Annex A:

healthwatch
York

Mental Health in York: A Progress Review

January 2026

Contents

Content warning: This report contains information that may be distressing to some. This includes but is not limited to: repeated examples of mental health problems, trauma, suicide, self-harm and self-injury.

Although these topics are discussed to highlight the challenges some people are experiencing in our city, please continue with caution and consider your own mental wellbeing whilst reading.

For further information on advice and support available in York, please refer to our Mental Health and Wellbeing Guide:

https://www.healthwatchyork.co.uk/seecmsfile/?id=37

Cover photo by Priscilla du Preez CA via unsplash

Executive Summary

Since our Breaking Point report[1] was published in 2023, we have continued to receive feedback about people's experiences of local mental health services. This report outlines some of that feedback and reflects on whether anything has changed since the Breaking Point report was published.

This report covers the areas raised by the Breaking Point report, but also other areas of mental health support that people have raised with us.

As with all of our work the comments included are the views of people we spoke to, not the views of the Healthwatch York team.

It reflects all the feedback we have received in the past 18 months to the 24 September 2025.

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[1] https://www.healthwatchyork.co.uk/resource-hub/publications/reports-2023/

Background

Our Breaking Point report (June 2023) took a qualitative approach to research. Staff carried out 29 in-depth, semi-structured, interviews with people supporting those with lived experience; held five workshops with the TEWV crisis team, acute hospital mental health liaison team, York Carers Centre, a drop-in session and York voICeS meeting to review the data gathered. In total the team spoke to 67 people including 43 staff members, 15 carers and nine people with lived experience.

The key findings were:

- Mental health services are under severe pressure throughout England, and have been for a long time.
- Tees Esk and Wear Valleys NHS Trust (TEWV) (specifically) has faced major problems with some of its services, particularly in Middlesbrough.
- The people we talked to for this research told us it is hard, sometimes impossible, to access help when it is most needed.
- Some of the problems stem from under-funding, but others appear to be cultural - poor training, poor communications, poor attitudes.
- Despite their own negative experiences, many participants recognised that there is a system issue rather than an issue with individual staff members. It is important to recognise that staff members are under significant pressure and require more support and training to provide the best possible care for those in crisis.
- There is no doubt that our current system is letting people down, to the point where people have died.
- Without urgent action, we will continue to fail some of our most vulnerable people.

- The people we talked to made recommendations for improvement, specifically an increase in lower-level support and preventative care, follow up care to keep people well following a crisis, and clarity on what a crisis is (see page 104 in the Breaking Point report for the full recommendations).

What we’ve heard

Between January 2024 and 24 September 2025 we heard from 146 people about their experiences of mental health care and support. We have analysed the feedback and compared it to what we heard in the Breaking Point report below to see what has changed since 2023.

Crisis Care

Breaking point outlined a number of things including:

- Many people in crisis experience long waiting times and inadequate responses when calling crisis lines. People have to ring many times and sometimes wait for hours before the crisis team answers. …
- It is extremely concerning to hear that people who are feeling suicidal are being told that they have ‘capacity’ and can choose to proceed with their plans ‘if they choose to’. …
- Our research found many concerns about crisis lines including: unhelpful advice, long wait times, and a lack of warmth or empathy from the crisis line staff. …
- Some individuals report feeling unsupported and abandoned after reaching out to the crisis line multiple times without getting the help they need. …
- Some people have had positive experiences, where they received quick and appropriate support, leading to successful outcomes. However, others have had negative experiences where they feel invalidated and rejected, and some have even ended up feeling worse after contacting the crisis team.
- … there have been concerns about the crisis team’s ability to deal with complex diagnoses. …

Some things have changed since 2023. NHS 111 option 2 is now the way for anyone to access mental health crisis support. The call is triaged by NHS 111 staff and then passed on to the appropriate crisis team for support. Since this was introduced, we have had far fewer people saying that they are having to wait long times for their calls to be answered or that their calls are never answered.

However, despite this change and some positive feedback about NHS 111 staff, we have heard many comments which are very similar to those we heard for the Breaking Point report.

Below are some of the experiences we have received between January 2024 and July 2025 about crisis mental health care:

- Person phoned crisis line after taking quite a lot of tablets. When they explained, the crisis line staff member replied 'why haven't you taken more then?' They later made a complaint and received an apology, but it was really upsetting at a difficult time.
- Person had a breakdown in early January 2024 linked to a number of traumas she had experienced in the past 10 years. She contacted the mental health crisis line who told her she should 'just get on with it' and after she considered suicide that she 'needed to think positive'.
- Person's friend was attacked. This triggered childhood trauma and resulted in bruising and the person losing the use of their legs. They went to A&E …When the friend started screaming the staff suggested that they go home and phone the crisis team. They did. It took ages to get through and they kept getting transferred to other people. On each occasion the friend was told they had to go through the attack and the trauma it triggered. No one was willing to read the previous notes. Repeating the trauma increased the person's anxiety. At one point when the friend was struggling the crisis team put the phone down saying the person was in too much crisis. One person on the

crisis line said 'if your friends think you are so ill, why don't they take care of you.' After the experience at A&E the friend phoned the crisis line every day but no help was ever offered."

- "Yesterday I was in a bad crisis all day, I called the crisis team but because it was before 5pm they told me I needed to contact my Community Mental Health Team (CMHT) worker, so the crisis team asked the duty worker in the CMHT to call me. I waited all day I heard nothing. So at about 6pm last night I called the crisis team back and the lady I called on 111 said "I can tell you need help so I'll put you through to the crisis team" a few minutes later the lady in the crisis team answered when she first answered she said "hello you're through to the crisis team how can I help?" So, I started telling her how I was feeling and half way through that conversation she said to me "well have you tried contacting the crisis team?" I was literally speaking to the crisis team and told her I felt suicidal so why ask me to call the crisis team when I was already speaking to her. … My mum called back on 111 and spoke to the same lady again and she was shocked by what the person in the crisis team had said. She put me through again to the crisis team and we spoke to a man this time. His response was "we can't help you because we can't take away your feelings" and then followed it up by saying "you need to take accountability for your actions"
- "My brother took his own life ten days ago. He was screaming for help from everyone, including the crisis team, but no one helped him."
- "… I really struggle with the crisis team. I called a few weeks ago and they were dismissive. They told me to have a hot chocolate or cup of tea and go to bed and I would feel better. They also said that because I was under the CMHT they couldn't really help. I am really hoping that the new Acomb mental health hub will help. They said it will open in March and I would love to know when. The Haven is good, but no help when you have a crisis in the middle of the night. I need somewhere that is always open."

- “I had to call the crisis team last night because I was self-harming again. I really didn't want to call them but I had no choice. So I spoke to 111 and 111 was lovely and put me through to the crisis line. A few minutes later a lady in the crisis team answered and when I told her I was struggling and had been self-harming etc her response was "well you've been like this a while haven't you, so I don't know what your problem is". She then said she would go away and read my notes so she put me on hold. I waited over half an hour on hold so in the end I hung up because I didn't even know if she was going to come back to the phone. An hour later she called me back and then said "sorry I can't remember what we was talking about so can you repeat it again" so then when I said to her that she was the one who said she was going to go away and read my notes she said "yes I've read your notes and it looks like you have been offered a lot of stuff so again I don't know what your problem is." She also said I had been offered the "managing your emotions" work which I told her I have agreed to do but that isn't gonna help me right now when the CMHT will not even tell me when I can start this. She then started getting really nasty so I hung up.”
- “My brother has a number of mental health issues and has had for most of his life. He used to have a community psychiatric nurse, but the services have dwindled. Now when he contacts the crisis line he is told to meditate and given an appointment in six months. Thankfully he is doing OK at the moment.”
- “My daughter had suicidal thoughts and rang the crisis line. Four weeks later she got a message saying 'don't suffer in silence'!”
- “I have rung the crisis line but they say they can't help you if you are drinking. The only time I got support from the mental health team was after I was in a coma in hospital and they were told to help me as I'd been on oxygen and people always get support if that happens. They have never helped when it comes to my mental health linked to substance misuse.”

- “I rang the crisis line yesterday at 8pm and waited until 9pm for triage. The triage person told me to remove the negative thoughts from my mind and replace them with positive ones. I actually laughed at the advice, given after I said I was feeling suicidal. They put me through to the crisis team and the first thing the person said was: 'how many units of alcohol have you consumed today?' I have substance misuse issues, so they must have read my notes. But they didn't ask anything about how I was feeling, just about my drinking, saying that I sounded drunk. After five minutes of questions about my drinking I cut her off, acknowledged I was dependent on alcohol and said I had rung the crisis line as I was feeling suicidal. They said that drink was a big part of my problems and carried on talking to me about alcohol. I ended the call as it was causing more harm than offering help. The Community Mental Health Team had said to call the crisis line if I needed help as they can no longer help me. But the staff on the crisis line are making it impossible for me to call as it makes things worse.”
- “The crisis team are a waste of time and never offer any help with anything.”

We have also heard from voluntary sector organisations who are being left to support people in crisis as the crisis line is referring people to local organisations who are not trained to support people in crisis. We also heard from people seeking help who are referred to voluntary sector organisations:

- “Women are going to the women's centre after contacting the crisis line and saying that the crisis line has referred them to the women's centre for support. The women's centre keeps telling TEWV that that is not appropriate and they can't support people in crisis, that is the role of the crisis team. The referrals stop for a few weeks and then start again. The centre has supported women who have tried to take their own lives on more than one occasion and who say that the crisis team has said they can't help. The women's centre team often has to take women to A&E because there is no other option and no support available from the crisis team."

- "I called to ask IAPT York for help as I'm having suicidal thoughts. They told me I needed to go to IDAS instead. I haven't found the energy to do it yet."
- "I had an assessment with IAPT and talked through what I was experiencing. They said I needed counselling, but they didn't provide it and gave me a list of links for places I could try - no NHS referral, just a list of organisations. It is not good enough. Surely the local mental health provider should be able to refer you for counselling."

In general, the feedback we have had has not changed in the two years since the Breaking Point report. However, in June 2025 we did hear a more positive experience from one person:

- "Over the past six to seven months I have noticed that the crisis team seem to be better at responding to me when I call. In that time, they haven't told me that I was being childish, that I just need to go to sleep and they haven't hung up the phone on me. They seem more receptive and will listen more."

We are aware that the new mental health hubs are being developed, with the first one opening later in 2025. We are hopeful that these will be able to provide appropriate support for some of those people we have heard from and particularly those with complex mental ill health.

Addiction

The Breaking Point report heard from 11 people about experiences of addiction and mental health issues. It reflected: 'We found evidence of a lack of understanding and support for individuals who have both addiction and mental health issues (dual diagnosis). The system is difficult to navigate and there are disparities in treatment options for addiction. …'

In December 2023, TEWV published a new policy: Management of coexisting mental illness and substance misuse (Dual Diagnosis)[2]. This policy's objectives state:

'By adhering to this policy, the Trust will ensure that service users are managed in line with national standards of good practice and that service users are not discriminated against due to their mental health needs being perceived as drug or alcohol induced. This Policy supports this by setting out the expectation that service users:

- receive care based upon their needs, provided by the service (or services) best placed to meet those needs,
- have an appropriate care co-ordinator or lead professional allocated,
- receive care delivered in a collaborative manner from a care plan if multiple providers are involved; and
- are cared for by staff in mainstream substance misuse and mental health services who are competent and capable of responding to dual diagnosis needs.'

While we have only heard from one person linked to this issue since January 2024, their experience is not in line with this new strategy:

"I was previously under the central CMHT team, but after a period of homelessness, I have moved into a flat and have transferred to the west CMHT team. Under the central team I didn't get any therapy

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[2] https://www.tewv.nhs.uk/wp-content/uploads/2021/11/Management-of-coexisting-mental-illness-and-substance-misuse-Dual-Diagnosis-Policy.pdf

which they said they can't provide as I am alcohol dependent. However, I had a CPN who helped to coordinate my care and support from other agencies including IDAS. It was very helpful and meant I was more stable. I attended all my appointments and regularly met with my CPN - even when he fell asleep in my first three appointments. When I was transferring between CMHT teams, my CPN said that the west team might not support me because of my alcohol use. They told me on Friday that there is a meeting today (Tuesday) that I need to attend with my previous CPN, their manager and the manager of the West team. Due to the late notice, none of the people who support me from other agencies were able to attend. At the meeting they said that the west team can't support me in any way. They have previously said that they can help if my alcohol intake is at an acceptable level, but they have never told me what that is. I don't know why they can't support me. Only three months ago I was an inpatient at Foss Park."

Foss Park Hospital

The Breaking Point Report found: '… Foss Park Hospital has been the site of several disturbing incidents involving patients with mental health issues. The hospital appears to have long waiting times for patients and discharges that may have been premature.'

Since the report we heard:

- "…'Nurses' were little more than paid witnesses and guards and there were allegations of sexual abuse, sexual safeguarding issues and dehumanising names: 'pet, treasure'."
- "Some staff were nice however they seemed to not have the time for you. They never sat down and spoke with you. I was in crisis for hours leading me to have a nasty head injury. They just seem to care for the beds to be free as I was rushed to resus and they discharged me

two days later without a safety plan. Food wasn't good. I was a high risk for self-harm. However I was allowed razors in my rooms as well as long chargers (even though I was having persistent incidents) and meds. Staff would leave me in distress for long periods of time rather than help me and on one occasion a head nurse came into my room when I was in distress (crying) and engaging in self-harm and they said 'be quiet there's other people on the ward trying to sleep. This is a hospital'. On many occasions when I was unwell I brought harmful objects onto the ward with no questions from staff which poses a high risk to staff myself and other patients."

- "... They were sectioned early in the year and went to Foss Park and had a bad experience. They were voluntarily admitted to Cross Lane Hospital in Scarborough where the staff were brilliant and they had a much better experience."
- "In February 2024 I had a breakdown and was taken to the emergency 136 unit at Foss Park. I was then transferred to Scarborough as there were no beds at Foss Park. Before I went to Scarborough, the crisis team tried to get my son to look after me, but he said no. I was really angry that they tried to do that. I was in Scarborough for two and half days and that was fine. Then I was transferred back to Foss Park. I was scared as I didn't know what was happening. The day after I arrived at Foss Park I didn't feel safe. I have diabetes and I told them, but they didn't seem to know what they were doing. I explained my normal routine - that I get up early, check my bloods and usually have breakfast by 6am. They just said that they couldn't test my blood sugar until after breakfast and breakfast is at 9am and couldn't be changed. When they did my prick test to check my blood sugar, they never did it properly. They also couldn't provide me with a diet for diabetics and weren't worried that there were lots of biscuits and sweets around that I could have eaten. They never checked me at night and I could have been in a sugar coma. They didn't seem to care at all. After my section ended, I felt so

scared that I walked home (to Poppleton). They didn't seem bothered when I left and I didn't have a phone with me. They just asked how long I'd be gone. While I was there I didn't see a doctor and usually the nurses were having a chat in the office. They were hardly ever on the ward. Often there were men on the women's ward, which wasn't good. Two of the night nurses were lovely, but they were the only ones. I had a meeting at Foss Park about my care. It was me and eight people from TEWV in a room. It was really intimidating."

- "I am writing to formally complain about the decision to discharge my daughter from a Section 2 detention in a psychiatric hospital when she is clearly not ready. She has received no assessment, treatment or therapy during her admission and continues to suffer from severe delusions and agitation. It is deeply concerning that she has been released without any meaningful intervention, despite her ongoing mental health struggles. Her condition has not improved, and I fear that discharging her prematurely puts her and the family at serious risk. As her parent, I strongly believe she still requires inpatient care and appropriate treatment before she can be safely discharged. I would like to understand how this decision was made and why her need for further care was overlooked. I urge you to review this case as a matter of urgency, as I am deeply worried about her and the family's well-being and safety."
- "This place needs to be investigated and major changes need to be implemented or it needs to be shut down. Another one of those 'hospitals' literally paying people to care who do not care and are abusing their position of 'power' to shout at patients, bully and belittle, unable to manage their own emotions and instead of recognising patients struggling and helping to de-escalate with compassion entering into intimidating screaming matches. … Patients are left milling around all day with no engagement or activities or any therapeutic input so have to support each other whilst staff hide in the office. Night staff scream at patients and make

already vulnerable people feel more unsafe. … Also last time I was here they discharged me after a week and put me in a taxi to the cliff side I had jumped off of to find my car - I was still very suicidal. How does that make any sense to anyone with an ounce of common sense? There are a few staff who genuinely care but, unfortunately, they cannot make up for the fact that some staff members are getting away with at best bullying and at worse psychological, emotional, and physical abuse."

Again, we also received some positive feedback about Foss Park. This was particularly about support for an older person.

- "Staff at Foss Park Hospital are always there to support my dad. As daughters, we cannot fault their care."
- "My friend's husband had very difficult dementia and was in Foss Park. She said they were wonderful and praised them highly for the care they gave to someone who could be difficult."

Waiting times

The Breaking Point report recorded 11 responses around waiting times for care and support. (This was separate to the issues of waiting to talk to someone via the crisis line). It summarised that 'The length of waiting lists for mental health services continues to be a major concern for many service users. Long waits for care discourage people from seeking help and put them at risk of reaching a point of crisis. Some service users have experienced waiting times of more than 18 weeks, and this delay in accessing care can put additional pressure on an already over-stretched system, including crisis teams, contribute to and increase mental health crises.'

We are still receiving similar feedback with similar difficult outcomes for people:

- “I went to my GP about my mental health. They said they'd refer me to mental health services, but I am still waiting eight years later.”
- Person has a number of mental health issues and is on a waiting list for support from TEWV. In the meantime they feel they need some counselling and support and asked for advice on where to turn.
- Person is a high functioning manic depressive and is autistic. They were in touch with TEWV pre lockdown and had an autism assessment in summer 2019. Since then, they have heard nothing. They were told that they would be seen in six to eight months after the assessment. After the lockdown they chased this up and were told it would be two years, but no one has been in touch.
- Person has been waiting since April for Eye Movement Desensitisation and Reprocessing therapy (EMDR) and was told they would receive it in October. But they still hadn't heard anything on 24 October and feared they would still be waiting for an appointment in 2025.
- Person's son-in-law (who works at the hospital) is struggling with their mental health. They have sought help via the NHS but been told it is an 18 month wait. Instead, they have gone private and are paying £300 for a psychiatrist/therapist appointment. This has left the family struggling financially, but the person’s son-in-law needs help.

Broader mental health services

The Breaking Point report noted 19 statements about broader mental health services. It said:

‘The current mental health system is struggling to cope with the demand for services, and there is a lack of preventative services and referral options for professionals. This often leads to people seeking help in A&E or relying on voluntary organisations …. People are calling for a mental health service that is more holistic, similar to the Trieste model. There are also concerns about the services for children, autistic people and older people.’

Since January 2025 we have received a number of experiences that echo this reflection about a range of community services, including the Community Mental Health Teams (CMHT), Children and Adolescent Mental Health Service (CAMHS), assessment services and diagnosis services for people who are neurodivergent and older people’s services including dementia diagnosis.

One general piece of feedback which spans a number of services was:

- “The mental health support in York from the NHS is in my opinion awful. I myself work in support services (homelessness) and experience mental health services not only personally, but professionally. NHS services are so cold, unapproachable, judgemental, and often just look at you as a suicide risk rather than actually caring about you - asking the obligatory "do you have any plans to kill yourself" and if it’s a no, they'll just fob you off, telling you to self-refer to somewhere else… If it’s a yes, they will probably forward you to the crisis team that is often just passing the buck back to the GP. Appointments are short, rushed, and often you are sat with a doctor who has little empathy, and often gives little if any advice on anything, or prescribes medication with absolutely no explanation of side effects, and no proper follow up other than a text "medication review" where you reply "Continue" if you're feeling OK. It’s so ridiculous. It feels like you're driving your own treatment.”

CMHT

Our feedback indicates that there are still issues with community services struggling to meet demand:

- Person has care from CMHT, and they are concerned that the care is inappropriate. They have previously been accompanied when going out in the evening, but won't do that now, and overall care is being reduced. They feel unable to complain as they are told they are making things up, and believe that they will stop receiving care if they make any further comments. They have accessed local support, but no more is available.
- “Suffering from post-natal depression, the GP had referred me to the CMHT, and expected them to make contact within two weeks. Eight months later the GP called me to see how I was getting on with CMHT but I hadn't heard from them. I later had a telephone consultation and they said I needed to be referred to IAPT. I then didn't hear from IAPT and assumed I had just got lost in the system, but 14 months later out of the blue I received a call from them asking if I had received any care.”
- Person had been referred to a mental health care coordinator by her GP as a result of a shutdown in the GP practice waiting room. The person wasn't confident that the care coordinator would provide any help. The care coordinator's approach was to say that life is not always easy and there are ups and downs. This despite knowing the person had struggled with mental health issues including an eating disorder as well as an autism diagnosis. When they were discussing the person's eating disorder and she talked about the limited calories she was eating the care coordinator didn't really comment or offer any support to try and address the issue to have a healthier diet. They just said the person can solve their own problems and knows what they are doing. The person is on a waiting list for support but it has a two year wait. They have

previously asked to be referred to a dietitian, but this has not happened.

- “I was referred to the Community Mental Health Team last year after I left Foss Park. During that time I also got referred to an occupational therapist who I saw for three or four months. But while my mental health issues didn't go away, the CMHT discharged me. Now I only have my GP to help me and it is always a different GP so really difficult.”
- “I was in the homeless hostel in Fulford having just come out of Foss Park. I was at my worst time for my mental health and contacted the CMHT saying that I had been harming myself and was thinking of taking my life. They suggested I should have a bath. It was awful and no help at all. You have to be at death's door to get any help.”
- “Re TEWV community mental health team, I have been under them for a few years and keep getting messed around by them. The doctor at Huntington House has taken me off all my medications. The only help they will offer me is the "managing your emotions" even though the CMHT know everything I have been through. When I am in crisis and I call the crisis team they don't ever answer my calls, and I always get told someone will be in touch but they never bother contacting me back. In the past the paramedics have called the crisis team and I always get told somebody from the crisis team will be in touch but nobody ever contacts me back regarding this. When I am feeling like doing something to myself I get told "well that's on you if you want to do that". When I was discharged from the hospital, they refused loads of times to refer me to the home treatment team even after the doctor had referred me and I was referred by the nurses from the hospital ward when I got discharged. The home treatment team rejected those referrals as well. I have been referred loads in the last two years by different people and I have not seen anyone within that

time. A while ago the ambulance came out to me and I was told I would get referred to the West team but that did not happen even when I was told I would get referred there."

- "I have mental health issues and mobility issues. I am a patient of TEWV and the Community Mental Health Team. I have been talking to them about support they can offer me and have explained that they will need to come to my home as I am struggling to get out. They have told me that they don't want to do anything that could mean I associate trauma with my home and that somewhere else would be better. I understand that and have explained that I am happy for them to come to my home. However, they are saying that they can't do that which means I can't get the support I need."
- "I have had contact with the mental health services for a while. They have never been helpful. I have asked for support and treatment, which they said they would give me but either they don't or three weeks before they were going to discharge me, they tried to fit everything in, which obviously did not work. I have an eating disorder and they discharge you when you get to a certain weight, but that is the time I really need help to keep me at that weight or improve things. So, you end up having to go straight back as there is no support to help and you spiral into the problems again. Currently I am paying £80 every other week for private counselling as I get no help from the NHS."
- "I have just started therapy around trauma. I had one session, the person was very good and said they thought I need to process my trauma. I was really pleased as this was the first of 18 planned sessions. But then the person told me she was going on holiday for three weeks, so the next session would have to wait. I feel so frustrated. I had just started something that I really need and now it has to go on hold. It might have been better to start after she had been on holiday."

- “My son is 27 and he is getting no support for his mental health. He has tried his GP and talking therapies, and was booked on for talking therapy, but then it was cancelled and he has heard nothing else. He has been put on a waiting list for the Community Mental Health Team but the waiting list is nine months and he needs help now.”
- “I went to Huntington House for talking therapy. The man who ran it was very good and I found it helpful. However, I was told they thought I needed counselling as a result of some of the things I have experienced in my life. But they then said that they don't do it here and that was it. They gave me a piece of paper with some organisations on, but they are from the voluntary sector. They never said they could refer me, just left it that they couldn't do it. It is frustrating when they provide the local mental health services, which surely includes counselling.”
- “I paid for therapy from The Retreat as I couldn't get any help from local mental health services. I had to wait 7 - 8 months and was referred to Huntington House. I wanted trauma therapy but they said they couldn't help and said they didn't do that. I saw a psychiatrist who was good but they then passed me on to a younger person who said that I should eat well and walk and that was it. It was no help at all. I asked about EMDR and the person I spoke to said they were reading a manual and hoped to be offering the therapy soon. I was not at all reassured by that!”

We also heard from someone about communications and care issues. They had a suggestion about how to contact people, as well as sharing the impact of waiting times for treatment:

- “In April 2024 I went to the GP as I was having mental health issues. They referred me to trauma therapy (EMDR). I had an assessment from a mental health team who agreed that would be the best treatment but there was a waiting list of six months. In October I hadn't heard anything and my trauma issues had increased, so I contacted my GP again. They said they'd chase up the referral. … I got a phone call from a withheld number. Because of my history I find withheld numbers triggering (my abusive partner used to use a withheld number to call me). I did some breathing exercises and did answer the phone. I explained to the person on the phone but they just said 'at least you answered, most people don't answer the call'. They then went on to tell me that there was a long waiting list but that other people also needed help and made me feel quite worthless. So, I was still on the waiting list and they offered online support. I said I didn't want that … as I was struggling. … I do feel that the staff need much better training about dealing with people who need mental health support. Also, if they are going to call on a withheld number, they should put that in a letter or text message to explain and say when they will ring. Then people can prepare. Or if that isn't possible, they need to find a way to let us know who is calling or have a code, so call with three rings and then ring back so people know who it is. It should not be the case that their contact triggers people who already have issues."

We have also heard from people who are getting the support (or some of the support) they need:

- "I have been really struggling with my mental health. I went to my GP who referred me to a community nurse. They have been OK, but in my recent appointment they said I could have talking therapy. This is what I have been asking for all along. So, it is great they are offering talking therapy as I know it will help. I just wish they had done this first."

- Members of the person's family have been to the Hub in York for support for mental health and found it very helpful. They were seen immediately and given appropriate support.
- “Huntington House was brilliant for me via one-to-one support. However, when I asked if there were any groups I could go to, they said no. I really like groups where they are led well and you can see that you are not alone and shouldn't be isolated. But they just said there were no groups full stop, which was disappointing.”

CAMHS

The Breaking Point report did not refer to mental health services for children and young people. We continue to get feedback, often from the parents of children and young people trying to access support and particularly about waiting times to access support:

- “My daughter has still not been seen after six months despite self-harm and writing a suicide note.”
- “My child has been waiting for CAMHS assessment since 2021. In April 2023 we were told his file had been lost. Three weeks later I was told it had been found, but we are still waiting to be seen as my child's mental health spirals and no one will confirm we're at the appropriate place in the queue (i.e. joined 2021, not when the file was rediscovered) or how much longer we will have to wait.”
- “My child (13) has had EBSA (Emotionally Based School Avoidance) for five+ years now. We eventually got them autism and ADHD diagnoses at ages nine and 11 (I had been trying to get these since kindergarten). They were prescribed ADHD meds but couldn't take them as they can't take pills. They began showing trauma symptoms after a toxic friendship, but we were unable to get help from CAMHS and paid for private therapy, without a diagnosis because we could not afford both. They have been displaying

escalating anxiety symptoms for six+ years, in the last two years including panic attacks and dissociation. They are further damaged by the evidence that nobody outside the family cares. We finally got some support last year, but the Face Your Fears intervention did not give them any tools that I had not already taught them. Now they are displaying symptoms of depression as well. They have desperately low self-esteem and despite a move to a specialist school which does not pressure them, and which they cope with if we can get them in, we are still failing to get them there three days out of four. This isn't surprising as they struggle to get to their hobbies too, often failing or arriving for the last five minutes. Their sleep has been severely disrupted for five years. We feel very alone. My spouse and I are struggling to care for them and work. We feel they desperately need to see a child psychiatrist, but this is not on offer and I don't even know how to find one. Does Right to Choose exist for CAMHS? Are there even any private ones? We can't find out. I am extremely worried about the things they are saying about themself, their self-esteem is nothing. But they are not - that we know of - self harming, so there's no support. I can't bear to see how bad they are and it's not enough?! The GP is currently monitoring their weight but wouldn't refer them back to CAMHS "because nothing would happen".”

- Person's daughter is 15 and has complex issues including mental health issues and they are autistic. The problems have been building for a long time and they are in touch with CAMHS. It was clear the young person was going to need a hospital admission for the past four months, but nothing was put in place. Now the young person has been sectioned and is in York Hospital on a children's ward with young children as there is no appropriate mental health bed available. All the healthcare professionals say there is nothing they can do to help as my daughter is not in the right place and she isn't. Mother said: 'I am astonished that TEWV only started looking for a bed for her when she was sectioned even they knew this was going to happen for months'.

- Person's child is waiting for a CAMHS referral and has been waiting for months. They have also tried The Island but found they are no longer accepting referrals as they are so busy as so many children and young people are waiting for CAMHS.
- Mother shared her experiences supporting her child. They are female leaning non-binary, born male. They came out aged 12 in the middle of distressing autistic burnout. There were no signs of gender questioning in early childhood, so this came out of the blue for the family, but they are doing everything they can to support their child and reduce their distress. The path to autistic burnout began in year 6 as a reaction to a lack of flexibility in the teaching process. There were further incidents at school including another parent making inappropriate contact with the child. Parents were led to believe this was dealt with, but with benefit of hindsight wish they had taken the matter to the police. This led to autistic burnout at end of year 6, and a complete breakdown in year 7. Then lockdown happened. Their child told their mother in March of their new name and new gender. Two to three months later, they communicated by What'sApp as they were in burnout and non-verbal that they did not understand why their parents had not got them hormone blockers. Mother confirmed she wouldn't know how, and their child sent them a link to Gender GP. Mother informed CAMHS of what was happening - CAMHS were visiting monthly at this point. Staff visiting were really unsupportive and disapproving of Gender GP. Mother understands this, but feels there were no other choices made available to them. Every day their child said "if you don't do this I will kill myself." One of the staff members responded with "I guess they will just have to learn to sit with it." There seemed to be no compassion or understanding about what hearing this would feel like for a parent. A referral was made to the

Tavistock clinic but there was a four-year waiting list. In August there was an MDT meeting where it was agreed to take a watch and wait approach. In November, without the parents' knowledge, CAMHS made a referral to the Safeguarding team. In December the family received a call as an urgent safeguarding referral following the November meeting. Other people at the MDT meeting do not remember a discussion about referring to safeguarding. A doctor at the gender clinic in Leeds provided very supportive feedback regarding the actions the family had taken. As well as concluding there was no safeguarding issue, the Safeguarding lead asked to share this advice with the rest of the team anonymously as it would be helpful for such referrals in future. … TEWV have said they will put training in place, but in three years the family have seen no evidence of a change in their behaviour which has been judgemental, stigmatising and unsupportive. At the very least health services need to do no harm, but the family feels that by invoking safeguarding at such a time, they increased the potential for harm to occur. They are also concerned about the quality of advice around autism - if they had followed the advice provided by TEWV they believe that this would have damaged their child's wellbeing further. They feel there is an absolute failure to understand their child and what good support would look like for them. Workers need to patiently build trusting relationships.

- Person seeking information about what they can do to expedite autism assessment for 17-year-old son before he turns 18 and moves to adult services. They previously had contact with the CAMHS crisis team last year, but this was not helpful. Later referred to community CAMHS and had one good care coordinator who has now left York. They were told that they would be allocated a new care coordinator but have heard nothing since. Son's health is deteriorating, and they are concerned about his manic episodes and panic attacks, and the delay for his autism assessment is having a further impact on his mental health.

- Person concerned about the treatment their child is receiving at Huntington House from the mental health team. They were agreed to provide psychotherapy but it never happened. Parent has made a complaint, but they don't think they are doing anything and they haven't heard back from them. Tried to escalate and spoke to social services, who tried to do an assessment, but child was abusive towards social worker so she stepped away. Concerned about continued deterioration in their child's health and lack of support, which has impacted their own mental health and they are also now under the mental health team.
- “My son and daughter have ADHD. My son was diagnosed which was quite straightforward, but he had an EHCP. My daughter is on the CAMHS waiting list, but it is taking a long, long time. She is 14 and needs support but can't get that at the moment without a diagnosis. We are trying to get her an EHCP to see if that helps. But I want to know if there is a Right to Choose option for young people.”
- “The only thing Orca House does well is breaking promises. They don't care what happens to the families in their care just as long as they don't actually have to follow anything up or God forbid do some paperwork. After nagging daily for four months, I finally got a letter I'd requested and it wasn't even basic English. It was clearly just a bunch of copy/pasted phrases and half weren't even relevant to the child. I sent it back and asked them to proofread it and they changed one sentence. One! I need to submit this with legal documents and my five-year-old would have done a better job. Absolutely disgusted with the whole system. It's a joke and the kids that desperately need the care it supposedly offers are absolutely screwed.”

- “My daughter is 11 and really struggled in lockdown. She managed to go back to school for most of year 5 but only managed a few days in year 6 when she wouldn't go to school and then wouldn't leave the house. She has been diagnosed as autistic (privately) and was referred to CAMHS. They assessed and discharged her. They said that all the could offer was talking therapies and as she didn't speak in the assessment, they couldn't help. They thought the school could help, but they couldn't and she won't go to school. One of the significant problems is that any intervention is far too late. So I did manage to get an EHCP and she was referred to Huntington but at best she will engage for between five and 45 minutes. If this had been available before, maybe she would have been able to continue going to school, but by the time she went she had been out of school for at least a year when she wasn't interacting. The help needs to come when the struggles start, not years later. I have had to give up work and it is all taking its toll on me. I am on a waiting list for counselling.”
- “Before Christmas my mum filled in a form for me to see a GP about the fact I am really not sleeping. I have been referred to CAMHS. There is such a long waiting time. I am waiting for an autism assessment as well. It is so difficult to be on so many waiting lists and nothing is happening to help me.”
- “My son (9) is probably neurodivergent but hasn't got a diagnosis. He has had traumatic experiences at school and has increased eating issues from July 2024 to the point now where he will only drink, not eat. I have been trying to get help since July. I asked my GP first and they referred him to a psychiatrist, but they said he was too complex for them to support. We saw CAMHS last September but they said they can only help with the eating issues if he completely stopped eating. … I know there is something wrong, but my son can't verbalise it and I have run out of who to turn to.”

- “My daughter is doing her GCSEs. When we were last in touch with CAMHS, they said they were discharging her because she was doing exams. I asked what would happen when my daughter goes to college and they said we'd have to start again via the college.”
- “I tried to get mental health support for my daughter but I got nowhere with the NHS, so I paid for support from the Tuke Centre.”
- “My daughter says that CAMHS is a waste of space. They have not been helpful for her son who is autistic and has suspected ADHD. CAMHS didn't listen to her and what she said about her son, but just what the school said. The school have been good in terms of their support but the son is now moving to secondary school and there is no support from CAMHS.”
- “My son is neurodiverse and has mental health issues. We went to the GP about this and asked for a referral to CAMHS about his mental health. However, they only referred him for his autism, so he has never been seen. He only got his referral to CAMHS last week. And in the waiting time, he has had a lot of issues at school which have led to trauma that I think he will never recover from.”
- “They referred our child to the Specialist Teaching Team, which was just what we thought was needed. Initially, they did not understand our child’s needs when in autism burnout. I would say 80% of their advice would have caused harm. They were the opposite of helpful when our child came out as trans and had no idea how to support us or our child. We lost all trust in the team as they caused harm.”

In 2024-25 our Core Connectors, young volunteers aged 18 – 25, talked to their peers about their experiences of healthcare in York. They received a number of comments about mental health. The report, ‘Young people’s experiences of health and social care’[3] included:

- CAMHS was mentioned repeatedly as not effectively supporting those who need it: “Found the CAMHS worker very rude and dismissive.” Feedback was also received that just general advice was given.
- Upon turning 18 many people told us they had been ‘dropped’ from CAMHS, with little or no planning for how they can move or be referred into appropriate adult services. Some were told to reapply which created more barriers. A lack of continuity of care was a major concern.
- When it came to mental health crises, young people said access was a major problem. They said waiting times were long, the support available was difficult to navigate, and there was a lack of support.
- It was mentioned that there was a need for more mental health support within schools.

We also had feedback about transition from CAMHS to adult mental health services:

- “So many young people slip through the net when they are moving from CAMHS to adult mental health services, including my daughter. The whole mental health system isn't working. … They need to make contact with mental health professionals easier, review the waiting lists, provide more specialist care, particularly for neurodivergent people, and understand the connections between different parts of people's lives and different conditions.”

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[3] https://www.healthwatchyork.co.uk/wp-content/uploads/2025/03/Core-Connector-report-March-2025.pdf

- Person's son (18) has a diagnosis of ADHD. He has just transferred from CAMHS to the adult service and has received no support or any contact. He was on melatonin before the transfer, but that isn't prescribed to people over 18. He was offered one week's sleeping tablets and no more.
- Person felt her son was abandoned by services in York particularly when he turned 18. He did get some support from Lime Trees, but after 18 he felt abandoned and that the psychiatrist he saw did not care. The only people who helped him were the ambulance staff, who took him to hospital after suicide attempts, and the police. The crisis team did visit him in hospital the day after a suicide attempt, but they said that he was OK to be discharged and didn't need support. Three days later he was back in hospital after another suicide attempt. The son's father kept a diary of the issues for his son, but when he shared it with TEWV staff he was told that as his son was over 18 it was 'none of his business'. The family found the mental health staff very arrogant and heard 'in my x years of experience' a number of times. However, none of the staff could help despite their experience. Two of the son's contemporaries also took their own lives having not got any help from York's mental health services.

Complex conditions

The Breaking Point report touched on the experiences of people with complex mental health issues through its case studies and comments from people. However, it did not focus on these experiences. Since the report was published in 2023, Healthwatch York has heard from a number of people with complex mental health issues who feel they have been let down or not supported by mental health or other services. We have raised concerns with organisations across the health and care sectors in York. We have called for a strategy to better support these people who are known by services, but don’t seem to be getting the help they need. Feedback we have received includes:

- Person (C) is aged 30, non-binary and has dissociative personality disorder, complex PTSD and suicidality. They have a care plan in place that should provide 24/7 care. C keeps escaping from home and attempting suicide. Each time this has happened (up to nine occasions), they are reported to the police and then taken to Foss Park Hospital. They are then discharged on the day following admission with no treatment or support in place. A support worker from Generate accompanied C to a meeting about their care at Foss Park. It was attended by a number of TEWV staff and others virtually including a social worker and advocate. C was asked what they needed and begged for help. The TEWV staff were very rude and dismissive. The meeting chair asked C 'what is your problem'. The Generate contact asked if C had received any medical intervention and was told that was something for the care team. They also asked why C was being discharged and no answer was given. C again begged for help and was told that was down to the psychiatrist and care team. Nothing was given before C was discharged the same day.
- Person has had much contact with TEWV and the community care team. But they now feel they are being ignored. They have been in hospital eight times in the last 10 days due to suicide attempts. They are under safeguarding, but TEWV is not helping. They rang the crisis line but they wouldn't help. TEWV has already told them what they would say to the coroner if they died and that it isn't TEWV's responsibility. They have tried other voluntary sector services but are told they are too high risk for support. They made a complaint about TEWV in June (where a

staff member said to them: 'I don't work for people like you. We don't want people like you in our service …') The complaint hasn't been resolved … TEWV has now told the person to go to the First Contact mental health practitioner at their GP practice, but the first appointment is in March and they need help now. They don't know what to do.

- Person is 38 (with a developmental age of 15), has been diagnosed with schizophrenia, is autistic and has ADHD. He has been under the care of TEWV including three recent placements, a DOLs and time at a centre in Bradford. The person has had issues with some placements where he experienced violence or poor care and has run away. He will sometimes refuse to take his medication and refuse to eat or drink. At one point he lost three stone as a result of this. He has been an inpatient at Foss Park and recently his behaviour escalated as he was struggling. A TEWV doctor determined that the person didn't have schizophrenia, despite having had that diagnosis for 22 years and receiving medication which helped his behaviour. This meant his medication was stopped as he was seen as an informal patient. But his behaviour got a lot worse … The staff at Foss Park couldn't cope and on one occasion sent him out of the hospital at 3am. He ended up at A&E at 6am… TEWV has now discharged him but didn't tell him or his parents. He has a section 117 for care, but no care was arranged and he was left homeless. On one occasion when he was waiting at Foss Park at 8am to go back in, TEWV staff called the police to take him to the Council to arrange accommodation. He didn't know what was happening as no-one had explained and he still thought he lived at Foss Park, so went back there. TEWV have said he has capacity, but he doesn't. They also say that the issue is his behaviour not a mental health condition. On one occasion while at TEWV he was so frustrated that he threw a chair as he didn't know what was happening. TEWV are now prosecuting him, although he doesn't understand. He went to court, said his name and then burst into tears, calling for his mum. The judge has sent him to Hull prison hospital waiting for a trial as they didn't know where else he could go. His mum feels that TEWV has washed its hands of him as they don't have the skills to be able to support him. When he was in Bradford (Action for Care) he did have some distress, but the two workers who supported him took him out and felt he was a lovely lad. His mum feels that TEWV should not have changed his diagnosis, should have kept him on his medication and kept him on a section 3. They should have sourced counselling and support for him and treated him as a person. They need better training to support people who are autistic and have challenging behaviour. The staff aren't able to cope, so instead left him to wander the streets and then left him homeless. There has been no duty of care and his mum doesn't feel she can ever forgive them for the awful treatment and support.

- “I've been in mental ill health on and off since age 15 with depression, OCD, overdoses etc but found York’s mental health team the worst I've ever dealt with. TEWV is not interested, does not help if you don't score them a gold star. That has been bad enough for me, then my 32-year-old son saw them on Thursday and was dead less than 42 hours later. They and others were negligent in my opinion. But hey, he's only a national insurance number to them. …. After six overdoses, cutting up since my son's death, they then got rid of me saying they couldn't help me.”
- Person has complex mental health issues and has been trying to get support from TEWV for 18 months. They have previously been in touch with the Community Mental Health Team. They have PTSD, trauma and other issues. Initially they were referred to a number of charities each of whom dealt with separate issues.

But the person wants to talk to someone who understands everything they are experiencing and how the different issues interact. They were referred to IAPT who rejected them as their needs were too complex. They then filled in a self-referral form for IAPT making sure the form didn't suggest they had complex needs. This did lead to them being added to the waiting list for support. However, while waiting the person felt a need to call the crisis line. The person who answered said they could help and this led to the person being removed from the IAPT waiting list as you can't be in touch with two different mental health services at the same time. Then the crisis team got back in touch to say they recommended counselling. But the person had tried that before. So, they were taken off the IAPT waiting list and just told to try and access counselling, and left with nothing concrete. The person experienced mental health services in York before TEWV became the provider and said that while there were issues with the previous provider, they were open, people spoke to you and tried to help and were referred for 12 weeks of therapy. Now it feels like there is nothing at all.

- “My son is 26 and has a number of mental health issues. We also think he is autistic, but he hasn't got a diagnosis. He has had contact with TEWV and the crisis team, but they have discharged him and said he is too difficult for them to help. They said they think he is autistic but haven't done anything about it. … Every time he is sectioned we have a meeting and they see that he is struggling and I am struggling and say we need support but nothing ever happens and there is nothing. I know he can be hard work, but there is no-one to help us. He often talks about taking his own life. Once he rang the crisis team and spoke for an hour to a woman who was good and talked about everything he needed, but then nothing happened or he was offered something online, but he can't do things online. He needs one-to-one help and someone who will take the time to understand him and help him get the support he needs, but there isn't anyone willing to do this. Our GP has been very helpful, but there is a limit to what they can do."

- A professional from the voluntary sector said: "The lack of long term support for those with complex mental health issues and a history of trauma is a real issue. Practitioners like GPs and Local Area Coordinators who are accessible and open access often feel left holding people and risk in the community with very little support and collaboration from TEWV teams who too easily close and discharge people."
- Another professional said: "The crisis services and hospital provision are not fit for purpose as they lack compassion and CMHTs avoid any complexity. There is a lack of support or unwillingness to support people with personality disorder diagnosis and psychosis – the EIP (Early Intervention in Psychosis) Team offers good support but only for people experiencing psychosis for the first time and eligibility criteria is high."

Eating disorders

The Breaking Point Report did not include the experiences of people with eating disorders. Healthwatch York does not get a lot of feedback about this topic, but those we have heard from are not getting the support they need:

- "I wanted support for eating disorders, I felt disregarded as I was binging rather than anorexic. I feel the service is too clinical. The mental health team said I'm a healthy weight. If I'm not going to kill myself there's no help."

- A young adult with anorexia has experienced very long waits for help. Now they have a BMI of 14 amongst other very concerning health issues, but are still waiting to be seen.
- “My son (9) is probably neurodivergent but hasn't got a diagnosis. He has had traumatic experiences at school and has increased eating issues from July 2024 to the point now where he will only drink, not eat. I have been trying to get help since July. I asked my GP first and they referred him to a psychiatrist, but they said he was too complex for them to support. We saw CAMHS last September but they said they can only help with the eating issues if he completely stopped eating…”

Treatment

We have heard from a number of people about their experiences of treatment including group therapy, therapy and medication:

- “I've been treated with CBT twice for moderate anxiety. Yes, I agree I have anxiety but the mental health team does not treat the cause. I have had a private psychologist tell me I have PTSD, but I never get past the CBT stage with the NHS. I need my past trauma dealing with!”
- “I got a referral fairly quickly, which I was very grateful for. However, I took part in a group CBT session! It was dreadful; this should not be allowed. People need treating as people! It was a lecture, no opportunity to explain my problems just generic crap that you would get from a leaflet. As a senior healthcare professional I found it incredibly patronising to ALL, not just me. The moment a picture of a lion came on the slides for fight or flight I switched off. Pointless exercise, I needed more help. I can’t see this exercise working going forward for anyone.”
- Person has had mental health issues since they were in their 20s. They were eventually diagnosed with complex PTSD and borderline

personality disorder. They feel they have had to fight for every treatment they have ever had and nothing was offered without a battle.

- “Foss Park is good. It is state of the art, but it doesn't always have beds. I have been treated by TEWV for a number of years, including going as an inpatient to Middlesbrough. It is awful. They think they know best, but they don't. The care and treatment is appalling. It was so much better when it was under York and Leeds Trust. I hope it goes back to them. TEWV is awful.”
- “My son has an acquired brain injury and as a result developed depression in his mid-20s. He has been on anti-depression and anti-psychotic medication since, even though he has never been psychotic. We want to make sure the medication is reviewed but are struggling to do that. The GP is helpful, they listened and referred my son to TEWV, but then he just gets discharged again with the same medication. It just feels you are on a treadmill and no one is listening. We really want him to have a thorough medication review, but it never happens. The system doesn't work.”
- “The psychiatrist at Acomb Garth has put me onto 20mg Fluoxetine. When he agreed to put me onto that, I had presumed he would agree to lower the dose of the Mirtazapine we had discussed. I've also been saying for ages to both the CMHT and GP that I wanted to come of the Mirtazapine because it does not work anymore and just take the Fluoxetine. But he told me to stay on both together. He also warned me of the side effects of taking both things together, and how serious that can be. They're not even offering any other therapy to help with the complex PTSD apart from medication even though they admitted therapy could help alongside this. The psychiatrist said he would get my care coordinator to keep an eye on me for the next two weeks, but … she refused to have any contact with me in between sessions. … I had to email my care coordinator about something on Monday and the response was "xx will discuss this with

you at your next session". So, they put me on medication that can cause serious reactions and then my care coordinator refuses contact with me in between sessions, and when I contact the GP they say they don't know much about it because it is supposed to be Acomb Garth dealing with everything at the moment in relation to this. … I was told yesterday by the CMHT that a letter had gone to the GP yesterday about them reducing my Mirtazapine and we have spoken to the GP today and he said no letter has come through yet and for me to continue taking both the Fluoxetine, Mirtazapine and Lamotrigne on a night time together until the GP gets this letter through even though they are aware of the risks of this serotonin syndrome."

- "My daughter is 19. She is autistic and has an Education Health and Care (EHC) plan. She is studying at Bishop Burton and had been doing well, but her mental health has deteriorated as it has taken a long time for her to get any adult mental health support. There was a large struggle to get any support when she transitioned to adult services. Basically, there was no support. She did have a social care assessment, but it took six months for me to get a copy and they said they can't get involved until the mental health team has done its work. I would really like to see a case coordinator involved for young people transitioning to adult services. There should be a case conference when a young person is 15 with everyone involved to look at what needs to happen over the next five years. That doesn't happen. There are annual reviews but we, as parents, have to push for people to be there and things to happen. When I asked about case coordination, I was told that lots of people are involved, but that is the problem, there needs to be someone with an overview who looks at someone's needs holistically. That isn't happening."

- "I struggle with them about medication for my mental health. I feel I need to have a conversation as sometimes things work and sometimes they don't and I don't know what to do, but I don't feel I can have an open conversation. I often feel I am being dismissed and I either have to take the medication or not, there is nothing in between and no option to talk about it."

- "I had an appointment with [the psychiatrist] from TEWV, we discussed my PTSD and he admitted it's that what's causing most of my problems. In the appointment we discussed a possible medication called Buspirone that comes in liquid (as I can't swallow tablets) he told me he would need to go away and speak to their pharmacy. I've just received a letter from them telling me they can't prescribe me Buspirone now as apparently the only place they would be able to source that from is too expensive for the NHS. So, it's fine for me to have flashbacks nightmares and everything else. He stopped me from getting Diazepam as he wrote to the GP and told them not to prescribe me anymore for my anxiety due to my suicide risks and now he has said no to Buspirone which helps anxiety due to costs. He mentioned Pregabalin which I've tried and it's not helped me and it's not been proven to help PTSD like Buspirone has and then the is another one he mentioned that can affect your heart (I already have POTS which is a heart condition) and my cardiologist has said we need to be careful with what I'm taking. The doctor even admitted Buspirone does not affect your heart and you can take it every day and it works exactly the same way Diazepam does but it has fewer risks with it. …They have refused point blank to address my CPTSD, and have not offered any form of therapy or anything."
- "I have been accessing talking therapies to help with a range of issues. They told me it would be 20 sessions when I got to 15 sessions. However, this increased my anxiety as I really need the support. The therapist has been good and gave me two more sessions, but that is it and they can't refer me for more sessions, even though I need more. My GP has referred me, but it can take up to a year to get back into the system by which time all the

good things from the past sessions will have been lost. I have broken down twice about this, including with my therapist. It is not good enough. Mental health issues aren't like a broken leg. They don't heal quickly and I need more support."

- "A 12 week online mindfulness course provided by NHS (which I did find supportive). Occupational therapist who was offering graded exposure support (which I did not find useful or relevant)."
- "I got offered 6 weeks and then discharged then got referred again and the same cycle happens all over again. I referred myself to IAPT and they refused to help me, they never even called me back."
- "Was referred for talking therapy had the assessment was told because I wasn't suicidal I wasn't eligible, received nothing further."
- "The mindfulness support course was good but not the in depth psychological treatment I feel I required. I was very let down with the way system is run - you can only be under one mental health team in York at a time so you can access what they offer i.e. I couldn't access talking therapies' employment support because they were under different teams - this was confusing, unhelpful and infuriating."

First contact mental health practitioners

First contact mental health practitioners were introduced as part of the Community Mental Health Transformation programme and have been in GP surgeries since 2021. They aim to reduce the number of people trying to get initial support from secondary care services and provide quick assessments and one-to-one support. They also help people to access local services that can help their wellbeing. While the roles are based in GP practices, the posts are funded by TEWV.

We didn’t get feedback about the roles in our Breaking Point report, but have received feedback since then:

- “I saw the mental health practitioner after a two week wait. I was really struggling. They were helpful and recommended support. They also talked to me about possibly being autistic and suggested I think about using Right to Choose to get an assessment via Psychiatry UK so I could get help from Access to Work as I was struggling at work and they felt there is help I could access with a diagnosis. I have asked for a referral and am now waiting.”

Neurodivergence

Since the Breaking Point report and our work on the local autism and ADHD assessment process, we are increasingly hearing from people who are neurodivergent and are struggling to get an assessment or the support they need. This includes getting mental health support.

Currently the assessment process for adults for autism or ADHD is via The Retreat and for children and young people is via CAMHS.

We have heard:

- Person's 48-year-old son is struggling to find appropriate support for his mental health and is still waiting to get an autism assessment. The son was diagnosed as schizophrenic at 17, but his autism hasn't been recognised which has made things very difficult. He has had good support from staff at Huntington House but is struggling for social contact now and is often at home on his own, only going out to the shops.
- “Since Covid my daughter has been struggling. She presented as OCD and germophobic. She has been avoiding school as a

result of bullying due to her OCD. She has been back and forth between school and CAMHS and still hasn't got a diagnosis - she is in her GCSE year. I am now doing a Level 3 counselling course so I can support her, especially when she moves to adult care.”

- “My son is autistic, has a learning disability and mental health issues. He currently isn't getting any help, where can he go?”
- “I am currently having ND therapy and have five sessions left. So far it has been helpful and the person delivering the therapy is very good. However, we have mostly looked at compassion focused therapy looking at putting in place a safety plan for me. That is good, but it is psychological and I know I also need some practical help. I have asked if they can refer me to an OT. I have asked for support, but not heard yet. (person’s funding request for OT support submitted by her GP and therapist was turned down by the ICB).”
- Person has been diagnosed with autism and ADHD. They sought private diagnosis due to NHS waiting times, but found the company ADHD360 not great, as they kept messing up the medication. Eventually they went back to their GP, who recognised their diagnosis, but explained that they needed to refer them for medication. Person later phoned TEWV to ask about medication and was told there was a two year wait minimum until they could have an appointment. Person had no further meds so went 'cold turkey' which they found very difficult, and now will need to wait two years to get medication sorted.
- Person under the care of Community Mental Health Team was advised by them to seek autism and ADHD assessments. They were sent the pre-assessment forms four times, filled them in

and returned them each time, was told they were being referred and were on the waiting list, but two years later their GP told them they had never been added to the waiting list. At that stage, their only option was the Do-It profiler, but nothing came of it because at that stage they were not in one of the at risk groups. A week later, they would have been in a risk group, but they couldn't go back and revisit it, so lost their chance. They became very unwell and were admitted as an in-patient to a mental health hospital out of area. Whilst they were an in-patient they eventually got to see their medical records and were shocked by how much wrong information they contained.

- Person was diagnosed with autism two years ago. They found the process of getting a diagnosis difficult. They had gone through an assessment previously, but they weren't even in the room, just their parents. They felt that they really needed the support of their family throughout the process to help with all the forms and meetings, very difficult for a person with autism to manage on their own. Now that they have their diagnosis it has given them clarity and a greater understanding, which is really important.
- “The Retreat was fantastic at diagnosing me with ADHD and autism. The aftercare was good too. I have six grandchildren who are neurodivergent. They live in different places and we are having to pay privately to get them diagnosed. I wish they could get the service I got from the Retreat.”

Dementia

The majority of feedback we get about dementia is asking about what community support is available. We then signpost our dementia guide[4]. However, we have heard from some people about the assessment and diagnosis process:

- My wife waited for 11 months for an appointment at the memory clinic. Once she got there, we got top notch care, but the wait was not good. We have had good support from Dementia Forward and OCAY, but it was a shame about the wait and no information provided while waiting."
- "My wife was referred to the memory team in November about possible dementia. They booked a CT scan for her and said we would hear by Christmas. In January we hadn't heard, so I followed up and was told there was a 19 week wait. Due to a fall she went to A&E and they arranged a CT scan. I asked if they could share the results with the memory team at Huntington House. A meeting with the memory team then said that they need my wife to have an MRI before they can confirm the diagnosis. When I asked about the CT results, I was told they are still waiting for the full CT scan results so they can compare them with a scan from 2018. At the moment, they have just got the acute findings so there is still no formal diagnosis. My wife was really struggling so I rang the crisis team. They were fabulous. They told me to contact my GP practice to put pressure on radiology to get the CT results to the memory team. After the diagnosis we have been told she will be discharged to the community team."

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[4] www.healthwatchyork.co.uk/wp-content/uploads/2025/06/DR_Final-low-res-HWY-DemGuide25-1.pdf

Initial response from Tees Esk and Wear Valleys NHS Foundation Trust

Our commitment to compassionate, high-quality mental health care in York

We recognise that every person in York deserves safe, compassionate and high-quality mental health care - every time they reach out to us. We deeply regret that there have been times when we have not met this standard for our patients, their families, or our colleagues. To anyone who has experienced disappointment or distress as a result, we are truly sorry. Listening to the voices and experiences of our community is at the heart of how we move forward. We are grateful to Healthwatch York and all our partners for sharing their insights and for working alongside us.
Thank you to those people who have bravely recounted their experience, your stories matter, and they guide our efforts to make meaningful changes.

We view the findings of this report as an opportunity to reflect, learn, and grow. We know that real improvement is only possible when we work together - with our partners and with the people we serve. Through this collaborative approach, we are already seeing positive changes, and we are determined to build on this momentum:

- Bringing support closer to home: we have strengthened support in local communities, including the health hub on Clarence Street. This hub brings together York Mind, York Carers Centre, City of York Council, and our Trust colleagues to provide mental health and wider support where it's needed most.

- Innovative crisis support: as part of the York Mental Health Partnership and Connecting our City, we have helped secure funding for a new 24/7 community mental health hub in the west of the city. This will be the first of its kind in our area and is one of NHS England's six pilot projects for crisis avoidance centres.
- Faster access in crisis: anyone needing urgent mental health support can now access help through NHS 111 (option 2 for mental health). This change has led to significant improvements, with calls now answered within two minutes on average.

This report is clear that there is more we can and must do, and we are determined to deliver safe and kind care to the thousands of people in York who are referred into our care each year.

We are committed to being a trusted partner in our community - supporting people to get the help they need, when they need it. We will continue to listen, learn, and work together with patients, families, and partner organisations to deliver safe, compassionate, and effective care for everyone in York.

Interim response from the Chairs of York Mental Health Partnership

The York Mental Health Partnership (YMHP) notes the Healthwatch York Report: Mental Health in York - A Progress Review.

As part of our mental health system oversight and facilitative work, we will support partner providers to address the issues expressed in the report. We understand and acknowledge the degree of distress that the report represents and will continue to foster and leverage collaborative, co-produced and accessible mental health provision. Going forward, our expectation is that the York neighbourhood based mental health hubs will play a pivotal role in addressing concerns expressed in the report. YMHP will discuss the report at its meeting in February 2026 and will identify key contributions and ways to support partner providers to address the concerns.

Conclusion

While some things have changed since our Breaking Point Report was published in 2023, too often people are sharing the same experiences and the same issues with us. From crisis care to community support, many people in York do not feel they are getting the right support to enable them to live their best lives.

The recommendations from the Breaking Point Report have not been demonstrably acted upon. That report said that York's mental health services were failing vulnerable people and that people had died as a result of poor support. What we have heard since 2023 has not changed our view.

We continue to hear from vulnerable people who don't feel they are getting the support they need. We are also aware of people who have taken their lives despite trying to get support for mental ill-health. We recognise that the move to NHS 111 option 2 for people to seek crisis help with mental health has meant people can talk to someone more quickly. Unfortunately, we continue to hear that the support they receive once they speak to someone on the crisis line, not NHS 111, is not always appropriate.

We welcome the development of the new mental health hubs. We are hopeful that these will fill a current gap and provide much better support for local people. We also welcome TEWV's commitment to early help through First Contact Mental Health workers. These specialists in mental health working within GP practices are providing easier access to low level mental health support. Together, these give us reasons to be optimistic about the potential to transform both delivery and experience of local services.

However, this report outlines the challenges that people trying to access effective mental health support face all too often. Urgent action is needed to identify gaps in current services and to find a creative and effective solution that brings together the strengths of the NHS and voluntary sector.

People in York deserve a comprehensive and holistic approach to mental health services. This must cover everything from lower level support and preventative care to care for people with the most complex needs. We believe this is possible, but it needs a different approach and integrated services across sectors. We anticipate the work to develop Neighbourhood Health Centres will provide fresh opportunities to transform support together.

healthwatch York

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