Welsh Government Draft Suicide and Self-harm Prevention Strategy 2024-2034 June 2024: Crisis response

About Crisis

Crisis is the national charity for people facing homelessness across Wales, Scotland and England. We know that homelessness is not inevitable, and we know that together, we can end it.

We provide services directly to people experiencing homelessness, carry out research into the causes and consequences of homelessness, and campaign for the changes needed to end it.

In Wales, our Crisis Skylight South Wales team works across Swansea, Neath and Port Talbot to support people at risk of or currently experiencing homelessness to end their homelessness through housing stability, financial security and employment, good health and wellbeing, and positive relationships and social networks.

About this response

This response has been written by our Wales Policy team, with input from our members with recent lived experience of homelessness and the South Wales Skylight staff team, including our in-house clinical/forensic psychologist.

Introduction

Homelessness and mental health, suicide and self-harm

Poor mental health can be both a cause and a consequence of poor housing conditions and/or homelessness and people who are homeless often find it difficult to access the mental health support services that they need.

Many of our members become homeless as a result of traumatic events such as a bereavement or fleeing abuse. In addition, the very experience of being homelessness is inherently traumatic. Many of the people we support are living in chaotic temporary accommodation with nowhere to go during the day or are sofa surfing between houses. Others who sleep rough are also facing violence and stigma. For many, the lack of personal space and the uncertainty of when they will be in a secure and stable home further exacerbates difficulties with mental health and wellbeing.

Suicide is the second leading cause of death amongst people experiencing homelessness in England and Wales. The most recent ONS stats show that 13.4% of people who died in England and Wales whilst homeless in 2021 were deaths by suicide.[1]

Many of our members have experienced suicidal thoughts. When describing their experiences of mental health whilst homeless, members have commented:

"If had not been for my support worker at Crisis. I may well have taken the final exit."

[1] Office for National Statistics (2022) Deaths of homeless people in England and Wales: 2021 registrations

"I couldn't see a way out of it. I just didn't know where to turn... I wanted to walk into the sea."

Although there is limited research specifically on self-harm amongst people experiencing homelessness, as the strategy acknowledges, many of the risk factors for suicide, self-harm and poor mental health are the same, and so it can be assumed that people who have experience of homelessness are more likely to self-harm.

Indeed, we know that many of our members have experience of self-harm.

When asked how experiencing homelessness had affected their mental health, one member responded:

"The frequency of self-harm increased 3 times and severity increased 4 times."

Crisis would also note that people who are experiencing homelessness can face particular barriers in accessing mental health support. For example, there are barriers in registering with a GP which make it difficult for people to access timely support when self-harm and suicide ideation emerges.

Crisis was a part of the Expert Review Panel that considered how legislative reform could help to end homelessness in Wales. The panel's stakeholder engagement revealed a multitude of barriers for people experiencing homelessness and trying to access mental health support.

For example, the panel heard how co-occurring mental health and substance use needs often struggle to access support because services are reluctant to treat both issues at the same time. This results in members being 'ping-ponged' between mental health and substance misuse services.

The Expert Review Panel made a number of recommendations to improve the connections between public services and mental health services. These include recommendations for clearer pathways between mental health and housing services as well as legal duties for referral and co-operation between public services, and adoption of a case co-ordination approach for people requiring support from more than one public service. It also includes calls to encourage replication of existing good practice for supporting the mental health of those experiencing homelessness.[2]

The draft strategy

Crisis welcomes the Welsh Government's efforts to introduce a new strategy for suicide and self-harm prevention in Wales and is pleased to see the acknowledgement within the strategy of the need to tackle the wider determinants of mental health.

We would, however, strongly urge that poor housing conditions and homelessness are acknowledged as one of these determinants, and that people experiencing homelessness are added to the list of groups at particular risk of suicide and self-harm.

[2] Expert Review Panel (2023) Ending Homelessness in Wales: A legislative review

As mentioned above, the Expert Review Panel made a number of recommendations around improving access to mental health services for people experiencing homelessness. This included the following recommendation:

That the Welsh Government considers how its new mental health strategy and guidance around the Mental Health (Wales) Measure 2010 can recognise the connection between homelessness or insecure housing and mental health, emphasising the importance of collaborative working between mental health services and housing options/homelessness services."[3]

While we welcome that the draft mental health and well-being strategy does acknowledge people experiencing homelessness as being at a higher risk of experiencing difficulties with their mental health, it is disappointing that the same is not true of this strategy. Indeed, given the close connection between these strategies and the increased risk of suicide and self-harm among those experiencing homelessness, we feel that the heightened risk for those experiencing homelessness must also be reflected within this strategy.

Within our consultation response to the draft mental health and well-being strategy, we have urged that the Welsh Government develop specific actions to support the mental wellbeing of those experiencing homelessness. Similarly, we note that the Suicide and Self Harm prevention strategy will be accompanied by detailed delivery plans setting out SMART objectives. We would very much welcome the opportunity to work with the Welsh Government to consider objectives for ensuring those experiencing homelessness are accessing the support they need to prevent and respond to self-harm and suicide ideation, plans or attempts.

1. To what extent do you agree with this vision?
"People in Wales will live in communities which are free from the fear and stigma associated with suicide and self-harm and are empowered and supported to both seek and offer help when it is needed."
What are your reasons for your answer?

Being able to access support at the earliest opportunity is crucial. However, as identified above, we know that there can be particular difficulties for those who are experiencing homelessness in accessing mental health support, especially timely support.

Many people who experience homelessness face extremely long waiting lists for mental health services. In the meantime, self-harm and suicidal feelings can build and develop, as people continue to live within chaotic environments or poor conditions. Other people who experience homelessness face significant difficulties accessing support. For example, some struggle to afford transport to get to appointments or do not have the ability to join appointments online. Others cannot get an appointment as they may have lost access to their GP when they lost their address and struggle to register at a new GP surgery.

Last year, Crisis helped to convene a panel of experts to review homelessness legislation in Wales. As part of this, the panel consulted widely with people with lives experience of homelessness and frontline professionals. Many raised the importance of access to

[3] Expert Review Panel (2023) Ending Homelessness in Wales: A legislative review

mental health services and as a result, the panel recommended that there be clearer referral pathways from housing services into mental health support.

In addition, it highlighted areas of good practice where services were co-funded or co-located to improve access to mental health services and asked the Welsh Government to consider how practices like these could be further encouraged across Wales.

The panel report also highlighted the difficulties of experts by experience who are struggling with substance misuse. Often substance misuse and mental health problems co-exist and with each issue reinforcing and exacerbating the other. However, the panel heard that often people with substance misuse struggle to access services as service providers disagree over which issue is the primary issue to be addressed first. Crisis is of the opinion that people require simultaneous support for both.

Furthermore, the panel recommended that care assessments should routinely consider housing security given that this can be a driving factor and exacerbating factor in mental health issues.

We hope that, as the Welsh Government develops its delivery plans to sit underneath this strategy, these key recommendations may be considered further. Crisis would welcome the opportunity to be involved in discussions to this end.

In response to this vision, we also wanted to note, that while of course we support empowering people to support their own wellbeing and that of others – there is a balance to this.

While we want to see greater awareness among professionals of support for those with suicidal thoughts and who are self-harming, this should be an accompaniment and never be a replacement for accessing the specialist support a person requires.

In addition, we must be mindful that signposting individuals who are already experiencing trauma to webpages and information can be inaccessible – not all of our members have easy and regular Wi-Fi access. For others, a long list of signposts can feel daunting and overwhelming. We must be careful not to shift the full responsibility of a person's care onto the person or their peers rather than mental health services.

One of our members commented:

"There are many actions I should be taking myself but I'm not able to because of my mental health.

I have limited energy. Being homeless forces you to transfer your energy from struggling with mental health to struggling with homelessness".

If we shift full responsibility onto the individual, we risk reinforcing the feelings of shame that they already feel because they are not able to help themselves.

Crisis also notes the refence to stigma in this vision. Many of our members feel stigmatised just for being homeless, as well as for experiencing difficulties with their mental health too. Stigmatisation has a significant impact on a person's self-confidence, wellbeing and ability to build a life beyond homelessness. Crisis is a firm believer in taking

a trauma-informed approach to supporting people. We would welcome trauma-informed training across housing options services to help address this.

2. In the strategic vision section there are 6 principles that underpin the strategy. Do you agree these principles are the right ones?

What are your reasons for your answer to question 2?

Crisis welcomes the principles outlined in the consultation document- especially, the principle of "focus on inequalities and at-risk groups." As identified throughout this response, we strongly urge that the strategy acknowledge people experiencing homelessness as one such at risk group.

We also particularly welcome the principles suicide and self-harm as everybody's business; the need for person centred support; and the importance of multi-sectoral collaboration. For many people experiencing homelessness, difficulties with mental health can be a cause and/or consequence of homelessness. As such, supporting someone to build a life beyond homelessness requires recognition of the intersectionality of their support needs and close collaboration between the agencies that work to support them.

It will also be crucial that the delivery plans developed to accompany these principles include specific actions to assist those who are experiencing homelessness.

3. The strategy identifies priority and high-risk groups. Do you agree that these are right? What are your reasons for your answer?

As outlined above, we would strongly urge that people experiencing homelessness are added to the list of at-risk groups, given the heightened risk of mental ill-health for people experiencing homelessness.

This would better reflect and support the wider mental health strategy, which acknowledges those experiencing homelessness as an at-risk group.

4. To what extent do you agree with the following high-level objective.
Objective 1: Establish a robust evidence base for suicide and self-harm in Wales, drawing on a range of data, research and information; and develop robust infrastructure to facilitate the analysis and sharing of information to focus resources, shape policy and drive action.
What are your reasons for your answer to question 4?

Two sub-objectives have been suggested to achieve the objective 1.
Do you agree with the sub-objectives identified?
What are your reasons for your answer?

Alongside the strategy we will be publishing 3–5-year delivery plans. What actions do you think we could include in the plan to deliver against the objectives?

Crisis would suggest that research and data analysis should include specific consideration of at-risk groups. Including people who are experiencing homelessness.

As highlighted elsewhere in this response, Crisis considers multi-agency collaboration to be fundamental in supporting people. As such, we welcome the reference here to looking at information sharing between agencies and would urge that this includes looking at how, with a person's consent, information can be better shared between mental health services and housing options services.

5. To what extent do you agree with the following high-level objective.
Objective 2: Co-ordinate cross-Government and cross-sectoral action which collectively tackles the drivers of suicide, and reduces access to means to suicide.
What are your reasons for your answer?

Four sub-objectives have been suggested to achieve the objective 2.
Do you agree with the sub-objectives identified?
What are your reasons for your answer?

Alongside the strategy we will be publishing 3–5-year delivery plans. What actions do you think we could include in the plan to deliver against the objectives?

Crisis believes that a cross-governmental, cross-sector approach is imperative in reducing homelessness. We believe that multi-agency working can help to improve early identification and prevention and to meet the holistic needs of an individual. Given that mental health and homelessness are frequently intersecting needs, this cross-collaboration approach can also be important for preventing self-harm and suicide.

We feel that this also compliments the approach set out in the Welsh Government's White Paper on Ending Homelessness in Wales, including calls for a case co-ordination approach to supporting people experiencing homelessness with complex needs. We urge that detailed delivery plans include specific actions (informed by the findings of the Expert Review Panel and linking to the proposals in the White Paper on Ending Homelessness) looking at how collaborative cross-sectoral working can better support the mental wellbeing of those experiencing the trauma of homelessness.

Crisis would also emphasise that, when looking at delivery plans, the Welsh Government should work with criminal justice partners on prisoner suicides. We know that housing insecurity is often a challenge for prison leavers and many struggle with uncertainty of where they will live upon release. This can have a significant impact on their outlook on life after prison. We are aware of current work in England on suicide prevention with the Independent Advisory Panel on Deaths in Custody (IAPDC) and National Police Chiefs' Council (NPCC), which will be helpful in this regard. There are also connections that could be made with the Welsh Government's working group looking at housing and prison leavers.

6. To what extent do you agree with the following high-level objective.

Objective 3: Deliver rapid and impactful prevention, intervention, and support to those groups in society who are the most vulnerable to suicide and self-harm through the settings with which they are most engaged.
What are your reasons for your answer?

Three sub-objectives have been suggested to achieve objective 3.
Do you agree with the sub-objectives identified?
What are your reasons for your answer?

Alongside the strategy we will be publishing 3–5-year delivery plans. What actions do you think we could include in the plan to deliver against the objectives?

Crisis agrees with the broad sentiments of this objective and considers it crucial that people who are experiencing homelessness should be included within those groups who are vulnerable to suicide and self-harm.

However, we would highlight that many people experiencing homelessness are socially excluded and so there may not be a setting through which they are particularly engaged. It is crucial that these people are not overlooked when it comes to prevention, intervention and support.

We also welcome the approach of using different settings to engage people – depending on the settings with which individuals are most engaged. Indeed, through our role on the Expert Review Panel, we heard how people with lived experience of homelessness benefitted greatly where services co-locate to improve access to mental health support.

We are also well aware of how helpful outreach services can be where mental health nurses visit people experiencing homelessness directly, ensuring that people known to be at risk are able to access support.[4]

In addition, there is much evidence to demonstrate the success of the Housing First model in supporting many people out of homelessness. This model focuses on wraparound support for an individual, which can include on-site mental health support.

With regard to objective 3a., as expressed throughout this response, we would suggest that people experiencing homelessness are added to the list of at-risk groups, given the heightened risk of mental ill-health for people experiencing homelessness.

We would also suggest a few additions to the list of 'key settings' where the most vulnerable to self-harm and/or suicide might present, including:

- Local authority Housing Options services
- Home Office services
- Third sector organisations that provide support with, for example, housing/homelessness, drug and alcohol dependency, immigration issues, legal advice.

[4] For example, see: First-of-its-kind nursing outreach launched to support people sleeping rough on streets of Bridgend | ITV News Wales.

With regard to the development of the delivery plans, we would urge that this includes plans to encourage the expansion of good practice and positive outreach models, as identified above, across Wales. We would also suggest that these delivery plans look at recommendations made by the Expert Review Panel on ending homelessness in relation to supporting mental health. Crisis would be happy to assist.

7. To what extent do you agree with the following high-level objective.
Objective 4: Increase skills, awareness, knowledge and understanding of suicide and self-harm amongst the public, professionals and agencies who may come into contact with people at risk of suicide and self-harm.
What are your reasons for your answer?

Two sub-objectives have been suggested to achieve objective 4.
Do you agree with the sub-objectives identified?
What are your reasons for your answer to question 7b?

Alongside the strategy we will be publishing 3–5-year delivery plans. What actions do you think we could include in the plan to deliver against the objectives?

Crisis believes there is a need to increase skills, awareness, knowledge and understanding of suicide and self-harm amongst the public, professionals and agencies who may come into contact with people at risk of suicide and self-harm.

In particular, we wish to emphasise the importance of raising awareness and of trauma-informed training among housing services staff. Many people with lived experience of homelessness often tell us that they have experienced a lack of understanding of the intense strain homelessness places on their mental wellbeing and of the trauma that they face. They emphasise the importance in ensuring that housing options teams are trauma informed.

For example, a member said:

"The staff [in housing options] need and must gain trauma informed training delivered by a lived experienced team. A person-centred trauma informed approach to delivering a successful service that creates real positive changes is critical to service delivery and the clients using them."

8. To what extent do you agree with the following high-level objective.
Objective 5: Ensure an appropriate, compassionate and person-centred response is offered to all those who self-harm, have suicidal thoughts, or who have been affected or bereaved by suicide promoting effective recovery and reduced stigma.
What are your reasons for your answer?

Crisis agrees that person-centred support is vital. As outlined above, a key element of person-centred support is ensuring that the service is accessible – especially for harder to reach groups such as those experiencing homelessness. It can be helpful to look at co-location of services, outreach services and providing in-house support through Housing First models.

Another key to ensuring that support is person-centred is the provision of a variety of different types of mental health support. Whilst some of our members struggle to access the medication that they need, others report that medication is the main or only source of support offered to them.

One Crisis member told us:

"'Antidepressant' drugs should not be the first/only offer from GPs."

As with many people who are struggling with mental health difficulties, our members often find that medication is helpful, but that psychological therapy is also needed. Individuals have different therapeutic requirements. Indeed, some of our members prefer light touch group support, while others intensive 1:1 sessions.

A Crisis member outlined their experience as follows:

"Whoever I tried to get help from, I was just told to take tablets and it would go away. But I don't take tablets. I did go to [community mental health team] - there was nothing, just men's groups... I was at my lowest ebb, I didn't know where to go or what to do."

Another member explained:

"...[I feel that] online [therapy] is unhelpful for people with more severe issues than say, short term depression. Many people need more intensive treatment...."

Missed appointments and disengagement

Many people experiencing homelessness have chaotic lifestyles because of their housing situation which may lead to them missing appointments. For example, one Crisis member explained that they were unable to attend mental health support and appointments with the NHS mental health team due to the curfew at the shelter they were staying in:

"Homeless shelter - curfew at 5pm meant I cannot engage with neurodiversity support group, could not attend hospital appointments because I had to be back".

Other members have struggled because their appointments are sent to them in writing and they cannot read, or their appointment requires them to make a phone call to opt-in to the appointment, but they do not have access to a smart phone or the phone credit to make the call.

For these reasons, Crisis feels strongly that missed mental health appointments should be considered in a trauma-informed and person-centred way. Stating the cost implications for the NHS on a missed appointment letter only adds further shame and stigma to those experiencing mental health difficulties. Automatically marking one missed appointment as disengagement and not following up often leads to disengagement with the mental health pathway altogether, which entrenches mental ill-health and homelessness. We would emphasise that collaborative working between agencies could be helpful in identifying that a person has missed an appointment and considering whether further support is needed to reach out to the person.

Further, people who disengage with the pathway should not automatically be expected to go back to the beginning of the pathway and the end of the waiting list when they are in a position to re-engage with support.

A Crisis member shared the following story:

"My treatment was delayed due to being evicted, I then started it while in temporary accommodation but was unable to concentrate on it due to being overloaded with stress and not feeling safe at all in the accommodation- I was sleep deprived and fearful due to antisocial behaviour where I was staying. I will need to go back on a waiting list to re-do this treatment at a later date."

If we are to achieve a truly person-centred approach, each individual should be able to re-enter the pathway at the most appropriate point for them at the time that they re-enter, rather than being forced to start from scratch. This would ensure that people do not have to unnecessarily repeat their story in order to engage with the appropriate mental health support and are not forced to wait for extensive lengths of time before being treated.

Two sub-objectives have been suggested to achieve objective 5.
Do you agree with the sub-objectives identified?
What are your reasons for your answer?

With regard to sub-objective 5a, Crisis strongly supports the idea of joint working across sectors to establish a clear description of a timely, pro-active, person-centred and compassionate response to all those who present with self-harm or as at risk of suicide to any part of the system.

Crisis has always been clear that joined up, connected working across public services is key to making homelessness rare, brief and unrepeated. It is also key to the wellbeing of a society – it is crucial that public services work in a joined-up way to provide the holistic support that people need.

One of our members commented that mental health services need:

"Better joining up between services so you don't have to tell your whole story over and over again."

Alongside the Strategy we will be publishing 3–5-year delivery plans. What actions do you think we could include in the plan to deliver against the objectives?

There are a number of actions that will need to be undertaken in order to achieve this objective.

Referral pathways/mechanisms

There should be extensive consultation with professionals working within all public services to establish how simple referral pathways/mechanisms could be used by all public services to refer and communicate. Crucially, this must include housing options services. During our work with the expert review panel, we heard frustrations from frontline homelessness workers who struggled to find clear ways to refer people through for support from NHS mental health services. As was recommended by the Expert Review

Panel, it is important to ensure clear referral pathways from housing services to mental health services – and vice versa – are developed.

In addition, we would suggest learning from good practice that already exists across Wales and beyond.

With regard to links between homelessness and health, particularly in secondary care, it would be useful to consult with Cardiff and Vale Health Inclusion Service (CAVHIS), and Pathway, the UK's leading homeless healthcare charity. In primary care, lessons could also be learnt from the successful rollout of IRIS, the specialist domestic violence and abuse training, support and referral programme for General Practices that has been implemented in 6 out of 7 health board in Wales.

Beyond health, Crisis' Critical Time Intervention team and Built for Zero project could assist in advising on strengthening links between homelessness and prison and probation services.

Join up between emergency intervention and other parts of the system

Many of our members access MH111#2 and have a positive experience of the support provided via this service when they report imminent suicidal thoughts. However, they report that once the immediate crisis has subsided and they are deemed to be 'stable', they are then put on a long aftercare waiting list and have no access to support whilst on this list. This risks re-deterioration of their mental health whilst they wait, especially because a lot of people experiencing homelessness do not have informal support and social networks to help them through their time spent on the waiting list.

Further, the 'stability' experienced after the initial connection with emergency intervention services is often a direct result of the intense care, support and compassion from these services, so the removal of this support without immediate transfer to other support leads to repetition of the patterns of behaviour that led them to suicidal thoughts in the first place.

Response to reporting suicide risk

Crisis staff have a duty to report concerns to statutory services when we think a Crisis member is at imminent risk of suicide so that the statutory service can make wellbeing checks. However, we are often told that the person is not deemed to be an imminent risk and no checks are made.

In addition to the concerns about the increased risk of suicide for Crisis members, we would like to note that this is also a difficult situation for frontline staff, who are left in a state of frustration and anxiety.

Crisis would encourage the Welsh Government to ensure these procedures are improved.

Communication

When we asked Crisis members how working across public services could be improved, a key theme was improvement of communication and information sharing between public services.

For example, Crisis members said:

"Communication is key and needs to be improved."

"I think doctors and the job centre should be more effective when passing information on to housing options so they can process peoples applications more fairly"

There also needs to be better communication within mental health services to enable improved joint working. One Crisis member explained that they had been engaging with the community mental health team but that *"they don't communicate well with each other, so they are unable to put a clear picture [of my mental health] together."*

Raising awareness through training

To create a collaborative and cohesive joint working model across public services, there needs to be an understanding of the expertise of other services.

With regard to joint working between housing and mental health services, there must be greater awareness about the causes and consequences of homelessness. This will need to be achieved through comprehensive training and leaders taking accountability for ensuring that the training is reflected in practice.

Governance, oversight and leadership

Without effective governance, oversight, and accountability at both local and national level, it will be impossible to successfully implement effective joined up working across public services.

To facilitate effective oversight of connections between mental health and homelessness, we would suggest that each health board identifies a homelessness lead.

We also note that the White Paper on Ending Homelessness outlines that the Welsh Government will explore how Regional Partnership Boards might assist multi-agency working to better support those experiencing homelessness in the region. Crisis believes that this type of regional working is imperative, and we hope to see these plans progress to help deliver better connected services – including mental health and housing services.

Commissioning and funding

The way that services are commissioned and funded is key to ensuring that services can work flexibly to meet the diverse mental health support needs of people experiencing homelessness. There are positive examples of how co-funding and co-location has helped to improve connections between mental health and housing services.

9. To what extent do you agree with the following high-level objective.
Objective 6: Responsible communication, media reporting, and social media use regarding self-harm, suicide and suicidal behaviour.
What are your reasons for your answer?

Two sub-objectives have been suggested to achieve objective 6.
Do you agree with the sub-objectives identified?
What are your reasons for your answer?

Alongside the Strategy we will be publishing 3–5-year delivery plans. What actions do you think we could include in the plan to deliver against the objectives?

Our members often tell us that they feel stigmatised for being homeless and, this in turn, can have a detrimental impact on a person's mental wellbeing. People are pushed into homelessness for a number of reasons. Just as we need to think about how we communicate on mental health, it is also important to ensure that we communicate carefully about homelessness so that we breakdown existing stereotypes and reinforce a trauma-informed approach.

10. This is an all-age strategy. When we talk about our population we are including babies, children and young people, adults and older adults. Do you feel the strategy is clear about how it delivers for various age groups?
(If you have answered "no", please tell us why.)

No response.

11. We have prepared impact assessments to explain our thinking about the impacts of the strategy. This includes our research on the possible impacts. Are there any impacts, positive or negative, that we have not included?

We are pleased to see that the impact assessment concludes that this strategy will have a positive impact on people living in poor housing conditions, but we would advise that more specific actions related to people experiencing homelessness will be necessary to ensure that the impact is as effective as intended.

12. We would like to know your views on the effects that the Strategy would have on the Welsh language. Is there anything we could change to give people greater opportunities to use the Welsh language? Or, can we do more to make sure that the Welsh language is treated no less favourably than the English language?

No response.

13. We have asked a number of specific questions. If you have any comments which we have not addressed, please use this space to make them.

Crisis welcomes the opportunity to respond to this draft suicide and self-harm prevention strategy.

As identified throughout this response, we would urge that the strategy is amended to include a clear acknowledgment of the increased risk of self-harm and suicide among those experiencing the pressures and trauma of homelessness.

In particular, we would urge that as the Welsh Government develops its detailed delivery plans, specific consideration is given to supporting this group – including improving access into the service and encouraging the expansion of good practice models of support. Crisis would be happy to provide further information and support to this end.

For further information, please contact Senior Policy and Public Affairs Officer for Wales, Jasmine Harris: Jasmine.Harris@crisis.org.uk.