Evaluation of the Changing Futures 'Three Lens Model' Pilot

June 2025

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Executive summary

"She was the key to unlocking his future… he's now in recovery, with his own place, after five years in a tent."

The Plymouth Three Lens Model (3LM) pilot, delivered through the Changing Futures Plymouth programme, was an innovative approach to supporting individuals experiencing Severe and Multiple Disadvantage (SMD). In Plymouth, it has long been recognised that most mental health support for people experiencing SMD is provided by non-clinical teams, based in the voluntary and community sector and outside of secondary mental health services. It has also been recognised that navigating the mental health system to access timely support can be challenging for service users and professionals advocating on their behalf. By integrating diagnostic, trauma-informed, and strengths-based perspectives (the three lenses), the model aimed to create a coherent framework for mental health support that could be practically applied across statutory and voluntary services.

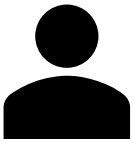
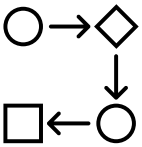
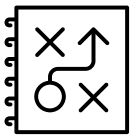
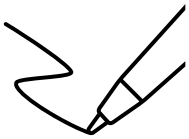
The pilot centred around embedding an experienced mental health practitioner into non-clinical teams such as probation, homelessness outreach, and voluntary sector organisations. By embedding a mental health practitioner, the hope was to strengthen relationships between VCSE partners and statutory mental health partners through the development of skills, understanding and connection while growing capacity in the system to safely support people experiencing distress. Over nine months, the practitioner worked flexibly across services, offering joint visits, informal supervision, training, and strategic advocacy. This relational and assertive outreach approach, which contrasted restrictive access routes, thresholds and criteria often seen in traditional services, adapted to the needs of individuals, and proved transformative. The practitioner supported 79 individuals, with 54 of them receiving effective care without needing referral to secondary mental health services. This demonstrated that teams and systems outside of specialist mental health services, when enhanced with clinical support and guidance, could holistically meet complex needs more effectively.

The pilot also facilitated access to housing for eight individuals who had previously been unable to secure accommodation. This was achieved through cross-sector collaboration and the provision of health evidence for priority need status. The co-location of a mental health practitioner helped staff navigate fragmented systems, challenge rejected referrals, and advocate more confidently for their clients. The practitioner's input was described as pivotal in improving outcomes, particularly for those traditionally viewed as 'hard to reach'.

Staff across probation and VCSE services reported increased confidence and knowledge in working with mental health and trauma. The practitioner provided informal supervision and access to targeted training, including trauma stabilisation, which contributed to improved staff competency and wellbeing. The role bridged gaps between siloed services, enabling smoother communication and more coordinated care. The pilot highlighted the importance of relational support, continuity, and flexibility in engaging individuals with complex lives.

Feedback from service users reinforced the value of trusted professionals, safe environments, and accessible support. Some described barriers such as stigma, mobility issues, and lack of weekend services, which underscored the need for assertive outreach and person-centred care. The practitioner's work was consistently praised by both staff and service users, with many expressing frustration at the discontinuation of the role and advocating for its reinstatement or expansion.

In conclusion, the pilot successfully demonstrated how building relationships while embedding clinical expertise into non-clinical settings can improve outcomes, empower staff, and bridge systemic gaps. Provision of bespoke, wraparound support using the three lenses to individuals helped prevent further crisis and supported recovery. The Three Lens Model provided a coherent and flexible framework that resonated with practitioners and service users alike. The report strongly recommends sustained investment to support and prioritise using these approaches when working with SMD, noting that even one full-time practitioner over nine months made a measurable difference across the system.

Joint visits to enhance partnerships and shared understanding 	**Bespoke support** to suit individuals and led by them 	**Flexible support** to meet people where they are at when it matters to them 
Navigating systems and advocating for easy access 	**Developing a shared understanding** with people using services and knowing when to escalate concerns 	**Supervision** for staff working with SMD, focusing on vicarious trauma and stress 
Workforce development and learning opportunities for this working with SMD 	**Strategic work** to improve pathways and maintaining support for individuals 	**Learning and evaluation** to constantly learn, develop and improve 

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1. Introduction

This Changing Futures pilot is the practical application of two models, both underpinned by ideas which need testing in our stressed, often bewildering mental health system. First that because much, if not most, mental health support for people with complex needs is provided by teams outside of secondary mental health services, experienced mental health workers should be providing embedded outreach support to those teams. Secondly, as articulated in the Plymouth Three Lens Model, we need to bring together the different ways of thinking about mental health and illness as one model in order provide coherence for populations and staff.

"The expertise that the Three Lens Model has been able to provide outreach workers has been fundamental to changing how practitioners work with rough sleepers."

This report describes what happened in the pilot and provides practical theories as to how others can put the ideas into practice to make a real difference to individuals and to support the system.

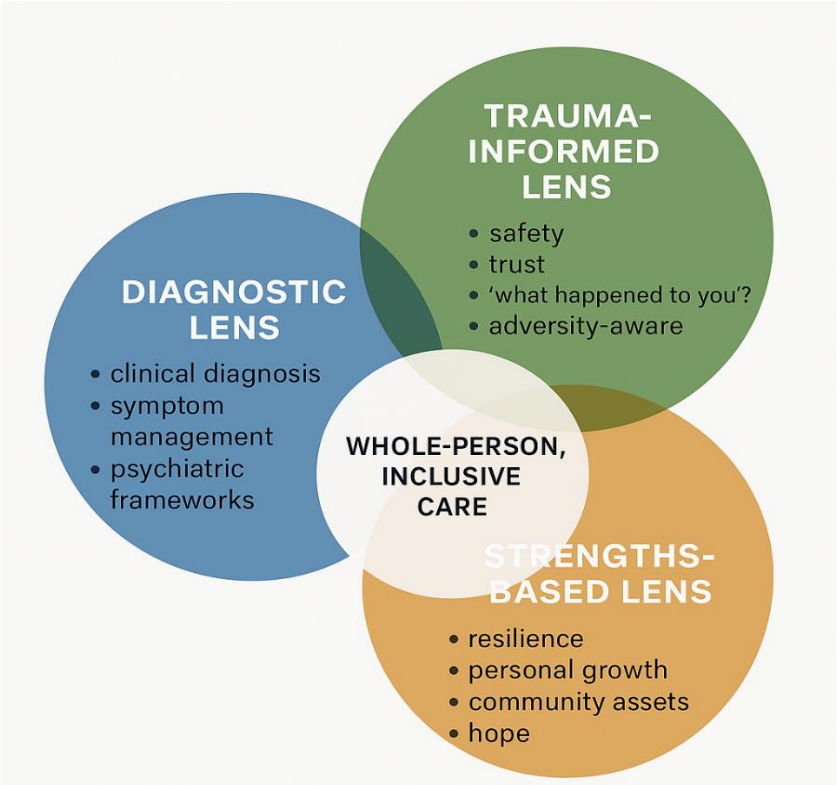
1.1. The Plymouth Three Lens Model

The Plymouth 'Three Lens Model' was developed by opinion leaders from the Voluntary, Community and Social Enterprise Sector (VCSE), Primary Care and Mental Health Care within Plymouth and wider Devon. The aim of the model was "to bring together different ways of understanding mental health difficulties and their origins, to provide coherence (rather than bewilderment) for community residents and practitioners in the face of multiple, at times competing, models and approaches." There is an ambition to agree on practical ways to create a balance between the more dominant diagnosis-based models of practice and other important approaches, including trauma-informed, strengths-based and person-centred frames of reference.

Combining these lenses to provide a more holistic, bio-psycho-social approach, the mental health support aimed to:

- Recognise the importance of past trauma, adversity and loss, current relationship challenges, social inequality and injustice and survival responses to develop shared understanding between staff and person using service (therapists might call this a formulation) and to include these in the plan for support (i.e. the process is **trauma-informed**).
- Use the **diagnostic** tradition and our understanding of neuroscience to help an individual understand the different emotional and psychological experiences they have (traditionally called symptoms) and the types of self-help strategies, therapies and medications that might be helpful in the future (i.e. recognises value in diagnostic and biological knowledge of mental health).

- Identify personal, relational and community strengths which have contributed to skills already developed, and progress these to further address adversity (i.e. is **strengths based** and socially oriented care).



Please see *Appendix A* for the full paper "A Shared Approach to Mental Health – The Plymouth Three Lens Model."

1.2. Changing Futures Plymouth

Changing Futures in Plymouth is funded by the Ministry of Housing, Communities and Local Government and the National Lottery Community Fund and aims to improve outcomes for adults experiencing severe and multiple disadvantage (SMD), including combinations of:

- Homelessness
- Substance Use
- Mental Health Issues
- Domestic Abuse
- Contact with the Criminal Justice System

(Ministry of Housing, Communities and Local Government, 2021).

The ethos of the Changing Futures Plymouth team is to support services that are already operating in the area, by testing and learning from innovative ways of working. The aim is to embed this learning into existing teams to provide a legacy of long-term support and systems change.

Changing Futures provided support both to develop the Plymouth Three Lens Model, and to put it into practice within the SMD environment.

1.3. Key Teams

Team name	Organisation	Offer
Complex Needs Team (CNT)/Livewell Community Substance Use Services	Livewell Southwest	Multi-disciplinary team of community mental health nurses, social workers, support recovery workers, with specialist skills and knowledge in mental health and substance misuse.
George House (BCHA Hostel)	Bournemouth Churches Housing Association (BCHA)	Provides temporary supported accommodation for individuals and couples over the age of 18 who are homeless.
Devonport Lifehouse	Salvation Army	Supported residential, medium term accommodation solution for single 18+ males or females who are experiencing homelessness.
Shekinah Homeless Drop In Centre	Shekinah	Provides a range of services for homeless, addicted, socially excluded, and vulnerable adults
The Women's Pod	Probation Service	Supporting women who are on probation.
Homelessness Intervention Team	The Harbour Centre	Providing drug and alcohol support to people experiencing homelessness
Changing Futures Plymouth	Plymouth City Council and partners	Programme supporting city wide partners to work innovatively to improve outcomes for people experiencing SMD.
Rough Sleeper Team	Plymouth Access to Housing (PATH)	Help people who are rough sleeping get into accommodation, and supporting those at risk of sleeping rough, preventing them from reaching the streets.

Plymouth Soup Run	Volunteer led organisation	Community and faith driven service providing free food and hot drinks to homeless, hungry and vulnerable people 365 days a year.
Health Inclusion Pathway, Plymouth (HIPP)	Livewell Southwest	Supporting people experiencing homelessness with complex health and social care needs access standard services and complete medical treatments.
Peer Research Network	Improving Lives Plymouth (ILP)	Staff members with visible and valuable lived experience influencing service improvements, promoting trauma informed workplace practices, and engaging with people using services in creative ways.

2. Key Pilot Objectives

A Mental Health Lead (RR) was recruited from within Livewell Southwest to fulfil the role of Three Lens Model practitioner for twelve months on a secondment basis. RR is a trained occupational therapist (OT) with considerable experience working across mental health systems in Plymouth, working with people experiencing SMD, and works to the person-centred ethos of the three-lens model, utilising, strengths based, diagnostic and trauma informed approaches with individuals.

2.1. Initial role objectives:

- Enhance practitioners' knowledge and practice when working with mental distress and increase their confidence in navigating the available mental health support in the city.
- Support the design, development and delivery of Three Lens Model focused training.
- Work strategically with mental health teams to improve navigation of mental health services/no wrong door provision, for people and partners working in non-clinical organisations, based on experiences of staff and people using services.
- Work with a peer researcher to co-produce development, implementation and evaluation of the model.
- Work with evaluation colleagues to evaluate the impact of the model on staff and the people using services.
- Work with senior leaders to explore possible opportunities for sustainability and lead implementation.
- Be an active member of the Changing Futures Team, attending meetings and events, and representing Changing Futures as appropriate.

Due to delays in the recruitment of a Mental Health Lead, and the changing landscape of services, the initial plan required adaptation. Initially, Plymouth Probation Service and The Harbour Centre were identified as organisations RR would work with to trial the pilot. It was recognised that the Complex Needs Team (CNT) had expanded to 'Livewell Community Substance Use Services' which included Psychology services, co-located at The Harbour Centre. The Psychology offer included joint working, training, supervision, formulation, reflective practice and debrief which covered many of the main aims of The Three Lens Model pilot. The pilot was trialled for six months in the Homeless Intervention Team based at The Harbour Centre due to the SMD focus. However, uptake was not significant enough for the pilot to be sustainable and after exploration of other services in The Harbour Centre, and trialling different ways of engaging with the staff, the pilot at Harbour ended due to a perceived lack of need within the service.

Additionally, after an initial exploration of The Women's Hub at Plymouth Probation Services it was identified that a similar pilot was being implemented from Devon Partnership Trust (DPT), and would run until April 2026. This pilot was offering joint assessment, supervision and formulation which covered the entire Plymouth Probation Service as well as Exeter and Torquay. Due to this, two full days a week in Plymouth Probation Service could not be justified based on the number of practitioners in The Women's Hub, and so the Three Lens Model offer was reduced to one day per week.

2.2. Adjustment to the Objectives:

As often happens with innovative, test and learn pilots it was necessary to work with a degree of flexibility and adjust to the service need. During the time spent with Homeless Intervention Team it was recognised that whilst the Livewell Community Substance Use Services offer two hours of mental health clinic slots each week to Shekinah, George House and Devonport Lifehouse, there was a gap in provision for people who were street homeless which required an assertive outreach approach: a proactive method of engaging with individuals in their own environment to offer support and services.

Following a period of appreciative enquiry, teams across the city who engaged with people experiencing SMD and who were keen to try a new way of working were identified to receive input from the Three Lens Model pilot, These were (i) PATH's Rough Sleepers Team and (ii) the Plymouth Soup Run (also working closely with the Shekinah drop-in centre). The offer was shaped to complement and enhance (not duplicate) the work of Livewell Community Substance Use Services.

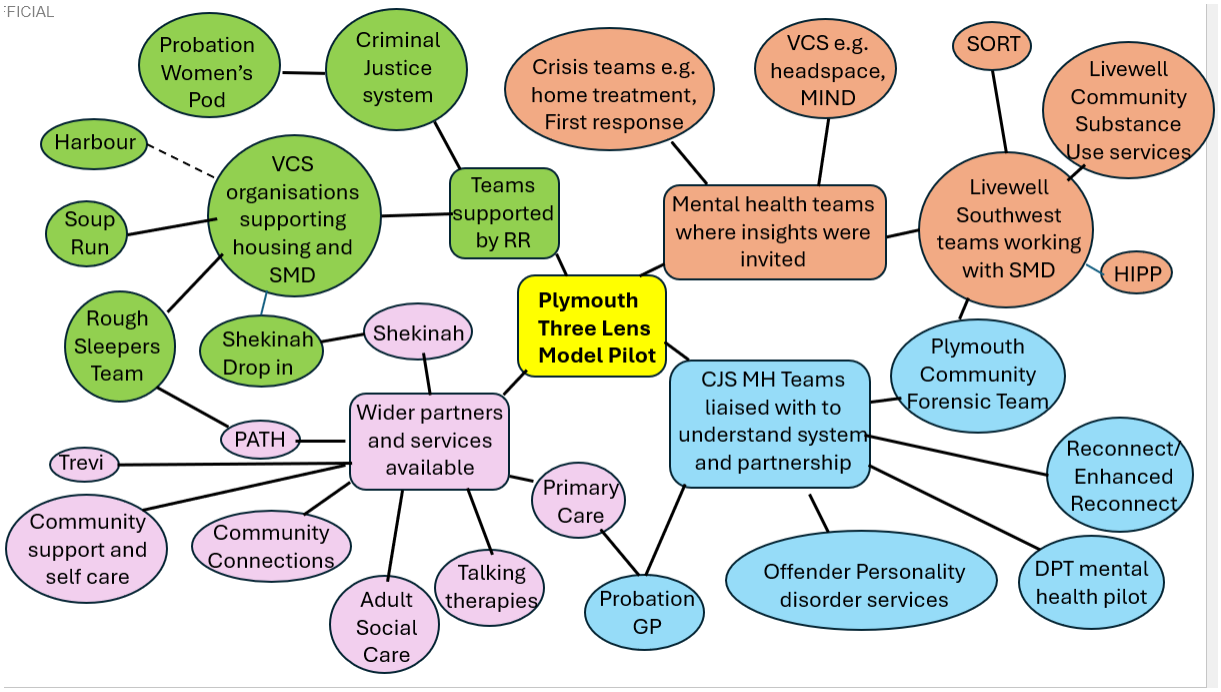
The initial objectives of the role remained, but with the following additional components:

- Completing joint visits via street outreach during PATH working hours (this could include early morning visits from 06.00-09.00 if needed).
- Joining the Plymouth Soup Run from 20.30-22.30 one evening per week to engage with people who did not often attend other services.
- Conducting joint visits at Shekinah flexibly throughout the week for people who have been signposted to attend during PATH morning welfare checks.
- Joining Shekinah's drop-in session every Friday between 09.00-13.00. The Homeless Outreach General Practitioner and Harbour 'Homeless Intervention Team' also ran clinics here at this time, which meant that they could access mental health focused advice and support during their clinic time to streamline support.
- Attending the weekly PATH Rough Sleeper Team multidisciplinary team meeting each week, to advocate from a mental health perspective. This was also attended by Plymouth City Council, BCHA, Trevi (women's charity), Plymouth Soup Run, Shekinah and Health Improvement Pathway Plymouth (HIPP).

- Providing written evidence for Plymouth City Council to support people to gain a ‘priority need status’ when somebody was street homeless with a health condition that would make them particularly vulnerable when sleeping outdoors.

3. The Plymouth Context – Mental Health Provision

3.1. Plymouth complex needs system teams and the Three Lens Model pilot.



There are existing mental health offers available to support people experiencing SMD. This section summarises those offers to give an overview of existing services, and how they interface with one another which has shaped the pilot and recommendations. In addition to the specialist services, GPs provide limited mental health care for those registered, including the GP Outreach Service providing care in homeless hostels, Shekinah drop-in and Plymouth Probation.

3.2. Homelessness

3.2.1. Livewell Community Substance Use Services

As Livewell Community Substance Use Services is co-located in The Harbour Centre, this provides an opportunity for cross sector working. This incorporates the CNT, Psychology services, Plymouth Specialist Addiction Services and the Community Home Detox Team. The CNT works with people who are currently open to The Harbour Centre for drug and alcohol intervention and who may experience combinations of mental health needs, physical health needs, homelessness and contact with the criminal justice system. The CNT offers a Monday-Friday, 9-5 service and includes Social Workers, Psychologists, Mental Health Nurses and Support Workers. There is currently no Occupational Therapy or Psychiatry provision. The CNT offer two hours of support per week to George House, Devonport Life house and Shekinah via a bookable clinic for brief advice, signposting and onward referral. Appointments are offered to anybody accessing those services, regardless of their substance use need. To receive longer

term mental health support from the CNT a person would need to be accessing The Harbour Centre via self-referral or the Criminal Justice Pathways. The CNT can accept referrals directly from Health Inclusion Pathway, Plymouth (HIPP) and can also refer directly into other secondary mental health teams following their mental health clinic assessments.

3.2.2. *The Health Inclusion Pathway, Plymouth*

The HIPP is a collaboration between Adelaide Street and St Levan GP Surgery, University Hospitals Plymouth, Plymouth City Council, Livewell Southwest and the VCSE of Plymouth Alliance. HIPP employ a Mental Health Nurse who jointly works as the Operational Manager. HIPP also employ a psychologist, offering wider support to The Plymouth Alliance. HIPP does not currently have Psychiatry provision. The HIPP works primarily from Derriford Hospital, supporting people experiencing homelessness who are frequently attending the hospital and who do not have support from any other community services. HIPP also offer clinics and short-term follow up post-discharge to embed people into relevant teams in the community. The HIPP team is not a secondary mental health service, but through the employment of a mental health nurse, they are able to conduct skilled mental health focused assessments and refer on to the most appropriate service that is available. Currently, however, not all mental health teams in Livewell Southwest accept referrals from HIPP. The team offers a Monday-Friday, 9-5 service.

3.2.3. The Specialist Outreach Recovery Team

The Specialist Outreach Recovery Team (SORT) is an amalgamation of the previous Assertive Outreach Team and Community Recovery Team. Since the developments of the Community Mental Health Framework, the Specialist Outreach Recovery Team offers a therapeutic, rehabilitation focused remit for the city. The assertive outreach remit for the city is currently being reviewed via the Assertive Outreach Working Group. SORT work with people in Plymouth experiencing 'Complex Psychosis' who have rehabilitation needs. This includes combinations of severe and enduring experiences of psychosis which may also include homelessness, co-occurring substance use, learning disability, neurodivergence, physical health concerns, contact with the criminal justice system, frequent admissions to hospitals and difficulty maintaining contact with traditional mental health services. SORT only accept referrals from other secondary mental health services and psychiatric wards where all attempts to engage the client via less intensive means have not been successful. SORT work with individuals who are homeless if referred via another secondary mental health team, but they do not specifically offer assertive outreach to engage people via homeless Drop-in spaces, hostels or via street outreach. SORT does not accept referrals from the HIPP or GPs. SORT offers a Monday to Friday, 9-5 service.

3.2.4. *Livewell Southwest*

Livewell Southwest offer a wide variety of other Mental Health Services, but are specialists in their area, and do not specifically have homelessness or SMD in their inclusion criteria in practice. Therapy focused services often advocate for people to have stable housing before accessing therapeutic interventions.

3.3. Criminal Justice

3.3.1. The Offender Personality Disorder Service

The Offender Personality Disorder Service, provided by DPT, has practitioners based in the Plymouth Probation Service. They are a Monday-Friday, 9-5 service and work alongside the Forensic Mental Health Service. They work with individuals who have committed offences and who also have a diagnosis of a Personality Disorder. They provide consultation, advice, and joint working as well as Mentalisation Based Therapy.

3.3.2. Reconnect and Enhanced Reconnect

Reconnect is a service provided by DPT. They are not based in the Probation Service offices but provide 'care after custody' and work alongside the Probation Officer. The aim is to transition individuals leaving custody into the relevant community-based services, including mental health care if this is indicated. This support can commence up to twelve weeks prior to release, lasting for up to six months post release. If somebody is considered to present as high or very high risk of harm to others, they are referred to Enhanced Reconnect. This is a psychologist led service and covers Devon, Cornwall, Dorset, Somerset, Bristol/Avon, Gloucestershire and Wiltshire. The service operates Monday to Friday, 9-5.

3.3.3. Plymouth Community Forensic Team

Plymouth Community Forensic Team is provided by Livewell Southwest, they work with individuals who are detained in secure hospitals in England and have a Section 117 entitlement to their care. The team also work with people in the community once discharged, with a focus on admission avoidance and work collaboratively with mental health teams and Liaison and Diversion (services which identify people who have mental health, learning disability, substance misuse or other vulnerabilities when they first come into contact with the criminal justice system as suspects, defendants or offenders) through case consultation and formulation. The Plymouth Community Forensic Team is not currently commissioned to provide support to Plymouth Probation Service practitioners, though there are times that they may jointly support an individual. This service operates Monday-Friday, 9-5.

3.3.4. Probation Mental Health Pilot

From April 2024-2026 DPT planned to trial hosting a Mental Health Nurse consultation post based in Plymouth, Exeter and Torquay Probation Services. This service operates Monday to Friday from 9-5. It provides advice, consultation and joint assessment to

Probation Officers, is focused on mental health. The nurse works with all teams in Probation, apart from the Women's Pod in Plymouth Probation Service, where the Three Lens Model pilot is based. This was planned to continue until April 2026, but due to the evaluation of the pilot indicating a lack of need and engagement, it will end one year early in April 2025.

3.3.5. Probation GP Clinic

A GP Clinic is offered at Plymouth Probation Services once a week as part of the GP Outreach service, where people with mental health and physical health concerns can be referred to a GP who has a particular interest in mental health. This can lead to referrals to mental health services if indicated and provide advice and guidance for the Probation Officer.

4. Practically Testing the Plymouth Three Lens Model

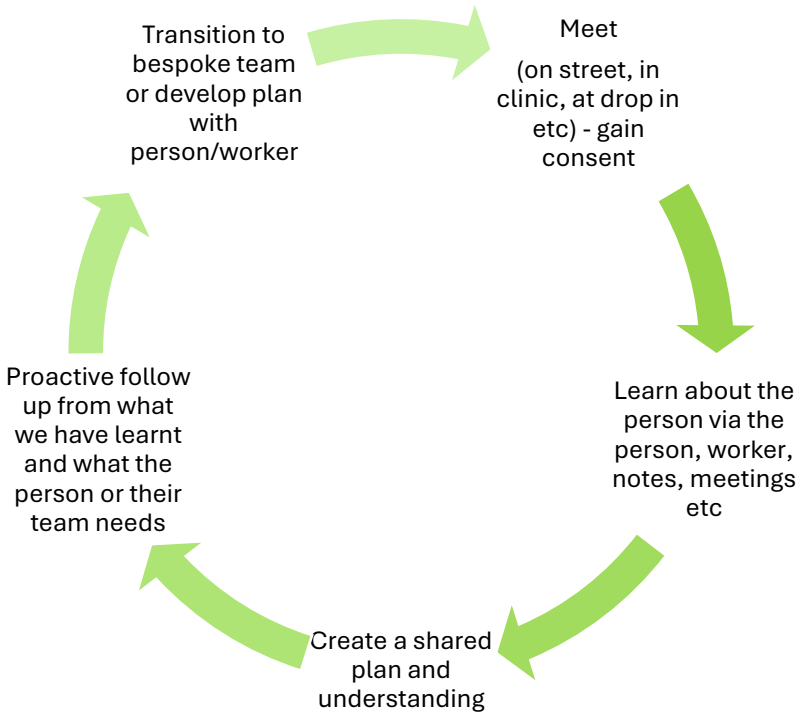
RR was based across each identified service for one day per week over a nine-month period to test practical ways to embed, adopt and upskill non-clinical practitioners to use all three lenses (diagnostic, strengths based and trauma informed) when working with SMD.

Referrals to request support from the Three Lens Model were completed by:

- Homelessness outreach workers
- Homelessness drop-in staff
- Probation Officers
- Substance Use Practitioners
- Homeless Outreach General Practitioner's
- Housing Officers
- Volunteers
- Complex Needs Navigators

Whilst the pilot was predominantly aimed at supporting the staff to develop their mental health knowledge jointly with the service user they are supporting, once the pilot was established some individuals did self-refer and ask for support directly from RR.

RR's approach to the work



- No fixed ‘caseload’
- Information sharing agreements and consent forms signed on entry to each service.
- Support can be provided individually for practitioners or jointly with the person.
- Agreement at each meeting what the plan is next and allocation of roles and actions.
- Notes and plans are recorded via SystmOne health system if clinically indicated.
- Weekly Rough Sleepers Team meeting to ensure nothing is missed.
- No fixed agenda, time slot or meeting place
- Inclusion criteria: experiencing mental distress, experiencing homelessness or unstable housing, using substances or alcohol and/or working with probation.
- No discharge, if the person moves out of area or goes to prison or hospital, the team will see them again when they return

5. Insights and Learning from Three Lens Model and Plymouth Mental Health Systems

5.1. Data Collection Methods

Changing Futures Plymouth have worked alongside Wilkinson Evaluation, The Plymouth Health Determinants Research Collaboration (HDRC) and ILP Peer Researchers to develop the evaluation for this pilot.

A number of data gathering approaches were implemented to understand Plymouth's systems for mental health support for people experiencing SMD and the impact of the pilot on voluntary and community sector partners RR worked alongside. These were:

- An anonymous survey was sent to statutory and voluntary mental health service providers in Plymouth (appendix B).
- Reflections from RR on the impact and challenges experienced during the pilot.
- A listening group facilitated by Peer Researchers with people attending the Shekinah drop in. Four people attended the group.
- An initial one-hour focus group with Plymouth Probation Service's Women's Pod attended by seven people.
- A closing one-hour focus group with Plymouth Probation Service's Women's Pod attended by seven people.
- A closing focus one hour group with Shekinah, Plymouth Access to Housing (PATH) Rough Sleepers Team and the Soup Run attended by seven people.
- An anonymous survey sent using a Microsoft Form via email to The Harbour Centre teams to understand the reasons for lack of uptake, this had no responses.
- An anonymous survey (see appendix C for questions) sent using a Microsoft Form via email to Plymouth Probation Service (Women's Pod), Shekinah PATH (Rough Sleepers Team) and Plymouth Soup Run and had ten responses. There is no breakdown of where responses are from due to the anonymity of the survey.
- An anonymous survey (see appendix D for questions) was sent to the wider services that have worked closely with the Three Lens Model including Plymouth City Council, Trevi, Shekinah/PATH Complex Needs Navigators and PATH Multiagency Rough Sleeper Support Workers and had six responses.

5.2. Staff Questionnaire - Understanding the Plymouth Mental Health System and Services

The purpose of the survey sent to statutory and voluntary mental health service providers in Plymouth was to gain insight into how the broader mental health system works with people experiencing SMD, and to influence to model as it developed. The survey (see appendix B for questions) invited information about barriers and enablers staff in the mental health system might face when working with SMD, and suggestions for improving access to support for this cohort of service users.

Questions were sent to service leads in Livewell to ensure they were happy with what was being asked, then internal email lists were used to share it with individuals working in mental health teams across Livewell. It was sent to VCSE teams using their generic email addresses on their websites. It was sent to 191 practitioners in total and received 38 responses.

The survey also aimed to understand more about how the current mental health structures in place in the city, including the Plymouth Alliance, Community Mental Health Framework (CMHF) and the Creative Solutions Forum, and how these are working to join up support for people experience SMD and mental health needs:

- **The Community Mental Health Framework** - aims to "maximise continuity of care and ensure no 'cliff-edge' of lost care and support by moving away from a system based on referrals, arbitrary thresholds, unsupported transitions and discharge to little or no support. Instead, move towards a flexible system that proactively responds to ongoing care needs." (NHS England, 2019).
- **The Plymouth Alliance** – A partnership developed with an ambition to "coordinate a complex needs system which will enable people to be supported flexibly, receiving the right care, at the right time in the right place." The provision of support is for people who have needs in relation to homelessness and may also have support needs in substance misuse, mental health, offending and risk of exploitation. Livewell Southwest is a member of The Plymouth Alliance alongside BCHA, Hamoaze House, The Harbour Centre, PATH, Shekinah and The Zone.
- **The Creative Solutions Forum** - a "monthly meeting comprised of a core group of complex needs providers and commissioners in public health, adult social care and mental health. It is a deliberate mixture of practitioners, managers and commissioners to promote co-operation, build relationships of trust and better support the management and mitigation of risk. The aim is to provide an additional multi-agency, multi-disciplinary response, which can agree bespoke packages of care, enable better risk sharing and risk management between agencies, and facilitate better outcomes for people than could be achieved with 'usual care'." (Co-Operative Councils Innovation Network, 2025).

The survey received 39 responses which have contributed to recommendations about the three-lens model, offering insight into the broader system, partnerships and

pathways, and how it currently meets needs in a way that is trauma informed, strengths based, and enables access to clinical care when indicated.

5.2.1. Enablers to working well

Cross Sector Working

Cross sector working was frequently raised as an opportunity to work more efficiently, to build relationships and address barriers.

"[We need to] enhance/develop the skill set and different approaches to working with people, among the professions within the mental health provision/services. Job roles should be more inclusive of other professionals, not just having a clinical registration. This can invoke a medical model and not look at the bigger picture, wider determinants of health and cultural shift that is needed to move forward in a more holistic manner."

"Inpatient wards would greatly benefit from more input from supporting agencies. We do feel isolated and not able to fully get the support needed for some of our patients."

"A hub or smaller hubs in each community that has multiple services in one place … Mental health support, drug/alcohol services, physical health and dental checks, benefits and housing, activities, group work, peer supporters, outreach services etc."

Assertive Outreach Approach

Developing the ethos of assertive outreach was a frequent recommendation. The new Assertive Outreach Working Group for the city is a welcome addition to address the loss of Plymouth's Assertive Outreach Team, who would previously have worked with some of the people experiencing SMD outside of the typical 9-5 working hours. However, there is also a need for an assertive approach for people who do not experience psychosis, but who traditional services find hard to engage.

"I would also argue there is a place for 'assertive teams' due to the mass discharge of 'non-engagers'."

"The majority of our mental health services are not set up to successfully support these individuals. They need flexible service boundaries, longer appointments, joined up working and less pressure to discharge after missing an appointment."

"Our more assertive teams work well when a person is open to them, but it's accessing them that's the issue. They only accept referrals from secondary mental health teams who have sky high thresholds to gain initial access. More provision is needed to go out and assertively engage people in the first place without needing to jump through hoops".

- The need for this is supported by NICE guidelines, Integrated Health and Social Care for People Experiencing Homelessness (2022), section 1.5.13, which recommends outreach services that include support for people who:
    - have primary healthcare needs
    - have drug and alcohol treatment needs
    - have mental healthcare needs
    - fear engaging with services, for example, because of previous negative experiences from providers, discomfort using male-dominated services or concerns about eligibility including immigration status
    - may lack mental capacity or need support to recognise their care needs and engage with providers.

5.2.2. Barriers to working well

Gaining access to secondary mental health provision

When people were presenting as requiring support from secondary mental health teams, such as treatment in hospital or the community mental health team (support to people who have serious or long-term mental health conditions within their community), staff raised that access these services for people was challenging:

"Pathways are unclear, restrictive, unresponsive and leave workers and those they work with feeling angry and dejected. There is a lack of universal understanding of what mental health teams can and can't provide which leave all involved feeling frustrated."

"There are often barriers to accessing seamless support within mental health services, i.e., declined referrals from secondary or therapy services. Short-term work does not meet the needs of individuals experiencing SMD due to the importance of ensuring safety and building trust with service users who experience several different difficulties."

Recommendations for improvement included a space where different teams came together to discuss people who are regularly being rejected from multiple different teams. A forum of this nature does already exist in Livewell Southwest in the form of Multi Agency Team meetings (MAT Meetings). These meetings provide discussion for any individual who has a mental health need (regardless of diagnosis) and other co-occurring needs to explore how those needs are met within The Plymouth Alliance. This can include people falling between primary and secondary care services and those transitioning from child to adult services. These meetings are currently in the process of

being redeveloped and communication with teams about how to access them will follow.

"Regular meetings between professionals to discuss suitable pathways for people who are slipping through the net."

"Lead practitioners from every service having regular contact as a measure of discussing cases and offering up ways of joint working to meet client's needs."

Co-Occurring Substance Use

Co-occurring substance use was repeatedly raised as a barrier to gaining effective, compassionate mental health support.

"No wrong door needs to be further implemented as there is plenty of exclusion from some services- mental health in particular - due to 'non engagement' or substance use."

Recommendations for improvement included embracing the Human Learning Systems approach to enabling people to work effectively with complexity and working to NICE guidelines.

"We need an open and supportive culture within the systems in the city, that work together to meet the needs of people with good sense and generosity of spirit. Promotion of Human learning systems and more work around building a shared culture across organisations of compassion and understanding."

"[We need] implementation of the NICE quality standards for Dual Diagnosis, cultural change away from exclusion due to substance use in secondary mental health,"

Variable Attitudes and Values

Inconsistent values in attitudes in teams were considered to impact care for people with complex needs.

"What does not help is the spectrum of values and attitudes within teams - it undermines consistent approaches."

In response to a question about what prevents access to quality support for people experiencing SMD, on person answered:

"Values based care relating to criminal history and homelessness (i.e. 'no rehab potential')."

Lack of Resources

Lacking access to resources and low staffing levels were barriers to flexible, person-centred approaches. It was recognised that more funding into mental health services is not expected to be possible and reviewing current resources would be a viable solution.

"My experience of working in Plymouth is that there are loads of great services but often barriers between them (particularly relating to mental health). I think this is ultimately about limited funding/staffing within community services who have very little scope to assertively engage people with SMD, resulting in poor experiences for both patients and staff within services. This becomes a vicious cycle. I think we should focus on improving mainstream services and making them more accessible."

"There are a small number of very experienced staff in our organisation who are ideally suited to this work, who have developed strong networks and interagency relationships with these key agencies, who may not be being utilised effectively. The mental health service leads could approach them to form part of a service hub."

Training and Development Needs

- 37% of respondents required further training in housing and homelessness
- 37% felt the need to develop their knowledge of the other services available in Plymouth
- 26% identified a need for further education about substance use
- 68% of respondents rated their confidence in working with people experiencing SMD as a four or above out of five (five being the most confident)
- The remaining 32% rated their knowledge as a three out of five

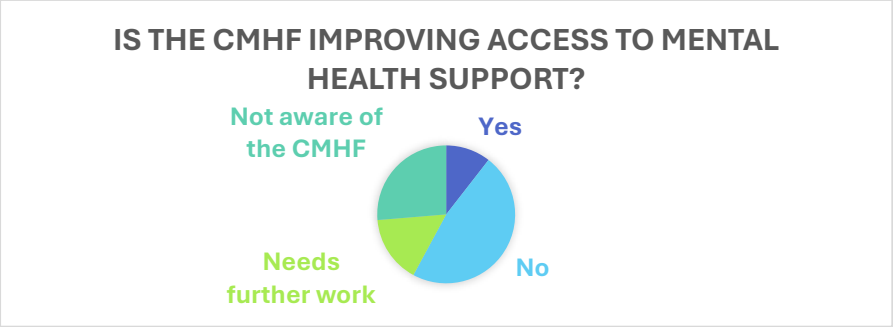
These results, and the feedback from the teams, indicate that the barriers to working with people are not solely a training or education need, and the current focus on workforce development may need to be broadened to other aspects of system change over the last year of the Changing Futures Plymouth programme.

5.2.3. Current structures

The CMHF, the Plymouth Alliance, the Creative Solutions Forum (see section 5.2 for more details) are initiatives that aim to improve access to care and support to suit individuals and their specific needs. Mental health staff members that participated in the survey were asked about these to gauge understanding and engagement.

The Community Mental Health Framework (CMHF)

The CMHF was introduced in Livewell Southwest in 2021. Survey participants were asked if they felt that it has achieved what it set out to do, and how this has impacted care for people experiencing SMD.



48% of participants felt that the CMHF was not working in its intended form to improve access to services for people, 26% were not aware of what the CMHF was.

"I've seen slight improvements within a couple of teams, but mostly the interpretation of this has been to provide signposting."

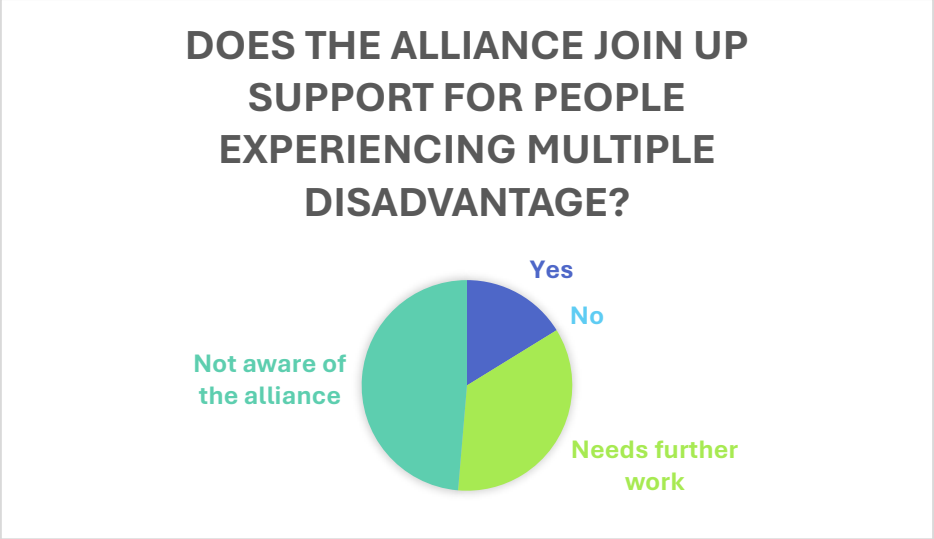
"No change, I have worked in health care for twenty years and if anything, things have become worse, everyone protects their own service."

"Potentially useful, but I believe it is now excluding individuals with mental illness from services that would have previously seen them. I think the psychosocial model of care is very important and needs to be expanded, but this has come at the expense of individuals with serious mental illnesses being excluded from services as difficulties are solely defined as psychosocial."

This aligns with the recommendations from Theemis Consulting into the 'Independent Investigation into the care and treatment provided to VC', which states, "The community mental health framework may have led to an unintended consequence of easing of oversight of some people with significant needs through the removal of the Care Programme Approach aspect of care. National leaders should assure themselves that there aren't negative consequences of some of the actions." (Theemis Consulting, 2025).

The Plymouth Alliance

Survey participants were asked:



48% of participants from mental health services did not know what the Plymouth Alliance was. For those who were aware of The Plymouth Alliance, 38% felt that overall, it contributed positively to joining up care for people but required further work to refine this. No respondents felt that The Plymouth Alliance was not working at all.

"I think the benefits of this are probably felt within Complex Needs, SORT and HIPP and perhaps within the voluntary sector. It's not something the more generic mental health teams feel part of, although the majority of people who access these services do have SMD."

"The Alliance function as an alliance needs further development. It currently builds and establishes professional connections but does not yet operate as a larger unified entity with a shared purpose."

"It does help to join up support for people but individual professionals' awareness of the alliance can hinder networking between services where it may be useful."

Creative Solutions Forum

During the pilot, Four people who were being supported via the Three Lens Model Pilot were referred to Creative Solutions for discussion. There was a recognition from the chair of the meeting that not everybody presented at the forum will have a clear outcome, but there was an open space to consider all avenues and endorsement from leaders to work in a more flexible way. Of the four people discussed one person has returned to prison, one person has moved out of area and two people remain street homeless. Whilst hopes were high and actions agreed for a creative resolution for people during the discussions, it was apparent following the forum that there is not a clear and robust follow up process to review how actions are progressing.

5.3. Three lens Model Pilot Outcomes

This section summarises the impact of RR's work with teams on people using services and team members. Section 5.5 offers specific case studies and feedback from staff members worked with.

5.3.1. Individual Outcomes

Seventy-nine individuals were supported via the Three Lens Model pilot through a combination of joint visits, case discussion, debrief, health evidence provided for priority need status and multi-agency meetings.

Of those individuals 54 people required no onward referral to secondary mental health services and were effectively supported by the systems that were already in place, with extra guidance from RR.

Twenty-five people were referred into Mental Health Services. Two people are successfully working with an appropriate mental health team. Six referrals were rejected, eight remained on waiting lists for assessment at point of writing report and for nine people services were unable to engage them after accepting the referral.

Eight people were provided with housing via The Plymouth Alliance after previously not being able to access this. This was achieved through a cross-sector approach from the VCSE and statutory services, health evidence for priority need status and Occupational Therapy evidence for reasonable adjustments.

5.3.2. Workforce Development

RR sought and supported access to workforce development opportunities. This helped enhance how members of the teams she was supporting understood work with trauma and mental health, and gave opportunity and further develop skills and understanding to work in a three-lens way.

Emails with offers of free training opportunities focused on SMD were sent regularly to all teams involved with the Three Lens Model pilot, Plymouth Probation Service and all team managers in Livewell Mental Health Services. Please see Appendix E for details of the training offered.

Trauma Stabilisation Training was offered to the Three Lens Model teams. This was designed and delivered by the Devon Sexual Violence Pathfinder project, with an aim to provide a practical course, building on the knowledge gained from attending Trauma Informed Practice training. Fifteen practitioners from the Women's Pod, Harbour Homeless Intervention Team, PATH Rough Sleepers Team and Shekinah attended. Pathfinder aims to collaborate with mental health providers in Plymouth to provide this training long term on a rolling basis. Feedback shared by the Pathfinder team suggested

that all participants reported feeling more confident in their knowledge of trauma stabilisation after attending the course:

"*I believe that my work will change because I completed this training. I feel much more confident in using these approaches going forward.*"

"The training was informative and helped to reiterate that we are doing things well, and also how important it is that we stay well!"

"I liked the focus on the here and now, and symptomology rather than diagnosis."

5.4. Understanding Experiences of People Using Services

Two peer researchers spent time with people attending the Shekinah drop-in to understand their experiences of accessing mental health support. People were wary of participating anonymously in appreciative enquiry, but four people agreed to be part of a listening group. All participants shared current experience of problematic substance use. They were not aware of the Three Lens Model pilot, naturally due to RR's work being primarily with staff, so the focus of the listening sessions was what helps people's mental health / ability to access services.

Themes created from the listening group include perception of the mental health system, accessibility of services, discharge from hospital, trusted professionals and safe environments.

5.4.1. Perception of the mental health system

All participants shared that they have approached various services but quickly lost motivation due to the amount of effort it takes to *consistently* engage when trying to 'survive.' Participants report needing to prioritise finding shelter and meeting their basic needs (e.g. food, prescriptions) over mental health care.

'…I have had to choose and have prioritised getting my prescription and keeping my shelter over getting any other support.'

Mental health conditions, distress and mood (e.g., depression, trauma, low motivation) inhibited all in the listening group from connecting with services consistently.

The group also discussed confusion about services and fear of stigma. Some participants shared that they felt unsure where to go for help or don't believe they meet criteria for mental health services because of their specific circumstances. One individual expressed reluctance to repeatedly tell their story, fearing being misunderstood,

'…I don't want to keep repeating myself to people that probably wouldn't understand anyway.…'

5.4.2. Accessibility of services

Physical access was discussed as a challenge for all members of the group. They all had mobility issues which made it difficult to physically reach or maintain contact with services spread across the city. There is also a cost implication for many to get to appointments. They shared that missing appointments often leads to being 'dropped' quickly from support programs.

The whole group stated that there is nothing open over weekends,

'Sundays are the worst day of all'.

They all access the Soup Run, and for those in the Night Shelter accessibility was referred to frequently;

'I have nowhere to go between 8am and 10pm'.

5.4.3. Discharge from hospital

Three of the group had been discharged from hospital with no accommodation in place.

'When I was discharged I found out that I'd been evicted for non-payment of my rent. I knew it was coming but after 3 weeks in hospital I came out with nowhere to go. I am now in the Night Shelter.'

The group agreed that this is a high priority to ensure people leaving hospital had follow up care in place.

5.4.4. Trusted professionals

People spoke favourably of some members of the HIPP team, their support to access the night shelter following hospital discharge, and having positive relationships with them.

"Having Dr Jameson on our side is a big plus — he tries to fit in as many people as he can."

Good relationships and knowing individuals from the Soup Run and Rough Sleeper Team were also discussed as helpful.

5.4.5. Safe environments

People appreciated being able to attend Shekinah during opening hours, particularly given its location and flexible support offered:

"Shekinah feels out of the way, which is positive to some because there are no dealers hanging around outside and people can focus on themselves."

"Shekinah is an absolute lifeline… I'd have nowhere safe to go or nothing to eat without Shekinah."

5.5. Key Themes from Teams Participating in Three Lens Model Pilot

The following themes and quotes were identified from the evaluation focus groups and survey responses from teams RR worked with during the pilot:

5.5.1. Relational Support and Presence

Individuals working in probation and homelessness/ housing services felt that they faced significant challenges in accessing mental health support for their clients. Specifically, rigid service models and complex referral pathways often excluded those

with the most complex needs. RR's day-to-day presence and interpersonal support were highly valued. She was described as proactive, approachable, and available - qualities that differed to previous experiences with similar roles that were more detached or administrative.

"She would come in and sit with us... what do you want to talk about? That was really good, because she was present."

"So the fact that she's really proactive, and coming in, we didn't have to chase, she'd be there, like, if you're stuck, you could just message her..."

5.5.2. Access to Specialist Mental Health Knowledge and Supporting Professional Development/Provision of Informal Supervision

RR acted as a trusted, consistent contact for those supporting vulnerable individuals. Specifically, through working in a trauma informed manner, RR was able to educate and support understanding for staff on how complex trauma impacts engagement and behaviour. As a result, staff felt better informed, which contributed to improved practice and better outcomes and experiences for service users.

"It is the really difficult to reach people that we have a difficulty understanding. She's able to sort of reflect, sit back, and immediately she's absolutely great. So in MDT meetings ... she'll articulate, and she'll describe different experiences (of) trauma that person might have experienced, different diagnosis ... and then put into context a little bit as to why, and get people thinking."

"But actually, the pilot very much was about trauma informed and not just labelling and judging, but about looking holistically and looking at a person as a whole and trying to come up with solutions that are going to work, rather than just throwing anything at that person."

"You know, when you have a knowledge about diagnosis or how things are, why people might present a certain way...knowledge is power, isn't it, in terms of it gives you a better understanding of how to work with that individual, but also what's going on and why things may be happening, yeah, and that might influence how you then build the support around that person?"

RR supported and initiated professional development for staff. Participants consistently reported signposting to training opportunities they otherwise would not have encountered. These included courses on trauma stabilisation, neurodiversity, and understanding complex conditions such as dual diagnosis and psychosis. This role also led to a deeper understanding of mental health legislation and care pathways. This knowledge proved crucial in enabling staff to better advocate for clients and deliver more informed support.

"But she sent us emails, hasn't she? Of you know, this is good training to access. I mean, the one she sent us about the neurodivergent work that's coming out of Nottingham. I've done two of those courses since she's sent us, and it's great. You know, it's knowledge I didn't have that I have now, because of [NAME]."

"There's all sorts that we've had access to because of [NAME]...Um, so we've had access to training that we potentially wouldn't have had access to, wouldn't even know about, probably, um, which has been really helpful to us in completing our roles."

Voluntary services valued the provision of informal supervision provided by RR. Specifically, such services struggle to access information or support during their daily activities with clients who are generally complex and who can be volatile, particularly when struggling with their mental health.

"Like, for me personally, it's been really good, because nobody ever sits and talks to me particularly about what we're doing, you know, or how it's going."

5.5.3. System Navigation and Advocacy

Many individuals accessing services were unable to self-advocate due to trauma, mental health challenges, or system complexity. The three lens model practitioner role helped interpret criteria for accessing services, ensuring clients met thresholds. Advocacy provided by RR was viewed as crucial in securing access to services and appropriate care.

"A lack of proactive services often means people with mental illness become trapped in a revolving door of rough sleeping and unsuitable accommodation offers. [NAME] changed that."

"And so you do need a response for people who are at the very extreme end of the process, yes ... but you need, you need some way (for) connecting people who can't access a conversation ... they can't comply with what we're asking them to do, and so we're not solving that problem to allow them to get out of the cycle."

Through her outreach work, her knowledge of individual histories and engagement with people over multiple services supported the provision of more effective and personalised interventions.

"And the other thing is, she's worked across services, and I think that's been a great thing. So, she's worked down here. She's worked with [NAME OF SERVICE], she's worked with the [NAME OF SERVICE], on the whole, people don't work quite so much across services."

5.5.4. *Empowerment of Staff*

RR provided emotional support, advocacy, and help in navigating what were felt to be fragmented systems. RR provided guidance which helped staff feel more confident in their roles, particularly when challenging decisions made by other services. Where staff may previously have accepted rejected mental health referrals, RR supported them to advocate assertively for service users. Her presence acted as a catalyst for professional assertiveness and critical thinking, particularly in complex casework involving mental health service navigation.

"But it has changed how I would probably approach other professionals if I feel a decision I don't agree with that probably, yeah."

"They talk about services they think we would know about which is that, like, maybe the NHS and how that works, but we're not the NHS, and we don't work like that, so it's very different for us. And you try and get clarification, and it's just even more confusing. The answers you get back sometimes, and [NAME] been able to give us understanding and said, look, actually given support and saying, actually, I think you can't push back on that."

5.5.5. *Improved Outcomes for Service Users*

The data provided several examples where RR's input directly contributed to improved outcomes for service users. This included securing appropriate housing, navigating mental health pathways, and accessing support that had previously been denied or unavailable. Her contribution was seen as a pivotal factor in helping clients move toward recovery and stability, particularly in long-standing or complex cases.

"So one chap has been rough sleeping in a tent for five years in [PLACE] with [NAME] intervention, he's now on Monday, moving into one of their homes that [NAME OF SERVICE] manage, but I'm pretty confident without that intervention, it would have taken much longer. We would have got there, but [NAME] was able to describe his needs and have his back when it comes to actually meeting the sort of threshold around priority need."

RR's relational approach to her assertive outreach work allowed for deeper connections with service users who are traditionally viewed as 'hard to reach'.

"So one gentleman, very complex gentleman in the city at the moment, [NAME] was worried about him, and you know, we needed to make sure we knew where he was

on Tuesday night. [NAME] had already spotted him in the car park. She knew he needed more time. She'd already got a good relationship with him. You know, that she built up so she could give him some really focused, dedicated time on Tuesday night, which I couldn't have done."

5.5.6. Continuity of Support

Data suggested that service users benefited from consistent relationships with workers who understood their history. RR worked in a relational and holistic manner, which meant that trusting relationships could be built to foster continued engagement.

"[NAME] was a constant person, and fully understood the importance of clients feeling that they could trust and engage with her. If they didn't, [NAME] would source another way, or person, that the client would feel comfortable with. As a team we have learnt from her, clients have benefited from her and this service and [NAME] now being lost will have a huge impact. [NAME] had a passion of steel for fighting for what is right and getting the best outcomes for people who were not able to fight. She became the voice for people who were not being heard."

"She could provide one to one support, a listening ear when people were low, vulnerable or in distress. Also, because she worked across the other services … [NAME] had often met people in a variety of situations, so she had a whole view of people. As [NAME] herself said, people can be at their most vulnerable during the evening. Especially knowing a night of rough sleeping is ahead of them."

5.5.7. Service Fragmentation and Gaps

Services were often perceived to operate in silos, resulting in duplicated efforts or missed opportunities for tailored support. RR's role functioned as a crucial link between siloed services. Participants described how she successfully bridged gaps between probation, housing, mental health teams and council services. Her presence often facilitated smoother communication, leading to better-coordinated care and outcomes for service users.

"She was the key to unlocking his future… he's now in recovery, with his own place, after five years in a tent."

"And actually, what we find is we've got a lot of women on substances, and often there's a lot of trauma behaviours, but because they're on substances, it's just [labelled as] drug related. So, you just don't get the additional support. You don't, it just feels like a lot, lot of the time you're trying to get support for someone, and

it's like, well, they use drugs. They need to stop using drugs before we can treat any mental health."

"We're actually getting somewhere... getting the right kind of support... reaching people we weren't getting through to before."

Poor communication between services often created confusion and frustration for both service users and staff. RR's ability to connect professionals and services led to reduced duplication, clearer communication channels, increased opportunities for collaborative working, and better outcomes.

"Or she would contact their keyworker and then just link him into that email, yeah, start the conversation off for you, which was really good."

"So, from [NAME], we were able to find out all this background information that's really important. It then went to the case worker so they were then able to get in contact with social services, like make the necessary referrals to try and get the right kind of support in place that person."

5.5.8. Accessibility and Flexibility of Services

Services were perceived as often inflexible, and as requiring clients to fit into strict timeframes or conditions. Through working within an assertive outreach model, RR was able to adapt to the client's needs and increased engagement. RR's involvement allowed for more responsive, needs-led decisions.

"What she was able to do is that she was able to see what the barriers were to progression. And then she didn't say, well, that means I can't work with you anymore. She was able to say, let's overcome those barriers."

"And actually, what we find is a lot of services, potentially because of they're just underfunded. They don't have the staff, they don't have the capacity ... if you've got, like, appointments, and then between nine and five and you've got attend at this appointment, and you've got someone who's really chaotic, and there's got a lot of things going on, they're not going to keep to that, they're [not] going to come to you for their appointment on time. That doesn't happen. And I think you need to roll with that. Sometimes, actually, we're not working with someone that's able to do that. So there needs to be more outreach stuff. There needs to be more flexibility in the way that we work to try and capture those people."

"Not many organisations appear experienced in working with rough sleepers in an outreach-based capacity and understanding fully the trauma of rough sleeping let alone

other previous traumas the person has experienced. It has to be outreach based. And workers have to be prepared to truly listen."

5.5.9. Multi-Agency Working and Information-Sharing

Services are impacted by information-sharing being limited by legal, technological and organisational barriers. RR's outreach approach has enabled there to be a 'bridge' between services, improving communication and care coordination. Support offered by RR has helped prevent costly crises (e.g., hospital admissions and repeated intensive input from the judiciary system).

"This is, like one person in particular, really, really challenging, because she presents differently to everyone, and that's been part of the problems … but [NAME] has been involved in some professional meetings. She's given guidance."

"They're going to need to work with that person for probably quite a long time, because they're really challenging, and there's a lot of complex needs there, but you feel good because you know that actually they've got the right kind of team around them, and yeah, occasionally we might then have some input, because they probably will come back to us at some point. But as long as they've got the other team around them as well, I think we've got a better chance of helping that person long term, because otherwise they'd just be coming back and forth quite quickly."

5.5.10. Funding and Commissioning Challenges

Short-term or siloed funding was felt to undermine the continuity and effectiveness of services to meet the needs of people who are living with SMD and complexity.

"It has kind of bounced back to what we didn't have. It's like, instantly, I, like, I said to you this now didn't I. Yeah, like, within a couple of weeks of her not being here. I'm kind of in cases I'm lost again, yeah, and trying to get any, so if they say our email, the generic email box, you don't get an email back for months."

5.5.11. Lasting Impact and Advocacy for Continuation

Participants spoke of this role as a linchpin in enhancing professional practice, improving service user outcomes, and bridging critical gaps in communication between services. Her contribution was seen as both practical and transformative, providing a model for how embedded, relational, and knowledgeable professionals can elevate service delivery across sectors.

Participants were united in expressing regret and frustration at the discontinuation of the role. Many emphasised its unique value and advocated for its reinstatement or expansion, citing benefits to professionals and service users alike.

“I don't think she could have done it any better … I think it was brilliant, and it was probably the best kind of pilot or service that we've ever had help from. And we've had quite a few different agencies, haven't we that work with us here and there, and by far, is best for me, yeah.”

“You've got quite a challenge in presenting this, between making it how good it is to have [RR] in post, doing all those things with the [Occupational Therapy] head on, the way of working, and how much it is about the person…So I think to me, that's the headline, that Occupational Therapy brings something special to the situation, and you have an exceptional person in the post.”

“And we all we kicked up a fuss when we found out it was finishing. We tried everything. We went up ahead like above, and we really tried to keep it because we were saying, this is like, the one of the one services that you've bought in that really works for us. It's really good [for] the people we work with, it's benefiting. We're actually getting somewhere. We're getting the right kind of support, or we're getting through to some of the people that might make those kind of decisions or should be involved in those discussions that we weren't getting before… they're all shouting the same things like, why are we stopping this? We know it works. This should be where we should be putting some money into.”

There was clear consensus that this type of role should receive greater investment and be made a permanent feature within the system.

“So it's almost if we wanted to continue, we have to be able to tick those boxes to make it so that the other services see what the value is. I mean this, you know, the hospital, the work she will be doing will be preventing hospital admissions, because people will be getting into accommodation so, you know, she's saving the hospital money. So there is, there are lots of places where this kind of model will impact on the wider system, and that's why the system should invest in it.”

“And we just, I just think it's so powerful, the work that one person done that actually bri…bridged the gap and interlinked other services with us as well as the people that she worked with, what would that be like if we had two? You know, just on that point, or just that time that she was there, that fundamental improvement with all of us and the people and the information that she brought forward, that's why we was just so upset.”

6. Recommendations

The following recommendations have been developed via the multiagency Three Lens Model steering group, in consultation with key stakeholders and learning from the evaluation.

Recommendation	Rationale	Action	Timeframe
Strategic investment in to structured, permanent Assertive Outreach roles.	Assertive Outreach is underfunded and inconsistently integrated into formal systems. National reviews of assertive outreach are underway, and action plans are requested to consider how people with a serious mental illness are engaged by services. This has a focus on people experiencing psychosis but needs to be broadened to other areas of complexity, including the mental health of people who are homeless.	A core team in Livewell Southwest will meet monthly to create an action plan for their enhanced assertive outreach provision for the city. The Three Lens Model pilot lead will attend meetings to share learning from the pilot and evaluation in relation to people who are homeless or involved with probation services.	12 months
Cross Sector Working.	There has been clear evidence of improved communication, relationships between services and outcomes for individuals through embedding statutory staff into the VCSE and vice versa. Whilst multi agency spaces were recommended, this would take significant time, cost and resource. Upskilling staff and providing time to work across the alliance could be a more viable model.	Development of 'champions' in each mental health team in areas of homelessness, substance use, domestic violence and criminal justice. Champions to be afforded monthly time in other services and to be responsible for keeping their team up to date with service developments and training opportunities. Mental health champions to be identified in the VCSE and probation services to develop	12 months

		links with statutory mental health services and spend time in respective teams. Building relationships through the Team Around Me work that is happening in Plymouth will provide another forum for this way of working.	
Keyworkers from the CNT to be assigned to each hostel and homeless Drop-in.	Attendance at the CNT mental health clinics has widely varied and explorations from the CNT are underway to understand why. This pilot has evidenced that having a consistent practitioner available supports both staff and service users in building trust and rapport.	CNT plan to assign a Mental Health Practitioner to each clinic space, instead of operating on a rota basis. This will include flexibility to work outside of these fixed clinic slots via the daily CNT duty worker as required.	Two months
Flexible mental health support to people who are street homeless.	Many of the people that have been reached through the Three Lens Model pilot do not access traditional support avenues and are the furthest away from services.	Complex Needs and HIPP to offer duty support to PATH 'Rough Sleepers Team' and Plymouth Soup Run, to provide a gateway into mental health services for people who are not in immediate crisis. They will provide timely, on street (where required) assessment to people to identify their mental health needs and refer on to the correct service.	Three months
Trusted Assessor status for HIPP Mental Health Lead	Currently, the pathway into secondary mental health services from the HIPP is not simple. With the current landscape in mental health services and difficulties in gaining access to secondary mental health care, this leaves the people who require assertive engagement (for example, from the Specialist Outreach Recovery Team) unable to access the services that were developed for them.	Exploration of 'Trusted Assessor' status (currently happening in Devon) for the Mental Health Lead in HIPP, to enable them to overcome barriers to accessing secondary mental health services and avoiding re-traumatisation from repeated assessments for service users, in line with the Your Story approach. In the interim, the Specialist Outreach Recovery Team accepting referrals directly	12 months

	This also links with the current Your Story and Team Around Me work that is happening in the city.	from the Health Inclusion Pathway Plymouth would ease the complicated referral processes currently in place.	
Easily accessible mental health evidence for housing 'priority need' status.	Our evaluation found that having a dual trained professional, with knowledge of psychological, neurological and physical health needs, helped to support people into accommodation where it was previously declined, due to providing a clear, functional explanation of people's needs combined with access to the health records.	Health Inclusion Pathway Plymouth will continue to provide this written evidence via a telephone or email duty service to the Plymouth City Council 'Homeless Outreach' Housing Team.	One month
Supervision offers for the VCSE.	Having a trusted, consistent person to have case discussion, debrief and supervision with was highlighted as a benefit of the pilot. This could support with staff retention and reducing rates of burnout and workplace related stress.	Changing Futures Plymouth are piloting a multi-agency reflective practice space which will be held in a group setting. The Alliance Workforce Development Coordinator is exploring an alliance wide 1:1 peer supervision offer, including the training that is required for this, using learning from this pilot. This aims to provide a cost-effective way of offering supervision which is non-hierarchal and selected by the practitioner.	12 months
Multiple Disadvantage board.	To provide and oversee governance for work taking place in relation to improving outcomes and access to services for people experiencing SMD. This will support implementation of learning from Changing Futures pilots and provide accountability for system and service improvement.	The Changing Futures team will bring together partners to co-create a board in Summer 2025, including colleagues from the Integrated Care Board, Plymouth City Council, Livewell Southwest and The Plymouth Alliance.	Six months
Coproduction of services.	Peer Researchers are currently embedded into George House and Devonport Lifehouse hostels, which has helped to build trust and rapport when completing appreciative enquiry. Replicating this across Shekinah, PATH and The	A Peer Researcher from ILP to collaborate with Healthwatch Plymouth to spend 12 months working across these teams. With an aim to complete Appreciative Enquiry into the health inequality, particularly in relation to mental health, of people who are street	12 months

	Soup Run would help to ensure that the voices of people who are street homeless are heard.	homeless and/or using probation services. Findings to be used to complete a SMD toolkit for mental health practitioners.	
Skill share.	The Plymouth Alliance staff worked with reported key areas that they felt their skills were lacking. Predominantly in mental health, housing/homelessness, substance use and knowledge of other services. This knowledge is already available within practitioners completing the day-to-day work, but it is not being consistently shared.	Learning from the Three Lens Model to inform the Alliance Workforce Development Plan. Practitioners in each area are being identified who are interested in developing workshops in their area of expertise and provide them on a rolling basis. This compliments the Pathways and Partnerships work that is already happening in the city.	12 months
Training needs analysis across The Plymouth Alliance for Learning Disability and Neurodivergence.	Many of the people worked with via the Three Lens Model Pilot had diagnoses of Learning Disability, Autism, Attention Deficit Hyperactivity Disorder and other Neurodivergence. There were regular reports of not feeling that reasonable adjustments and appropriate communication were always considered across services. There was also an evident lack of long-term care co-ordination for these individuals.	Respective leads across mental health, housing, probation, substance misuse and domestic abuse services to understand their teams training needs in Learning Disability and Neurodivergence and work with Alliance Workforce Development Co-Ordinator and Changing Futures Plymouth to address these needs. To explore Oliver McGowan training expansion outside of health and social care settings.	Six months
Flexibility in working hours for mental health practitioners in the complex lives system and/or assertive outreach.	Many services in the Complex Lives system in Plymouth currently work on a Monday-Friday, 9-5 basis. Flexibility is required to engage people, gain a full holistic view of their needs and provide a more timely response.	There is a plan for the Complex Needs and HIPP teams to join the Plymouth Soup Run on a rota basis with consistent practitioners who can get to know the community. Also to have the possibility to join the Rough Sleepers Team street outreach sessions earlier in the mornings, as and when required, for people who move on earlier in the day and do not attend traditional clinics. Flexible working	Six months

		agreements and lone working policies to be consulted.	
Assertive, early engagement for people at risk of losing their tenancy who have mental health needs.	Through exploration of the 'Journey Maps' of people who are homeless in Plymouth, there are key points where a change in trajectory was possible. Typically, this included combinations of a decline in mental health and subsequent difficulties in maintaining a tenancy.	Cross sector working between mental health services and tenancy sustainment teams to be built on, led by the mental health and housing champions across services.	12 months
Changing Futures to complete an Appreciative Enquiry with key stakeholders to review the Three Lens Model recommendations.	Support to be provided from Changing Futures to ensure that teams feel they have the correct knowledge and skills in their teams to develop the learning and changes.	A Changing Futures Project Officer to be assigned to oversee this, alongside the Appreciative Enquiry work from ILP and Healthwatch Plymouth.	12 months
Exploring further opportunities for embedding a Peer Researcher into homelessness services to capture voices of living experience	This may help to further build trust and ensure that the voices of the people experiencing street homelessness are heard by stakeholders in Plymouth. ILP continuing to develop their partnership with Healthwatch Plymouth can support this, following their report, "Our Stories, Our Voices: The Power of Lived Experiences with Gifted women" (Healthwatch Plymouth, 2025). Teams suggested are: Shekinah drop in, Plymouth Soup Run and PATH Rough Sleepers Team	Changing Futures core team to explore capacity for this with the peer research team at ILP.	Two months
Develop understanding of the Plymouth Alliance	The survey with mental health teams suggested that many are not aware of or clear about the Plymouth alliance. Increasing this awareness	To discuss with Alliance Leadership team and ALT comms group.	Two months

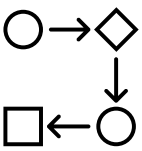
and its purpose with Mental Health Teams	could strengthen partnership working and create cohesion for people with multiple needs.		
Develop and communicate a clear follow up process for the Creative Solutions Forum.	The implementation of such a process would ensure that there is reassurance that there are no structural barriers to completion of proposed tasks, provide a safety net and encourage professional accountability. It would be helpful to have a review of actions via Creative Solutions in the assigned core group after an agreed period.	Changing Futures and HDRC to share recommendation with the Creative Solutions chair and ask for feedback on how this has been implemented.	Two months

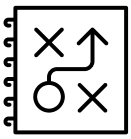
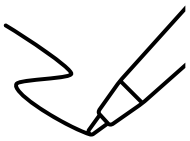
7. Conclusion

"The fact that they don't have a 'home' is often mentioned as a barrier [to accessing mental health support]. The last six months have definitely highlighted that this a construct that professionals have created rather than an actual reality. Outreach mental health has been proven to be possible and with evidenced outcomes too. A number of rough sleepers would not be spending Christmas indoors this year if it had not been for [NAME's] work these last six months. [This is] a direct result of your hard work and persistence to bridge the gaps in a system that does not work at all for rough sleepers. For some this will be their first Christmas indoors for many years."

7.1. Key Elements of a Practical Three Lens Model Approach

Evaluation activities described above, RR's reflection of the work undertaken and conversations with partners have produced 9 key elements that support working with people experiencing SMD and using the Three Lens Model approach:

Joint visits: Joint visits with the Three Lens Model Practitioner to build a shared understanding and spend time in the person's community. 	**Bespoke Support:** Bringing together a bespoke community of support around the person, led by the person. In line with My Team Around Me. 	**Flexible support:** Advice from Three Lens Model practitioner, via duty email or telephone on the days that the practitioner was not based in their service. This included written healthcare evidence for 'priority need' status for housing. 
Navigating systems: Support to navigate the mental health system and advocate for referrals where required. This included attending multi-disciplinary meetings and referral meetings with their keyworker. 	**Developing a shared understanding:** Case discussion to provide guidance for sessions, navigating conversations with people in distress and when to escalate concerns. Debrief could also be provided following incidents. 	**Supervision:** Providing a space to process the work that people do in SMD, with a focus on vicarious trauma and stress. 

Workforce development: Workforce development opportunities sent to Three Lens Model teams via regular emails. Provision of bespoke Trauma Stabilisation Training. Weekly emails sent to Mental Health Services providing links to training in SMD. 	**Strategic work:** Strategic work with Livewell Southwest to improve pathways into mental health services. Liaison with teams, with a focus on keeping support in place once a person had been accepted into a team. 	**Learning and evaluation:** Work with ILP Peer Researchers and Plymouth University Health Determinants Researchers to evaluate the model and link peer researchers with Three Lens Model teams. 

The pilot appears to have been successful in identifying potential ways of improving how to better integrate mental health care into stressed SMD systems – in particular supporting staff outside of health services and in attempting to find ways, for those in need, to get into the system to receive specialist support. While not formally assessed, the coherence of the Three Lens Model its inclusion of trauma informed, strengths based and diagnosis aligned components appeared to provide a helpful framework.

RR was welcomed and appreciated by staff. The flexible way of working which included face to face work with individuals, advice and emotional support for staff, liaison back into mental health services were all important modes of working. RR's background as an experienced mental health OT, her belief in a new way of working and her knowledge of the city were all likely important contributors.

7.2. Conclusion and next steps

This pilot and the Three Lens Model were developed from conversations among statutory and voluntary sector organisations that took place during the Covid-19 pandemic, expressing desire to explore more flexible ways of working with mental distress in a challenged system. Changing Futures Plymouth invested in this pilot to test and learn the Three Lens Model being applied in practice over twelve months. The model sought to support non-clinical workforces working with those experiencing significant mental distress. The aim was to understand if the support to non-clinical colleagues and person-centred nature of the model would improve outcomes for people experiencing SMD at an individual, service and system level. The teams in the VCSE and probation had existing skills to work in a trauma informed and strengths-based way, and these were further enhanced by the support provided by RR. However, navigating clinical services when needed presented significant challenges, and teams have reported that a close working relationship with a clinical professional has given them the knowledge and language to advocate for their clients to make successful referrals when clinical input was required.

The last twelve months have demonstrated the importance of relationships and trust between services, particularly clinical mental health teams, VCSE and probation colleagues working closely with people experiencing SMD. The recommendations offer opportunity to bring these services closer together into a working partnership that centres individuals, their needs, and being true to the 'no wrong door' ambition of the CMHF. It has also highlighted the value of not only occupational therapy in this space, but also the value of experienced mental health practitioners working closely and collaboratively with non-clinical workforces. It highlights the need for a flexible and assertive outreach approach to support people with complex lives in a way that matters to them at that moment in their journey.

Funding and resources are an ongoing challenge for mental health services and partners, and whilst the evidence presented here provides endorsement for further investment to support the provision of such roles, adaptations to existing mental health teams working with SMD to adopt an assertive outreach approach also has potential to make a significant difference. One full time post working across teams over the course of 9 months has demonstrated improved outcomes for people experiencing SMD and support for non-clinical teams.

The recommendations will be reviewed periodically by Changing Futures and other key stakeholders that have supported this pilot in the year following the release of this report. There is commitment to embed legacy through working collaboratively and relationally to enable services to enhance how they support people in a way, time and place that matters to those they support.

8. Appendix

8.1. Appendix A: A shared approach to mental health – The Plymouth Three Lens Model

Aims

This model has been developed as a means:
a) of bringing together different ways of understanding mental health problems and their origins in order to provide coherence (rather than bewilderment) for community residents and practitioners in the face of multiple, at times competing, models and approaches, and
b) to agree practical ways forward to create a balance between the currently more dominant diagnosis-based model of practice and other important approaches including trauma-informed, strengths-based, and person-centred etc. It has been developed by opinion leaders from VCSE, primary care and mental health care from the Plymouth and wider Devon system who have an interest in mental health. Next steps include wider consultation and testing the ideas with both communities and patients/service users and those with formal leadership roles.

Background

Diagnostic approaches to understanding distress and mental health problems (based on the broadly similar ICD and DSM approaches) have influenced the practice of assessment and treatment of mental health problems for half a century. They also influence the research which is done to test treatments and the ways services are configured. While their weaknesses (lack of objective tests, overlaps, changeability with time etc) have been acknowledged, a practical coherent alternative has not been developed. Instead, a range of other approaches to understanding and practice have been developed. These include strengths based (including Solution Focussed, Assets Based), Trauma Informed and other meaning-based, non-diagnostic approaches such as the Power Threat Meaning Framework, Open Dialogue, Narrative Therapy. In addition, a range of more generic ways of working have been developed which have the potential to bring these approaches together. These include the use of the 'psychological formulation' (developed by psychologists and psychiatrists to 'eclectically' bring in different approaches to create an individualised understanding of the person, the bio-psycho-social model, person centred (or personalised) care. Additionally, values-based approaches emphasise engagement in addressing inequalities and breaking down unhelpful power differences; and positive risk management approaches take a system approach to risk. These tend to overlap considerably but emphasise different aspects. Furthermore, there are links between these approaches and different means of treatment/support (such as the wide range of therapies, psychotropic medication and social prescribing).

Meanwhile our understanding of the brain, through the study of neuroscience, including genetics and epigenetics, continues to highlight the lack of robustness of the diagnostic model. And also providing a scientific understanding of how trauma and loss can affect brain function, and of how current adversity can contribute to a range of psychological states mediated by brain function. In summary science and social science both point towards an as yet far from complete understanding of mental health; and that it is not just theoretically complex but also for each individual currently unknowable i.e. we can't be sure, for an individual, the extent to which trauma has caused symptoms, or about the

extent to which a diagnosis based on specific criteria relates to specific underlying brain pathway problems. We propose it is important to be open and confident about these uncertainties.

Bringing strengths based, trauma informed and diagnostic approaches together
We have attempted to combine the most important features of three of the most distinct approaches (diagnostic, strengths based and trauma informed) into a coherent model by using principles from generic approaches (formulation, bio-psycho-social, person centred), neuroscience and values-based care:

Whole person bio-psycho-social mental health support will:
- Recognise importance of past trauma, adversity and loss, current relationship challenges, social inequality and injustice and survival responses when developing an individual's shared understanding (therapists might call this a formulation) and in the plan for going forward. (i.e. the process is trauma-informed)
- Use the diagnostic tradition and our understanding of neuroscience to help an individual understand the different emotional and psychological experiences they have (traditionally called symptoms) and the types of self-help strategies, therapies and medications that might be helpful in the future (i.e. recognises value in diagnostic and biological knowledge of mental health).
- Identify personal, relational and community strengths (assets) which have contributed to skills already developed and progress to address adversity, and which could contribute to wellbeing going forward including addressing social adversity (i.e. is strengths based and socially oriented care).

The components of the approach need to be built into the everyday lives of individuals engaged in 'self-care', the work of practitioners both in every contact and in formal therapy, and into the health system. It is work in progress; detail can be added; and there will continue to be differences of view.

Assumptions and Challenges
In order to promote this way of understanding mental health and its origins, and also to create what could be considered a more cohesive approach to organising services and support, and to being alongside and supporting individuals in distress, a set of assumptions and challenges are laid out.

1. *Language, approaches and experience of services.* While the language we use to describe different approaches and in our practice is important (having potential both to confuse and to help understanding), the organisation of support is also crucial and can lead to people feeling held and/or empowered, or bewildered, retraumatised and without agency. We need to use plain language to explain the different models and concepts and how they can be part of a coherent approach. This should both help practitioners work together in an integrated way and help residents in our communities understand how to get help when needed and how to contribute to the community's wellbeing. We also need to develop systems of care which reflect the coherent approach, and therefore in themselves support wellbeing and avoid harms (e.g. through being rejected, "processed", "passed around", having long indeterminate waits or discharged).
2. *Enormity of challenges but opportunities.* We recognise the significant challenges for shifting thinking and practice towards a more integrated model. Nationally there is no

accepted or even proposed model for doing so coming from government, academics or professional bodies. We propose a combination of a) listening and discussion, b) development of a local plan, c) practical support.

Challenges:

- Perception that national policy requires diagnostic approach can lead to formal leaders objecting to change
- The idea of a diagnosis being an actual disease/disorder rather than a (not very robust) model has been taken up not just by non-specialist practitioners but by whole groups in the population. The benefits of diagnosis being seen to mitigate blame and responsibility.
- Our models of mental health and illness pervade multiple spaces beyond health care – face book groups, the benefits system, schools
- The relatively small effect sizes of treatments are not widely recognised, and (low and higher income) communities may resist suggestions that after years of promoting the benefits of early diagnosis and treatment there needs to be shift in the other direction
- For young people in particular there is a shift to being supported by institutions (schools, universities, social care) to recognise themselves as ill and needing support from services leading to increased medicalisation
- Currently health and social care systems feel to providers at breaking point which means there is often no time allocated for reflection on what's happening or planning for changes.
- Inequalities with respect to income and protected characteristics may be worsening due to both changes in health care delivery (e.g. digital) and to promotion of need for diagnosis (e.g. requests for ASD diagnosis).

Opportunities:

- Individuals change over time – while both individual patients and practitioners may initially resist new ways of thinking about mental health, explaining but not pushing a complementary trauma informed and strengths-based model may support shift in thinking over time
- Leaders locally are engaged in discussions, understand the issues and together have the opportunity to encourage significant shifts in thinking and practice – most rules are not legal but norms and protocols developed by individuals locally so can be changed
- While not articulated explicitly the Community Mental Health Framework (CMHF) does encourage a broader approach (reporting framework is still diagnostic but outcomes framework is not)
- Trauma informed and meaning based practices, which provide an opportunity to move beyond the 'brain or blame' dichotomy has developed significant traction though community groups, practitioners and leaders, and while it can be set up in opposition to diagnostic models there is the potential for working alongside in a powerful coherent model
- The crisis in workload and workforce is an opportunity because system leaders need to recognise the need for an alternative to current practices; one which better resources and draws more heavily on strengths and opportunities in voluntary sector and communities

Practical steps

1. Model for practice (not discussed explicitly in meetings, this is a first go at bringing different approaches as it seems vital to find a way to do this in practice).

The proposed model needs to work across different scenarios – supporting someone in self-care; everyday (universal service) clinical contacts; initial and ongoing contacts with specialist mental health services; formal therapy. We will describe application of the model to each

scenario below. Here we describe a generic approach as three steps (not often consecutive).

A. Engagement (trust building) and past history
This important part of encounters draws on the fundamental and essential use of relational skills of relational skills tailored to the needs of the individual to build trust, and narrative approaches and person-centred approaches:

- Listening to current concerns and eliciting a narrative to gain a sense of the past and present – losses and past trauma may be brought up but before some trust is developed asking directly about these may create difficulties
- Understanding past mental health care input including diagnoses, therapies and medication (from past records and according to the individual)
- Gaining an understanding of current priorities (may be social, or emotional or physical) and goals.

B. Developing a shared understanding
This is the core of the work of bringing together trauma informed, strengths based and diagnostic approaches. Current strengths are set alongside seeing symptoms as survival strategies, and this understanding of the present can be understood as caused by past losses and traumas, as well as positive nurturing and genetic disposition:

1. Understanding symptoms (mental state) about the present (and contrasting to the past), as well as behaviours and function, might follow a system broadly aligned with psychological and psychiatric practices:

a. Emotions: Dominance of low mood, anxiety, anger or elation? How is mood changing – with days and over time?
b. Thinking: Clarity, attention; positive/negative re self; ability to imagine what others think, paranoia/worry about others' intentions (appropriate, exaggerated, delusional (fixed and illogical)); obsessive. etc
c. Perceiving world around us: Feeling of being 'present' vs self/world unreal; flashbacks (as if back in a traumatic past event); voices or see things when no one present. etc
d. Physical: Sleep, appetite, tiredness, pain
e. Behaviours/actions (positive and negative): getting out/staying in; self-harm, looking after self; eating and substance use;
f. Function: abilities to wash and self-care, get food etc; abilities to function in work, relationships.

2. Enquiring beyond symptoms, perhaps using the 3 Ps model, adapted to focus on positives too, provides the basis for linking current mental state causally to the past and present context:

a. Predisposing: trauma, loss and family history, invalidating environments as well as positive, nurturing ones
b. Precipitating: what led immediately to current situation if anything
c. Perpetuating: ongoing stressors and social-political contexts (housing, relational, financial, (un)employment), as well as assets (friends, family, home, work)

> Note. Also acknowledging the significance of personal characteristics such as ethnicity, income, age, gender and sexuality

3. Bringing (some/all of) this together in a 'shared understanding'. Working together to examine obvious and possible causal links between what's come out in and 1 and 2 above (see figure as example of a tool to do this as a diagram if preferred):

a. Asking, 'what is your understanding of why you feel how you do?' (may see in terms of trauma, biomedical, diagnosis, spiritual etc) – important to understand individual's starting point
b. Explaining range of ways that might be helpful (confidently, valuing each, but not pushing any as 'The Way'.
c. Explaining (confidently, but with lack of certainty) how different aspects might link or contrast for the individual: – e.g. how certain experiences (symptoms) may indicate that a diagnostic approach could be helpful as well as emphasising how symptoms can be understood as survival strategies and how together with identified strengths we get a more rounded understanding, e.g. how repeated traumas can over time can lead to shifts in brain functioning leading unpredictably to different experiences.
d. A (more or less comprehensive) shared understanding of the individual's situation can be agreed (or differences acknowledged) which might include an individual's experiences and behaviours (symptoms) described primarily as a single or several diagnoses, and/or as a set of prioritised symptoms/problems, if possible with causal links between them (might be called a formulation). Resultant problems with function, key strengths and agreed goals, as well as historical causes and/or current stressors and assets, together provide a more whole person picture.

C. Developing a shared plan
This is the future oriented part. For some individuals it may be a plan that's discussed informally in lay situations, or for practitioners it can be an outline (and not comprehensive) plan written in health care records, or a more formal plan (Care Plan).

1. Bringing threads together:
a. Plans may be in place already and need revising
b. Planning can occur v early during interactions – with individuals bringing a plan as a request
c. Goals identified or agreed earlier may provide basis for plans

2. Using the 'shared understanding' with prioritised problems (including diagnoses if made and social issues) and goals, to decide on plans may be assisted by different types of reasoning:
a. An individual's intuitive or thought through ideas about what might help
b. Practitioners' ideas from knowledge of evidence about what might help for each problem/goal/diagnosis
c. Thinking together about the whole, as well as 'zooming in' on specifics, to consider conflicts or synergies between possible plans, and what to prioritise.

3. Agreeing and sharing the plan:
a. Review potential plans to see how they cover biological, social and psychological domains, and how they fit with trauma informed and strengths-based principles (e.g. peer support), as well as diagnostic approaches.
b. Agree a set of specific immediate and future plans, potentially with named people, and if desired with target dates.
c. Agree how and whether to share shared understanding and plan.

The description of the model may feel lacking in detail or too prescribed for experienced expert mental health practitioners; we hope it will encourage them to incorporate aspects of the model into their practice, and to use it to work across disciplinary boundaries in locality teams around the individual patient/service user.

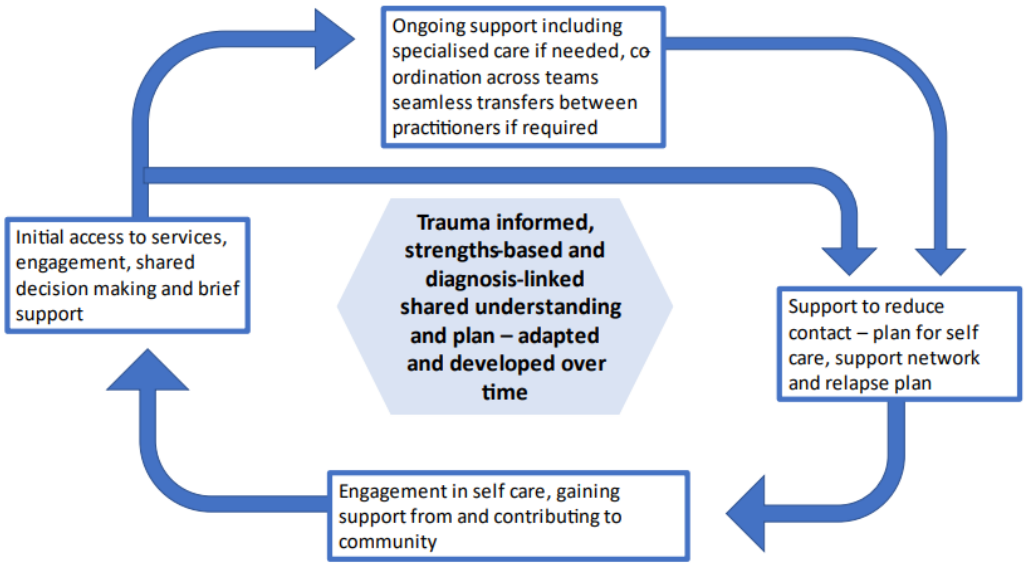
For less experienced or generalist practitioners, and individuals engaged in 'self-care' it may feel too ambitious; we hope that, with appropriate support, it will be possible for people to move away from overly simplistic or single-issue models.

While the model is focussed on language, how practices are carried out are informed by trauma informed and strengths and values-based approaches. Practice should be flexible and personalised – going as slowly or quickly as needed, and trauma sensitive practices (such as only enquiring further with assent (permission) etc) are crucial. Kindness and support to build on personal strengths can be part of most contacts with services as well as in the community.

2. **Different scenarios through an individual's journey – where to invest.**

The model described above is deliberately generic, but to provide cohesion for individuals and systems it needs to be relevant across a range of diverse scenarios - from individuals building their own personal plans for wellness and/or recovery to individuals requiring coordinated ongoing care. The figure depicts this range of scenarios both for those needing different intensities of support and over time for all individuals.

Self-Care. A supportive caring community, encouraging an ability to deal with distress and build coping strategies and a meaningful life is arguably the most important area for development. We have policies and now initial investment to support existing assets, and a buoyant Trauma Informed Network show signs of changing cultures in line with the proposed model. *Self-care and community supported care could be further enhanced by a comprehensive online guide to both local and national resources informed by the principle of the model, as well as by further investment in community connectors and peer support.*



Initial Access and brief support. The last five years has seen a step change in the capacity of services for mental health problems in Plymouth. The development of primary care based

mental health teams funded through the community mental health framework and the development of voluntary sector services including specialist services for debt and employment as well as more social prescribers and community connectors is a very positive basis on which to build. *What is needed now is a programme of support and education for practitioners across primary care mental health and voluntary sector to understand each other's roles and perspectives. We proposed that the shared approach to mental health can provide a unifying framework for training and facilitation for better joint work. Additionally, and as a priority, a comprehensive guide to gaining access to mental health support alongside selfcare which recognises the different roles of the range of services and incorporates trauma-informed, strengths based and diagnosis linked model should help overcome current confusion around access amongst communities and non-specialist practitioners.*

Ongoing support. Specialist services are under significant pressure, but there is an opportunity to reduce the use of high cost (in and out of area) in-patient care by developing a cohesive set of teams able together to provide care for those most in need and prioritise resource towards positive interventions over more risk averse practises of containment/observation. Developing such a culture change has already started through positive leadership. It is likely to require input from senior managers and integrated care system leaders to promote positive risk management. This will enable practitioners to work together to create a more balanced system including the strength-based principles, trauma- informed practices alongside traditional diagnosis-led care.

Supporting individuals to have less contact with specialist services. Politically this is perhaps the most difficult aspect as it is uncomfortable to tell people resources are limited. So, it will require prolonged community engagement and consultation. of creating a balanced system by ensuring practitioners are not feeling overwhelmed, are able to use their many skills as well as bring kindness into everyday care and support empowerment through using changes in language and testing a range of new interventions which are not led by the most specialist mental health practitioners in the system. This principle applies to those with high and low need. It will also be supported by the development of a comprehensive guide to services.

8.2. Appendix B: Survey questions sent to Statutory and Voluntary Mental Health service Providers

1. How would you rate your knowledge of working with people experiencing multiple disadvantage?
2. Are there any gaps in your knowledge or training base relating to multiple disadvantage?
3. What are they?
4. What helps you to provide good support to people experiencing multiple disadvantage in your service?
5. Does anything prevent you from being able to provide good support to people experiencing multiple disadvantage in your service?
6. Do you have any suggestions for improving mental health provision for people experiencing multiple disadvantage in Plymouth?
7. Does your team currently complete outreach work to people who are experiencing mental health conditions who might be considered as ‘hard to reach’ through traditional practice?
8. What is your experience of the Community Mental Health Framework ‘no wrong door’ provision for people experiencing multiple disadvantage?
9. What is your experience of working in 'the alliance' in Plymouth? Does this help to join up support for people?
10. Any other comments?

8.3. Appendix C: Survey Questions Sent to Teams Participating in the Pilot

1. How would you rate your knowledge of working with people experiencing mental distress or a mental health condition?
2. Where are the gaps in knowledge? Has this increased or decreased in the past six months?
3. How would you rate your knowledge of mental health services in Plymouth and how to request support?
4. Is there any particular support that you find difficult to access? Has your knowledge increased or decreased in the past 6 months?
5. Have you utilised the support on offer from the Changing Futures 'Three Lens Model' pilot?
6. If yes, what have you used this for? (This could be case discussion, training sessions, joint visits etc). If not, what has stopped you from accessing this support?
7. What has been the most beneficial aspect of Changing Futures working with your team?
8. What has been the least beneficial aspect of Changing Futures working with your team?
9. Where do you consider there to be gaps in mental health provision for people who access your service?
10. If Changing Futures were to continue offering mental health support to the workforce in 'multiple disadvantage' for another year, where would you consider this to be best placed?
11. Do you have any other comments?

8.4. Appendix D: Survey Questions Sent to Wider Teams that have Worked with the Three Lens Model

1. Have you utilised support from RR as part of the 3 Lens Model pilot in your work?
2. If yes, what has been the most beneficial aspect of having an Occupational Therapist/Mental Health Professional situated in homelessness?
3. What has been the least beneficial aspect of having a mental health practitioner situated in homelessness?
4. How would you rate your knowledge of mental health services in Plymouth and how to access them?
5. Is there any particular support that you find difficult to access? Has your knowledge increased or decreased in the past 6 months?
6. Where do you consider there to be gaps in mental health provision for people who access your service?
7. If Changing Futures were to continue offering mental health support to the workforce in 'multiple disadvantage' for another year, where would you consider this to be best placed?
8. Do you have any other comments?

8.5. Appendix E: Three Lens Model Workforce Development.

- The Societal and Economic Impact of Acquired Brain Injury
- Drug Science – Deep dive into Nitazines
- Changing Futures Co-Production in Commissioning Toolkit
- Changing Futures Nottingham ADHD and SMD training
- Acceptance and Commitment Therapy
- Trauma Informed Practice for SMD
- NHS Addictions Provider Alliance 'Stigma Kills' training pack
- Cuckooing – Multiagency safeguarding, powers and practice webinar
- Street Drugs Discussions: ADHD and Co-Morbid Substance Use Disorder
- Neurodivergence in the context of SMD
- Right care, right person webinar
- Excluded even within inclusion health? The importance of exploring and addressing the health and wellbeing needs of people selling sex. A public health approach to sex work webinar
- Improving access to services for people experiencing SMD and co-occurring conditions (online course)
- Trauma stabilisation training (course)
- Understanding mental health for highly sensitive people workshop
- Good practice discussion on preventing homelessness on release from prison
- Mental Health Overview of Plymouth Services created and disseminated
- Homelessness series from Kings College
- Understanding modern slavery
- Understanding and responding to psychosis workshops
- Understanding emotionally unstable personality disorder workshops
- Hearing Gypsy, Roma and Traveller Young Adults in the Criminal Justice System webinar
- Prevent Training
- Trauma Sensitive Assessment Practice's with the 'Your Story' Approach – Changing Futures Plymouth Webinar
- Implementing Person Centred Risk Assessments
- Polyvagal Theory – Safety from the inside out (Camden and Islington Trauma Informed Network)
- Learning Disabilities and Homelessness Toolkit
- Neurodivergence and Homelessness Webinar (Changing Futures Nottingham)
- Identification and Prevalence of Severe and SMD in Mental Health Webinar (Changing Futures Nottingham)
- Changing Futures Plymouth Three Lens Model Webinar
- Street Drugs: A deep dive into mephedrone
- Psychotherapeutic Assessment Processes in the Diagnostic Assessment of ADHD for Adults with Severe and SMD
- An introduction to Human Learning Systems
- Prison Yoga Project (Camden and Islington Trauma Informed Network)

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