Welsh Government Draft Mental Health and Wellbeing Strategy 2024-2034

A response from the Frontline Network Wales

June 2024

1. Introduction

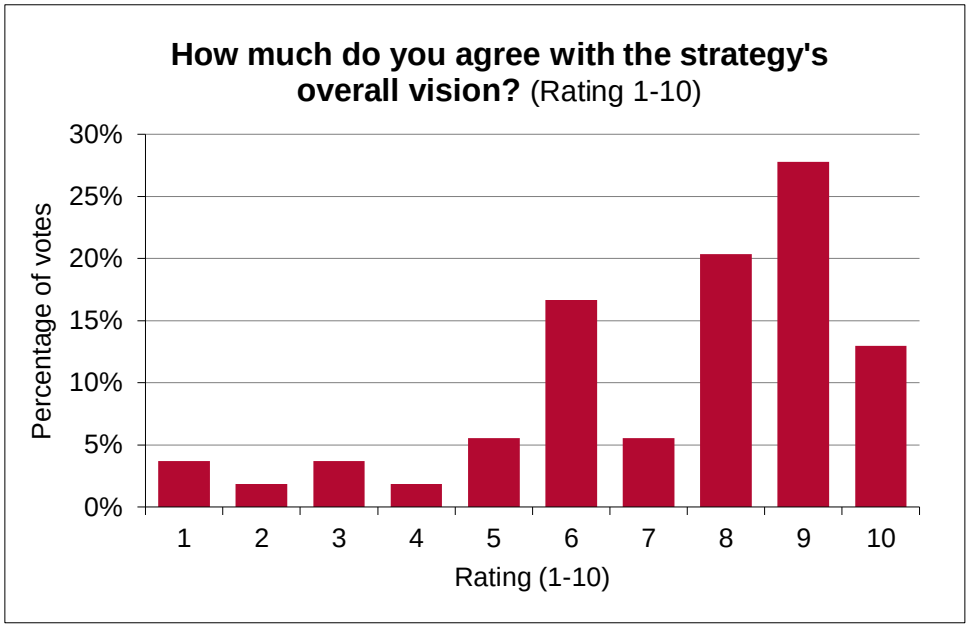
1.1. The **Frontline Network Wales** is delivered by Cymorth Cymru in partnership with the St Martin-in-the-Fields charity. It aims to give frontline homelessness and housing support workers in Wales an opportunity to share their views and experiences, to make their voices heard, and influence policy and practice.

1.2. During April and May 2024, we held three online meetings where we presented key elements of the draft strategy, used online polling to collect feedback, and listened to frontline workers' experiences of supporting people experiencing mental health problems. Over 100 people from 36 organisations registered for these events and 58 people took part in the interactive polling.

2. The Strategy's Overall Vision and Principles

2.1. During the first part of our engagement sessions we outlined the strategy's overall vision alongside each of the ten principles of the strategy.

2.2. When asked to rate the vision on a scale from 1-10, attendees selected a wide range of scores, as shown in the graph below. However, the majority of attendees selected eight or more out of ten, with an average rating of 7.4. People who selected lower scores seemed to be primarily concerned about how realistic the vision was, rather than disagreeing with its ambition.

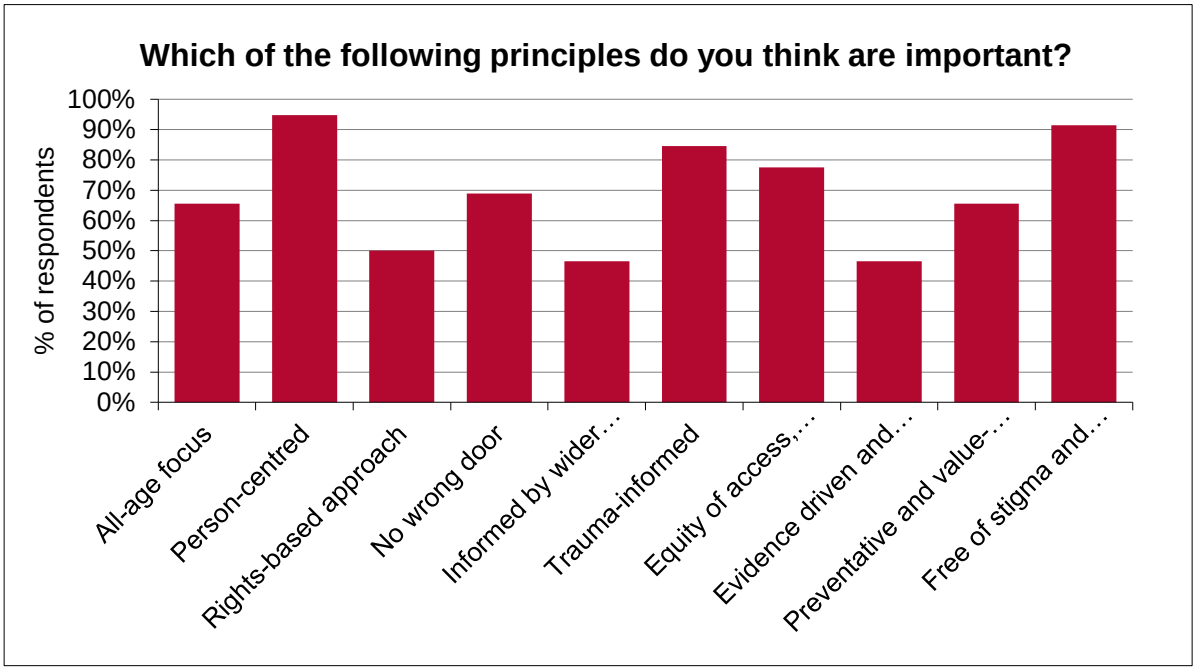


Average score = 7.4

2.3. We also outlined the ten principles included in the strategy and asked attendees to select the principles that felt the most important to them. Some people selected most or all of the principles, while others chose to select the few that they were most passionate about.

2.4. As illustrated in the graph below, all of the principles were well received but some garnered greater support than others. Four of the principles were selected by over 70% of attendees:

- Person-centred approach (95%)
- Free of stigma and shame, blame and judgement (91%)
- Trauma-informed (84%)
- Equity of access, experience and outcomes without discrimination (78%)



2.5. We then asked attendees to comment on the principles and identify whether anything was missing. Most expressed their support for the principles but highlighted concerns about whether the vision and principles could be delivered in practice, particularly in light of the current pressures facing mental health services:

> *"They are great as long as they are adhered to."*

> *"They all look good, but will they work in practice is a big ask?"*

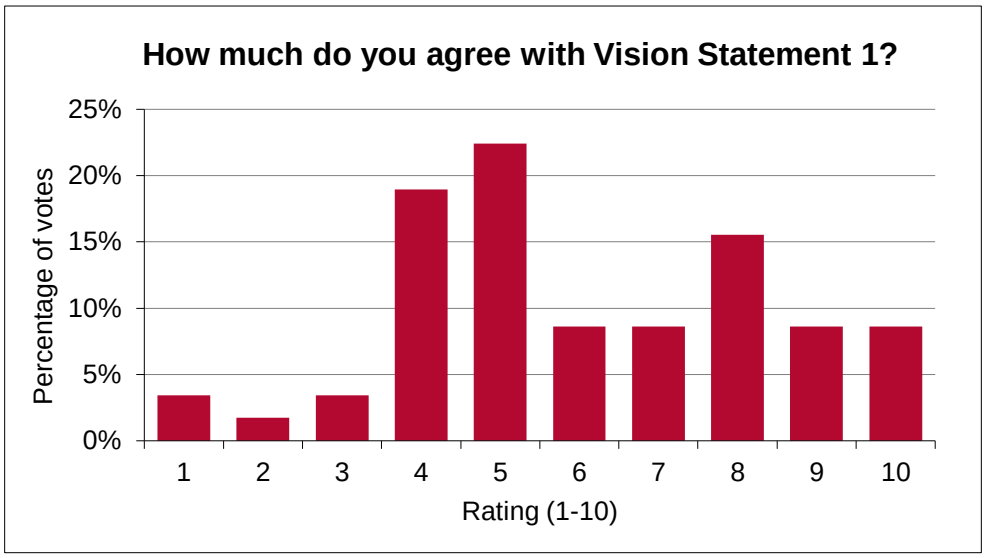
> *"The principles sound like an ideal scenario, in reality mental health services are overrun."*

2.6. When reflecting on the principles, respondents highlighted the following priorities, many of which appear in the principles and/or the vision statements and actions later in the strategy:

- Reduced waiting times and faster access to treatment and support
- Greater investment in mental health services and wider community services and assets that support people with mental health problems.
- Effective collaboration and multi-agency working between services, with particular reference to mental health, housing and the criminal justice system.
- Reduced stigma and judgement, better access to services and improved quality of the response for people with co-occurring substance use and mental health problems.
- More training to ensure everyone working with people who have mental health issues are trauma-informed and aware of co-occurring conditions and disabilities i.e. neurodivergence, learning disabilities, substance use.
- Greater provision for people who are homeless or in prison with mental health conditions.
- Consideration of the geographical challenges in equal access to mental health services, particularly in rural areas and areas with high-levels of poverty.
- Equal access to mental health services for Welsh speakers, users of British Sign Language, and languages other than English.
- Greater emphasis on the social model vs. the medical model, as well as the need to offer alternatives to medication.

3. Vision Statement 1

3.1. We asked attendees how much they agreed with Vision Statement 1 on a scale from 1-10. Across the meetings we calculated an average score of 6.1, demonstrating moderate support for the Vision Statement.



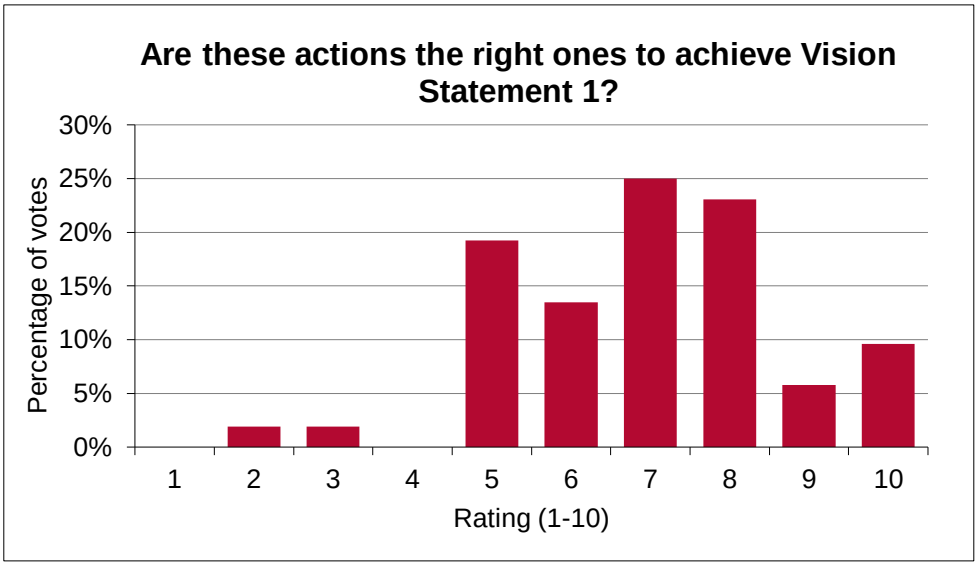
Average score = 6.1

3.2. Some people said they selected a lower score because they were concerned about implementation. The relatively low score may also reflect the homelessness sector's experience of working with people in crisis, and their focus on the need to improve access to good quality mental health services, rather than on whole population mental wellbeing.

> *"Held back on highest score because good ideas need good implementation and that's often lacking."*

> *"Sounds like a lot of jargon that can't be implemented. Keep it simpler - more funding more CPN to support people."*

3.3. We further outlined the high-level actions for achieving the vision statement and asked attendees if these were the right ones to achieve Vision Statement 1. Respondents scored the actions an average of 6.9 out of 10.



Average score = 6.9

3.4. When asked if respondents had any comments to make on Vision Statement 1 and its associated actions, it was clear that attendees supported them, but expressed scepticism about implementation and resources. Several respondents highlighted the existing pressures faced by services, and expressed concern that without proper resourcing, these challenges would be carried over into the new strategy. Some people also reflected on the lack of funding for some of the community-based services that these actions would rely on.

> *"The facilities that are available just don't have the resources to be able to help enough people, then they develop a reputation of failure that then leads to distrust."*

> *"Agencies are already under pressure due to funding. How will this be different?"*

3.5. Others commented on their experience of homelessness and housing services being left to pick up the pieces when mental health services been unable to provide the necessary support.

> *"They are great statements and action plans. But it's whether these are achievable with current structures and funding. And will this fall back on housing …. Again?"*

3.6. One of the actions that received a lot of support was action VS 1.5, which focuses on the mental health of the frontline workforce. Support for frontline staff is seen as crucial, to prevent burnout from ongoing exposure to trauma, as well as in response to traumatic incidents. We strongly advocate for the provision of training and trauma support for all staff working with people experiencing mental health problems, including those working in housing and homelessness. However, the resourcing must be available to provide this support, whether it is a nationally available or built into the commissioning process for third sector services. If provided nationally, it should be also be available to staff outside of the NHS system, such as people working in sectors such as homelessness, who are supporting people with mental health problems. Staff pay should also reflect the level of skill required and demonstrated by frontline workers when supporting people with mental health problems, within the health service and in a range of other public sector and third sector roles.

> *"Front line staff need reassurance and more support and training to support and deliver a empathic and professional services. Otherwise, they leave due to pressure."*

> *"The burnout for frontline staff who try support and empower change is too high, due the pay restrictions for frontline staff imposed by budgets, [the] staff recruited are not always [able to cope]."*

> *"Mental health check ins with employees after significant traumatic interactions."*

> *"Gaining knowledge and confidence is great, will there be more training opportunities for those who offer the support?"*

3.7. Both in response to Vision Statement 1 and the broader strategy, there was a significant push to end stigma within services, particularly for those with co-occurring mental health substance use conditions. For many frontline workers, this was one of the main barriers to someone being able to access the treatment and support they need, an issue that causes frequent challenges for people in homelessness and housing support services. We therefore believe that action VS1.4 to address stigma should include the stigma facing people with co-occurring conditions.

> *"Biggest barrier is co-occurrent substance misuse, mental health services telling people to come back when they're sober even though they use every day. Just because they've stopped using doesn't mean their presentation has changed."*

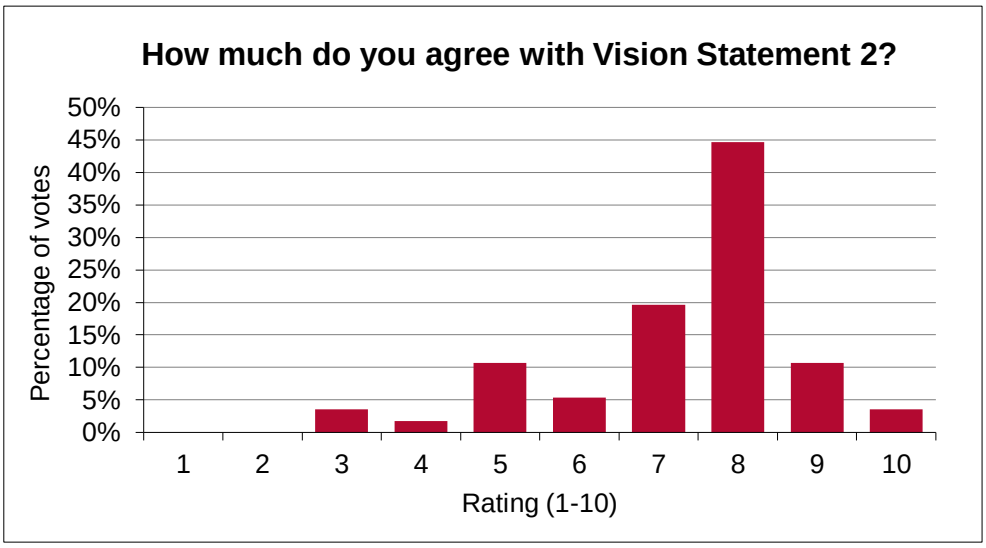
3.8. Other comments included support for the focus on early support in childhood, however, with some calling for easier access to services for parents. Some frontline workers went a step further and called for support family members, parents and carers. By providing a continuum of care for family members and carers in this way would not only be in line with the life-course approach to mental health care, but would also be an important addition to promoting mental health literacy among adults, which could be passed on the children, as well as playing a central part in building the understanding the role of the parent-child relationship.

> *"Early years vision is positive however services need to be easier to access by parents."*

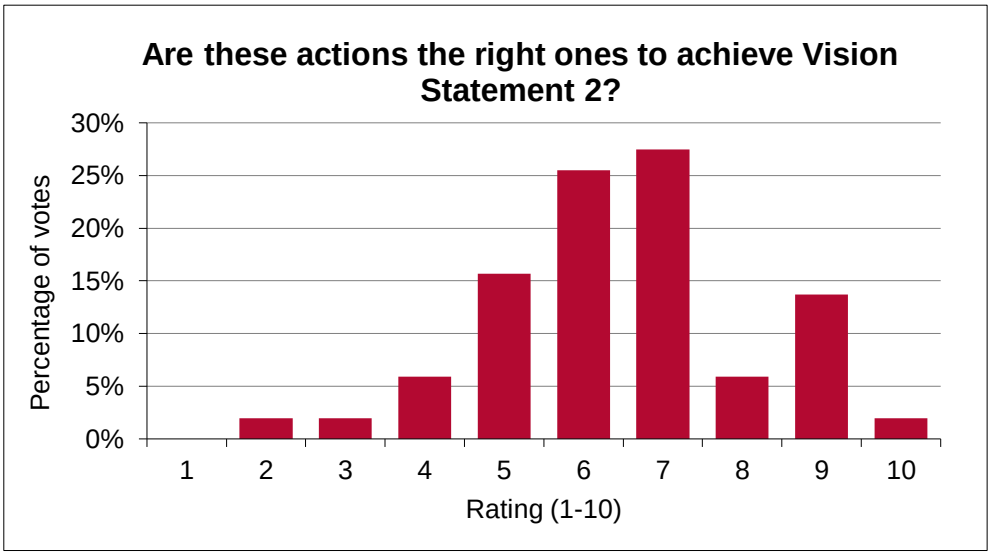
> *"I agree with the last statement touching upon early support in childhood. This is crucial to help bring down the high and unmanageable numbers of adults suffering with mental health issues, that filters into many services. Support for the child, siblings, guardians and extended family members could have such a massive impact on the longer-term support needed."*

4. Vision Statement 2

4.1. There was stronger support for Vision Statement 2, with 80% of frontline workers rating it 7 or more. The average score was 7.3. out of 10.



Average score = 7.3



Average score = 6.5

4.2. The respondents rated the associated actions at an average of 6.5 out of 10 when asked if they were the right ones to achieve the overall vision statement. This is partially a reflection on the actions being very process driven, regarding impact assessments and indicators, rather than some of the service reforms that frontline workers want to see within services.

> *"Will this actually help the people we support in terms of accessibility and promotion of good mental health?"*

4.3. There was support for collecting indicators and monitoring the use of impact assessments to ensure that processes were followed, and that progress could be effectively tracked. However, there were concerns about consistency in terms of adhering to guidelines and the impact of performance monitoring on wider funding and resourcing. Some frontline workers highlighted the need to ensure services complied with updating impact statements and following through on training, while another expressed worry that funding for services would be determined by key performance indicators, which may not reflect the value and impact of their work.

> *"Great aim but in practice will it be done - particularly in relation to current Equality Impact Statements - compliance is the key and continually updating it for the person/cohort."*

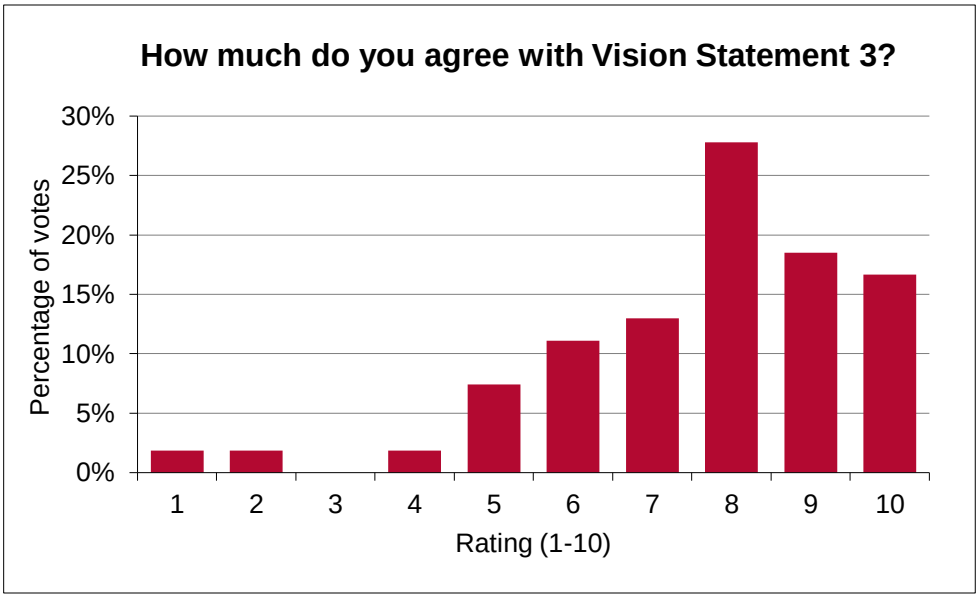
> *"This will be hard to 'police' by the government but if it works will be very welcome."*

> *"Cross-government can lead to local facilities being taken away and put into cities that people in more rural areas will have difficulty reaching. Funding the counties themselves would be a much stronger way to reach people."*

4.4. Frontline workers were also concerned about whether the proposals for collecting indicators and monitoring performance would result in better access and experiences for marginalised or vulnerable populations, particularly those that fell under the radar or between services, such as people experiencing homelessness, people with co-occurring conditions or people who are neurodivergent. Therefore, consideration should be given to how any indicators will report the experiences and outcomes of people who are traditionally underserved by services.

5. Vision Statement 3

5.1. There was strong support for Vision Statement 3, with an average rating of 7.6 out of 10.

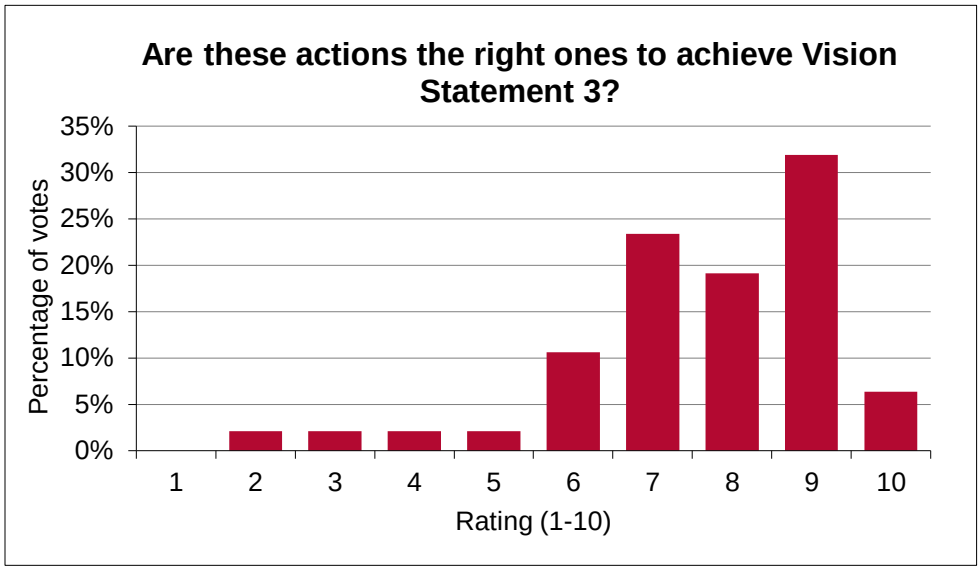


Average score = 7.6

5.2. It was clear from conversations with frontline workers that a joined-up, multi-agency approach was viewed as a critical factor for achieving the strategy's vision. Many of the people they support do not enter the system through traditional routes, highlighting the need for the right support to be available wherever they reach out for help.

> *"Joined up approach – brilliant if it comes off. Everyone needs to know who to refer to, what different agencies do, how best to direct people."*

5.3. The actions under Vision Statement 3 were also well received, with an average score of 7.6 among respondents.



Average score = 7.6

The importance of housing and homelessness

5.4. Despite the strong support for Vision Statement 3, many people were concerned by the absence of housing and homelessness in the list of actions. **Frontline workers were very clear that there should be an additional action under Vision Statement 3 about improving access and outcomes for people experiencing or at risk of homelessness.**

> *"Housing not mentioned!"*

> *"Why aren't housing services in this as we are typically the frontline workers for the most vulnerable people."*

5.5. Safe, secure, good quality housing is one of the key foundations for good mental health and wellbeing. Preventing homelessness can prevent mental health problems from developing or worsening. Providing timely mental health support can also prevent homelessness from occurring. Mental health problems, both diagnosed and undiagnosed, are prevalent among people experiencing homelessness and this is a group that is often under-served by traditional mental health services. There has been some very positive partnership working across homelessness, mental health and substance use at a Welsh Government, regional and local level over the last few years, but there is still a huge amount more that can and should be done.

Homelessness and housing support workers as key partners

5.6. Many people felt that more should be done to involve frontline homelessness and housing support workers in coordinating the right support for clients. Developing close working

relationships between mental health services and homelessness services was seen as vital to deliver a holistic and psychologically informed approach to helping clients. It can also be useful for maintaining contact with people who lead transient lives, or to prevent people from having to repeat their story across various services, which risks exacerbating their mental health issue from having to relive trauma.

> *"Not everyone fits in the same box, therefore, support/care has to be tailored to the individuals needs and again, listening to the frontline staff who work with the clients day in day out."*

> *"Referrals with MH can be lost because of the constant moving around, in temporary accommodation, sofa surfing, hostels etc. Referrals are sent to the first address. We need a database that has the current address or the ability to notify their support worker."*

> *"Young people coming into services have already been let down by other services so have experienced trauma […] young people don't like repeating their stories there should be more seamless flow of information."*

5.7. Many frontline homelessness and housing support workers are best placed to understand the needs of the people they support, but feel that their expertise is often dismissed by the health service when advocating on behalf of the people they support.

> *"Why don't they just contact us? We are on the frontline, see people day-to-day, through the ups and downs, but we just get dismissed. How many people fall through the gaps because they don't listen to us?"*

> *"Frontline workers never contacted and are dismissed by mental health services, even though they work with clients, day to day and can offer background on a person's mental health and behaviour. It undermines the expertise of frontline workers."*

5.8. The process and accessibility of referrals into mental health services was also raised, with particular references to the difficulty accessing GPs and the MH111#2 line for people experiencing or at risk of homelessness. It was suggested that homelessness and housing support staff should have the ability to refer clients into mental health services.

> *"A direct line for housing officers to refer for MH support rather than having to go through GP referral."*

5.9. Despite accommodation being part of mental health care and treatment plans, many frontline workers believed that people's housing needs are not being addressed appropriately. It was therefore understood that with better partnership working between housing and mental health, that clearer more informed decisions could be made surrounding a person's housing requirements based on the understanding of their mental health condition, their history and the risks involved.

5.10. The Welsh Government's White Paper on Ending Homelessness proposes a case coordination approach for people who are involved with multiple public services, which could help to address these types of challenges.

Discharge from mental health services

5.11. There were also concerns raised about the current disconnect between mental health and housing with regards to discharge from services. Several people talked about experiences of supporting people who had been being discharged from hospital or community services without

housing or support in place, leading to relapse of a mental health condition. Recognition of the risks of early or unsupported discharge were similarly recognised by the Welsh Government-commissioned Expert Review Panel on legislative reform and in the subsequent White Paper on Ending Homelessness. Frontline workers believe that a requirement to consider the risk of homelessness when discharging patients from mental health services (in-patient and community) would be a welcome addition to the strategy.

> *"People are discharged early from mental health services resulting them ending up in crisis. How can this be more authentic and not tokenistic in order to meet needs."*

> *"Typically, when someone's mental health improves they are discharged from services. Will there be a scheme they can move onto in order to aid good mental health?"*

Impact of temporary accommodation on mental health

5.12. Several frontline workers raised the impact of temporary accommodation on a person's mental health. The quality of temporary accommodation was a seen as a common factor for exacerbating an individual's mental health, with many housing professionals feeling powerless to challenge the quality of housing in these circumstances. It was agreed amongst frontline workers that opportunities were being missed to provide good quality accommodation for the most vulnerable, including developing more Housing First provision, or putting a greater duty on local authorities to maintain the quality of existing stock or prioritise people with experiencing mental health problems and homelessness.

> *"People get put in the worst temporary accommodation and it exacerbates people's mental health – there should be provision for professionals to challenge the quality of the accommodation"*

5.13. These suggestions from frontline workers also chimed with recommendations put forward in the Expert Review Panel's Legislative Review, including that of the duty to implement minimum standards of suitability and avoiding placements in accommodation that is overcrowded or unfit for human habitation.

Mental health crises leading to homelessness

5.14. Housing staff told us that it was extremely difficult to get a response from mental health services when a tenant was experiencing mental health problems. This could sometimes escalate to the point that a tenant abandoned the property or caused damage that led to eviction. They said that a faster and more effective response from community or crisis mental health services would have reduced the risk of the person losing their tenancy.

> *"We're encountering a lot of vulnerable people with mental health difficulties, when we signpost or refer people they never get anything back from the referral due to the assumption that housing associations can cope, having to contact police instead. Often not getting a response until the crisis is over or it's too late".*

5.15. Many support workers raised cases of clients being evicted and having their homelessness duty closed or being made intentionally homeless for causing property damage during a mental health crisis. In many of the cases mentioned, it was clear that there was a lack of consideration of clients' mental health needs, with many individuals being punished by the police or some housing providers, through arrest or fines, even when there was a risk to life.

> *"People who have been evicted being placed in unsuitable TA. Sometimes they're classed as intentionally homeless and given tents despite being high-risk and too unwell to seriously grasp what's happening."*

> *"Finding a lot of clients being placed in TA and might cause damage to the property to their self-contained when in a crisis, being evicted and having their homeless case closed by the council, being charged for the damage caused despite being on the lowest level of benefits or not even remembering causing damage due to the nature of their mental health condition"*

> *"I have two clients who are at risk of losing their tenancy due to their mental health but there's not enough understanding of mental health from some landlords."*

Criminal justice system

5.16. The role of the police in attending welfare calls was a common concern raised by attendees, particularly with many police forces adopting the Right Care, Right Person approach over the last few months. It is therefore a priority for the frontline network that clarity around the role of the police was provided, both for the safety of clients and staff.

> *"How does this work with the police reducing their response to mental health/welfare calls and there being no community emergency mental health support, only A&E."*

> *"Police in North Wales no longer attending MH emergencies, need to lay out clearly who is responsible for attend certain incidents."*

5.17. The disconnect experienced by people entering or leaving prison was also referenced by a number of frontline workers. Some talked about medication being unavailable when leaving prison and others said people didn't have access to it when entering prison. Overall, there was a feeling that people with mental health problems and other co-occurring issues or trauma can sometimes be caught in the 'revolving door' of prison and homelessness.

> *"People going to prison can sometimes have their medication stopped."*

> *"Better advocacy for homeless people and people in prison with MH issues."*

> *"Revolving door of mental health, prison and homelessness."*

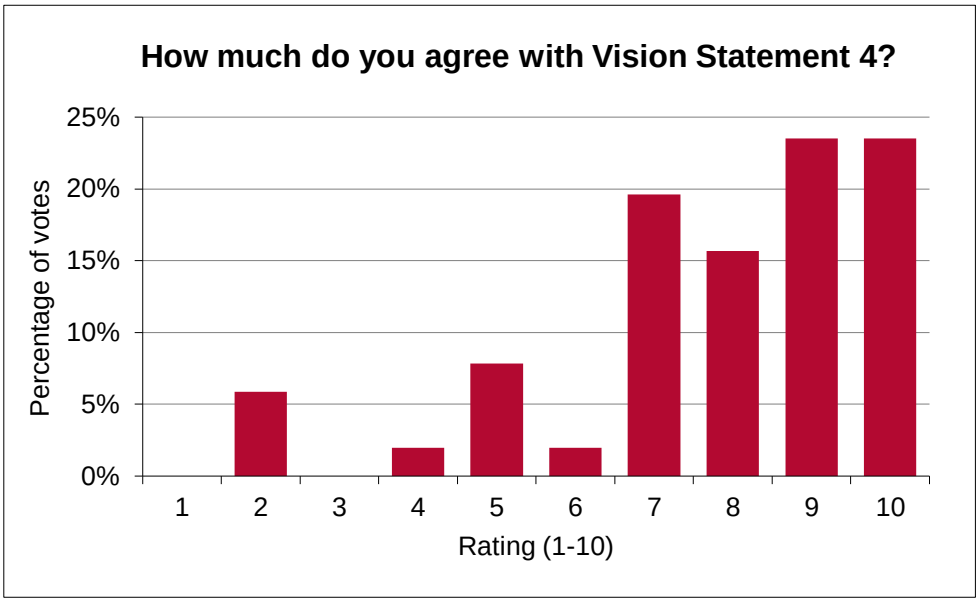
Resourcing collaboration

5.18. Frontline workers talked about the importance of funding and resources to enable collaboration between different services or parts of the system, fearing that lack of capacity would otherwise make this difficult. There are good examples of this, particularly with the Welsh Government complex needs funding, which has been combined with homelessness and substance use funding in some areas to create multi-disciplinary teams. This has facilitated rapid access to mental health, substance use and trauma professionals for people experiencing homelessness. These professionals have also helped people to access mainstream health services, something that would have taken a long time, or seemed impossible, otherwise.

> *"I think the vision statement 3 actions underestimate the challenge in getting different organisations to collaborate on support. My previous role was working for a homeless prevention team and we funded a role in substance misuse who then attended our team meetings and was point of contact for our team to understand what support our service user was receiving and needed to do going forward. […] ultimately without funded positions integrating approaches between teams it won't happen."*

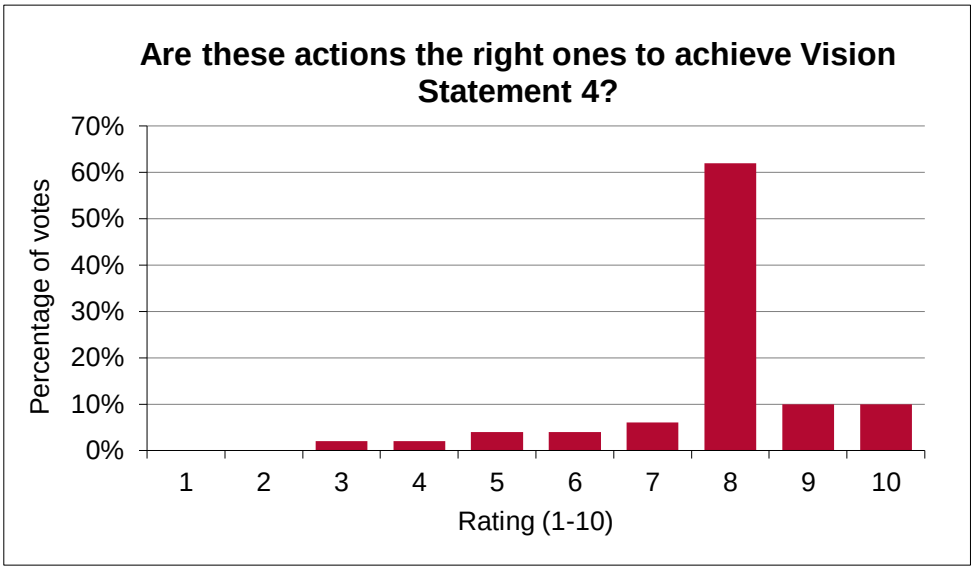
6. Vision Statement 4

6.1. There was very strong support for Vision Statement 4, with frontline workers rating the statement an average of 7.8 out of 10, reflecting the strong desire to see improvements in how the mental health system responds to the needs of people they support.



Average score = 7.8

6.2. The associated actions also received strong support with an average score of 7.9 out of 10.



Average score = 7.9

6.3. The additional comments made by frontline workers were supportive of the vision and the associated actions, but with concern about whether the aspiration will become reality. Others spoke of the urgency required to implement these changes.

> *"Vision is lovely with wrap around services as it should be however the reality is possibly something different."*

> *"Just urgently need all of the above to be put in place before we hear of more suicides."*

6.4. Many people were pleased to see reference to co-production and supported the intention for people with lived experience to play a central part in setting priorities and developing services.

> *"Great to see the words co-production used in this including people with lived experiences."*

6.5. However, the main concerns from frontline workers highlighted many of the current issues within primary care and mental health services, which were seen to be a hinderance to the success of the vision statement and preventative care if left unresolved.

Primary care

6.6. Many people criticised the waiting times and difficulty accessing GPs, which put many people off seeking help until they were in crisis.

> *"Waiting times creates barrier to people seeking help till they are in crisis, skipping prevention measures."*

> *"Will improvements in primary care include reduced waiting times?"*

6.7. Similarly, the need for better communication between mental health services and GP services, to ease the transition from mental health services and prevent breaks in medication or people being passed between services. It is clear that additional provisions should be put in place for people with more serious co-occurring conditions (as previously mentioned), where approaching a GP may be challenging or an impossible pathway for an individual to access help and engage long-term with services.

> *"Transition from MH service - scripts sent to GP after discharge from MH not smooth, needs better transition to prevent break in meds."*

6.8. Some respondents also raised concerns about the approach of primary care services to treating mental health conditions, including GPs exerting pressure on people to take medication. Numerous people called for alternative treatment and support options to be offered.

> *"I support a young person who won't access the GP as they feel they will be pressured to be medicated. Will therapeutic routes be promoted at GPs?"*

> *"There's a difference between someone taking medication and accessing therapy, while others that don't accept medication are not being offered alternative therapies when they should have every right to it."*

> *"Barred from therapies if not accepting the medication – compliance with medication necessary for access to therapy."*

Inadequate crisis response

6.9. Throughout our conversations, frontline workers cited long-waiting times for appointments and referrals for mental health assessments which consequently deters people from seeking support until they're in crisis. Several people provided examples of people being unable to access primary or community services, which resulted in people's mental health deteriorating to a point of crisis and resulting in them going to accident and emergency departments. Frontline workers told us that they would be waiting with someone in a crisis, but the response from the emergency department would be wholly inadequate. On multiple occasions, frontline workers referred to cases where the most vulnerable people were offered low level support, such as self-help guides, despite previous challenges with substance misuse, overdose or even suicide.

> *"One client was waiting 4 months for an appointment when presenting to A&E as suicidal, while someone waiting for 4 years for an appointment – people are desperate."*

> *"I supported an 18 year old who overdosed on his medication. We went to A&E, they did a mental health assessment and said there was nothing they could do. They told him to go back to his GP and go back on his medication. It took him so long to accept help and now we're back to square one. Now he doesn't want to get help."*

> *"The emergency services are lacking within hospitals where they could be waiting for hours when in crisis or you call the crisis team and you get an appointment within 6 weeks."*

> *"People go to A&E after overdosing. Given phone numbers and leaflets. No follow up. We're waiting 4-5 months for an assessment."*

> *"Clients are going into health saying 'I'm going to kill myself, but told there's no beds, go home. How will the strategy change lives?"*

> *"I've had clients say they're going to harm themselves and being dismissed by MH and hospital services."*

> *"We worked with somebody who we were very concerned about their mental health – GP referred to MH – said they just need grief counselling, he was ringing the police, begging to be sectioned."*

> *"We provide supported housing to vulnerable people with mental health difficulties. When we try and refer we don't seem to get anything back. Because we're in supported housing they think we can manage it. We can't get support until it reaches crisis. I was trapped with someone for 5 hours with someone with a knife who was suicidal."*

Response from MH111#2

6.10. Although VS 3.1. and VS 4.12 suggest extending of the MH111#2 line as part of increasing access, frontline workers told us that there needs to be careful consideration as to how this service can be improved.

> *"An improvement or alternative is needed instead of MH111#2."*

> *"111 number didn't work – phoned in a crisis and nobody answered."*

> *"Client said that 111 didn't work, called and didn't get a response."*

Exclusion from services due to 'non-engagement'

6.11. There was a trend of clients being excluded by mental health services due to people not responding to letters or turning up to appointments. This inflexibility and lack of trauma-informed approach disproportionately affects people who are already marginalised and face multiple disadvantage. In turn, this strongly affects the trust that people have in services and often results in reduced engagement from clients leading to dismissal and blame from services, rather than the recognition of, and support for, the root issues. For many frontline workers, the cycle of referrals and dismissals was put a huge amount of pressure on housing support staff to hold up clients, further demonstrating the sentiment that the problem continuously falls on housing.

> *"It's about making sure that the agencies responsible for mental health are onboard with the strategy. Many of the services operate an opt-in system, has tenants that are really unwell and because they struggle to engage with services, they're being taken off lists even though their engagement relates to their mental state."*

> *"If they don't engage, respond to letters, phone calls or appointments, they get taken off [the service]."*

> *"What do you say to people when you're supposed to be supporting them and you're not able to get them help?*

Co-occurring mental health and substance use problems

6.12. One of the most common issues raised by frontline homelessness and housing support workers was the failure of the current system to meet the needs of people with the most complex needs, with access to services often delayed on denied for individuals in these situations. Co-occurrent substance use and mental health issues were cited as one of the biggest barriers to finding the right help, with frontline workers claiming that clients' substance use was often used as an excuse by mental health services not to engage, with services refusing to help clients because they were under the influence or behaving abnormally, therefore resulting in 'revolving door' situation. There was also seen to be no alternative for clients looking to get mental health support if they were unable or willing to abstain from alcohol or substances, therefore making it harder for the clients to engage. The challenge of finding support for people using substances while seeking mental health support was also noted to be particularly problematic in cases of domestic abuse, with survivors not being given priority due to being substance user despite the known mental health effects of VAWDASV on survivors.

> *"Currently trying to get a diagnosis of Korsakoff Syndrome, client not looking to go to the drug and alcohol team as they're not looking to get abstinent, there's no in-between"*

> *"People using substances to self-medicate are taken to mental health services who [then] claim that they're mentally ill or having intrusive thoughts because of their substance use. Seen to be an excuse for MH services to not deal with clients. Mental health services were also sent out to someone that the outreach team has referred but they refused to help them because they were under the influence and behaving abnormally, [without] realising that they're behaviour may be because of MH not substance use. It just results in a revolving door situation"*

> *"Sometimes if people have been on drugs they are not a priority with DV cases I've been working with"*

> *"The biggest barrier is co-occurring. People are asked whether they have used alcohol today and told to come back when they're sober. They're alcohol dependent. They use alcohol every day. Withdrawal would be a medical emergency!"*

6.13. Alongside an increased understanding and care for those with co-occurring issues, it was suggested that Wales required an improved approach to dual diagnosis facilities and information sharing between agencies.

> *"Had experience of dual diagnosis working in Birmingham, however coming back to Wales feels it like it's ten years behind. With the system in Birmingham you can log on and connect with all services - a good example but not perfect"*

Marginalised Groups

6.14. The was a shared sentiment among frontline workers that support for specific marginalised groups was lacking, leading to many slipping through the net. For example, several frontline workers raised concerns about access and outcomes for people with learning disabilities or people who were neurodivergent. People also called for the resources and mechanisms to be in

place to enable all people with a disability to access services with reasonable adjustments, such as access to British Sign Language.

> *"I think it's really important that people with other issues such as neurodivergencies, learning disabilities and drug alcohol problems etc. who often fall between the gaps receive the help they need rather than being pushed from pillar to post or offered help that's unsuitable."*

> *"I was supporting an autistic lad. The autism team said that the mental health team was taking over so they withdrew. Mental health assessed him in October or November, but no-one has seen him. All I see is people referring, going around in circles. No-one wants to take the time to actually help."*

> *"Having facilities and accessibility integrated into every area of support from first contact is important to prevent barriers, instead of it being an afterthought."*

> *"I think that providing sign language training across Wales being made widespread would really open access to those who need it."*

6.15. The experiences of supporting LGBTQ+ clients, particularly young people, were shared by some frontline workers. Facilities and support for LGBTQ+ were described as lacking, with clients waiting significant periods for referral. Support for trans people was seen to be an area where there was a significant lack of facilities or a trauma-informed approach.

> *"Within the LGBTQ + community the facilities are lacking and it can take up to 10 years just to be seen. Have to see two clinical psychologists before being able to referred and having to work hard to prove who you are. It's very daunting for them."*

6.16. Similarly, the support available for survivors of VAWDASV was seen to lack a trauma-informed response, leading to many survivors being marginalised. For example, frontline workers described clients fleeing domestic violence as being punished by social services or not being trusted with their own understanding of their own mental health issues. In some cases this resulted in dismissal or the passing of clients from service to service without help being provided.

> *"[Had a] DV client [whose] children have been taken into foster care – [she was] suicidal, given anti-depressants and referred to mental health – open about being bi-polar however 'specialist' disagreed and said it was BPD and sent her back to her GP."*