MEAM

Year 4 thematic report: statutory mental health involvement in MEAM Approach partnerships

October 2021

CordisBright

COMMUNITY FUND

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1 Introduction

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

- The people who shared with us their experiences of access to and support from mental health services, which make up the personal case studies throughout this report.
- 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.
- Local staff and mental health partners across the MEAM Approach network who facilitated and participated in this year's research.

1.1 About this report

This report presents the findings of thematic research into the involvement of statutory mental health services in MEAM Approach partnerships, which formed part of the year 4 evaluation of the MEAM Approach. The evaluation is being delivered by Cordis Bright, an independent research and consultancy organisation. It takes place over five years between 2017 and 2022.

The research aimed to address five specific research questions. These were:

1. Why are statutory mental health services rarely involved in MEAM Approach partnerships?
2. What would enable and encourage statutory mental health colleagues and services to join and actively participate in MEAM Approach partnerships?
3. What is the impact on clients and local systems when statutory mental health services are part of partnerships?
4. What does good access to and support from statutory mental health services look like for people experiencing multiple disadvantage?
5. Are there other types of support or opportunities, outside of those delivered by statutory mental health providers, which can help clients to achieve better mental health and wellbeing?

Local MEAM Approach leads are encouraged to use this report to consider how (if at all) statutory mental health partners are involved in their local MEAM Approach partnerships, why and how to enable further involvement, and to what extent local people experiencing multiple disadvantage have effective access to

and support from mental health services. Local MEAM Approach leads can discuss support for this work with their MEAM partnership managers.

This report should be read in conjunction with the main report for year 4 of the evaluation, and the technical appendix.

1.2 Structure of this report

The remainder of this section sets out the data and methods used in this report.

Section 2 sets the scene for this report by summarising the key challenges in access to and support from statutory mental health services for people experiencing multiple disadvantage.

Section 3 outlines how the involvement of statutory mental health partners in local MEAM Approach partnerships can help bring about more effective access to and support from statutory mental health services.

Section 4 provides an overview of the level of involvement in local MEAM Approach partnerships by statutory mental health services, and the ways in which they tend to be involved.

Section 5 summarises the key barriers to and enablers of statutory mental health partners' involvement in local MEAM Approach partnerships.

Section 6 considers other forms of effective support for mental health, beyond statutory mental health services.

Section 7 provides a brief conclusion.

1.3 Methodology

This report is based on the following data and methods:

- Three focus groups conducted with local MEAM Approach leads from 24 local areas.
- In-depth research in six of these local areas, which involved a combination of semi-structured interviews and focus groups with at least five stakeholders in each local area. As part of these deep dives, we also conducted five case study interviews with people experiencing multiple disadvantage who had experienced effective access to and/or support from statutory mental health services.

- Semi-structured interviews with 14 mental health partners[1] and other key stakeholders with insight into mental health involvement in local MEAM Approach partnerships.
- A focus group and semi-structured interviews with nine members of MEAM staff.

The findings of this report are based on the views of these stakeholder groups. Where relevant, we have highlighted when specific points or views belong to specific stakeholder groups, or when views differed between stakeholder groups. Although there are several instances where we draw on the wider literature on mental health support and good practice in providing mental health support to people experiencing multiple disadvantage, the methods have not included an extensive review of this literature – the report is largely based on consultation with the stakeholder groups described above.

All fieldwork for this year's research was conducted virtually and in partnership with the expert by experience research group, who were also involved in analysing the qualitative data and shaping this report. More detailed information on research methods and analysis processes is available in the year 4 technical appendix.

Case study evidence included in this report

The six areas which were the focus of in-depth research serve as useful case studies to illustrate the key features of and challenges to statutory mental health involvement in local partnerships identified by stakeholders across the network more generally. They are identified throughout the remainder of this report as local areas G, L, M, N, T and U.[2]

The report also includes four case studies based on what four people told us about their experiences of statutory mental health support. These have been chosen to showcase what effective access to and support from statutory mental health services can look like for people experiencing multiple disadvantage, and how this can make a difference to their lives. All names of people (clients and their support workers) in these case studies have been changed to protect anonymity, and the case studies have been agreed with the people on whom they are based.

[1] By "mental health partners" we mean people from (mostly statutory) mental health services in local areas. This involves a wide range of people, including people in operational as well as strategic roles, and people from specialist as well as mainstream generalist mental health services. It also includes a wide variety of engagement with local MEAM Approach work: in some cases people were involved in local MEAM Approach work and considered themselves partners, while in others they had little involvement in or awareness of local MEAM Approach work.

[2] During the year 2 evaluation, all areas were allocated a letter to allow for anonymised reporting about them. For consistency, the same letters have been used in all subsequent years of the evaluation. Areas which joined the evaluation in year 3 and year 4 have been allocated a letter which does not already designate another area.

Keith's story

Keith's journey

Keith had been seeking support for his mental health for several years. In his early twenties, he received counselling after waiting for a period of 18 months. He later moved to a new area, where he described difficulties in accessing support and a lower level of mental health provision:

> *"I spent seven and a half years in [area], where mental health support was nil. I was told by one counselling service they couldn't accept me because I had suicidal thoughts. I was told by the doctor that my only option was to section myself."*

During this period, Keith described the difficulties of this experience and how this caused him to lose hope:

> *"A lot of barriers to get through. For a long time I lost hope of there being some sort of change in life."*

Keith then moved to a further new area, where he currently lives. Last year, he was made homeless and began living in a night shelter, where he began working with a key worker from a local homelessness service. His key worker then referred him to a new homelessness liaison service (who are part of the local MEAM Approach partnership) which was based in the local council but employed staff from the local NHS Trust. Through this service, Keith began receiving support from a psychologist called Jill.

Support received

Keith began working with Jill three months ago. Originally, he met with Jill for one hour a week, but during the lockdown and Christmas period they instead kept in touch over email.

So far, the work with Jill has focussed on discussing what Keith hopes to get out of it:

> *"We do a lot of diagnostic work. Talking about my past and what it is that I want to go on to receive support with in the future."*

Keith values the time spent discussing his previous experiences and aims and goals, and how this is considered when planning his support, where previously it was not. Keith feels that the personalised nature of the support is key:

> *"We did two or three sessions where we spoke about what I'd been through in the past and what help I'd had from mental health services in the past […] It's more in tune with my own goals – that's the one thing that's particularly helpful. I think certainly in [previous area] when I received counselling, it was very sort of blanketed. It was just counselling – 'oh you've got a mental health disorder, have some counselling'. Here it's more tailored to what my specific needs are."*

Keith's work with Jill so far has included light therapy, work on how to deal with emotions, and building self-confidence. Jill has also referred Keith for trauma therapy. Keith feels positive about the support from Jill:

"I'm happy with the services I'm accessing. Especially after not receiving the support for so long. It's been an absolutely lifesaver really, quite literally."

Impact of support

Keith can see the difference that the work with Jill has begun to make in his life. Jill has equipped Keith with strategies for dealing with his mental health issues, but he is still at an early stage of this process and has not got to the root causes yet:

"I wouldn't say the issues have got any better, but the way I deal with the issues. That's not got a lot easier, but it has certainly got a little easier."

Importantly, the work with Jill has allowed Keith to start setting some goals and aims for the future. For example, he plans to join a local swim club once it re-opens, and is also interested in getting involved in voluntary work:

"I will be looking into volunteering once the shops are open again. I want something to break my day up a bit. With lockdown at the moment – I'm leaving the house once or twice a week to get bits. It would be nice to have another reason to get out."

Keith feels that, while he has not yet achieved his goals, Jill is helping him get to a place where he can begin to focus on achieving them:

"I wouldn't say helping to achieve them. But it's laying the ground to go on and achieve them in the future. It's not achieving goals in terms of mental health - but in terms of how I deal with it. I'm starting to take a lot more time for myself nowadays […] I'm starting to become a bit more wise in terms of what needs to be done rather than not doing it."

Although Keith is still at an early stage in dealing with his mental health issues, he is optimistic about the future:

"It has made a difference, not in how I'm feeling, but how I deal with how I'm feeling. The only improvement in the way I'm feeling is the hope that I've finally been able to access the services and finally get the help I need. And recognising that – for once – I do have a future ahead of me."

2 Challenges in access to and support from statutory mental health services for people experiencing multiple disadvantage

2.1 Overview

People experiencing multiple disadvantage face a range of challenges in accessing and receiving effective mental health support from statutory mental health services. These challenges are already well-documented. This section briefly summarises some of the main challenges in access to and support from statutory mental health services that have already been identified by research on mental health and multiple disadvantage outside of the MEAM Approach evaluation, illustrated by some examples from the evaluation research. This is by no means a comprehensive list of the challenges and barriers.

2.2 Challenges in access to statutory mental health services

People experiencing multiple disadvantage are often **caught between gaps in mental health service provision**. They are often deemed too "complex" for primary care services such as IAPT (Improving Access to Psychological Therapy), but below the eligibility threshold for secondary care services. They are therefore often able to access neither primary nor secondary care mental health services.[3]

People experiencing multiple disadvantage are also likely to be accessing care and **support from multiple services**. For people receiving support from multiple services and **requiring multiple assessments**, the chance of dropping out from care is higher, leading to delays in treatment and increased waiting times.[4]

Locations that are not easily accessible or discreet, **"traditional" opening hours** (i.e. not out-of-hours), and the **inflexibility of services** around missed appointments, can also all serve as major barriers for people experiencing multiple disadvantage to access these services. Some people may also feel **coerced into using treatments or services that they feel do not reflect their preference** or readiness to change, and previous **poor relationships** with practitioners can also serve as a barrier to further engagement.[5] A **lack of understanding of how trauma affects behaviour** can also result in people experiencing multiple disadvantage being refused assessments when symptoms

[3] CFE Research and University of Sheffield (2020). Improving access to mental health support for people experiencing multiple disadvantage, Evaluation of Fulfilling Lives: Supporting people with multiple needs.

[4] NHS England, NHS Improvement and the National Collaborating Centre for Mental Health (2019). The community mental health framework for adults and older adults.

[5] NICE (2016). Coexisting severe mental illness and substance misuse: community health and social care services, NICE guideline [NG58]

of trauma such as drug use, behavioural problems and violent relationships are assumed to be "lifestyle choices" and the person to be "difficult" or "untreatable".[3]

Primary health care registration requirements (such as ID or proof of address) often prevent people experiencing multiple disadvantage from accessing mental health support (see local area case study 1 below), as does the **complexity of navigating the multiple pathways of the mental health system itself.**[3]

People with **co-occurring mental illness and substance misuse** experience particularly acute difficulties in accessing effective mental health support.[6] They often fall through the gaps between services, are refused mental heath assessment because of their substance misuse needs and are not effectively supported by either mental health services or substance misuse services.[7] This is discussed in more detail in the box overleaf.

> *"Everyone should be given the same chance to be referred. At the moment, they are discriminated against […] for being a drug and alcohol user. We need a fair referral system that allows everyone to be assessed and given the level of service they should be given."*
>
> Mental health partner

Local area case study 1: geographical boundaries restrict access to pathways in local area T

Local area T is a large geographical area covered by several CCGs and health services. There is significant variation across the area in terms of access to mental health services. Administrative issues around geographical boundaries present challenges for people in accessing mental health support.

"The biggest barrier for mental health […] it's a whole district and borough boundary thing. This client […] he'd been rough sleeping, and he got emergency accommodation. But because his GP was not in the same district he was in, the mental health services in the district refused to pick him up. After a year, he was sectioned and finally got support. A whole year! Just because his GP was in a different district."

Partner, local area T

Administrative issues related to geographical boundaries can be a particularly significant barrier to accessing mental health support for people experiencing multiple disadvantage who may have more transient lifestyles or struggle to prove a local connection.

[6] This co-occurrence is often referred to as a "dual diagnosis"; however, this term is used in different ways by people with different professional backgrounds. In this section we talk about people who present with substance misuse and mental health needs (regardless of any formal diagnosis).

[7] Drug and Alcohol Findings (2010). The complexity and challenge of 'dual diagnosis'. [Accessed 06/07/21]

"Dual diagnosis": challenges in accessing mental health services for people with co-occurring substance misuse and mental ill health

The existing literature identifies a range of barriers to accessing mental health services for people with co-occurring mental illness and substance misuse. The 2016 NICE guidelines highlight: a) the **inflexibility of services** – for example, when services do not allow people using substances to attend, or fail to take into account people's ability to attend appointments ; b) the **fear of stigma, prejudice or being labelled** as having both mental health and substance misuse problems; c) **differential attitudes** towards either mental health or drug and alcohol-related issues between agencies, including negative attitudes and preconceptions; and d) **a lack of training** among staff members in these services.[5] The challenge of delivering effective support is further complicated by the fact that different sectors and services are guided by **different policies.**[7]

The NICE guidelines offer responses to these barriers, including that people must not be excluded from secondary care mental health services because of substance misuse; the need for a person-centred, multi-agency approach to care planning that ensures other support needs are addressed; and that existing services should be adapted rather than specialist "dual diagnosis" services created.[5]

However, poor access for people presenting with both needs remains prevalent across the MEAM Approach network. MEAM Approach partners from mental health services and other agencies understand there to be a range of contributing factors, including **a lack of consensus or clear policy** around "dual diagnosis", a **lack of flexibility from mainstream mental health services to work with people while they are using substances**, and a **lack of leadership from senior strategic figures** who could implement changes to these policies. Negotiating access to mental health support for people with both mental health and substance misuse needs was often perceived by mental health partners in operational roles as being beyond their remit – more senior and strategic intervention is required:

"I don't think [mental health services'] involvement [in the MEAM Approach partnership] is the issue […] The problem is the remit. They're there, they'll work with us. But we always get the same answer. The biggest barrier is substance misuse - they have a substance misuse issue, we can't get past it."

Local area lead, local area M

These barriers are likely compounded by the fact that the term "dual diagnosis" is used in a variety of different ways by people working in health and social care in the UK.[5] People from mental health services may use a more clinical definition of the term, indicating a formal diagnosis of severe mental illness among people who use substances. People from non-clinical professional backgrounds may use it to refer to a person who is presenting with any combination of mental health and substance misuse needs, regardless of formal diagnosis.

2.3 Challenges in support from statutory mental health services

Once accessing support, people experiencing multiple disadvantage may find that mental health services are not designed around their needs and face a range of challenges in how mental health support is provided. Individuals may experience **stigma from staff** and may be passed between services without appropriate care or support as a result of **negative attitudes or biases of staff.**[5] This can also lead to a **mistrust of professionals**, resulting in **poorer engagement with services**. Linked to this, when people engage with multiple agencies, workers within some services may **abdicate responsibility** because other service providers are involved in supporting the person.[8]

A major issue reported in the literature (as noted above) is that statutory mental health services **will often require a person to address their substance misuse before** they can receive mental health treatment or even a mental health assessment.[3] Staff are also **ill-equipped to work with people experiencing multiple disadvantage**, often due to a lack of training around the delivery of effective care for this cohort.[8] Often services can fail to take a **trauma-informed and strengths-based approach** to supporting individuals.

Traditional models of delivery – including the methods of communication used, institutional settings, and long waiting times can lead to disengagement and exclude people experiencing multiple disadvantage.[3]

Many of these challenges are underpinned by the planning and commissioning process. **A lack of consultation with people with lived experience** can result in statutory mental health services that are not inclusive of people experiencing multiple disadvantage, for the reasons described above. Similarly, **commissioning processes** for mental health services that do not seek to share responsibility or work more jointly with services across the system can **inhibit innovations in practice** and result in services that find it difficult to accommodate people experiencing multiple disadvantage.[3]

Amy's story

Amy's journey

Amy had previously been getting support for her mental health from local services, but the support had not been very joined-up:

> *"I was let down before – too many workers not keeping in the loop with each other, and mixed messages, not on the same page."*

At one point she was working with a Community Psychiatric Nurse (CPN) who did not seem very engaged or aware of her needs. When Amy went into mental health crisis, she felt unsupported by her CPN:

[8] Centre for Regional Economic and Social Research, Sheffield Hallam University (2020). Understanding Models of Support for People Facing Multiple Disadvantage: A Literature Review. Fulfilling Lives Lambeth, Southwark, Lewisham.

"They had no plan for me, didn't keep in the loop, and everything went belly up."

Amy was eventually sectioned and spent six months in hospital before being discharged on to the street. Amy was homeless for six months and then spent some time in prison. During this period, she began working with a multiple disadvantage navigator (who was involved with local work developed using the MEAM Approach). After being released from prison, Amy's navigator arranged for her to start working with a new CPN called John.

Support received

Amy began working with John one year ago. John would come to Amy's house on a weekly basis. He would ensure she was on stable medication, discuss her needs, and work closely with Amy's navigator and social worker to ensure they were working towards the same goals. Receiving support from someone who understood and focussed on all her needs holistically, John's partnership working with Amy's other support workers, and the good relationship she had with John were all important to Amy:

"He was on the same page as other people. It was practical, it was about the things I needed – diet, housing, benefits or funds. We had a good relationship, we got on well. It was suited to me and all my needs."

Impact of support

One of the most important impacts of working with John for Amy was moving into stable accommodation, which she attributes to the close working between John, her navigator and her social worker:

"The housing – that felt like a big shot for my mental health. It stabilised me. I was in hostels for 18 months. Now I'm in my own flat, because all three were working together […] It's good for my mental health."

Through her work with John, Amy has developed strategies for managing her mental health and has seen major improvements:

"My mental health – I've come on leaps and bounds. I have different strategies and how to cope – how to notice signs when it comes, and stuff. […] Mental health was central."

John has now retired and Amy will be going on to work with a new CPN. Amy feels the work they have done together has stabilised her mental health and put her in a place where she can focus on other goals in her life. While acknowledging that she still has work to do, Amy has seen positive developments for herself, including getting more involved in community groups, and re-establishing a relationship with her children:

"[Navigator] is getting me into some women's groups and mixing with different people. I'm looking forward to that. That will be good for my mental health. […] I'm also getting a relationship back with my kids."

3 How does involvement in local MEAM Approach partnerships improve access and support?

3.1 Overview

Effective access to and support from statutory mental health services for people experiencing multiple disadvantage is not prevalent across the MEAM Approach network. Improving access and support for this group is important: providing better access to mental health services can often stabilise people's mental health and allow them to address other issues in their lives. This section outlines how access to and support from statutory mental health services could be more effective and how the involvement of statutory mental health partners in local MEAM Approach partnerships can contribute to these improvements.

3.2 Improving access to and support from statutory mental health services

Mental health partners and other stakeholders involved with MEAM Approach partnerships described what effective access to and support from statutory mental health services should look like for people experiencing multiple disadvantage. They identified four broad features of effective access: equity of access to referral and treatment pathways; flexible and creative approaches to ensuring access; shared/single assessments and care plans; and timely assessments and interventions. They also identified four features of effective support: trauma-informed approaches; holistic support that addresses wider needs; flexible support; and positive and trusting therapeutic relationships. Local area case study 2 below demonstrates how more flexible access delivered through assertive outreach has improved access to mental health support for people in local area N.

Local area case study 2: flexible access through assertive outreach in local area N

Mental health assertive outreach in local area N is provided via two roles employed by the local mental health trust. These staff are located within the specialist outreach and navigation service for rough sleepers, which is delivered primarily by a consortium of voluntary sector providers. The workers provide outreach to improve access to and engagement with mental health support, among other services, by people experiencing rough sleeping or living in temporary accommodation, many of whom are experiencing multiple disadvantage.

After engaging people via assertive outreach, the workers then support them to identify priority areas which they wish to address and to access support for these issues via other services.

As summarised in Figure 1 below, the involvement of statutory mental health partners in local MEAM Approach partnerships can help overcome some of the barriers faced by people experiencing multiple disadvantage described in section 2 and bring about more effective access to and support from statutory mental health services. Our research suggests their involvement can contribute to the following areas: quicker and better access to mental health support; flexible, trauma-informed support; increasing access to a broader range of suitable services; joint assessments, improved information sharing and more person-centred, coordinated support; improved partnership working and better mutual understanding; better support and supervision for staff supporting people experiencing multiple disadvantage; and culture change.

The involvement of statutory mental health partners in local MEAM Approach partnerships can also help other partners to support their clients more effectively in other areas of their lives:

> *"Sometimes in substance misuse, it can feel like we're papering over the cracks, when someone actually has a lot of mental health issues underneath the substance misuse that would benefit their long-term recovery if they could address them. For MEAM clients that's right down to being able to sustain housing or gain employment, as well as supporting their recovery from drug and alcohol use. […] Yes, they [mental health service] are like a missing cog. We're part of this machine trying to support people. We can only do so much and there's this cog missing that would just add to that package of care. When people relapse, it's because they haven't had that time to work through the underlying issue. If we could have that in place it could try and stop that revolving door."*
>
> Substance misuse partner

Figure 1: How the involvement of statutory mental health partners in local MEAM Approach work can improve access to and support from statutory mental health services

Key area of impact	How involvement of statutory mental health services in MEAM Approach partnerships helps bring about the impact
Quicker and better access to mental health support	**People are offered support more pro-actively** or **at a place/time that is convenient to them**, and/or **barriers to accessing mainstream mental health services are removed** when statutory mental health partners are involved in MEAM Approach partnerships**.** This tends to happen either through specialist mental health services for people experiencing multiple disadvantage, or through the advocacy of specialist workers with mainstream services – see key findings 3 and 7 in the year 4 main report for more discussion on these two routes. The involvement of statutory mental health partners in MEAM Approach partnerships more generally also contributes to improving access to mental health support. This is particularly the case when **people representing mental health services act as a bridge between their service and MEAM Approach partners from other services** (as described in section 5.3) or work to ensure that **pathways are in place that allow for quicker access** to support. Quicker access to support in turn allows for **earlier intervention** in some cases. This has a positive impact for people, who may be prevented from reaching crisis point by earlier intervention.
Flexible, trauma-informed support	People receive **mental health support that is more suited to their needs** when statutory mental health partners are involved in MEAM Approach partnerships. Through working with colleagues from other partner organisations and "learning by doing", staff from mental health services can learn about the wider needs of people experiencing multiple disadvantage, and how best to support them. **Staff training and development** can also ensure that care is delivered in a more **flexible and trauma-informed way**, while **mental health partners who have a more consultative role** in MEAM Approach partnerships can assist partner agencies to embed trauma-informed approaches to care within their services. This can in turn lead to **increased trust and better engagement from people experiencing multiple disadvantage**, particularly from those who were previously uncomfortable engaging with statutory services. See Samuel's case study for an example of the importance of positive and trusting therapeutic relationships.

Key area of impact	How involvement of statutory mental health services in MEAM Approach partnerships helps bring about the impact
Access to a broader range of suitable services	Through the types of work described above, the involvement of statutory mental health partners can lead to a broader range of services working in flexible, trauma-informed ways, and being Psychologically Informed Environments (PIE). As a result, **a broader range of services (both mental health specific and others) are becoming open to and suitable for people experiencing multiple disadvantage**.
Joint assessments, improved information sharing and more person-centred, coordinated support	The involvement of statutory mental health partners in MEAM Approach partnerships facilitates the delivery of **joint assessments** by partners, for example by a mental health practitioner and a multiple disadvantage coordinator, and the **sharing of data related to the assessments** between partner agencies. A mental health partner described the positive impact that further involvement of statutory mental health partners in their MEAM Approach partnership could have on people at the point of access: *"You go from service to service and tell your story every time to different assessors. If we worked together in a partnership, we could share that information between ourselves with their consent. Some people don't want to tell their story."* Mental health partner More broadly, **improved information sharing** can lead to more **joined-up and person-centred support from statutory mental health services and other partners,** leading to **better results for the people they are supporting.** When statutory mental health services are involved in MEAM Approach partnerships they are better placed to access information from a range of different systems and professionals to bring together a more complete picture of a person's experiences and circumstances, and other areas of need in their life, with greater insight into risks, medical histories and other relevant information achieved through forums such as multi-disciplinary team meetings. Keith's case study is an example of the positive impact that taking a person's past experiences into account and offering person-centred support can have on their life. *"Speaking to each other - networks, being able to approach without going through lots of different barriers, joined-up work together, having the person not having to repeat lots of information shared with consent... It gets better results, merging resources together and being able to achieve more."* Mental health partner

Key area of impact	How involvement of statutory mental health services in MEAM Approach partnerships helps bring about the impact
	Finally, involvement in the MEAM Approach partnership allows for **sharing of risk** between agencies, and for services to develop **coordinated action plans** that ensure all services are supporting people towards similar objectives. Amy's case study is a good example of the positive benefit of coordinated support plans.
Improved partnership working and better mutual understanding	The involvement of statutory mental health partners in MEAM Approach partnerships can **improve the relationships between services** across the system. Involvement can also lead to **better mutual understanding between mental health services and other partner agencies**, as the partnership working enables workers to learn about the roles, remits and processes of each other's services and to learn to speak each other's "languages".[9] *"Sometimes we [statutory mental health services] are just seen as people who say no - it's about communication and understanding."* Mental health partner This in turn enables mental health services to support the wider needs of their clients more effectively: *"I've learned so much about housing, how drug and alcohol services work – it's invaluable. An awareness of where we can signpost people to, who has expertise we can draw upon."* Mental health partner
Better support and supervision for staff	The involvement of statutory mental health partners in MEAM Approach partnerships can facilitate the provision of **reflective practice, clinical support and pastoral support from mental health partners for non-mental health frontline staff.** This tends to be provided on an ad-hoc basis, as working alongside mental health

[9] Consultation with stakeholders from mental health services and other agencies indicates that staff from different services may use different terminology or have different understanding of terms relevant to their work (examples offered by stakeholders include "detox," "rehabilitation," and "dual diagnosis").

Key area of impact	How involvement of statutory mental health services in MEAM Approach partnerships helps bring about the impact
supporting people experiencing multiple disadvantage	colleagues can help equip them with the tools and confidence to support their clients' mental health and the contacts to signpost to. Some local areas also have more formalised processes for providing reflective practice: *"In terms of other workers in our network, our team is there for reflective practice and ad-hoc supervision, and hopefully helping people unpick the vicarious trauma, and being able to recognise it - what's theirs, what's their clients. Being able to manage their day-to-day more easily. […] The intention is to help people feel more confident and safer to do the difficult jobs they do."* Mental health partner For some, this clinical supervision was particularly useful for supporting staff members through the challenges of the COVID-19 pandemic: *"COVID was so difficult […] Staff wellbeing was quite poor – mental health partners provided us with support, some time to reflect on clients. […] Our [Homeless Mental Health] team has enabled us to do that."* Partner from in-depth research area
Culture change: increased awareness, reflection and challenge	In some areas, involvement in the MEAM Approach partnership has helped to **raise the profile of multiple disadvantage** within mental health services more widely, leading to **increased reflection and changes to working cultures**: *"The [specialist mental health] service, when they came under my remit, that helped raise my awareness about the populations that needed a different approach. It's about recognising that there is a massive service deficit for some parts of the population."* Mental health partner Involvement in MEAM Approach partnerships and delivering work under the MEAM Approach principles can also help **shift the onus of engagement from people experiencing multiple disadvantage on to services**: *"Trust is a huge issue – people have no reason to engage with statutory services […] I don't like the word engagement as the responsibility is always put on the client to engage with us. We need to*

Key area of impact	How involvement of statutory mental health services in MEAM Approach partnerships helps bring about the impact
	think about how we can work to make people work with us who have no reason to engage with us. It [MEAM Approach partnership] helps enormously with that." Mental health partner It can also help to foster **a healthy culture of challenge** within mental health services and other partners. The partnerships are a forum for services to challenge each other's approaches in a process some have called "unlearning", as well as to challenge stigma and biases inherent in the system more widely.

Samuel's story

Support received

Samuel was first referred into mental health services through a psychiatrist:

> *"I had brain scans at the hospital and was classed as unfit for work and schizophrenic. They put me on medication. That's when I was allocated a key worker from AOT [Assertive Outreach Team]."*

Samuel was living in a hostel when he first started working with a CPN. He now works with another CPN, Josh, from the same service. Samuel has been working with Josh for two years. Samuel speaks positively about his support from both Josh and the previous CPN, and also has a strong relationship with his multiple disadvantage navigator (who is involved with local work developed using the MEAM Approach).

Before lockdown, Josh would visit Samuel's home once or twice a week. They would spend time writing a list of things to do and thinking about goals that Samuel wanted to achieve. Samuel also used to take part in activities such as playing football and going for walks and coffees in town with his CPN, but this has not been possible recently due to lockdown.

Samuel has found it easy to engage with Josh because he was used to seeing him consistently:

> *"It's very easy to talk to a mental health worker when they're coming on a regular basis."*

For Samuel this consistency was important in establishing a relationship with his CPN. Samuel has a strong trusting relationship with Josh:

> *"He's a 100% worker and he would back me in everything. I trust him a lot."*

Impact of support

Samuel feels his life has turned around since he started working with his CPN:

> *"He's supported me down the road. I'm an ex-drug addict. He helped me with my usage, supporting me the best he can be. […] He's always been there."*

Some of the major changes in Samuel's life are changes in his behaviour and self-awareness. As a result of this, Samuel feels more in control of his life:

> *"Over a long period of time I've been wanting to change and make the right steps in life. Josh has supported me there, and always boosted me along. I've managed to change my behaviour and become more aware of what I'm doing."*

Samuel has begun to set himself some new goals such as to go for a coffee and a walk with an Occupational Therapist from the Assertive Outreach Team service, and to discuss with her the possibility of doing some voluntary work.

4 Overview of statutory mental health involvement in MEAM Approach partnerships

4.1 Overview

This section provides an overview of the level of involvement in local MEAM Approach partnerships by statutory mental health services, and the ways in which they tend to be involved. This is based on qualitative consultation, as set out in section 1.2, rather than a more extensive mapping exercise.

4.2 Level of involvement

Most areas across the MEAM Approach network described some level of involvement of statutory mental health services in their local MEAM Approach partnership. However, levels of involvement tend to be low (despite the benefits of involvement outlined in section 3) and local MEAM Approach leads are generally not satisfied with the level of involvement. Most areas across the MEAM Approach network would benefit from greater involvement of statutory mental health services in developing and delivering improved support for people experiencing multiple disadvantage.

When statutory mental health partners are involved with MEAM Approach partnerships, this involvement tends to be at the operational level, with strategic involvement much less common. Stakeholders from across the network have also described how operational involvement of statutory mental health partners is improving. This involvement tends to be via specialist roles or services rather than via mainstream services/community mental health teams (explored further in the next section).

4.3 Types of involvement

Statutory mental health services are involved in local MEAM Approach partnerships in a variety of ways. Figure 2 sets out the key types of involvement, starting with the most prevalent and descending to the least prevalent. In some areas, where their involvement is more developed, statutory mental health partners are involved in multiple ways; in other areas they may be involved in only one or two ways. Figure 2 also provides some examples of the different types of involvement from across the network.

Figure 2: Types and examples of involvement of statutory mental health services in MEAM Approach partnerships from across the MEAM Approach network

Type of involvement	Example from local areas in the MEAM Approach network
Operational involvement	
1. Mental health partners (usually specialist workers/services) attend MEAM operational meetings	In local area M a MEAM champion from each of the three principle mental health services (clinical statutory mental health team, social care mental health team and voluntary mental health service) attend MEAM operational meetings. Local partners report that the clinical mental health team could attend more consistently.
2. Mental health partners employ staff in specialist roles/services, who work in close partnership with staff delivering support developed using the MEAM Approach	In local area G a newly formed council-based specialist homeless mental health service is made up of a CPN and an assistant psychologist employed by the local mental health trust. The CPN works closely with multiple disadvantage coordinators to support the mental health needs of their clients – for example, the CPN assesses people on the coordinators' cohorts and also works with coordinators to make sure the mental health needs of these individuals are being met, such as by ensuring that people in temporary accommodation have internet access so they can access online mental health support. These staff members also take part in multi-disciplinary team meetings about support for individual clients.
3. Mental health partners work with other partners to support people experiencing multiple disadvantage in other forums outside of MEAM Approach partnerships	In local area M the clinical statutory mental health team is also represented at the complex case panel, a multi-agency operational group which discusses support for people on the designated MEAM cohort as well as other people whom services find difficult to support effectively.
4. Mental health partner has a consultative role – providing support and	Local area W has a specialist homeless mental health team which offers consultation, support and training to the local MEAM Approach partners:

Type of involvement	Example from local areas in the MEAM Approach network
training to MEAM Approach partners	*"My role is a consultation role, to implement psychologically-informed environments, embedding principles of trauma-informed care in hostels, and staff support. I hope to be able to act as liaison between hostels and mental health services"* Mental health partner
Strategic involvement	
5. Mental health partners attend MEAM strategic board meetings	In local area T the social care mental health team and representatives from the local trust attend the strategic MEAM steering group. However, some stakeholders highlighted that attendance from representatives from the trust is not consistent.
6. Mental health partners attend strategic boards where MEAM/multiple disadvantage is a standing item	In local area M statutory mental health partners attend a wider strategic meeting that focuses on community safety, in which the local MEAM Approach work is a standing item.
7. Mental health partners are bought into the MEAM Approach and "fly the MEAM flag" within their own organisations	In local area U, while there is currently no formalised MEAM strategic group, there is still strong strategic buy-in to the MEAM Approach from a number of key people, including partners from the local mental health trust and other mental health partners. Their involvement in the MEAM Approach consists of connecting key contacts within mental health services with representatives from other agencies involved with the MEAM Approach partnership and "flying the MEAM flag" within their own services (i.e. advocating for and showcasing the benefits of the MEAM Approach within their service).

John Paul's story

Support received

John Paul had been receiving support in his local area for over two years, since moving there. When he moved to the local area he was homeless, and an Advanced Nurse Practitioner and a local homelessness service helped him settle in, including finding him accommodation and making sure his medical files were sent over from his previous location. The Advanced Nurse Practitioner is employed by the local Mental Health Trust but based in a local homelessness service supporting people experiencing multiple disadvantage. The staff have the skills and connections to engage people in outreach-based support for both their mental and physical health and also to help them to engage with statutory mental and physical health services. This was particularly important for John Paul as he has some serious physical health conditions, and he commented on how this had helped him:

> *"I'd moved to [local area] and met [the Advanced Nurse Practitioner]. [Homelessness service] helped me move from there to here. They put me in a hotel. They had my files sent from the other places. My medical records are everywhere. The way things are, it's getting better."*

John Paul was supported to go to hospital for urgent treatment, which he would likely not otherwise have received. The Advanced Nurse Practitioner proactively approached him when he was unwell and came to his accommodation to conduct blood tests. A hospital appointment was made, and the Advanced Nurse Practitioner ensured that John Paul attended the appointment; although he had not turned up at the time that had been agreed, he was still able to have the appointment.

> *"After the tests, they said I was close to death. And [the Advanced Nurse Practitioner] made sure I went to hospital. She knew I was ill and she knocked on my door at 8 in the morning with another lady. They took blood samples from me. The next day, paramedics came this time, saying I had to go to hospital. So I went in. I was supposed to be there at 9 in the morning, and I didn't get there until 5. But [the Advanced Nurse Practitioner] held on, hoping I would go for hospital. She paid for the taxi."*

The support also extended after hospital, when information about his case was shared with the local homelessness service so that they could provide follow-up treatment after he was discharged.

> *"[The Advanced Nurse Practitioner] has played an important role. She's aware of the situation. The information was going to the appropriate places, of what follow up I should be having. She was being given the information which would be necessary when I was released from hospital, and she could then do the follow up treatment. She was quite aware of what I should be taking. It's getting there."*

Views of support

John Paul speaks highly about the work of the Advanced Nurse Practitioner. He feels she was aware of his case and knew him, and that they have built a rapport. This is helpful for building a trusting relationship and makes him feel that he has an advocate in meetings who can help him navigate other services:

> *"I started to get a rapport and I'm glad I have. She's a good listener. When she has her meetings with her staff, I'm sure that equally she's just as nice and in my corner."*

He also speaks highly of the support he receives at the hostel where he is living:

> *"The staff here have been so bloody brilliant. My support worker, them here are fantastic, and all being equal they're brilliant."*

However, John Paul's experience with accessing primary health care through the specialist primary care provider was more negative. This was partly due to it being physically difficult to access and partly due to the lack of familiarity with the GPs there, who he felt did not know him. John Paul feels the most important change needed to improve support would be to make the support more person-centred. He emphasises the importance of listening to individuals and not trying to shape them to fit into boxes.

> *"Listen to the patients more. They're trying to structure their patients. Listen to them, look at the evidence of their history, see how far they've come from A to B. Tailor the support around the patient."*

Impact of support

The support from [homelessness service] has had a significant impact on John Paul's progress and outcomes. He credits the staff with saving his life, and he feels that without their input he would have died.

> *"I do like [the Advanced Nurse Practitioner], she has helped me. If it hadn't been for [her] I'd be dead. She saved my life. I'll never get the chance to say, she did save my life."*

He is also positive about the impact of this support, and feels that it encouraged him to keep making progress.

> *"The way things are, it's getting better. It's pushing me to keep on the right side."*

However, he feels that the support received at the primary care provider has not had this positive impact, and feels that if they had supported him properly, his health outcomes could have been far improved.

> *"I think [primary care provider] has done me no favours. I don't mean any disrespect. They were always wanting me to get there and I couldn't, there are too many hills. I had a wheelchair. I'd still be walking if they'd done things right."*

5 Enablers and barriers to statutory mental health involvement in MEAM Approach partnerships

5.1 Overview

This section sets out the key barriers that prevent statutory mental health partners from being involved in local MEAM Approach partnerships, and the key enabling factors that can facilitate, encourage, and improve their involvement. These are based on qualitative consultation, as described in section 1.2, and are summarised in Figure 3.

The key barriers are discussed briefly in section 0, while section 5.3 sets out the key enablers in more detail, considering how each enabler supports statutory mental health involvement and how the enabler can be implemented.

MEAM Approach partnerships may wish to consider how to foster these enabling factors in their local area and find ways to minimise the barriers.

Figure 3 Barriers to and enablers of statutory mental health partners' involvement

Barriers to involvement
1. Lack of dedicated time and resource for statutory mental health services to engage with MEAM Approach partnerships
2. Competing priorities and partnerships for statutory mental health services
3. Differences in the working culture, practices and approaches to care in statutory mental health services and some of the other organisations making up local MEAM Approach partnerships
4. Reticence to take responsibility for managing risk in relation to this cohort
5. Size and complexity of mental health trusts
6. Information sharing/data restrictions
7. Reduced capacity to engage with MEAM Approach partnerships as a result of the COVID-19 pandemic
Enablers of involvement
1. Additional funding for specialist mental health services
2. Adequate time and resource within mainstream mental health services
3. More effective partnership working as part of the response to the COVID-19 pandemic
4. Specific roles acting as "bridges" between mental health services and other partners
5. Direct involvement in MEAM Approach partnerships
6. Training and workforce development
7. Strategic buy-in from statutory mental health services and related agencies
8. Commitment from leaders to "think differently"
9. Tenacity and persistence by MEAM Approach leads and others in the partnership
10. National directives and policy
11. Shared strategic priorities

5.2 Barriers

The involvement of statutory mental health partners in MEAM Approach partnerships is clearly important – when they are not involved this can contribute towards difficulties in coordinating support for people, gaps between primary and secondary care, people having difficulties in accessing mental health support due to substance misuse issues, and regression in other aspects of people's lives if their mental health is not addressed.

However, there are a range of barriers that can prevent statutory mental health services from being involved in their local MEAM Approach partnerships. These barriers to involvement often relate closely to the barriers people face in accessing effective support. The most frequently identified barriers are a lack of time and resource within statutory mental health services to effectively engage with MEAM Approach partnerships, and statutory mental health services being involved across many sectors and therefore "in demand" in many forums:

> *"The pressure we face - there are a lot of partnerships that want mental health at the table. We get invited to a lot of things. We can't be everywhere at once."*
>
> Mental health partner

Given their limited resource and time to engage with this work, there is a sense across the MEAM Approach network that mental health partners often do not see the benefit of their involvement in MEAM Approach partnerships, particularly if they are already involved in other multi-agency partnerships.

However, even when stakeholders from statutory mental health services are aware of the benefits and resource and time are available, significant barriers to their involvement in local MEAM Approach partnerships remain. Differences in working cultures and policies between organisations can mean that operational staff from mental health services are less able to work flexibly than workers from other partner agencies. Moreover, statutory mental health partners and other local statutory and voluntary sector agencies often have a poor understanding of each other's services. This lack of common understanding of the roles and remits of mental health services by other partner agencies (and vice versa) can discourage mental health services becoming more involved and creates additional barriers to their involvement:

> *"There's something about the difference in language and divides between the two "sides" - do mental health understand what multiple disadvantage services/clients need? And do multiple disadvantage services/navigators, etc. understand what mental health services can offer/ what is appropriate?"*
>
> MEAM staff

Other barriers include: the approach that many services take to people using substances (as described above); concerns about who should hold the risk and responsibility for people experiencing multiple disadvantage within the system (with mental health services deferring responsibility for people perceived as "risky"); the size and complexity of mental health trusts resulting in varying levels

of awareness of the MEAM Approach within organisations; and data restrictions resulting from different recording systems used across services or approaches to information sharing.

The COVID-19 pandemic also served as a barrier to further involvement in some instances, with the greater stress on mental health partners leading to de-prioritisation of work related to the MEAM Approach. See key finding 8 in the year 4 main report for more discussion on the impacts of COVID-19.

5.3 Enablers

However, our research has identified a range of factors that encourage and enable statutory mental health partners to become (more) involved in local MEAM Approach partnerships, and which can help overcome some of the barriers described above. The effectiveness of each enabler will vary between areas, depending on the context and barriers to statutory mental health involvement in each area. Although increasing funding and time/resource are important, in some areas it may be more feasible and therefore effective to foster other enabling conditions.

Section 5.3.1 outlines the **key enablers of operational involvement**, while section 5.3.2 outlines the **key enablers of strategic involvement**. Case studies from local areas are included where relevant.

5.3.1 Enablers of operational involvement

The tables below present an overview of each operational enabler and how it supports involvement of statutory mental health services in the operational work of local MEAM Approach partnerships.

Figure 4: Enabler 1: Additional funding for specialist mental health services

Additional funding for specialist mental health services	
Overview of enabler	External funding streams targeted towards specialist mental health services for people rough sleeping or experiencing multiple disadvantage are an enabler for involvement of mental health partners in MEAM Approach partnerships. In local areas where statutory mental health partners were effectively involved at an operational level, this was often due to targeted funding streams.
How this supports involvement	Targeted funding to mental health services for specialist support enables further involvement from statutory mental health services through creating specialist services or roles for working with people experiencing multiple disadvantage. These services/roles tend to understand the benefits of using the MEAM Approach and/or have the approach built into their specification.
How to make it happen	Areas with the additional external funding for specialist mental health services have typically received this from the Public Health England, NHS England and MHCLG funding programmes targeting rough sleepers.
Source of evidence	• MEAM staff consultation • Local area lead consultation • Mental health partner interviews • Deep dive consultation

Figure 5: Enabler 2: Adequate time and resource within mainstream mental health services

Adequate time and resource within mainstream mental health services	
Overview of enabler	Limited time and resource are often cited as one of the main barriers to statutory mental health services becoming more involved. Better general funding of mainstream mental health services can help create the required time and resource.
How this supports involvement	It is necessary to create time for mental health practitioners to attend and effectively participate in partnership work such as MEAM operational meetings, and for teams to be sufficiently resourced so that a representative can regularly participate in this work. Beyond participation in meetings and other partnership working, time and resource are also described as important for enabling mental health partners to work and think flexibly, which is a core element of the MEAM Approach: *"If we have more funding, it will enhance our service. […] We would have the capacity to be more flexible in our approach, respond sooner to situations. With MEAM, if patients are identified, with more resource we'd be able to respond sooner. We already have a significant caseload – all our clinicians are above their capacity."* Mental health partner
How to make it happen	Better funding for mainstream mental health services more generally would free up capacity for them to engage effectively with local work developed using the MEAM Approach. Local or national data demonstrating the impact of MEAM Approach work can also be used to build an evidence-based case for increasing time and resource specifically for involvement in local MEAM Approach work (see key finding 6 in the year 4 main report).
Source of evidence	• MEAM staff consultation • Local area lead consultation • Mental health partner interviews • Deep dive interviews

Figure 6: Enabler 3: More effective partnership working as part of the response to COVID-19

More effective partnership working as part of the response to COVID-19	
Overview of enabler	Although the pandemic posed challenges to further involvement of mental health partners in MEAM Approach partnerships in some cases, as described in section 0, the majority of stakeholders reported that partnership working between agencies that support people experiencing multiple disadvantage – including statutory mental health services – increased in response to the COVID-19 pandemic and the 'Everyone In' policy.
How this supports involvement	In some areas, this enhanced partnership working led to greater involvement of statutory mental health partners in MEAM Approach partnership work more generally; stronger working relationships developed between mental health services and other partner agencies (and the individuals within them) and mental health partners were able to see the mutual benefit of their involvement. The COVID-19-related partnership working also improved inter-agency understanding of each other's roles and remits, helping to reduce another barrier to the effective involvement of statutory mental health partners in MEAM Approach partnerships.
How to make it happen	Shared aims and responsibilities, created by the 'Everyone In' protocol, provided a focus and common ground for partnership working. The co-location of staff from different agencies in COVID-19 hotels or hostels also enabled partnership working. Local areas can build co-location and shared aims and responsibilities into their ongoing pandemic response and other future strategies. See also the year 3 thematic report, which identifies 11 key features of effective partnership working.
Source of evidence	• Mental health partner interviews • Deep dive interviews

Local area case study 3: statutory mental health services' involvement supported by funding and closer partnership working in local area L

The Homeless Mental Health team in local area L has recently been expanded through **NHSE funding**. The team consists of two social workers, a clinical psychologist and a CPN. The team's role involves assessing people who are homeless (or in danger of becoming homeless) and navigating the system with them to ensure they get to the services they need. The team can also deliver interventions and trauma management.

Local partners described how the team has helped to achieve positive outcomes for their clients. They noted the pivotal role the NHSE funding has played in the establishing and expanding the team:

"We've been really lucky to have received the funding for the Mental Health Homelessness Team. I can't imagine not having that service now."

Partner, local area L

The COVID-19 pandemic created the conditions for **closer partnership working** between the multiple disadvantage coordinators in local area L and the Homeless Mental Health team:

"Up until a year ago, my way of working was that if the client had a designated mental health worker, then I would link in with the mental health worker. It's only since COVID-19 that a relationship seems to have been formed between the mental health team and the Rough Sleeper/MEAM teams."

Partner, local area L

Co-location was also a key factor here. Being based in the same location (COVID-19 hotels and hostels) allowed partners from different agencies to draw on each other's expertise more informally, learn about each other's ways of working and develop closer working relationships.

However, the increased engagement with multiple disadvantage coordinators by the mental health team may not be sustainable, highlighting the need for continued work to sustain these newly formed partnership relationships:

"Once COVID conditions are no longer pressuring this partnership working, I don't think things will keep progressing. The pandemic has highlighted massive gaps in communication between organisations, it forced people to work together. The foundations are now there - but I don't know if this will continue and flourish and become something bigger. Sometimes what happens is that complacency kicks in..."

Partner, local area L

Figure 7: Enabler 4: Specific roles acting as "bridges" between mental health services and other partners

Specific roles acting as "bridges" between mental health services and other partners	
Overview of enabler	Specific people or roles within mental health services with a good understanding of multiple disadvantage and partner agencies (or vice versa) can serve as a conduit between mental health and other agencies, and/or act as a key point of contact for matters related to multiple disadvantage. These people are often described as "bridges" between mental health services and the rest of the MEAM Approach partnership.
How this supports involvement	People in such bridging roles can communicate well with both statutory mental health services and other MEAM Approach partners, and build understanding between them. This helps to address barriers to statutory mental health partners' involvement caused by differences in organisational cultures and a lack of common language and understanding of each other's services, remits and ways of working.
How to make it happen	"Bridging" roles are often held by specialist mental health workers, as in the case study from local area G below. Securing funding for and creating specialist mental health workers can therefore help put such "bridges" in place.
Source of evidence	• MEAM staff consultation • Mental health partner interviews • Deep dive interviews

Local area case study 4: specialist mental health worker as a "bridge" in local area G

In local area G there is a newly formed specialist homeless mental health service. The service is based within the council but the team includes a CPN who is employed by the local mental health trust. This service is described as a major success locally, because it is understood to have made a significant improvement in the lives of local people who are rough sleeping, and because it has brought the local mental health trust and MEAM Approach partnership to work together more closely:

*"The best examples of mental health engagement are where the trust has employed someone to work as a **bridge.** In [local area G] [the Homelessness CPN] is that bridge and gives navigators that language. That's where good practice is, someone to sit outside the trust, to be that engagement lead. She's overwhelmed, they need more of her."*

MEAM staff member

Figure 8: Enabler 5: Direct involvement in MEAM Approach partnerships

Direct involvement in MEAM Approach partnerships	
Overview of enabler	The direct involvement in MEAM Approach partnerships by statutory mental health partners can help overcome some barriers to their engagement and improve support for people experiencing multiple disadvantage. In turn, this can catalyse their further involvement.
How this supports involvement	Direct involvement enables increased engagement through two key mechanisms: • **"Learning by doing":** Through working with colleagues from other partner organisations, staff from mental health services improve their understanding of multiple disadvantage and become more skilled at supporting this group of individuals. Through this process individual staff members can better understand the need for working collaboratively and/or flexibly, and organisational cultures may begin to shift. • **Building understanding between organisations**: As with the increased partnership working in response to COVID-19, direct involvement in MEAM Approach partnerships helps improve agencies' understanding of each other's roles and remits, and to "speak each other's languages", overcoming a key barrier to the involvement of statutory mental health services.
How to make it happen	Local areas can create structured opportunities for statutory mental health partners to become involved in MEAM Approach partnerships and related delivery, such as formalising arrangements for joint outreach or partnership working to support individual clients. However, any level of participation by statutory mental health partners may be beneficial – this can then be developed into greater involvement over time, particularly if other enabling conditions are also present.
Source of evidence	• MEAM staff consultation • Mental health partner interviews • Deep dive interviews

Figure 9: Enabler 6: Workforce training and development

Workforce training and development	
Overview of enabler	Formal training for mental health staff on working with people experiencing multiple disadvantage helps ensure that better practice becomes more widespread regardless of existing structures and cultures, and that it does not depend on the few individuals who are directly involved in MEAM Approach work.
How this supports involvement	Formal training helps develop the workforce's understanding of how best to support people experiencing multiple disadvantage and ensure they have the right skills to support this group. This can influence individual staff members' practice and also help to shift organisational culture towards more collaborative and flexible approaches. Training shared between partner organisations can also support involvement indirectly, through improving inter-organisational understanding: *"We've had lots of workshops together now and realise even language has been a big barrier - a word in our service means something else in a mental health service (e.g. rehabilitation, detox). There was lack of understanding about what each other did and did not do... and there was lots of frustration. It was about challenging all of this. We do reciprocal training, do joint team meetings, and also joint training."* Substance misuse partner
How to make it happen	Local areas can deliver shared training for staff from all partner organisations on best practice in supporting people experiencing multiple disadvantage. This could be training run internally, by local organisations. The central MEAM team are also able to offer training on particular topics, such as trauma-informed approaches.
Source of evidence	• MEAM staff consultation • Mental health partner interviews • Deep dive interviews

5.3.2 Enablers of strategic involvement

The tables below present an overview of each strategic enabler and how it supports involvement of statutory mental health services in the strategic work of local MEAM Approach partnerships.

Figure 10: Enabler 7: Strategic buy-in from statutory mental health services and related agencies

Strategic buy-in from statutory mental health services and related agencies	
Overview of enabler	Strategic buy-in means there are senior leaders (in this context, from statutory mental health services and related agencies) who value, support and advocate for MEAM Approach work.
How this supports involvement	Strategic buy-in supports involvement of statutory mental health partners in MEAM Approach partnerships by ensuring that work related to the MEAM Approach becomes or remains a strategic priority for mental health partners. This enables further engagement in MEAM Approach partnerships for both strategic and operational staff from statutory mental health services. This prioritisation is of particular importance given the competing priorities and demands from multiple sectors: *"The requirements of different agencies – it's all about prioritising. If I was to do all I was asked to do I would need 100 hours in a day […] the people that shout the loudest are the ones I think are most important and who I give the most attention to."* Mental health partner Strategic buy-in is also necessary for giving staff permission and autonomy to work flexibly to support people: *"Just having mental health at the table would bring information about risk and needs […] But without permission for those workers to work differently it could still be limited. The involvement needs to be wider than just operational. And even if commissioners are involved, we still then need senior strategic leaders to work on this."* Mental health partner
How to make it happen	Local areas can use local or national data to demonstrate the impact of MEAM Approach work. They can identify key strategic priorities for statutory mental health partners and articulate the ways in which engaging with the MEAM Approach partnership and work can help partners to address these priorities. For example, this might mean placing an emphasis on how work developed using the MEAM Approach could address challenges around dual diagnosis pathways or reduce the resource required for repeat emergency support for people who are poorly supported by current services – see enabler 11.
Source of evidence	• MEAM staff consultation • Local area lead consultation • Mental health partner interviews • Deep dive consultation

Figure 11: Enabler 8: Commitment from leaders to "think differently"

Commitment from leaders to "think differently"	
Overview of enabler	A commitment from leaders in statutory mental health services to "think differently" increases their openness towards trialling new ways of working, or allowing staff to trial new ways of working, engaging with new partners and/or re-aligning their work with the principles of the MEAM Approach.
How this supports involvement	Commitment by leaders from mental health services to "think differently" in turn encourages and enables operational staff to work and think differently: *"It takes real commitment from managers to free up protected time for people to train differently, think differently, reflect together, allow each other to take risks and work differently."* Mental health partner When leaders "think differently" this can also help change overall organisational culture and policy. This is important because mental health services' less flexible approach to working with people experiencing multiple disadvantage is often described as a barrier to their involvement with their local MEAM Approach partnerships. *"The culture of mental health services hasn't quite shifted as quickly as the ideology of how flexibly we should be working with people facing multiple disadvantage."* Mental health partner
How to make it happen	Local areas can use local or national data to demonstrate the impact of MEAM Approach work. Case studies or similar approaches capturing the improvements experienced by individual people can be particularly effective in helping leaders and others to understand the importance of thinking and working differently. In addition, training for people in leadership roles can enable them to better understand multiple disadvantage and how to support people who experience it, as well as building the leadership skills required to push forward changes in culture and practice in their organisations/sectors.
Source of evidence	• MEAM staff consultation • Local area lead consultation • Mental health partner interviews • Deep dive consultation

Figure 12: Enabler 9: Tenacity and persistence by MEAM Approach leads and others in the partnership

Tenacity and persistence by MEAM Approach leads and others in the partnership	
Overview of enabler	Local MEAM Approach partnerships that have successfully engaged mental health partners have described how their tenacious approach of communicating the benefits of involvement led to statutory mental health services slowly becoming involved in the MEAM Approach work.
How this supports involvement	Engaging statutory mental health services with MEAM Approach partnerships can take time. A tenacious approach acknowledges that mental health partners may initially be reticent to involvement with MEAM Approach partnerships, due to long-established ways of working or a lack of resources to focus on the partnership, but that persisting in communicating the mutual benefit of involvement for mental health partners and the partnership more widely can eventually result in greater engagement from these services.
How to make it happen	This requires an enduring and consistent effort by committed local MEAM Approach leads and other partners who have committed to local work developed using the MEAM Approach, with a clear vision for success. In order for this to be possible, local leads need time built into their roles for building and maintaining relationships and for generating evidence targeted towards audiences in statutory mental health services.
Source of evidence	• Deep dive consultation

Local area case study 5: strategic buy-in and tenacity and persistence in local area U

The local MEAM Approach partnership in local area U has achieved **strong strategic buy-in from mental health partners**, particularly from one key individual who is a commissioning manager from Adult Social Care (whose portfolio includes mental health). Partners from local area U described how this strategic partner "flies the MEAM flag" (i.e. advocates for and showcases the benefits of the MEAM Approach within their organisation). They view this partner as driving mental health services' involvement in local work developed using the MEAM Approach by connecting key contacts within mental health services with representatives from other MEAM Approach partner agencies:

"He's a commissioner that really drives stuff like this. I think without him something like the MEAM House[10] wouldn't get off the ground, get the funding. He chairs the meetings. Having a commissioner that is dedicated is a real benefit. [He] pulls us together and holds us to account. He keeps the consistency and links us all together. He's a real key player in helping the city connect a bit more."

Partner, local area U

Partners in local area U also believe their **tenacity and persistence** has been key to engaging with mental health services and bringing them on board at a strategic level, a process that has taken several years:

"It's also about not accepting that mental health services are hard to reach. I've worked in other areas where it's a given that mental health won't come to meetings and won't get involved. […] We don't accept that in [local area U], we constantly push back on it and hopefully that is the difference […] It is a bit like Groundhog Day - we are saying the same things and going round in circles. But we have to be persistent to get the results. The MEAM house - we were talking about this six years ago, I think. It's been a long process – we've been talking about this for so long."

Partner, local area U

[10] This is a recently developed shared accommodation for three or four people experiencing multiple disadvantage, developed collaboratively with mental health services, a local homelessness service and the local authority housing service.

Figure 13: Enabler 10: National directives and policy

National directives and policy	
Overview of enabler	The involvement of statutory mental health partners in MEAM Approach partners is dictated by the priorities set out by and funding attached to national directives and policy.
How this supports involvement	National directives and policies hold influence over the priorities of statutory mental health services – as such, if multiple disadvantage is highlighted as an area of focus in national mental health policy, this can result in greater engagement from mental health partners in local MEAM Approach partnerships, as one mental health partner described: *"National directives are powerful and translate into local priorities. If the Long-Term Plan talked about multiple disadvantage that would help. […] Also, directives to work with community partners."* Mental health partner
How to make it happen	Gathering data and conducting evaluations will help build the evidence base for why and how statutory mental health services should be supporting people experiencing multiple disadvantage, which can be used to influence national policy. The community mental health services transformation programme[11] may provide an impetus or directives for the types of change to mental health services which would be of benefit to people experiencing multiple disadvantage. It may also offer opportunity for closer working between local MEAM Approach partners, people with lived experience and statutory mental health services.
Source of evidence	• Mental health partner interviews • MEAM staff consultation

[11] For more information, see: https://www.england.nhs.uk/mental-health/adults/cmhs/.

Figure 14: Enabler 11: Shared strategic priorities

Shared strategic priorities	
Overview of enabler	Shared strategic priorities are issues recognised as key areas of focus by senior strategic staff across multiple services/agencies /sectors.
How this supports involvement	Highlighting shared strategic aims (such as trauma-informed care or "dual diagnosis") has been described as an effective way of engaging mental health partners, emphasising how the priorities of mental health services align with the priorities of the MEAM Approach partnership. "Dual diagnosis" is now a priority area of concern for some mental health services and was highlighted several times throughout the research as a potential shared priority across multiple partner organisations. By demonstrating how the priorities of mental health services align with the priorities of the MEAM Approach partnership, there is scope for MEAM partners to gain greater strategic buy-in to their MEAM Approach work from strategic mental health leaders.
How to make it happen	Where shared priorities that relate to multiple disadvantage exist, their commonality should be recognised and form the basis of a shared programme of work in line with the priority.
Source of evidence	• Mental health partner interviews • Deep dive interviews

Local area case study 6: addressing the "dual diagnosis" challenge as a shared strategic priority

Local area G has good operational involvement from statutory mental health partners but wishes to increase its strategic engagement with local mental health trusts. There is a heightened interest in reviewing support and pathways for people with co-occurring substance misuse and mental ill health in local area G and ensuring suitable support for people with a "dual diagnosis" is a strategic area of interest for the local CCG. As such, the MEAM Approach partnership plans to engage with the CCG and other mental health partners on the shared strategic priority of dual diagnosis. This strategy illustrates how a focus on shared strategic priorities can be used to foster engagement with mental health partners at a strategic level and bring about change in key areas of strategic interest. This work could in turn lead to greater involvement of strategic mental health partners in the MEAM Approach partnership more generally, and more widespread improvements in access to and support from statutory mental health services for people experiencing multiple disadvantage (beyond those with dual diagnosis).

6 Other forms of effective support and opportunities

6.1 Overview

Although the focus of this research is on statutory mental health services, it is important to recognise that other types of support and activities can also play a key role in supporting people's mental health. This section sets out the main types of support and interventions identified by our research that may benefit the health and wellbeing of people experiencing multiple disadvantage.

6.2 Role of other (non-mental health) services in supporting the mental health of people experiencing multiple disadvantage

Some stakeholders highlighted that interactions with *all* services have an impact on people's mental health, and that there should therefore be an increased focus on "making every contact count" for people's mental health, with this being the responsibility of all services, not just mental health services.

> *"A misconception is that if people have mental distress and trauma, they automatically need secondary care. Often they do. But sometimes mental health services don't help - or do more damage than good. We need to recognise that all support services support people's mental health. That's our obligation, to help the wider network understand that. It can be frightening to work with people that are high-risk while not having this expertise. We can assure people - you can do this, you have that relationship. We can support you to do your own work beautifully - they might just need a bit of training or reassurance […] Mental health isn't the sole job of mental health services. It's about creating communities and societies that are able to recognise trauma."*
>
> Mental health partner

This is the approach being taken in local area G, as set out in local area case study 7 below, where efforts are underway to upskill staff from partner agencies so that they can understand when statutory mental health support is and is not required, and so that they are better equipped to support their clients' mental health themselves, where appropriate. While mental health trusts may not have the resources to support everyone themselves, there is work they can do within their limited resources to help ensure people have the best support possible from a range of partners.

Local area case study 7: the role of non-mental health services in supporting people's mental health in local area G

Strategic leads in local area G are focussed on supporting non-mental health services and their staff to support people's mental health. This work includes workforce development to help staff understand when people do – and do not – require support from statutory mental health services:

"We work really hard on workforce development to understand what is needed for our clients, to hopefully reduce the intensity of the claim that 'CMHT is what our client needs'. We are working on this - it is absolutely not always the case and we are trying to get this message to our frontline."

Partner, local area G

In parallel, they provide training to staff from all local services to equip them to better understand people's mental health needs and to support people's mental health where appropriate. They hope this will reduce the extent to which people experiencing multiple disadvantage "bounce" between services in the local system while also reducing pressures on statutory mental health services, by providing earlier support to people before they need statutory intervention:

"Strategically, there has been the problem of all mental health needs being sent to statutory services when it does not have to be the case. We want to run […] training to show how mental health is everyone's business, and how all services can work in this domain because of psycho-social mental health etc. We need to show how it's everyone's business to take the strain off statutory mental health services and enable all organisations to do work related to this at the appropriate level."

Partner, local area G

6.3 A specific role for the voluntary and community sector

Many partners from statutory mental health and other services described how voluntary and community sector services (both mental health specific and others) often support people who face barriers to accessing statutory mental health support (see section 2). The voluntary and community sector is therefore stepping in to support the people who are falling through the "statutory cracks":

> *"These are the services that people are using whilst falling through the statutory cracks, or whilst they are trying to become "stable enough" to get statutory support i.e. the dual diagnosis issue."*
>
> Partner from in-depth research area

While voluntary and community sector support should not be a substitute for statutory sector services for those who need them, many partners from mental health and other services noted that voluntary and community sector organisations can play a key role in providing mental health and wellbeing

support for people experiencing multiple disadvantage. For many stakeholders, the flexibility of the voluntary and community sector means that it is particularly well-placed to support people experiencing multiple disadvantage:

> *"What the voluntary sector brings to it is that we can be quite innovative and respond to clients. Being in the voluntary sector does provide a bit more flexibility on how we can do things, be more flexible. We also have a bit more time to work with people. We are also another route into statutory services, if we work with people we can refer them in."*
>
> Partner from in-depth research area

Yet, for many respondents, the voluntary and community sector is currently "undervalued" as a resource for supporting the mental health of people experiencing multiple disadvantage. They felt it would be beneficial for voluntary and community sector services to become even more involved in local MEAM Approach partnerships and the delivery of coordinated support. As a result, partners from several areas described strategic mental health priorities that involve strengthening the voluntary and community sector locally and its involvement in MEAM Approach partnerships. If this approach is to truly "value" the voluntary and community sector, then it must be accompanied by adequate additional funding and support.

6.4 Peer support

Some stakeholders highlighted the key role that peer support can play in improving the mental health and wellbeing of people experiencing multiple disadvantage, particularly in relation to building relationships and trust. For example, a mental health partner described the model of recovery they used in their specialist service and the central role played by support from other people with lived experience:

> *"My role as a psychologist is to help people stabilise. But for people who are experiencing psychosis - there is that need for some sense of connectedness to people who've experienced similar things to them. We can't offer everything. […] People need relationships to start building meaning. We need other organisations – Hearing Voices groups, people with lived experience, to support the work we do. And we can't do it without them and working in a linked-up way."*
>
> Mental health partner

6.5 Importance of meaningful activities

Meaningful activities, hobbies and other positive interests, such as art groups, sports teams and other recreational activities, are also central to people's mental health and wellbeing. However, when resources are stretched it can be difficult to focus on such interventions:

> *"Sport, art, leisure, books - there are lots of things that can be done to boost people, give people experiences, build confidence, allow them*

to follow their interests. But we are stretched so far it's hard for us to do things like this anymore."

Partner from in-depth research area

Stakeholders also described the importance of services and support that people could dip in and out of as required, and the need to move away from the expectation that people will have a linear journey to recovery.

Local area case study 8: connecting people into the community in local area U

The importance of meaningful activity in the community is recognised in the city-wide mental health strategy in local area U. Their approach draws on the community-based model used in the Italian city Triste, aiming to connect people with activities and opportunities already existing within their city. Local area U's strategy relates to support for everyone in the area, but the MEAM Approach partners recognise its particular relevance and importance to people experiencing multiple disadvantage, helping them to "live normal lives supported by community and family". Changing the culture and structure of a city-wide system is a long-term endeavour.

7 Conclusion

People experiencing multiple disadvantage face many barriers to accessing and receiving effective support from statutory mental health services. This year's thematic evaluation research shows that, when statutory mental health services are actively involved in their local MEAM Approach partnerships, it can help overcome these barriers and bring about more effective access and support, for example with more equitable access to referral and treatment pathways, more flexible and creative approaches to enabling access and delivering support, more trauma-informed approaches, and positive and trusting therapeutic relationships.

The involvement of statutory mental health partners in local MEAM Approach partnerships can also have wider benefits like improved partnership working and understanding between different organisations, improved information sharing and better supervision and support for workers supporting the mental health of people experiencing multiple disadvantage. This in turn has further positive impacts on people experiencing multiple disadvantage, staff and the wider local system.

However, despite the clear benefits, levels of involvement by statutory mental health services tend to be relatively low across the MEAM Approach network, with stakeholders describing many barriers to their involvement. To encourage and enable statutory mental health services to become more involved in local MEAM Approach partnerships, local areas and national policy makers should therefore focus on creating conditions that enable their participation.

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.

Most areas across the MEAM Approach network would benefit from fostering these enabling factors to encourage and support greater involvement of statutory mental health services in developing and delivering improved support for people experiencing multiple disadvantage.

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