that prioritises vulnerable people for housing.
SWYPFT (South West Yorkshire Partnership NHS Foundation Trust)	The NHS trust providing health care services in Calderdale, Kirklees, Wakefield and Barnsley. They jointly fund the MHN scheme and directly employ the navigators.
SystmOne	A NHS clinical data recording system that allows practitioners to record and access patients' medical information.
Tenancy	A legal arrangement where someone has the right to live in or use a property owned by someone else for a specified period of time in exchange for payment of rent.
Tenant (or customer)	A person who lives in or uses a property owned by someone else in exchange for rent.
Tenancy breakdown	Occurs when a tenant leaves a rented property either by their own choosing or at the landlord's request due to the tenancy agreement becoming unmanageable for the tenant and/or landlord, e.g., the tenant not paying their rent, or the landlord being unable to provide suitable accommodation for the tenant's needs.

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Glossary

Term	Definition
ToC (Theory of Change)	A comprehensive narrative description and a figurative illustration of how and why we expect that a new practice or intervention will lead to positive change. It helps an organisation or evaluation team to better understand what a new practice or intervention does and exactly how this will result in desired goals or outcomes being achieved.
WBCW (wellbeing caseworker)	Provides support and advice to tenants to enable them to overcome barriers and make positive changes to their lives.
WDH (Wakefield District Housing)	A social housing provider offering homes for rent or shared ownership across Wakefield and Yorkshire. They jointly fund the MHN scheme and host the navigators and host the navigators within their wellbeing team.
WDH wellbeing team	The WDH wellbeing team works with tenants and their families to tackle lifestyle and wellbeing issues. The wellbeing team comprises the following members: one wellbeing team leader, one housing coordinator, three wellbeing caseworkers, three navigators, two healthcare support workers and a wellbeing coordinator.

Appendices

1. Logic model template

Need	Inputs	Activities	Outputs	Outcomes	Impact

2. Full list of ERIC implementation strategies

Strategy	Definition
Access new funding	Access new or existing money to facilitate the implementation.
Alter incentive/allowance structures	Work to incentivise the adoption and implementation of the clinical innovation.
Alter patient/consumer fees	Create fee structures where patients/consumers pay less for preferred treatments (the clinical innovation) and more for less-preferred treatments.
Assess for readiness and identify barriers and facilitators	Assess various aspects of an organisation to determine its degree of readiness to implement, barriers that may impede implementation and strengths that can be used in the implementation effort.
Audit and provide feedback	Collect and summarise clinical performance data over a specified time period and give it to clinicians and administrators to monitor, evaluate and modify provider behaviour.
Build a coalition	Recruit and cultivate relationships with partners in the implementation effort.
Capture and share local knowledge	Capture local knowledge from implementation sites on how implementers and clinicians made something work in their setting and then share it with other sites.
Centralise technical assistance	Develop and use a centralised system to deliver technical assistance focused on implementation issues.
Change accreditation or membership requirements	Strive to alter accreditation standards so that they require or encourage use of the clinical innovation. Work to alter membership organisation requirements so that those who want to affiliate with the organisation are encouraged or required to use the clinical innovation.
Change liability laws	Participate in liability reform efforts that make clinicians more willing to deliver the clinical innovation.
Change physical structure and equipment	Evaluate current configurations and adapt, as needed, the physical structure and/or equipment (e.g., changing the layout of a room, adding equipment) to best accommodate the targeted innovation.
Change record systems	Change records systems to allow better assessment of implementation or clinical outcomes.
Change service sites	Change the location of clinical service sites to increase access.
Conduct cyclical small tests of change	Implement changes in a cyclical fashion using small tests of change before taking changes system-wide. Tests of change benefit from systematic measurement, and results of the tests of change are studied for insights on how to do better. This process continues serially over time, and refinement is added with each cycle.
Conduct educational meetings	Hold meetings targeted toward different stakeholder groups (e.g., providers, administrators, other organisational stakeholders and community, patient/consumer and family stakeholders) to teach them about the clinical innovation.

Continued on next page

Strategy	Definition
Conduct educational outreach visits	Have a trained person meet with providers in their practice settings to educate providers about the clinical innovation with the intent of changing the provider's practice.
Conduct local consensus discussions	Include local providers and other stakeholders in discussions that address whether the chosen problem is important and whether the clinical innovation to address it is appropriate.
Conduct local needs assessment	Collect and analyse data related to the need for the innovation.
Conduct ongoing training	Plan for and conduct training in the clinical innovation in an ongoing way.
Create a learning collaborative	Facilitate the formation of groups of providers or provider organisations and foster a collaborative learning environment to improve implementation of the clinical innovation.
Create new clinical teams	Change who serves on the clinical team, adding different disciplines and different skills to make it more likely that the clinical innovation is delivered (or is more successfully delivered).
Create or change credentialing and/or licensure standards	Create an organisation that certifies clinicians in the innovation or encourage an existing organisation to do so. Change governmental professional certification or licensure requirements to include delivering the innovation. Work to alter continuing education requirements to shape professional practice toward the innovation.
Develop a formal implementation blueprint	Develop a formal implementation blueprint that includes all goals and strategies. The blueprint should include the following: 1) aim/purpose of the implementation; 2) scope of the change (e.g., what organisational units are affected); 3) timeframe and milestones; and 4) appropriate performance/progress measures. Use and update this plan to guide the implementation effort over time.
Develop academic partnerships	Partner with a university or academic unit for the purposes of shared training and bringing research skills to an implementation project.
Develop an implementation glossary	Develop and distribute a list of terms describing the innovation, implementation and stakeholders in the organisational change.
Develop and implement tools for quality monitoring	Develop, test and introduce into quality-monitoring systems the right input – the appropriate language, protocols, algorithms, standards and measures (of processes, patient/consumer outcomes and implementation outcomes) that are often specific to the innovation being implemented.
Develop and organise quality monitoring systems	Develop and organise systems and procedures that monitor clinical processes and/or outcomes for the purpose of quality assurance and improvement.
Develop disincentives	Provide financial disincentives for failure to implement or use the clinical innovations.
Develop educational materials	Develop and format manuals, Toolkits and other supporting materials in ways that make it easier for stakeholders to learn about the innovation and for clinicians to learn how to deliver the clinical innovation.

Continued on next page

Strategy	Definition
Develop resource sharing agreements	Develop partnerships with organisations that have resources needed to implement the innovation.
Distribute educational materials	Distribute educational materials (including guidelines, manuals and Toolkits) in person, by mail and/or electronically.
Facilitate relay of clinical data to providers	Provide as close to real-time data as possible about key measures of process/outcomes using integrated modes/channels of communication in a way that promotes use of the targeted innovation.
Facilitation	A process of interactive problem solving and support that occurs in a context of a recognised need for improvement and a supportive interpersonal relationship.
Fund and contract for the clinical innovation	Governments and other payers of services issue requests for proposals to deliver the innovation, use contracting processes to motivate providers to deliver the clinical innovation and develop new funding formulas that make it more likely that providers will deliver the innovation.
Identify and prepare champions	Identify and prepare individuals who dedicate themselves to supporting, marketing and driving through an implementation, overcoming indifference or resistance that the intervention may provoke in an organization.
Identify early adopters	Identify early adopters at the local site to learn from their experiences with the practice innovation.
Increase demand	Attempt to influence the market for the clinical innovation to increase competition intensity and to increase the maturity of the market for the clinical innovation.
Inform local opinion leaders	Inform providers identified by colleagues as opinion leaders or ‘educationally influential’ about the clinical innovation in the hopes that they will influence colleagues to adopt it.
Intervene with patients/ consumers to enhance uptake and adherence	Develop strategies with patients to encourage and problem solve around adherence.
Involve executive boards	Involve existing governing structures (e.g., boards of directors, medical staff boards of governance) in the implementation effort, including the review of data on implementation processes.
Involve patients/consumers and family members	Engage or include patients/consumers and families in the implementation effort.
Make billing easier	Make it easier to bill for the clinical innovation.
Make training dynamic	Vary the information delivery methods to cater to different learning styles and work contexts, and shape the training in the innovation to be interactive.
Mandate change	Have leadership declare the priority of the innovation and their determination to have it implemented.

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Strategy	Definition
Model and simulate change	Model or simulate the change that will be implemented prior to implementation.
Obtain and use patients/ consumers and family feedback	Develop strategies to increase patient/consumer and family feedback on the implementation effort.
Obtain formal commitments	Obtain written commitments from key partners that state what they will do to implement the innovation.
Organize clinician implementation team meetings	Develop and support teams of clinicians who are implementing the innovation and give them protected time to reflect on the implementation effort, share lessons learned and support one another's learning.
Place innovation on fee for service lists/formularies	Work to place the clinical innovation on lists of actions for which providers can be reimbursed (e.g., a drug is placed on a formulary, a procedure is now reimbursable)
Prepare patients/consumers to be active participants	Prepare patients/consumers to be active in their care, to ask questions and, specifically, to inquire about care guidelines, the evidence behind clinical decisions or about available evidence-supported treatments.
Promote adaptability	Identify the ways a clinical innovation can be tailored to meet local needs and clarify which elements of the innovation must be maintained to preserve fidelity.
Promote network weaving	Identify and build on existing high-quality working relationships and networks within and outside the organisation, organisational units, teams, etc., to promote information sharing, collaborative problem-solving and a shared vision/goal related to implementing the innovation.
Provide clinical supervision	Provide clinicians with ongoing supervision focusing on the innovation. Provide training for clinical supervisors who will supervise clinicians who provide the innovation.
Provide local technical assistance	Develop and use a system to deliver technical assistance focused on implementation issues using local personnel.
Provide ongoing consultation	Provide ongoing consultation with one or more experts in the strategies used to support implementing the innovation.
Purposely reexamine the implementation	Monitor progress and adjust clinical practices and implementation strategies to continuously improve the quality of care.
Recruit, designate, and train for leadership	Recruit, designate and train leaders for the change effort.
Remind clinicians	Develop reminder systems designed to help clinicians to recall information and/or prompt them to use the clinical innovation.
Revise professional roles	Shift and revise roles among professionals who provide care, and redesign job characteristics.

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Strategy	Definition
Shadow other experts	Provide ways for key individuals to directly observe experienced people engage with or use the targeted practice change/innovation.
Stage implementation scale up	Phase implementation efforts by starting with small pilots or demonstration projects and gradually move to a system wide rollout.
Start a dissemination organisation	Identify or start a separate organisation that is responsible for disseminating the clinical innovation. It could be a for-profit or non-profit organisation.
Tailor strategies	Tailor the implementation strategies to address barriers and leverage facilitators that were identified through earlier data collection.
Use advisory boards and workgroups	Create and engage a formal group of multiple kinds of stakeholders to provide input and advice on implementation efforts and to elicit recommendations for improvements.
Use an implementation advisor	Seek guidance from experts in implementation.
Use capitated payments	Pay providers or care systems a set amount per patient/consumer for delivering clinical care.
Use data experts	Involve, hire and/or consult experts to inform management on the use of data generated by implementation efforts.
Use data warehousing techniques	Integrate clinical records across facilities and organisations to facilitate implementation across systems.
Use mass media	Use media to reach large numbers of people to spread the word about the clinical innovation.
Use other payment schemes	Introduce payment approaches (in a catch-all category).
Use train-the-trainer strategies	Train designated clinicians or organisations to train others in the clinical innovation.
Visit other sites	Visit sites where a similar implementation effort has been considered successful.
Work with educational institutions	Encourage educational institutions to train clinicians in the innovation.

3. Example monitoring framework for a mental health and housing navigation scheme

Aspects of Implementation	Referrals	Reach	Needs	Intervention activities	Completion	Satisfaction	Outcomes
Example data	Number of referrals.	Characteristics (e.g., age, gender, ethnicity).	Reasons for referral.	Number of contacts or sessions with the navigator.	Number of tenants who completed the intervention.	Service user feedback, from e.g., a survey or questionnaire.	Mental health measure.
	Number of tenants referred who were eligible.		Needs identified in assessment.	Length/duration of intervention (e.g., time between navigator support starting and ending).	Number of tenants who disengaged.		Subjective wellbeing measure.
	Number of eligible tenants who started the intervention.			Referrals to other services.	Number of tenants whose case was closed for other reasons.		Goal-based measure.
	Referral sources.			Direct interventions provided.			Housing security.
	Waiting list times.			Organisations tenants are signposted to.			
Suggestions for how to analyse these data	Compare to anticipated number of referrals specified in logic model.	Compared to the local general population and/or housing providers tenant population.	Examine most frequent needs/referral reasons and any patterns/ clusters.	Comparison to number of sessions and duration specified in logic model.	Examine retention and dropout, are there any patterns in the characteristics of those who dropout?	Identify strengths and weaknesses of the service from tenant perspective.	Before and after analysis.

4. Housing stability and/or security measures

Name	No. items	Constructs measured	Time to complete	Weblink	Licensing	Additional information
Validated tools						
TimeLine Follow-Back method Linda Sobell 1996	See below – housing related study.	See below – housing related study.	See below.	See below.	Copyrighted but free to download and use with appropriate acknowledge-ment.	Comprehensive and has demonstrated strong psychometric properties. See below re housing.
The residential time-line follow-back inventory (TLFB) USA	Not items, 34 location codes.	Covers eight domains: 1. Participant demographics and history 2. Physical health 3. Housing stability and the extent of homelessness 4. Substance use 5. Mental health symptoms 6. Perceived quality of life 7. Service utilisation and illegal activity 8. Contact with the legal system	1.5 hours.	https://core.ac.uk/download/pdf/56516849.pdf	See above.	Assesses all dimensions of housing status and stability – point-in-time assessments and longitudinal evaluations of housing and transitions (showing chronological records of respondents' history for the period between successive interviews). Time-consuming to administer, so not easily incorporated into studies measuring additional constructs.
Internally tested, semi-validated						
Homelessness Risk Screener. USA.	37 items in pilot instrument. 25 items included in final screening instrument (combined some items).	Types of domains covered: • Current living situation • Residential history • Types of living environments • History of homelessness • Residential transience • A variety of barriers to housing stability	N.A.	https://journals.sagepub.com/doi/epdf/10.1177/003335491412900506	N.A.	Item development: 1) cognitive interviews + 2) item refinement. Expert panel review contributed to instrument's overall content validity, while cognitive interviews contributed to face validity. Kuder-Richardson Formula 20 (KR-20) was used to field test at both stages and entire instrument.

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Name	No. items	Constructs measured	Time to complete	Weblink	Licensing	Additional information
Not yet validated tools						
Housing Security Scale (HSS) Frederick et al (2014) Canada	13 Likert-type questions. 5 response options. Scored out of 65 with higher scores reflecting greater stability.	13-item Housing Security Scale (1 – strongly disagree, 2 – disagree, 3 – not sure or neither, 4 – agree, 5 – strongly agree). 1. My current accommodation is only temporary even if I wanted to stay* 2. I get along with the people I live (choose 5 if you live alone) 3. The people I live with are reliable when it comes to obeying the landlord's rules and paying their rent on time (choose 5 if you live alone) 4. Where I live has subsidies, workers, or specific policies that help me to maintain my housing 5.In the last six months, I have had a history of maintaining my accommodation and I have not been evicted (includes moves as long as no period of couch surfing or homelessness) 6. I am settled in my place and know what to expect about living here (neighbours, rules, landlord) 7. I follow my landlord's rules (e.g., not smoking, not doing drugs, not being noisy) 8. I feel confident about my ability to pay my rent on time 9. I am working or enrolled in classes and I have been showing up on time and performing to a satisfactory level (includes if you are on summer break or if your work is seasonal) 10. Drugs and alcohol are a source of conflict in my personal relationships or interfere with my ability to fulfil my responsibilities or to work towards personal goals*	N.A.	https://onlinelibrary.wiley.com/doi/10.1002/jcop.21665	N.A.	Not validated but due to lack of alternative scales, still worth considering. Core dimensions were identified through qualitative interviews with 51 young people.

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Name	No. items	Constructs measured	Time to complete	Weblink	Licensing	Additional information
		11. I have legal troubles that may interfere with my ability to adequately maintain my housing or fulfil my personal responsibilities over the next six months* 12. I am satisfied with my current housing 13. Overall, my life feels stable to me. **Items reverse scored.*				
Not yet validated tools						
Measuring housing insecurity as an index of multiple variables USA Routhier (2019)	10	Constructed and tested a ten-item index that measures housing insecurity within four dimensions: 1. Unaffordability 2. Poor conditions 3. Overcrowding Forced moves	N.A.	https://www.tandfonline.com/doi/full/10.1080/10511482.2018.1509228	N.A.	Uses data from the United States Department of Housing and Urban Development's (HUD) American Housing Survey (AHS) to test the appropriateness of measuring housing insecurity as an index comprising multiple variables within the four related dimensions.
Housing Instability Index USA Rollins et al (2012)	10	The index is a count of ten possible risk factors for housing instability in the past six months.	N.A.	https://journals.sagepub.com/doi/10.1177/0886260511423241	N.A.	Index developed for the study; additional research will require a validation and potential modification of the measure. Includes four items that are only relevant to individuals with landlords. It does have promising face validity and includes an item measuring the number of moves but does not consider homelessness in its assessment of housing instability.

5. Goal Based Outcomes Tools

Name	No. items	Constructs measured	Time to complete	Weblink	Licensing	Additional information
Validated						
The Goal-Based Outcome (GBO) Tool Law 2019	Not item based. Record up to three goals set, ten scale.	Measures progress and outcomes of an intervention – whether goals have been met. Goals unique to individual.	Practitioners encouraged to use the GBO tool throughout interventions, session by session or at least frequently.	https://discovery.ucl.ac.uk/id/eprint/10158450/1/GBO%20version%202.0%20guide%20FINAL%201st%20Feb%202019.pdf	Licensed under creative commons and free to use. If adapted, need to reference the original measure: www.goals-in-therapy.com/contact/.	Suggested 'meaningful change' level for GBO, based on the principles of the reliable change index, is 2.45. Can be used in any setting, that is change-focused and goal-oriented – including adult and physical health contexts. Can be assessed subjectively by service users themselves (patient-reported) or objectively by the clinician (clinician-rated).
Not validated, evaluated through implementation in prisons and approved premises						
Goals and Plans Card Sort Task Davies et al (2022) UK	Ten life domains (adapted from the Personal Concerns Inventory) and 'other'.	Life domains: 1. Home – future living 2. Relationships – friends and family 3. Physical and mental health 4. Hobbies and interests 5. Learning and working 6. Money 7. Self-changes/personal development 8, Drug and alcohol management 9. Risk management 10. Pro social behaviour	N.A.	https://www.tandfonline.com/doi/epdf/10.1080/14999013.2022.2081743?needAccess=true&role=button	N.A.	Theory-driven psychometric tool that measure motivational constructs to support offenders in positive lifegoal pursuits. Extends the Personal Concerns Inventory (offender adaptation). Tool designed to be completed by or under the guidance of an appropriately trained individual. Most useful when used at intervals to support the respondent to monitor the progress toward goals and to re-evaluate goal priorities over time. Supports users to: identify and prioritise goals in life domains of importance to them; detail how a goal can be attained; and consider obstacles to attainment.

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Name	No. items	Constructs measured	Time to complete	Weblink	Licensing	Additional information
Not self-administered – collaboration of patients and psychotherapist						
The Goals Form Mick Cooper 2015	Not item based. Up to seven goals, seven rating scale.	Measure development study.	N.A.	https://onlinelibrary.wiley.com/doi/10.1002/jclp.23344 Form link: https://pluralisticpractice.com/tools-and-measures/	Licensed under the Creative Commons Attribution No fee as long as not changed and origin acknowledged	Psychometric properties generally good. Noncompletion of individual items was low, acceptability and test reliability were good at 96.8% and 0.88 respectively. Tool shows acceptable construct validity with moderate to strong correlation (psychological distress -0.92 to -0.57).
Not self-administered – led by a trained professional						
Goal Attainment Scaling (GAS) Kirusek and Sherman (1968)	Not item based. Identification of focal issue for treatment > identification of at least three goals > selection of indicator for that goal > set expected post treatment outcome (two outcome levels).	Goals based on individual. Patients set out, and then rate, expected levels of outcomes on a set of identified goals.	20 minutes with similar time for post-treatment and follow-up assessment.	Article: https://onlinelibrary.wiley.com/doi/epdf/10.1111/cp-sp.12281?saml_referrer Example Form: https://www.kcl.ac.uk/cic-elysaunders/resources#:~:-text=Goal%20Attainment%20Scaling%20(GAS)%20is.as%20to%20allow%20statistical%20analysis.	N.A.	Test–retest reliability, from end of therapy to eight-week follow-up, has been reported as acceptable r=0.7. Convergent validity, GAS scores have shown significant moderate to high correlations with other indicators of psychological health, such as the Target Complaints Scale (r=0.50) and the Brief Symptom Inventory (r=0.38) in time-limited psychotherapy. GAS procedure is unique among goal measures, in that it involves the setting, and rating, of expected levels of outcomes. GAS Guide and training slides: https://www.kcl.ac.uk/nmpc/assets/rehab/gas-goal-attainment-scaling-in-rehabilitation-a-practical-guide.pdf https://www.kcl.ac.uk/nmpc/assets/rehab/gas-made-easy-how-to-do-gas-in-5-stages.pdf

6. Depression, anxiety and global measures of mental health

Name	No. items	Constructs measured	Time to complete	Weblink	Licensing	Additional information
Centre for Epidemiological Studies Depression Scale (CES-D)	20	Major depression	5 mins	https://eprovide.mapi-trust.org/instruments/center-for-epidemiologic-studies-depression-scale	Free of charge and in the public domain.	CES-D has been validated across numerous US and UK community and primary care samples for screening for major depressive disorders, and showing good construct validity and internal reliability (Cronbach's α=0.88) (1,2). At the standard cut-point of ≥16, one study of a US primary care population found a sensitivity and specificity of 0.81 and 0.71, respectively (3). Also advocated by NICE guidance (4). 8-, 10-,11- item versions have also been used in some studies.
Generalised Anxiety Disorder Assessment (GAD-7)	7	Anxiety disorders (generalised anxiety disorder, panic disorder, social phobia and post-traumatic stress disorder).	<3 mins	https://www.phqscreeners.com/	Free of charge. Permission not required to reproduce, translate, display, or distribute the GAD-7.	The GAD-7 is well-recognised and extensively validated internationally An international systematic review which included UK studies found high sensitivity and specificity values of 0.83 (95% CI 0.71-0.91) and 0.84 (95% CI 0.70-0.92) respectively, when using a cut-off of 8. AUC across studies varied from 0.65 to 0.96, with 7 of 11 studies showing an AUC over 0.8, indicating good discrimination between those with and without an anxiety disorder (5). Advocated by NICE to assist with diagnosing caseness and severity of anxiety disorders (4). Brief 2-item version is also available.

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Name	No. items	Constructs measured	Time to complete	Weblink	Licensing	Additional information
General Health Questionnaire (GHQ-12)	12	Non-specific psychiatric morbidity.	<2 mins	https://eprovide.mapi-trust.org/instruments/general-health-questionnaire	The General Health Questionnaire© (GHQ) is protected worldwide by international copyright laws in all languages, with all rights reserved to GL Assessment, UK. For permission to use the GHQ from UK licensee contact permissions@gl-assessment.co.uk. For Licenses based in other countries, contact: https://eprovide.mapi-trust.org.	A cross-sectional UK study found very good internal consistency (Cronbach's α=0.92) and good construct validity, with increasing GHQ scores (indicating greater distress) seen in those who were unemployed, living in rented accommodation rather than owning a home, those with caring responsibilities for adult dependents and those with no friend or relative to confide about personal problems with (6). The GHQ-12 has also been found to show good test-re-test reliability in longitudinal UK samples (7). 28-, 30-, and 60- item versions of the GHQ are also available.
Kessler Psychological Distress Scale (K10)	10	Non-specific psychological distress	<3 mins	https://www.hcp.med.harvard.edu/ncs/k6_scales.php	Free of charge - copyright Ronald C. Kessler, PhD. No formal permission or approval required but could cite source include copyright (Kessler et al (2003). Screening for serious mental illness in the general population. Archives of General Psychiatry, 60(2), 184-189).	Originally developed and validated in the US where it shows good discrimination between those with and without caseness on the Structured Clinical Interview for DSM-IV disorders (AUC=0.88) and excellent internal consistency (Cronbach's α=0.93) (8). K10 and K6 not yet validated in any UK general population studies, but K10 has been extensively validated in cross-cultural settings internationally (9) (10).

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Name	No. items	Constructs measured	Time to complete	Weblink	Licensing	Additional information
Patient Health Questionnaire (PHQ-9)	9	Depressive disorders (corresponding to major depressive disorder, panic disorder, other anxiety disorder, and bulimia nervosa on the DSM-IV)(14).	<3 mins	https://www.phqscreeners.com/	Free of charge. Permission not required to reproduce, translate, display, or distribute the PHQ-9.	Extensively validated for the general population and primary care patients both internationally and in the UK. In a UK sample, at a cut-point of ≥12, the PHQ-9 has a sensitivity and specificity of 92% and 85%, respectively (15). Advocated by NICE to assist with diagnosing caseness and severity of depressive disorders (4). A brief two-item version is also available.