MEAM

MEAM Approach evaluation: year 4 report

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CordisBright

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1 Overview of the MEAM Approach

Cordis Bright would like to thank everyone involved in shaping and delivering this evaluation report. Particular thanks go to:

- Local staff across the MEAM Approach network who have gathered, collated and submitted the common data framework data to the evaluation, and the people who have consented to their data being shared with us.
- Local staff and mental health partners across the MEAM Approach network who have facilitated and participated in this year's research.
- The expert by experience research group for their help in designing research tools, conducting and analysing the qualitative research and for providing critique and challenge to emerging findings and early drafts of this report.
- The people who shared their experiences of access to and support from mental health services with us, which make up the case studies used throughout the thematic report accompanying this report.

1.1 Introduction

This is the year 4 report for the longitudinal evaluation of the MEAM Approach. The evaluation is being delivered by Cordis Bright, an independent research and consultancy organisation. The evaluation takes place over five years between 2017 and 2022 and assesses the impact of the MEAM Approach on people experiencing multiple disadvantage as well as on local systems. Cordis Bright is working in collaboration with an expert by experience research group to deliver the evaluation, which takes a mixed methods approach.

The year 4 evaluation explores the implementation and impact of local work developed using the MEAM Approach in 33[1] MEAM Approach areas, building on the scoping and evaluation work conducted in years 1, 2 and 3 of the evaluation. It also involved focused research on the theme of the involvement of statutory mental health partners in MEAM Approach partnerships.

[1] At the time of reporting there were 31 areas in the national MEAM Approach network. In addition to these 31 areas, the year 4 analysis includes client data from two further areas that previously left the network, but which provided anonymised client data for the period when they were in the network. There are also two areas in the Greater Manchester MEAM Approach network, which do not take part in this evaluation.

This report is accompanied by two other documents: the year 4 technical appendix and the year 4 thematic report on the involvement of statutory mental health partners in MEAM Approach partnerships.[2]

1.2 Summary of the MEAM Approach

The Making Every Adult Matter (MEAM) coalition is formed of the national charities Clinks, Homeless Link, Mind and associate member, Collective Voice.

In 2013, MEAM developed the MEAM Approach, a non-prescriptive framework to help local areas design and deliver better coordinated services for people experiencing multiple disadvantage.[3] As of June 2021, it is currently being used by cross-sector partnerships of statutory and voluntary agencies in 33 local areas[4] across England. More detail about how the network developed over time is included in section 2.7 of the year 1 (scoping) report.

The MEAM Approach includes seven core elements that should be considered by all local areas, but it does not prescribe a particular way in which these elements should be achieved. Most local areas using the MEAM Approach provide specific support for people experiencing multiple disadvantage, often via a team of "coordinators". However, the MEAM Approach also supports local areas to challenge and change local systems and services so that they work more effectively and sustainability for people experiencing multiple disadvantage.

There is no central funding available for local areas using the MEAM Approach, instead the local partnerships must come together to fund and deliver the local work. The "critical friend" support provided by MEAM is free of charge to the current MEAM Approach network members, as it is supported by a grant to MEAM from the National Lottery Community Fund.

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[2] All MEAM Approach evaluation reports are available here.

[3] MEAM (no date). The MEAM Approach: http://meam.org.uk/the-meam-approach/ [Accessed 21 May 2021]

[4] 31 of these areas are in the national MEAM Approach network and take part in this evaluation, while two are in the Greater Manchester MEAM Approach network.

1.3 Defining multiple disadvantage

People experiencing multiple disadvantage experience:

> *"a combination of problems including homelessness, substance misuse, contact with the criminal justice system and mental ill health. They fall through the gaps between services and systems, making it harder for them to address their problems and lead fulfilling lives".*
>
> MEAM[5]

It is estimated that in England 58,000 people face problems of homelessness, substance misuse and offending in any one year. Within this group, a majority will have experienced mental health problems. These figures are based on service-use data and under-represent certain groups, in particular women and racially minoritised people, who experience multiple disadvantage in different ways and may not have contact with services. MEAM is currently undertaking a programme of work around racism and multiple disadvantage internally and with partners across the MEAM Approach network.

1.4 Ultimate goals of the MEAM Approach

The theory of change for the MEAM Approach evaluation was developed collaboratively during the scoping phase of the evaluation, with input from MEAM, Cordis Bright, local areas participating in the MEAM Approach network, experts by experience and the National Lottery Community Fund. It represents a shared understanding of the aims and core elements of the MEAM Approach. The evaluation takes the theory of change as a starting point for exploring whether the MEAM Approach is achieving its goals and intended outcomes.

Figure 1 summarises the ultimate goals and outcomes of the MEAM Approach, as outlined in the theory of change.

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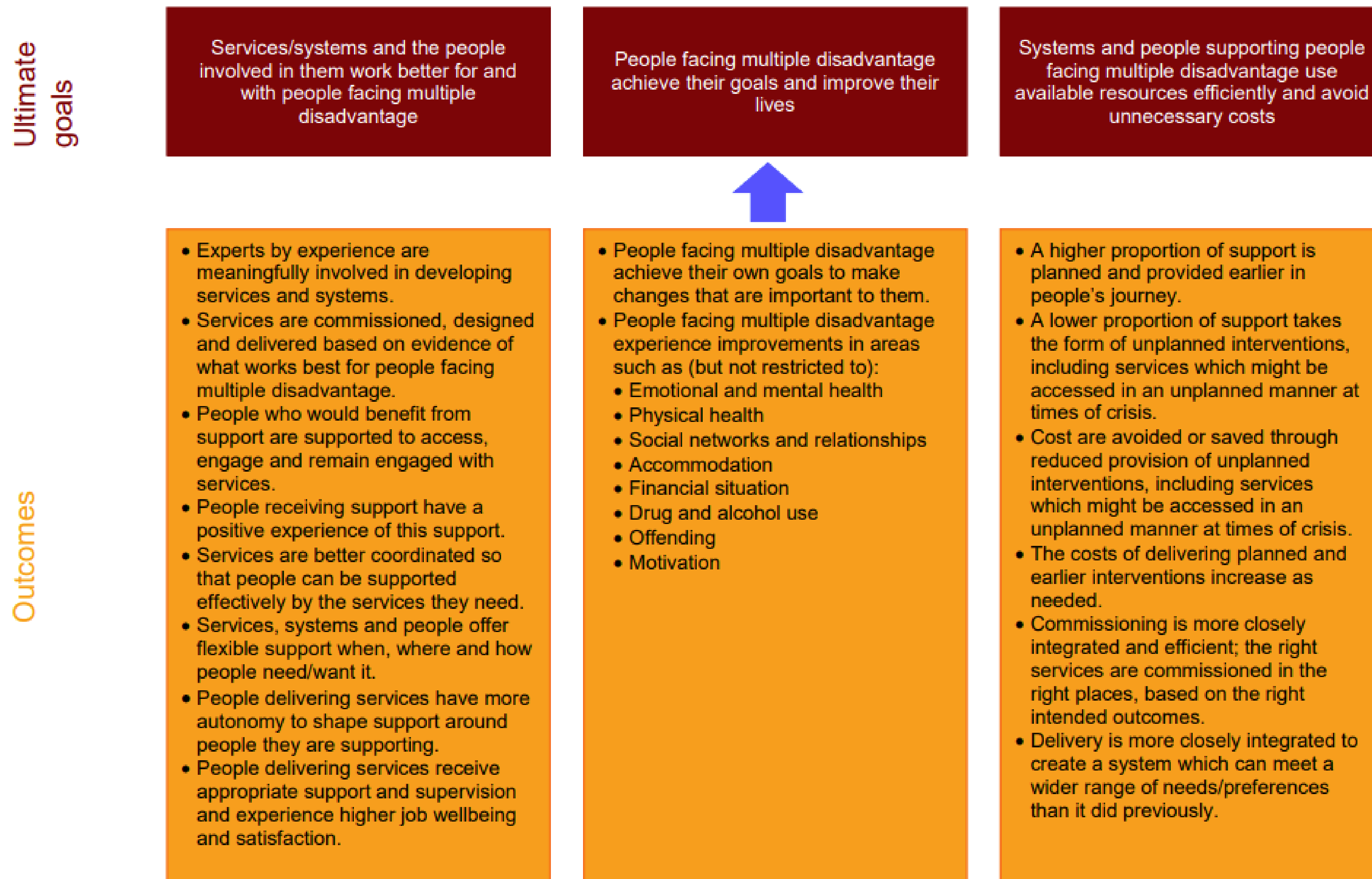
[5] MEAM (no date). About multiple and complex needs: http://meam.org.uk/multiple-needs-and-exclusions/ [Accessed 21 May 2021]

Figure 1: Ultimate goals outlined in the MEAM Approach theory of change



2 Overview of key findings

The key findings in this year's report are presented in three sections which map against the theory of change. The findings are supplemented by detailed thematic research on the involvement of statutory mental health partners in MEAM Approach partnerships, which is provided in the accompanying report.

2.1 Individual wellbeing and support

This year's individual wellbeing and support findings build on last year's findings with a larger dataset enabling analysis of change over time after 12 months of support. Change after a second year of support is also explored in relation to accommodation.

Key finding 1: Progress in improving wellbeing and circumstances. People are making improvements to their wellbeing and circumstances in the first 12 months of support. This is especially the case when their starting point is lower. However, the data also suggests that people may face barriers in making progress towards higher levels of wellbeing. For example, mental health continues to be an outcome area where progress remains limited after 12 months of support.

Key finding 2: Improvements in accommodation. People experience the most substantial improvements in relation to accommodation and tend to make further improvement over the course of their second year of support.

Key finding 3: Access to and support from statutory mental health services. People generally receive better access to and support from statutory mental health services when the services are involved in MEAM Approach partnerships. This improved access and support tends to be via specialist multiple disadvantage or rough sleeper services rather than mainstream mental health services. This year's thematic research on mental health presents a series of enablers that local areas can use to improve the involvement of statutory mental health services and the support provided to individuals.

2.2 Efficient use of resources

This year's analysis of resource use builds on the year 2 and 3 analysis by looking at change over people's first and second years of support.

Key finding 4: Use of unplanned services. There are statistically significant reductions in A&E attendance (a 33% reduction from an average 0.8 attendances to 0.5 attendances per person per quarter) and non-elective acute admissions (a 49% reduction from an average 1.3 days to 0.7 days per person per quarter) over the first year of support. There was a slight increase in mental health admissions and prison attendance and a decrease in arrests, but these findings were not statistically significant.

Key finding 5: Change in service use and accommodation costs. Reductions in A&E attendance and days in hospital for non-elective acute admissions are associated with reductions in cost of £44 and £403 per person per quarter respectively. However, the positive changes in people's accommodation (see key finding 2) are associated with cost increases.

2.3 People, services and systems work for and with people experiencing multiple disadvantage[6]

The three findings in this section explore progress around systems change. In previous years of the evaluation, little exploration of systems change has been possible due to the length of time required for this work to take place.

Key finding 6: Systems change work across the MEAM Approach network. Changing the system is difficult – there are many barriers and changes are often incremental. Our research suggests that local areas are making changes across six key areas of work, with the aim of improving the accessibility and quality of support for people experiencing multiple disadvantage. Harnessing pre-existing knowledge or innovations within the system, creating the space and capacity to think about and catalyse systems change, and having the "right" leadership in place can promote and support systems change.

Key finding 7: Spotlight on specialist services and systems change. Local areas have been developing specialist services, which can play a complex role in relation to systems change. Specialist services can help bring about changes to the wider system by sharing their understanding of the MEAM Approach and how to support people experiencing multiple disadvantage within mainstream services, by challenging existing approaches or barriers, and by supporting organisations to change their practice; but they can also disincentivise the wider system from making changes by removing the immediate drive or perceived need for wider change.

Key finding 8: The role of COVID-19 in systems change. The COVID-19 pandemic has created opportunities for systems change by requiring collaboration (for example, through the 'Everyone In' protocol) necessitating adaptations and flexibilities in how organisations support people experiencing multiple disadvantage, and building a shared cross-sectoral understanding of multiple disadvantage as a public health issue. However, it has also placed stress on agencies and limited their capacity to engage with work beyond the immediate crisis.

[6] This year's key findings have focussed primarily on how people, services and systems are working *for* people experiencing multiple disadvantage rather than how they work *with* people experiencing multiple disadvantage. This is partly because our research methods did not directly explore co-production in local areas, but is likely also a reflection of the fact that levels of co-production vary significantly across the network areas.

3 Evaluation methodology

3.1 Summary of methodology

Figure 2 summarises the year 4 evaluation methodology, which is described in detail in the year 4 technical appendix.

Figure 2: Summary of year 4 evaluation methodology

This report includes anonymised client-level data from year 1 (April 2017 to March 2018) to year 4 (April 2020 to March 2021). However, most local areas only started working with people during year 2 and some areas joined the network in later years.[7] Data was collected using the Common Data Framework (CDF) developed for the MEAM Approach evaluation. More information on the CDF can be found in the year 4 technical appendix.

3.2 Profile of the evaluation cohort

We had received anonymised data on 785 people[8] supported by interventions developed using the MEAM Approach from 25 MEAM Approach network areas by the end of year 4. This represents 40% of the 1,944 people[9] we understand to have been supported by 26 network areas[10] between 1 April 2017 and 31 March 2021.

[7] Three areas did not start working with people until year 4, and a further six areas had not yet started supporting people at the end of year 4.

[8] This figure in fact refers to episodes of support rather than individual people. Within this figure are 28 occasions of people returning for a second or third episodes of support during the evaluation period. Although the unit of analysis in this report is technically episodes of support instead of individual people, for simplicity (given the small number of returning clients) we use the terms “clients” or “people” when discussing the findings.

[9] 28 of these are known to be occasions of people returning for a second or third episode of support – see footnote 9.

[10] One of the 26 areas provided information on the number of people supported to date but was not able to provide client-level data within the year 4 evaluation period. The remaining seven areas included in the evaluation had not yet started supporting people within the reporting period and/or did not yet have a specified cohort of clients.

Note on the profile of the cohort

This section describes the profile of the cohort of people for whom data were shared with evaluators. It therefore does not describe the profile of the whole cohort of people supported by interventions developed using the MEAM Approach; there are people whose data were not shared with evaluators, for example, because they had not given their explicit consent for data sharing. We do not assume that the profile of the people in the evaluation cohort is similar to that of the whole cohort supported by interventions.

Neither does this profile describe the cohort of people included in the HOS, NDTA, service use and accommodation analyses. People were excluded from those analyses if they did not meet eligibility criteria or if data were missing.

The evaluation cohort is described in greater detail in the year 4 technical appendix. In summary:

- The age of people for whom ages were provided ranged from 18 to 72, with a mean age of 41 years.
- Women make up one third of the cohort, and men two thirds. Three people identified as transgender.
- 96% of people described their sexual orientation as heterosexual.
- 96% of people had UK nationality.
- 89% of people identified their ethnicity as White English/Welsh/Scottish/ Northern Irish/British.
- 11% of the people identified with other ethnicities: Caribbean (2%), White and Black Caribbean (2%), any other White background (2%), Pakistani (1%), African (1%), any other Black/African/Caribbean background (1%), White and Black African (1%), any other mixed/multiple ethnic background (1%), Irish (1%), Bangladeshi (<1%), Indian (<1%), any other Asian background (<1%), Gypsy or Irish Traveller (<1%), and any other ethnic group (<1%).
- At the end of year 4, the average length of support was 15 months.[11]

[11] This includes people whose support was ongoing at the end of year 4.

3.3 Further information

More information on the MEAM Approach, the network, and the evaluation methodology and findings can be found in the previous evaluation reports, including:

- The live evaluation framework, produced in March 2018.
- The year 1 (scoping) report, produced in March 2018.
- The year 2 mid-year report, produced in October 2018.
- The year 2 final report and methodology annex, produced in July 2019.
- The year 3 mid-year report, produced in January 2020.
- The year 3 technical appendix and partnerships thematic report, produced in August 2020.
- The year 4 mid-year report, produced in December 2020.

These are available here: http://meam.org.uk/the-meam-approach/meam-approach-evaluation/

4 Individual wellbeing and support

4.1 Key finding 1: Progress in improving wellbeing and circumstances

People are making improvements to their wellbeing and circumstances in the first 12 months of support. This is especially the case when their starting point is lower. However, the data also suggests that people may face barriers in making progress towards higher levels of wellbeing. For example, mental health continues to be an outcome area where progress remains limited after 12 months of support.

Data collected from people supported across the MEAM Approach network show that people are making good progress across a range of outcome areas. This is based on the Homelessness Outcomes Star (HOS), New Directions Team Assessment (NDTA) and accommodation data, full analyses for which are available in the year 4 technical appendix.[12]

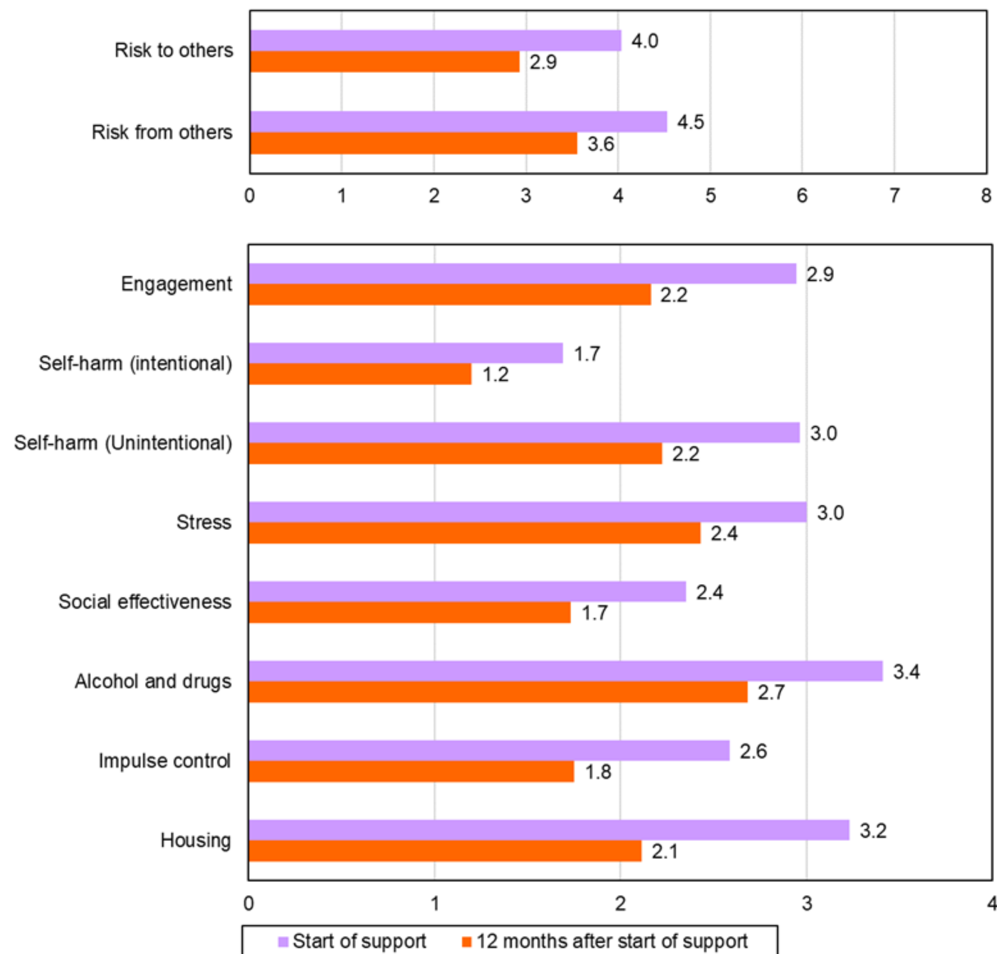
The HOS is a tool for supporting and measuring change across ten areas in a person's life. The tool measures progress across the "Journey of Change" from a position of being "stuck", where people are not able to face the problem or accept help, through to "accepting help", "believing", "learning", and up to "self-reliance", where they can manage the issue without help. By 12 months after the start of support, 89% of people had made progress along the Journey of Change in at least one of the outcome areas, and 66% had made progress in four or more of the areas (n=150). Fewer people experienced negative change, and among those who did experience negative change this tended to be in fewer outcome areas: 47% of people experienced negative change in at least one outcome area, but only 11% experienced negative change in four or more outcome areas.

This is supported by data from the NDTA, a scoring framework against ten areas in a person's life where higher scores indicate a higher level of need. There was a statistically significant improvement in scores in all NDTA outcome areas as well as in the overall NDTA score (Figure 3, n=162).

As discussed in the year 3 report, the MEAM Approach is likely contributing to these improvements through four key elements: presence of a multiple disadvantage coordinator, better coordination between services, flexibility of existing services and systems, and support provided earlier or at key moments in people's journeys.

[12] See year 4 technical appendix also for more information on the approach to analysis.

Figure 3: Mean NDTA scores for start of support and 12 months (n=162)[13] (reductions in scores can be taken as indication of positive progress)



The most widespread and the largest positive changes measured by the HOS relate to people's housing and managing tenancies. This is explored in more detail in key finding 2. Figure 5 shows that the other outcome areas where positive change is most common are motivation (58%) and managing money (56%); progress is least widespread in relation to drug and alcohol use (44%), physical health (44%) and emotional/mental health (48%) (n=149 to 150).

However, while people tend to progress well along the early stages of the Journey of Change, few people are reaching the later stages of "learning" and "self-reliance". This trend is particularly apparent in relation to people's emotional and mental health, for which only 12% of people are "learning" and "self-reliant" after 12 months of support (the smallest proportion compared with other outcome areas, including areas where larger proportions

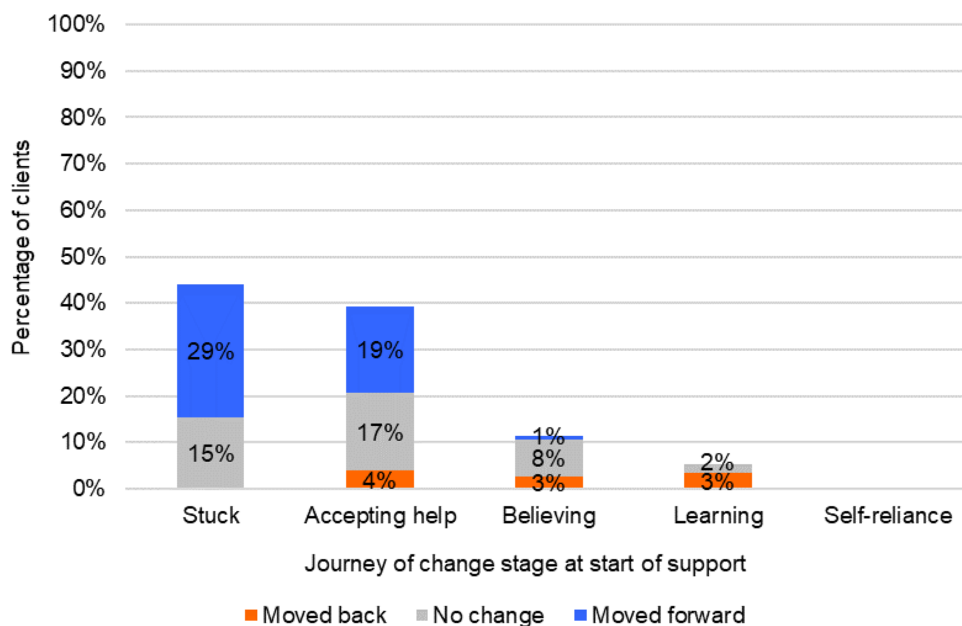
[13] All changes were statistically significant to the 95% confidence level using a paired t-test, meaning that there is a 95% chance that the change is **not** due to chance.

started out as "stuck"). Figure 4 shows that, of the 11%[14] of people who were at the "believing" stage on this indicator at start of support, only 1% had made progress 12 months later; and of the 5% who were already "learning" at start of support, no-one made positive progress and more people moved backwards than made no change. In contrast, substantial proportions of people made progress out of the early stages. Of the 44% who were "stuck" on this indicator at the start of support, 29% had made progress 12 months later; and of the 39% who were "accepting help" at start of support, 19% made progress.

This may indicate that receiving support is beneficial for emotional wellbeing, but that people face particularly high barriers to making further progress in this outcome domain at the higher levels. Factors are likely to include needing more time, the inter-dependency of emotional and mental wellbeing on other areas of people's lives, and the barriers to accessing effective mental health support faced by people experiencing multiple disadvantage.

> See section 2 in the year 4 thematic report for a more detailed discussion of the challenges in accessing effective mental health support.

Figure 4 Proportion of people moving forwards or backwards from Journey of Change stages for emotional and mental health between start support and 12 months (n=150)



[14] 11% of people were "believing" at start of support. Percentages in Figure 4 add to 12% due to rounding error.

Figure 5: Proportion of people moving between Homelessness Outcomes Star Journey of Change stages between start of support and 12 months, and the average (mean) number of stages of change (n=150, except for 'Drug and alcohol misuse", for which n=149)

Area	Positive change		Stayed the same	Negative change	
	% of people	Average no. stages of positive change	% of people	% of people	Average no. stages of negative change
Motivation	58%	+1.5	29%	13%	-1.5
Self-care	51%	+1.6	35%	14%	-1.7
Managing money	56%	+1.6	28%	16%	-1.3
Social networks	54%	+1.5	37%	9%	-1.7
Drug and alcohol misuse	44%	+1.7	42%	13%	-1.4
Physical health	44%	+1.5	43%	13%	-1.6
Emotional/mental health	48%	+1.5	42%	10%	-1.3
Meaningful use of time	55%	+1.5	33%	13%	-1.4
Managing tenancy/accommodation	59%	+1.8	31%	9%	-1.6
Offending	45%	+1.8	41%	14%	-1.6

4.2 Key finding 2: Improvements in accommodation

People experience the most substantial improvements in relation to accommodation and tend to make further improvement over the course of their second year of support.

This year's findings build on those from year 2 and 3 to give strong evidence of significant improvements relating to people's accommodation and tenancy. Importantly, the positive changes identified between first and fourth quarters of support tend to be even greater by the end of the eighth quarter of support. This is particularly encouraging as sustainable and appropriate accommodation is often a key contributor to improvements in other outcomes. Qualitative research from years 2 and 3 of the evaluation suggests that the MEAM Approach is likely to be a key contributing factor to the improvement in people's accommodation situation.[15] In year 4 this has likely been enhanced by the 'Everyone In' policy, through which 33,139 people who were rough sleeping, at risk of rough sleeping or in temporary accommodation that was not compatible with self-isolation requirements had been brought into accommodation by end of November 2020.[16]

The HOS data suggests that **tenancy and accommodation is the area of their lives where most people are seeing improvements** (59% of people experienced positive change, Figure 5, n=150). **It is also where people are seeing the largest positive changes**; tenancy and accommodation has the largest average positive change amongst the HOS outcome areas of 1.8 "Journey of Change" stages, and housing has the largest average decrease in score (meaning positive progress) of 1.1 on the NDTA scale (Figure 3, n=162). It is also the HOS outcome area where the fewest people are experiencing negative change (9%).

These improvements are also reflected in the data on people's use of different types of accommodation. **A reduction in rough sleeping was a key area of improvement.** Figure 6 shows that there was a statistically significant reduction in the proportion of people sleeping rough at the end of their fourth quarter of support (9%) in comparison with the start of support (49%, n=226).[17]

Encouragingly, the data shows not only that people are moving off the streets, but that they are moving towards more stable forms of accommodation. Figure 6 shows that there was a statistically significant 19% net increase in people in supported accommodation under licence between the

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[15] See, for example, key finding 1 in the year 3 main report, available here.

[16] National Audit Office (2021). Investigation into the housing of rough sleepers during the COVID-19 pandemic.

[17] We can also consider this data in terms of mean number of nights spent in each type of accommodation per quarter. In this case, there was a statistically significant 58% reduction in mean number of nights spent rough sleeping between first and fourth quarters of support, from a mean of 24.0 nights in the first quarter to 10.1 nights in the fourth quarter.

start of support and the end of their fourth quarter of support, from 8% up to 27% of the cohort (n=226). There was also a statistically significant increase in those in long-term supported accommodation (from 3% to 8%) and an increase in those in their own or shared accommodation (from 14% to 26%). There were no statistically significant changes in relation to other less stable forms of accommodation such as night shelters, private hostels and B&Bs, emergency beds and staying with family and friends.

People tend to make further improvements in accommodation over their second year of support. The findings from the smaller cohort of people with data at the start, end of fourth and end of eighth quarter of support show that the proportion of people in their own or shared accommodation rose from 11% to 23% between the first and fourth quarter, and then rose further to 28% at the end of the eighth quarter of support (n=115).[18] Similarly, the proportion of people rough sleeping fell from 51% at start of support, to 13% at end of fourth quarter and to 10% at end of eighth quarter. The picture in relation to temporary accommodation is less linear with the proportion of people in supported accommodation under license increasing between start (8%) and end of fourth quarter (37%) and decreasing by the end of the eighth quarter (30%), as people likely move on to more stable forms of accommodation. The proportion of people in emergency or assessment beds consistently decreased from 10% to 6% to 1%.

[18] See the year 4 technical appendix for further detail on this sub-group analysis.

*Figure 6: Accommodation at start of support and end of fourth quarter (n=226) (statistically significant changes[19] in **bold**)[20]*

Accommodation grouping[21]	Proportion of people in accommodation type…			Accommodation type	Proportion of people in accommodation type…		
	At start of support	At end of fourth quarter	Percent difference		At start of support	At end of fourth quarter	Percent difference
Rough sleeping	**49%**	**9%**	**-40%**				
Family and friends	5%	8%	+2%				
In accommodation (temporary or license i.e. no tenancy agreement)	**22%**	**39%**	**+18%**	Night shelter	0%	1%	+1%
				B&B/private hostel	6%	7%	0%
				Emergency or assessment bed within a service	8%	5%	-3%
				Supported accommodation (licence)	**8%**	**27%**	**+19%**

[19] Significant to the 95% confidence level based on McNemar chi-square test.

[20] i) Percentages are rounded to 0 d.p. – this creates some rounding errors in the change column. ii) See section 1.5.2 in the technical appendix for more detail about the approach to analysis.

[21] These groupings have been agreed with CFE Research to ensure that future analyses of accommodation use within the national MEAM Approach and national Fulfilling Lives evaluation are comparable.

Accommodation grouping[21]	Proportion of people in accommodation type…			Accommodation type	Proportion of people in accommodation type…		
	At start of support	At end of fourth quarter	Percent difference		At start of support	At end of fourth quarter	Percent difference
In accommodation (long-term supported, with tenancy agreement)	**3%**	**8%**	**+5%**				
In accommodation (own or shared tenancy, with or without floating support)	**14%**	**26%**	**+12%**	**Own tenancy (social housing)**	**8%**	**16%**	**+8%**
				Own tenancy (private rented)	**5%**	**9%**	**+4%**
				Own tenancy (owner occupier)	0%	0%	0%
				Shared tenancy	0%	0%	0%
Prison	7%	6%	-1%				
Other	0%	2%	+2%				
Not given	0%	2%	+2%				

4.3 Key finding 3: Access to and support from statutory mental health services

People generally receive better access to and support from statutory mental health services when the services are involved in MEAM Approach partnerships. This improved access and support tends to be via specialist multiple disadvantage or rough sleeper services rather than mainstream mental health services. This year's thematic research on mental health presents a series of enablers that local areas can use to improve the involvement of statutory mental health services and the support provided to individuals.

4.3.1 Improving access and support

For people experiencing multiple disadvantage, the stabilisation of their mental health can help them to start addressing other areas of their lives:

> *"If you address mental health issues, other things can be addressed as you walk along. This brings people "inside" and improves their prognosis."*
>
> Mental health partner

However, people experiencing multiple disadvantage face many challenges in accessing and receiving support from statutory mental health services.

In areas where statutory mental health partners are involved with their local MEAM Approach partnerships, people tend to receive better access to and support from statutory mental health services; stakeholders described how the involvement of statutory mental health services in their local MEAM Approach partnerships had helped to bring about quicker and better access to mental health services, more flexible and person-centred support from these services, and more coordinated support. This is a similar pattern to improvements identified in previous years of the evaluation when other types of services become more involved in the MEAM Approach partnerships.

See section 2 in the year 4 thematic report for a more detailed discussion on the challenges to access and support, and section 3 for how statutory mental health involvement in local MEAM Approach work can help to address this.

4.3.2 Effective access and support tends to be via specialist rather than mainstream services

In most cases, the improved access and support described above is provided via specialist mental health services or workers for people experiencing multiple disadvantage or sleeping rough, rather than mainstream mental health services.[22]

[22] By "mainstream" mental health services we mean generalist services that work with people with a variety of mental health conditions and/or people with a variety of support needs, rather than services whose focus is on providing care and treatment for mental health problems for people who are sleeping rough and/or experiencing multiple disadvantage.

Specialist mental health services can act as a gateway into mainstream mental health services, such as in case study 1 below, where specialist mental health service workers advocate for their clients and liaise with other mental health colleagues to secure access to mainstream mental health services.

However, strong pathways from specialist mental health services into mainstream mental health services do not appear to be very prevalent across the MEAM Approach network; people often continue to be excluded from local mainstream mental health services despite the existence of local specialist services. See key finding 7 for more discussion on the complex role of specialist services in bringing about systems change.

Case study 1: Improved access to mainstream mental health services in local area L

Local area L has a full-time specialist Homeless Mental Health Team, made up of two social workers, a clinical psychologist and a Community Psychiatric Nurse (CPN). The team's role is described as assessing and navigating the mental health system with people experiencing homelessness (although they can also deliver therapeutic interventions to this cohort).

Local partners described how this specialist team enables quicker access to mental health support for homeless people, but not only in terms of their specialist service – it also enables the people they support to gain quicker access to mainstream mental health services, as the local lead describes**:**

"It leads to better access to universal [mainstream] services as well – if we go through the normal access route, we're getting nowhere. But the clinical lead in one team communicates with another, and can get an in. Previously, they were batting it off."

Local area lead

4.3.3 Enabling statutory mental health partners to become more involved in MEAM Approach partnerships

This year's thematic report presents a series of enablers that local areas can use to encourage and improve the involvement of statutory mental health services in their local MEAM Approach partnerships, and thereby improve the access to and support from statutory mental health services for local people experiencing multiple disadvantage.

At an operational level, this includes factors such as additional funding for specialist mental health services, adequate time and resource within mainstream mental health services, and building on the effective partnership working that has developed in response to COVID-19. At a strategic level, factors include gaining strategic buy-in from statutory mental health and related agencies (perhaps by focussing on shared strategic priorities), a commitment from leaders to "think differently" and being tenacious in efforts to work with statutory mental health partners.

See section 5 in the year 4 thematic report for a more detailed discussion on the enablers to statutory mental health involvement in MEAM Approach partnerships.

5 Efficient use of resources

5.1 Key finding 4: Use of unplanned services

There are statistically significant reductions in A&E attendance (a 33% reduction from an average 0.8 attendances to 0.5 attendances per person per quarter) and non-elective acute admissions (a 49% reduction from an average 1.3 days to 0.7 days per person per quarter) over the first year of support. There was a slight increase in mental health admissions and prison attendance and a decrease in arrests, but these findings were not statistically significant

This year we analysed data from two cohorts of people: those with data from their first and fourth quarter (i.e. after one year) of support, and those with data at the start, in their fourth quarter and in their eight quarter of support (i.e. after two years). This allowed a longitudinal look at a smaller group of people, while maintaining a relatively large sample group for the main analysis.

The data show a **statistically significant reduction in A&E attendances** between first and fourth quarters, with mean A&E attendances **falling by 33% from 0.8 attendances per person in the first quarter to 0.5 attendances in the fourth quarter** (n=312, Figure 7). The year 3 research identified a similar reduction.[23]

The data also show a **statistically significant reduction in days spent in hospital for non-elective acute admissions** between first and fourth quarters, with mean days in hospital falling by 49% from 1.3 days per person in the first quarter to 0.7 days in the fourth quarter. This differs to the year 3 research, which found no statistically significant change in non-elective acute admissions.

There was a slight increase in mental health admissions and prison attendance and a decrease in arrests, but these findings were not statistically significant. We will return to this analysis in next year's report, when a larger dataset will hopefully enable more statistically significant findings.[24]

While people's improvements in relation to accommodation appear to be enhanced with a longer period of support, the data do not provide evidence for a similar pattern in relation to interactions with emergency healthcare and criminal justice. No statistically significant changes were identified when examining the first, fourth and eighth quarters of support for non-elective acute admissions,

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[23] The year 3 analysis took a slightly different approach to analysis, comparing service use levels at start of support to service use levels at end of support/most recent quarter of support, and therefore is not directly comparable.

[24] This differs to the year 3 analysis, which also found a statistically significant decrease in the number of arrests.

mental health admissions, arrests or nights in prison. The dataset for those with the longer support period does show a statistically significant reduction in A&E attendances between first and fourth quarter (a 53% reduction from 1.0 to 0.5 attendances per person per quarter). However, mean A&E attendance was a little higher again at the eighth quarter, at 0.6 attendances, meaning that there was no statistically significant difference between A&E attendances at the start of support and at the eighth quarter of support (n=145).[25]

However, this does not necessarily mean there is no link between a longer period of support and reduced A&E attendances (or between a longer period of support and changes in other types of service use). The sample for this period of analysis is relatively small and levels of service use are highly variable amongst the CDF cohort – this reduces statistical power, meaning that any changes are less likely to be statistically significant. It is also likely that one or both of the samples are not representative of the wider CDF cohort, and therefore the people in each sample may have quite different needs and experiences. We will also return to this longer period of analysis in next year's report.

[25] See the year 4 technical appendix for full detail on the three time point analysis.

*Figure 7: Use of services in first quarter and fourth quarter of support (statistically significant changes[26] in **bold**) (n=312 to 332)[27]*

Type of service use	Direction of change	Sample size	Valid sample as % of eligible people	Mean no. interactions per person per quarter				% of people with at least one interaction		
				First quarter	Fourth quarter	Change	% Change[28]	First quarter	Fourth quarter	Percent difference
A&E	↓	**312**	**68%**	**0.8**	**0.5**	**-0.3**	**-33%**	25%	23%	-2%
Non elective acute admissions	↓	**318**	**69%**	**1.3**	**0.7**	**-0.6**	**-49%**	13%	10%	-3%
Mental health admissions	↑	332	72%	1.0	1.1	0.1	+6%	5%	5%	-1%
Arrests	↓	331	72%	0.6	0.5	-0.1	-19%	29%	25%	-4%
Nights in prison	↑	332	72%	7.1	7.2	0.1	+1%	19%	18%	-1%

[26] Significant to the 95% confidence level using the paired t-test for mean no. interactions and McNemar chi-square test for % people with at least one interaction.

[27] i) Means are rounded to 1 d.p. – this creates some rounding errors in the change and % change column. ii) See section 1.5.2 in the technical appendix for more detail about the approach to analysis.

[28] The percentage change in mean number of interactions per person per quarter should be interpreted with caution because of the very low level of mean interactions during first quarter of support – the relatively high percentage changes relate to small changes in mean service use in real terms.

5.2 Key finding 5: Change in service use and accommodation costs

Reductions in A&E attendance and days in hospital for non-elective acute admissions are associated with reductions in cost of £44 and £403 per person per quarter respectively. However, the positive changes in people's accommodation (see key finding 2) are associated with cost increases.

The statistically significant reductions in A&E attendances between people's first and fourth quarters of support discussed in key finding 4 led to **a reduction in estimated costs of £44 per person per quarter**. The statistically significant reduction in non-elective acute admission hospital days between first and fourth quarters of support led to a larger **reduction in estimated costs of £403 per person per quarter** (Figure 8).

If we take people's first quarter of service use to be representative of their service use in the year preceding support, and assume that people maintain their fourth quarter of service use for a year after it, this would result in **an estimated annual cost reduction of £178 for A&E** and **£1,611 for non-elective acute admissions** per person.[29]

Stronger data are needed to comment on the economic impact of other changes in service use; there was a slight increase in mental health admissions and prison attendance and a decrease in arrests, but these findings were not statistically significant. We will return to this in next year's report.

As shown in Figure 9, the improvements in people's accommodation situations set out in key finding 2 are associated with cost increases, as people move from sleeping rough to more settled and stable accommodation.

[29] We compared service use data from the first quarter of support to data from the 12 months prior to support for the sample of people who have both data available. This analysis found non-elective admissions to be statistically significantly higher during the first quarter of support than the 12 months prior to support (pro rata'd) (n=234). As such, the first quarter of support figure is likely to be an over-estimate for the year preceding start of support, meaning that the actual reduction in admissions costs may be smaller than this estimate. There was no statistically significant difference for the A&E attendance data. See year 4 technical appendix for more detail.

*Figure 8: Mean service use costs per person from first quarter to fourth quarter of support[30] (statistically significant changes in level of service use[31] in **bold**) (n=312-332)*

Type of service use	Sample size	Valid sample as % of eligible people	Mean cost per person per quarter		
			First quarter	Fourth quarter	Change
A&E	**312**	**68%**	**£133**	**£88**	**-£44**
Non elective acute admissions	**318**	**69%**	**£829**	**£427**	**-£403**
Mental health admissions	332	72%	£430	£457	+£27
Arrests	331	72%	£426	£344	-£82
Prison	332	72%	£762	£771	+£9

[30] i) See the technical appendix for a breakdown of the economic tariffs used to calculate average cost per instance of service use and for more detail about the approach to analysis. ii) Mean costs are rounded to whole numbers, which introduces some rounding errors when comparing between first and fourth quarters.

[31] Significant to the 95% confidence level based on paired t-test, meaning that there is a 95% chance that the change is **not** due to chance. Significance tests are applied to the change in level of service use, not the estimated costs of those changes.

*Figure 9: Mean accommodation costs per person in first and fourth quarters of support [32] (n=226) (statistically significant changes in use of accommodation type[33] in **bold**)*

Accommodation grouping[34]	Accommodation type	Mean cost per person per quarter		
		First quarter	Fourth quarter	Change
Rough sleeping	Rough sleeping	£0	£0	£0
Family and friends	Living with family/friends	£0	£0	£0
In accommodation (temporary or license i.e. no tenancy agreement)	Night shelter[35]	**£1,272**	**£1,530**	**+£258**
	B&B/private hostel			
	Emergency or assessment bed within a service			
	Supported accommodation (licence)			
In accommodation (long-term supported, with tenancy agreement)	Supported accommodation (tenancy)	**£99**	**£308**	**+£210**
In accommodation (own or shared tenancy, with or without floating support)	Own tenancy (social housing)	**£207**	**£292**	**+£85**
	Own tenancy (private rented)			
	Own tenancy (owner occupier)			
	Shared tenancy			

[32] i) See the technical appendix for a breakdown of the economic tariffs used to calculate average cost per instance of accommodation type and for more detail about the approach to analysis. ii) The costs associated with nights in prison are reported in Figure 8.

[33] i) Significant to the 95% confidence level based on paired t-test. ii) Significance tests are applied to the change in use of accommodation type, not the estimated costs of those changes.

[34] These groupings have been agreed with CFE Research to ensure that future analyses of accommodation use within the national MEAM Approach and national Fulfilling Lives evaluation are comparable.

[35] We considered introducing a separate tariff for night shelter accommodation because we understand provision of night shelter accommodation to cost much less than the accommodation grouping tariff of £310 per week. However, there is relatively low use of night shelters among the evaluation cohort, and changes in use over time are not statistically significant. We therefore have applied a broad tariff across the whole accommodation grouping so as to maximise comparability with the national Fulfilling Lives evaluation.

6 People, services and systems work for and with people experiencing multiple disadvantage

6.1 Understanding systems change

A "system" refers to how different agents (such as people, services, organisations) interconnect and influence each other.[36] In the context of this evaluation, the "system" therefore refers to the way in which commissioning processes, services and the pathways between them are designed and operate, and the ways in which organisations and the people in them relate, work and think. In this report we follow the definition of systems change set out by The National Lottery Community Fund and the Fulfilling Lives programme:

> *"Changes to the people, organisations, policies, processes, cultures, beliefs and environment that make up the system. They ARE beneficial, sustainable in the long-term, transformational. They are NOT tokenistic, doing the same thing under a different name, overly reliant on key individuals."*
>
> The Fulfilling Lives programme[37]

Under this definition, flexing the system (making a one-off exception, for example) is not a system change in its own right, but it may be a good step towards longer-term systemic change.

However, there is an inherent tension in conceptualising systems change as an outcome and something that is "embedded" or "sustainable", in a constantly changing system.[38] It is perhaps more useful to think of systems change as a trajectory or continuum of work:

> *"Systems change being embedded and sustainable implies we've achieved this perfection. But the point of systems - they're constantly evolving. What we've changed now is hopefully right for now - but also needs to be dynamic so we can un-embed some things and change again. By definition it's got to constantly be evolving."*
>
> Local area lead

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[36] Egan M, McGill E, Penney T, Anderson de Cuevas R, Er V, Orton L, Lock K, Popay J, Savona N, Cummins S, Rutter H, Whitehead M, De Vocht F, White M, Smith R, Andreeva M, Meier P, Marks D, Petticrew M (2019). SPHR Guidance on Systems Approaches to Local Public Health Evaluation. Part 1: Introducing systems thinking. London: National Institute for Health Research School for Public Health Research.

[37] CFE Research (2018). *Promising practice: Key findings from local evaluations to date*, Fulfilling Lives: Supporting people with multiple needs.

[38] For more discussion on this topic: Egan et al. (2019). SPHR Guidance on Systems Approaches to Local Public Health Evaluation. Part 1: Introducing systems thinking. London: National Institute for Health Research School for Public Health Research.

6.2 Key finding 6: Systems change work across the MEAM Approach network

Changing the system is difficult – there are many barriers and changes are often incremental. Local areas are making changes across six key areas of work, with the aim of improving the accessibility and quality of support for people experiencing multiple disadvantage. Harnessing pre-existing knowledge or innovations within the system, creating the space and capacity to think about and catalyse systems change, and having the "right" leadership in place change are key to enabling and supporting systems change.

There is evidence of local areas across the MEAM Approach network making changes to how things work locally, with the aim of improving the accessibility and quality of support for people experiencing multiple disadvantage. However, embedding these changes and ensuring they are sustainable long-term is difficult, often taking place incrementally and over a long period of time. As such, systems change remains an ongoing challenge and an area for development for many local areas.

Our research identified six key types of systems change work taking place across the MEAM Approach network: leadership; approaches to coordinating support; infrastructure, pathways and processes; strategy and commissioning; co-production; and culture. Figure 10 presents examples gathered during this year's research. It includes integrated and embedded changes that have had a major impact on how the local system operates, but also examples of areas of focus for local areas where work is ongoing. There may be other similar examples of work taking place across the network, or indeed examples of other categories of systems change work being undertaken. However, these are the main examples highlighted by stakeholders during consultation as part of the evaluation.

Systems change work can have two types of impact. Some changes will themselves have a direct positive impact on people experiencing multiple disadvantage. Other changes to the system can play an enabling role, facilitating further changes that in turn may have a direct positive impact on people experiencing multiple disadvantage. Most of the changes listed here fall into the latter category.

Our research identified three broad categories of factors that enable systems change:

- Activities and approaches that harness pre-existing knowledge or innovations within the system to bring about systems change.
- Factors that create the space and capacity to think about and catalyse systems change.
- Having the "right" leadership in place.

Figure 10: Key areas of systems change work creating direct positive impact for people experiencing multiple disadvantage and/or enabling further changes to the system that may have direct positive impact for people experiencing multiple disadvantage

Area of system change work	Example	Type of impact	
		Direct positive impact	Enables further changes
Leadership	**Strategic buy-in and leadership** in MEAM Approach partnerships from partners like **Adult Social Care**		✓
	Long-term, funded roles at a strategic level whose remit is focused on multiple disadvantage and embedding MEAM Approach work (see case study 2)		✓
	Development of **strong strategic and operational partnerships** that focus on systems change (see case study 2)		✓
Approaches to coordinating support	**Multiple disadvantage coordinator model,** where the coordinator works with people on the MEAM Approach caseload and provides coordination with other services involved in their support. The coordinator may be affiliated with specific services or organisations but works independently of them. Their key role is support and coordination, rather than provision of specialist care.	✓	
	Long-term, funded coordinator-type roles, focussed on embedding the MEAM Approach, encouraging systems thinking and feeding information about barriers to strategic groups (see case study 2)	✓	✓
	Team Around the Person (TAP) model, bringing professionals from different disciplines and services together to plan how best to support a person	✓	✓
Infra-structure, pathways and processes	**Introduction of new specialist services (for people experiencing multiple disadvantage or who are rough sleeping)** across a range of sectors, including primary care and mental health (see key finding 7)	✓	✓

Area of system change work	Example	Type of impact	
		Direct positive impact	Enables further changes
Infra-structure, pathways and processes (continued)	**Specialist mental health teams/workers acting as a bridge** between mental health services and MEAM Approach partnerships	✓	✓
	Co-location of services supporting people facing multiple disadvantage		✓
	Development of **rapid prescription processes** for people experiencing multiple disadvantage	✓	✓
	Housing First embedded in local areas	✓	✓
Strategy and commission-ing	Services bringing contracts together to **co-commission** under one contract		✓
	Building multiple disadvantage into strategies and plans, to give strategic longevity that goes beyond individuals. This might involve focusing on specific groups experiencing multiple disadvantage who are a strategic priority for other services or sectors as a way of gaining strategic traction.		✓
Co-production	A **partnership to change how co-production happens**, focused on bringing people with lived experience into the workforce.	✓	✓
	Involving people with lived experience in decision making, redesigning services and developing strategies across the network	✓	✓
Culture	**Operational workers being enabled to work more flexibly** across the network	✓	✓
	Trauma-informed and strengths-based approaches to care embedded in services, for example with support from a **specialist mental health worker**	✓	✓
	Multiple disadvantage viewed as a public health issue, with a raised profile across different sectors		✓

Local leadership, partner engagement and partnership structures (operational and strategic groups) act as important foundations for systems change activity. For example, having a group of committed people with a common understanding of systems change who can drive change forward from different sectors increases the likelihood of bringing about change by having cross-sectoral leadership and responsibility for change held by several people rather than one key individual.[39] Systems change is likely to be more far-reaching when these leaders are ambitious, influential and are willing to “think differently”. However, it is also important that all levels of the system are well-connected so that there is scope for both bottom-up and top-down approaches to systems change. In addition, collating and making good use of data on individual outcomes and service use can enable local partners to put forward an evidence-based case for change.

Local area case study 2: Funded roles that catalyse systems change in local area W

Local area W has two funded roles that look specifically at multiple disadvantage, the MEAM Approach and partnerships and connections between agencies. One role is at a strategic level with a specific multiple disadvantage remit, while the second role is a coordinator-type role with a focus on embedding MEAM Approach work across local services and encouraging operational workers to “think systemically” about the barriers they face in supporting people experiencing multiple disadvantage. As a result of these funded roles there have been some positive changes to the local system, including co-location of services supporting people experiencing multiple disadvantage and a local system that is more aware of the cohort of people experiencing multiple disadvantage and the barriers they face in receiving support.

[39] An influential leader (or leaders) can also help create a culture of healthy challenge and criticism, which is important for enabling local stakeholders to address biases inherent in the system more widely and challenge each other’s approaches or ways of working. See the year 3 thematic report on MEAM Approach partnerships for discussion on key features of effective MEAM Approach partnerships.

6.3 Key finding 7: Spotlight on specialist services and systems change

Local areas have been developing specialist services, which can play a complex role in relation to systems change. Specialist services can help bring about changes to the wider system by sharing their understanding of the MEAM Approach and how to support people experiencing multiple disadvantage within mainstream services, by challenging existing approaches or barriers, and by supporting organisations to change their practice; but they can also disincentivise the wider system from making changes by removing the immediate drive or perceived need for wider change.

6.3.1 Local areas are developing specialist services

The development of specialist services for people experiencing multiple disadvantage is one of the key areas of systems change work across the network, as set out in Figure 10 above. These specialist services are from a range of different sectors. Several examples of these services are presented below in Figure 11.

Figure 11: Examples of specialist services from across the network

Local area	Specialist service
Local area J	A specialist GP practice for people who are street homeless.
Local area A	An “Abstinence House” accommodation service developed for people to stay in post-detox with support to enable their recovery, without being surrounded by potential negative influences in other accommodations such as hostels.
Local area U	A shared accommodation for people on the MEAM caseload, developed collaboratively with mental health, homeless and local authority housing services.
Local area L	A Rough Sleeper Hub, described as a “one stop shop” and co-locating several services that support this cohort.
Local areas L and N	A specialist mental health team that supports homeless people to navigate the mental health system, as well as delivering interventions and trauma management.

6.3.2 Specialist services as enablers of systems change

Specialist services such as those described in Figure 11 can represent positive changes in a number of ways. Firstly, they can **increase access to support and provide more relevant or flexible support** for people experiencing multiple disadvantage, as in case study 3. This is a direct positive impact - stakeholders that were involved with these specialist services described the positive impact that the services have in improving outcomes for people experiencing multiple disadvantage. As described in key finding 6, culture change for mainstream services is often incremental and takes time, and as such many stakeholders see specialist services as necessary for supporting people experiencing multiple disadvantage in a timely manner.[40]

As well as improving outcomes for people in the immediate term, specialist services can also **catalyse or enable change for the wider system**. Specialist services are often well-connected with mainstream services in their sector and other parts of the system. They can help bring about changes outside of their specialist service by sharing understanding of the MEAM Approach and how best to support people experiencing multiple disadvantage, and by challenging existing approaches or barriers to support. Specialist workers or teams can also work collaboratively with other services and organisations to change how they operate and to support their staff to change their practice, for example embedding trauma-informed approaches. In doing so, these specialist workers effect change in cultures, pathways and processes outside of their own organisation.

See sections 3 and 5.3.1 in the year 4 thematic report for discussion of the "bridging" role that specialist workers often play.

Finally, specialist services **represent an opportunity to explore and demonstrate what works** in supporting this cohort and the different approaches that can be taken, which can then be applied to the wider system.

[40] Multiple disadvantage coordinators can also be seen as a specialist service/team. Key finding 14 from the year 3 main evaluation report found that multiple disadvantage coordinators continue to be central to support coordination, services' flexibility, positive experiences of support and increased engagement with services. The year 3 main evaluation report is available here.

Local area case study 3: Improved access limited to specialist service in local area N

In this local area, two specialist workers are employed by the local mental health trust and based within the specialist outreach and navigation service for rough sleepers. Through assertive outreach, these specialist workers enable people experiencing multiple disadvantage to access and engage with mental health support, which is provided directly by the specialist workers who are skilled in working flexibly to engage people in discussions about their mental health as part of a person-centred and holistic approach. The specialist workers are able to access information from a range of different systems to bring together a more complete picture of a person's experiences and circumstances, and to provide support and advocacy for them to engage with other services.

However, at this stage, the mental health trust has not made widespread changes to improve its ability to engage with and support people experiencing multiple disadvantage, though it has begun to make minor changes to some processes which might improve access in the future. This means that people receive mental health support primarily via the specialist roles, and that moving them on to longer-term structured support with mainstream mental health services remains a challenge.

6.3.3 Specialist services as barriers to systems change

However, while specialist services may represent positive progress on an operational level, in some circumstances they do not necessarily yet have the influence required to change the system more widely in some local areas. This can be problematic, as one MEAM staff member noted:

> *"Operationally there has been a lot of progress – there are mental health roles within operational partnerships, but not necessarily embedded within statutory mental health. It's been a case of getting round the system rather than changing it."*
>
> MEAM staff member

In more extreme cases, specialist services can present barriers to changes to the wider system. Firstly, specialist services can remove the drive or the need for the rest of the system to change in order to meet the needs of people experiencing multiple disadvantage. See, for example, case study 4.

Secondly, it is often the specialist service or worker that is involved with local MEAM Approach work, as opposed to the larger mainstream service (for example, a specialist homeless mental health team works with the MEAM Approach partnership as opposed to someone from the community mental health team or the wider mental health trust). Again, this limits the extent to which the wider system feels the need to change, or even has the opportunity to learn about how it could or should change in forums such as MEAM Approach partnerships. This tension is described in more detail by a MEAM staff member:

> *"You don't see community mental health teams generally at operational meetings – it's only the specialist workers […] that turn up to the operational meetings. So it means this group is always specialist, which then doesn't have impact on the wider provision locally."*
>
> MEAM staff member

As such, while specialist services can represent positive opportunities to catalyse systems change, they also risk preventing change happening more widely across the system. The enablers of systems change described in key finding 6 will also help to create the conditions for specialist services to contribute to systems change. Future research could explore the specific factors associated with specialist services that help ensure that they contribute towards systems change.

Local area case study 4: Specialist services as a barrier to systems change in local area AD

As described in Figure 11, local area AD has a specialist GP practice for people experiencing multiple disadvantage, with approximately 150 patients. Local stakeholders reported that the patients at the practice generally report very positive experiences and improved outcomes through the practice's support. However, according to local MEAM Approach partners, the availability of this specialist GP service means that other surgeries in local area AD do not see the need to adapt their services, as they expect the specialist GP practice to cater for all local people experiencing multiple disadvantage. In this sense, the specialist GP practice is limiting the extent to which the wider system in local area AD will change.

6.4 Key finding 8: The role of COVID-19 in systems change

The COVID-19 pandemic has created opportunities for systems change by requiring collaboration (for example, through the 'Everyone In' protocol) necessitating adaptations and flexibilities in how organisations support people experiencing multiple disadvantage, and building a shared cross-sectoral understanding of multiple disadvantage as a public health issue. However, it has also placed stress on agencies and limited their capacity to engage with work beyond the immediate crisis.

The COVID-19 pandemic and its associated response presented opportunities to change how people experiencing multiple disadvantage access and experience support. Many of these changes were documented in a rapid evidence gathering report produced by Cordis Bright in May 2020 that examined some of the adaptations and flexibilities that had been introduced in response to the

pandemic, as well as their impact on people experiencing multiple disadvantage and the staff, services and systems that support them.[41]

Research for year 4 of the evaluation took place almost a year after the initial lockdown in the UK, and as such offers the opportunity to examine which of these adaptations and flexibilities were maintained over this period, meaning they may have the potential to become enduring changes. The key changes that were still maintained in late 2020 were:

- **Closer partnership working, and better engagement from certain partners** such as mental health services, in response to the 'Everyone In' protocol. COVID hotels and hostels were described in particular as sites of increased collaboration between partner agencies.

- **Flexibilities and changes to services and systems**. For many stakeholders there were a wide range of on-going flexibilities and changes which presented opportunities for more permanent change. These include more flexible prescribing practices, better information sharing between agencies, and improved data collection.

- **An enhanced understanding of multiple disadvantage as a public health issue** across multiple sectors. The pandemic and the local response challenged pre-existing assumptions across the system and created a wider cultural shift; the 'Everyone In' protocol raised the profile of multiple disadvantage and the impact of the pandemic highlighted health inequalities and vulnerabilities, making the case for support to be made more accessible for all. A MEAM staff member summed up this cultural shift, and noted how it could function as an argument for transformational change:

  "There's less acceptance that there are certain people you can't help. It's more about making services accessible for everyone."

  MEAM staff member

However, despite these examples of positive opportunities for bringing about systems change as a result of the pandemic, COVID-19 also presented significant challenges to driving systems change and also delivering work using the MEAM Approach more generally. These challenges included:

- **Decreased capacity** of partner agencies that were working in crisis mode, leading to a **de-prioritisation of work related to the MEAM Approach** (reported as particularly acute for some mental health services).

- **Negative impact on staff wellbeing,** with stakeholders reporting how difficult the pandemic has been, particularly for operational workers. Stakeholders also noted that they were anticipating increased rates of burnout among staff as the country moves out of the crisis period.

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[41] Cordis Bright (2020). Flexible responses during the Coronavirus crisis: Rapid evidence gathering.

7 Conclusion

The year 4 research enables us to present stronger evidence than in previous years (based on a larger dataset) that people supported by interventions developed using the MEAM Approach are making progress against a range of individual outcome areas over their first year of support, and that the most substantial improvements relate to their accommodation situation.

This year's larger dataset also enabled us to have a more nuanced understanding of the progress people are making. While people make considerable improvements in accommodation over the first year of support, these improvements are even greater after a second year of support. However, across many outcome areas, people seem to face barriers in making progress towards higher levels of wellbeing, and this appears to be particularly challenging in relation to mental health, where levels of progress remain limited after 12 months of support.

We hope in next year's report to be able to build our understanding of the impact of the MEAM Approach on individual wellbeing and support even further, for example through exploring change for clients over a longer period of time and increasing our understanding of how the MEAM Approach contributes to these improvements through more qualitative work.

The statistically significant reductions in non-elective acute admissions and A&E attendances, and associated estimated cost reductions, provide promising evidence of the potential benefits of the MEAM Approach for the wider local system, as well as the improved self-management of conditions and stability of the people being supported. However, differences between findings on service use in this year's and last year's reports reflect the high variation in levels of service use between different people who experience multiple disadvantage - a larger dataset next year will provide more confidence in these findings.

This year's findings in relation to systems change demonstrate that this work is challenging, complex, and requires commitment, but they also confirm that positive changes can be and are being made.

The key findings in this year's report have focussed primarily on how people, services and systems are working ***for*** people experiencing multiple disadvantage; how they work ***with*** people experiencing multiple disadvantage has received less focus. This is partly because our research methods did not directly explore co-production in local areas, but is likely also a reflection of the fact that levels of co-production vary significantly across the network areas.

Working with the expert by experience research group throughout the four years of this evaluation has been a powerful and informative experience. Their involvement has shaped the evaluation's research tools, analysis and reporting, and their involvement in fieldwork has enhanced the types of conversations we've been able to have with clients and MEAM Approach partners. We'd welcome the opportunity to explore co-production in greater detail in next year's research.

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