Breaking Point

A recent history of mental health crisis care in York
June 2023

healthwatch York

Contents

Content warning: This report contains information that you may find distressing including repeated reference to mental ill-health, distress, suicide and suicide attempts, mental health stigma, self-harm and self-injury. We portray the subject of mental health crisis care from personal experiences with the purpose of creating positive change. Please be mindful of your own wellbeing in deciding whether to continue reading this report.

For further information on advice and support available in York please refer to our Mental Health and Wellbeing Guide[1]

Contents....1

Introduction....3

What did we do?....21

Key findings from our work....23

Our findings in more detail....24

Case Studies....89

Participant recommendations....100

Recommendations....101

Initial response from TEWV....103

Conclusion....105

1 https://www.healthwatchyork.co.uk/wp-content/uploads/2023/04/MHWguide_Final-draft_pr01-1.pdf

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Thank you to the front-line mental health workers and the carers of people who have experienced mental health crisis care. And especial thanks to all the people with direct lived experience of mental health crisis care in the city who summoned the strength to recount their stories in hope of a better future for others. We hope this report does justice to your truth.

Cover image by Nik on unsplash

Introduction

This work aimed to capture the views and experiences of mental health crisis care from staff, patients and carers. By forming an understanding of the services in York for adults experiencing mental health crises, we aimed to identify ways to improve local services and support. Mental health is a key issue nationally and locally and there is a growing awareness that it is an area that needs urgent action. It is a priority for Healthwatch York and this project was carried out in the light of information already available, including our previous research and insights gained from feedback about the challenges faced by people when experiencing a mental health crisis.

The National Picture

There has been a problem in mental health crisis care across the country for at least the last ten years, despite commitments being made both nationally and locally. A Mind report from 2011[2] highlighted the importance of treating service users with respect, courtesy, and kindness, and creating a culture of service, hospitality, and safety in mental health crisis care. The report recommended that acute and crisis mental healthcare services should learn from the examples of good practice that can be found across the system especially in voluntary services and private providers. They found a lack of humanity and individuality in mental health crisis care. They recommended that individuals' definitions of what constitutes a crisis should be respected. They also suggested, based on examples of good practice, the use of nurse-led teams and of peer support from those with experience of mental ill health.

In a 2012 publication[3] Mind looked at crisis care statistics and reached the conclusion that crisis services failed to support thousands of people every year. The report looked at information obtained via Freedom of

[2] https://www.mind.org.uk/media-a/4377/listening_to_experience_web.pdf
[3] https://www.mind.org.uk/news-campaigns/news/mental-health-crisis-care-services-under-resourced-understaffed-and-overstretched/

Information requests to mental health trusts which revealed that services were 'under-resourced, understaffed and overstretched'.

- Services were understaffed: four in ten mental health trusts (41 per cent) had staffing levels well below established benchmarks.
- People were not getting the help they need: there was huge variation in the numbers of people accessing crisis care services and one in five people (18 per cent) who came into contact with NHS services in crisis was not assessed at all. Only 14 percent of people said that, overall, they felt they had all the support they needed when in crisis.
- People weren't assessed quickly enough: only a third (33 per cent) of respondents who came into contact with NHS services when in crisis were assessed within four hours, as recommended by the National Institute for Health and Clinical Excellence (NICE).
- Services were not available all the time: one in ten (10 per cent) of crisis teams failed to operate 24-hour, seven-day-a-week services, despite recommendations by NICE.
- People could not contact crisis teams directly: only half (56 per cent) of crisis teams accepted self-referrals from known services users and just one in five (21 per cent) from service users who weren't already known to them. This was despite NICE guidance that crisis teams should offer self-referral as an alternative to emergency services.
- Fewer than a third (29 per cent) said they felt that all staff treated them 'with respect and dignity'.

This report painted a picture of inadequate mental health crisis care and demonstrated that those who suffer from mental health crises were being failed nationally.

The evidence from 2012 furthered the points made the previous year, that increased dignity and respect were needed alongside a culture change to one of kindness and hospitality. The lack of self-referral ability demonstrated that crisis services failed to accept and take into account individual definitions of what constitutes a mental health crisis.

The Care Quality Commission (CQC) is the independent regulator of health and adult social care in England. Its role is to monitor, inspect and regulate services, including mental health services. CQC was asked by the government to try and better understand the perspectives of people who experienced a mental health crisis. The resulting report, 'Right Here Right Now'[4], published in 2015, detailed experiences of help, care and support during a mental health crisis. The review looked at the views of people who experienced a mental health crisis and the response they received. CQC wanted to understand whether people were being offered the right care at the right time, and if they were being given the information they needed. They also wanted to find out about the attitudes of those providing help, care and support. To produce the report CQC undertook:

- a national data review, 2011 to 2014
- a call for evidence in 2014 generating more than 1,750 responses
- a survey and mapping of health-based places of safety
- gathering information from local area inspections

The CQC review paid particular attention to cases of self-harm and to those detained under Section 136 of the Mental Health Act. It looked at their experiences of help, care and support from GPs, specialist mental health services and accident and emergency (A&E). People were asked whether they felt listened to and taken seriously, whether they were treated with warmth and compassion, and whether they felt judged. CQC found that, although there were examples of good practice, many people experienced problems getting help when they needed it, and found that healthcare professionals sometimes lacked compassion and warmth. Variation in responses was not just related to the local area but what part of the system people came into contact with. GPs and voluntary services scored well, but fewer than four in 10 respondents were positive about their experiences in A&E. Feedback also highlighted poor staff attitudes to injuries caused by self-harm. Other findings included:

[4] https://www.cqc.org.uk/publications/major-report/right-here-right-now-mental-health-crisis-care-review

- Many people went to see their local GP first when they were having a mental health crisis. 60% of people who visited their GP were satisfied with the experience.
- Most people reported that they came into contact with at least three different services when they had a mental health crisis. 12% said that they had come into contact with between six and ten services, indicating a need for better collaboration between services.
- People wanted to be involved more in their own care.
- The use of police cells as a 'place of safety' for people in crisis had fallen, but people under 18 can have problems accessing suitable places of safety.

GPs, ambulance services and police were seen as caring and empathetic. The voluntary sector and charities were also viewed as being more supportive. However, people's experiences in both A&E and specialist services were clearly inadequate. A&E had the lowest score of any service with only 36% of people saying they felt respected. Responses relating to self-harm were largely negative, with gaps in the service at times of high incidence (i.e. 11pm – 5am). The frequency of use of A&E for mental health was seen as an indicator that the system was not working at local levels. Irrespective of location or which services people came into contact with, only 56% said that the care they received helped, or was partially helpful in resolving their crisis.

In conclusion, CQC found that people often had poor experiences of mental health support and there was considerable variation across England. Although attitudes had improved there was still a long way to go until people experiencing a mental health crisis received the same sort of response as those experiencing a physical health emergency.

As a result of the CQC report, the Crisis Care Concordat was introduced in 2014[5]. This is a national agreement pledging to work together better to make sure that people receive the help they need when they are experiencing a mental health crisis and to improve the system of care

[5] https://www.crisiscareconcordat.org.uk/

which supports them. Its main focus is the response to crises, but there is some emphasis upon prevention and aftercare. CQC hoped that the Concordat would be a driver in improving practice and that local Crisis Care Concordat groups could have a major role in making sure that pathways for crisis care provide the right care to people in crisis when they need it.

In 2014, services involved in the care and support of people in crisis, including TEWV (Tees, Esk and Wear Valleys NHS Foundation Trust, which provides mental health services in York), North Yorkshire Police, Police and Crime Commissioner North Yorkshire, Vale of York Clinical Commissioning Group, York and Scarborough Teaching Hospitals NHS Foundation Trust, Yorkshire Ambulance Service NHS Trust and City of York Council signed the Crisis Care Concordat. The statement committed the organisations to working together to prevent potential and future crises. It defined a mental health crisis as:

"When people of all ages with mental health problems urgently need help because of their suicidal behaviour, panic attacks or extreme anxiety, psychotic episodes, or behaviour that seems out of control or irrational and likely to put the person (or other people) in danger."

The Concordat also included a clause detailing a 'parity of esteem', this is when mental health is valued equally with physical health:

"If people become mentally unwell, the services they use will assess and treat mental health disorders or conditions on a par with physical illnesses."

It focused on four main areas:

- Access to support before crisis point, ensuring that people can access 24-hour support and are taken seriously when they ask for help.
- Urgent and emergency access to crisis care, ensuring that mental health crises are treated with the same level of urgency as a physical health emergency.

- Quality of treatment and care when in crisis, so that those in crisis are treated with dignity and respect, receive consistent care and are kept well informed about their rights and the care they are receiving.
- Recovery and staying well, so that those who have experienced a mental health crisis are referred to appropriate services to prevent future crises.

By acknowledging that there was a problem and pledging to address this, services seemed to make a move towards positive change. However, our findings suggest that since the introduction of the Concordat, limited progress appears to have been made.

The Independent Mental Health Taskforce[6] published its 'Five Year Forward View for Mental Health' in 2016, clearly setting out the strategies for "improving availability of care and treatment for people with mental health problems; to improve their outcomes and wellbeing but also to tackle the wider costs of mental ill health to the health service and society as a whole".

In 2020 the Royal College of Psychiatrists reported that two-fifths of patients who were waiting for mental health treatment had had to resort to crisis services, with one in nine resorting to A&E[7]. The article showed the damaging consequences of long waiting times for mental health treatment; people had to wait so long for treatment that they reached crises that could have been prevented if they had been seen sooner by non-emergency services. The report found that people living with severe mental illness were left waiting for treatment for up to two years. It also gave the example of one man who waited four years for treatment after attempting to take his own life.

In summary, the report found that NHS mental health services were failing to address preventable crises and forced people to resort to emergency and crisis services. This is in discrepancy with the 2014 Concordat, which pledged to ensure that people can access support before a crisis. The

[6] https://www.england.nhs.uk/mental-health/taskforce/

[7] https://www.rcpsych.ac.uk/news-and-features/latest-news/detail/2020/10/06/two-fifths-of-patients-waiting-for-mental-health-treatment-forced-to-resort-to-emergency-or-crisis-services

article attributed this to inadequate staffing in the mental health workforce.

Although the report is from 2020, it strongly echoes the understaffed crisis care service of the 2012 Mind report[8]; it seems that despite the government and services committing to improvement, the system continues to fail to meet the needs of many people experiencing mental health crises.

In 2023, the BBC released an article on mental health crisis services' national failure to answer suicide calls[9]. Their research showed that one in five calls to NHS helplines were going unanswered. The BBC argued that this was resulting in increased pressure on A&E, a service already under extreme pressure.

The BBC article suggested that the issue stemmed from a lack of provision in wider mental health services, resulting in increased numbers of people reaching crisis point. As well as this, it argued that understaffing and lack of training meant that crisis line responders were unable to provide adequate levels of advice and referrals. The article also referenced coroners' Prevention of Future Deaths reports which indicated an understaffed service unable to effectively assess patient risk.

It is clear that, nationally, mental health crisis care services are struggling to meet the needs of those who use their services. However, that does not mean that it is impossible to provide good mental health crisis care. There are a lot of examples of good care across the country and, as Mind suggested in 2011[10], it is important to learn from them.

The government's plans for reform

The government commissioned an independent review of the Mental Health Act, chaired by Sir Simon Wessely. The resulting report was published in 2018[11].

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[8] https://www.mind.org.uk/media-a/4372/commissioningexcellence_web-version-2.pdf
[9] https://www.bbc.co.uk/news/uk-64235372
[10] https://www.mind.org.uk/media-a/4377/listening_to_experience_web.pdf
[11] https://www.gov.uk/government/publications/modernising-the-mental-health-act-final-report-from-the-independent-review

The government consulted on a range of reforms, taking account of the independent review. 'Reforming the Mental Health Act: Government response to consultation',[12] published in 2021, set out the government's plans in detail. The government intends to reduce the over-reliance on police in mental health crisis care. Under the current Mental Health Act, clinicians in A&E have no power to detain. This means they are being forced to involve the police in mental health care. The government believes that the solution is not just to extend these powers to A&E (although short-term emergency detention powers in A&E are an option), but also to address the problem at its source. It suggests that improving access to crisis services would reduce the numbers of people using A&E services.

The government also proposes increasing patient choice and autonomy, including for patients under the age of 16. New 'Advance Choice Documents' would give patients the opportunity for meaningful input about their treatment preferences. Patients would create these documents with the support of independent advocates when they are well, so that they can have some say in their own care. Patients will also be given the opportunity to name a Nominated Person so that this duty does not automatically fall to the nearest relative. The government also proposes that the statutory right to an advocate be extended to all inpatients, including voluntary inpatients.

To increase patient autonomy for children, the government proposes the introduction of a statutory capacity test for children. To further protect children, it recommends stronger requirements to make sure children are not placed in adult or out of area wards.

The government acknowledges that there are racial inequalities within mental health services and deems them to be unacceptable. To tackle the inequalities, it recommends that every health organisation is required to have a nominated person responsible for overseeing policies aimed at

[12] https://www.gov.uk/government/consultations/reforming-the-mental-health-act

addressing racial inequalities. As well as this, they recommend the introduction of a statutory right to culturally appropriate advocacy.

Additionally, the government recommends that Community Treatment Orders (CTOs) are abolished. These are an alternative to inpatient care, whereby a patient has compulsory treatment in the community rather than being detained. It was found that CTOs were used disproportionately for BaME patients and that there was insufficient evidence to demonstrate their benefit.

Next, the government recommends that there should be clear and evidenced grounds for detention under the Mental Health Act rather than the abstract risk-based justification that is currently used. It also recommends the removal of learning disabilities and autism as grounds for detention.

To make sure meaningful change is made, the government recommends the introduction of a Mental Health Commissioner to oversee the reforms and tackle racial inequalities. The government will publish a plan of how it will resource and implement changes.

The government has published a draft Mental Health Bill[13] to give effect to some of these reforms. However, the Bill will not be the only change made; it will be a part of an ongoing process to improve mental health services nationally.

Good practice

Across the country there are many examples of good care and, as was suggested by Mind over ten years ago, it is important to learn from these to make sure everyone who is in a mental health crisis receives good care. Below are some examples of good practice in mental health crisis care across the country.

[13] https://www.gov.uk/government/publications/draft-mental-health-bill-2022

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust is rated overall as outstanding by the CQC[14]. The chair of the government's independent review of the Mental Health Act, Sir Simon Wessely, referenced the Trust's street triage team as an example of good practice[15]. The street triage initiative ensures that those who are taken to a place of safety under a Section 136 are treated with understanding and helps to avoid preventable detentions under the Act. Mental health nurses are present in all custody suites and dedicated officers work within local hospitals, ensuring effective collaboration between the police and mental health services. All agencies involved in mental health crisis care are provided with specialist training to ensure people experiencing a crisis are treated in a caring and effective manner. This approach is a positive step towards removing the stigma around mental health issues by ensuring that all services, including the police, understand the needs of those in a mental health crisis. The initiative is commended and said to have reduced the number of people detained under the Mental Health Act as people with mental ill health can be signposted to the appropriate services rather than being unnecessarily detained.

East London NHS Foundation Trust is also rated overall outstanding by the CQC[16]. It is running a Community Mental Health Transformation Programme[17] which has been awarded the Quality Improvement and Service Transformation Award at the Positive Practice in Mental Health Awards 2021. The programme blends services across primary and secondary care and services provided by third sector organisations to prevent silo working and foster collaboration. This makes sure there is provision for those at risk of being left behind by the system, particularly those who do not require high level interventions from secondary care, but who still require support. By breaking down the barriers between services, people will be able to access the support that they need as soon as they

[14] https://www.cqc.org.uk/provider/RX4

[15] https://www.cntw.nhs.uk/news/ntw-and-northumbria-police-recognised-for-street-triage-team-work/

[16] https://www.cqc.org.uk/provider/RWK/inspection-summary#mhcrisis

[17] https://www.elft.nhs.uk/information-about-elft/community-mental-health-transformation-programme

need it. This will prevent further deterioration of individuals' mental health and reduce the need for crisis services. This programme has been developed based on feedback from GPs, carers, and service users to make sure no one falls between the gaps between service boundaries. This programme not only works alongside third sector organisations, but provides funding for them, ensuring needs of service users are met effectively and no one gets left behind.

Bradford District Care NHS Foundation Trust is also highly rated[18]. Bradford's First Response initiative[19] enables the provision of a joined-up service across different mental health care providers, the police and the voluntary sector enabling them to provide people with support early on, to prevent crises. This approach has reduced the number of people sectioned under the Mental Health Act and reduced demands on A&E. The first response service allows people to self-refer into psychological therapy for support and those who require more support are seen within an hour by a more advanced practitioner. In a similar way to the East London initiative above, Bradford has placed mental health staff in police control rooms, custody suites and A&E departments. The initiative also aims to work collaboratively across police and community services to prevent crises and ensure that those who are in crisis get the right support. Those who experience a mental health crisis, can access an in-depth leaflet outlining[20].

The South West Zero Suicide Collaborative deems even one suicide to be too many[21]. Rather than dismissing suicides as an unfortunate inevitability of mental ill health, it is committed to the idea of zero suicides. This project works in line with the framework set out by the government's National

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[18] https://www.cqc.org.uk/provider/TAD

[19] https://www.bdct.nhs.uk/services/first-response/

[20] https://www.bdct.nhs.uk/wp-content/uploads/2016/12/First-Response-concertina-leaflet-new-freephone-number.pdf

[21] https://www.england.nhs.uk/mental-health/case-studies/archived-mental-health-case-studies/zero-suicide/

Suicide Prevention Strategy. It works on initiatives to reach at-risk groups, for example reaching and supporting men through local pubs.

The Trusts with the highest CQC ratings and those commended for good practice are committed to providing joined up care and collaborating across different service providers. An emphasis on prevention and collaboration is evident throughout these initiatives. They all encourage services to work together to ensure that people are supported by the right service early to prevent as many people as possible from reaching the point of crisis. There is also a strong emphasis on working alongside community services provided by voluntary sector organisations; not just referring to them but also providing funding and resources. These good practice examples promote an understanding of a safe response to crises and ensure that those who are in crisis, and their carers, are kept informed and treated with understanding by fully trained members of staff.

Impact of the pandemic on mental health crisis services

According to the CQC (2022)[22], the pandemic caused a reduction in low-level community mental health services, which can reduce the likelihood of people reaching crisis point. The CQC is concerned that this reduction in community services has contributed to the increase in people being detained under the Mental Health Act (there was a 4.5% increase in detentions in 2020/21) and increased pressure on mental health crisis services. Whilst some of these community services have now started to rebuild after the pandemic, others are struggling to recover due to staff shortages and burnout is is likely to be increasing the number of people reaching crisis, but the pandemic also has had a significant impact on individuals' mental health due to the loneliness and isolation that resulted from lock downs and restrictions. In 2021 Mind released a report[23] based on a survey which asked 12,000 people how the pandemic had impacted their

[22] https://www.cqc.org.uk/news/releases/effects-pandemic-continue-add-pressures-mental-health-services-worsening-access-care

[23] https://www.mind.org.uk/media/8962/the-consequences-of-coronavirus-for-mental-health-final-report.pdf

mental health. It found that those who already had a mental health issue had been the most affected, and many of them had experienced increased severity of issues. It also found that since the pandemic, young people are more likely to be unable to cope with their mental health issues and are more likely to use coping mechanisms, such as self-harm, than adults. Undoubtedly this has had an impact on crisis services as it has likely caused increased demand for an already overstretched service.

The Regional Picture

Since 2015, the Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV) has been the Mental Health & Learning Disability NHS Trust for County Durham and Darlington, Teesside, North Yorkshire, York and Selby. TEWV has been under pressure for various reasons over the last few years. It has been criticised for a lack of effective risk management[24] and for a dismissive[25] and uncompassionate[26] culture. It has also received multiple calls for public enquiries. It is important to note, however, that the focus of criticism has been on areas outside York.

One of the fiercest criticisms of TEWV was set out in a report by academics from the University of Central Lancashire and the University of Leeds in 2022[27]. The authors, Langley and Price, identified that the same themes consistently emerged from coroners' reports and articles surrounding the deaths of 85 people who had used TEWV's services. The authors found that TEWV had repeatedly apologised for these mistakes and claimed that changes would be made, yet mistakes had continued.

[24] https://www.bbc.co.uk/news/uk-england-tees-56529121

[25] https://www.tewv.nhs.uk/content/uploads/2023/03/Independent-Review-of-Governance-at-TEWV-March-2023.pdf

[26] https://www.mind.org.uk/news-campaigns/news/mind-comments-on-west-lane-hospital-report-detailing-repeated-failings/

[27] https://www.researchgate.net/publication/360939741_Death_By_A_Thousand_Cuts_Report_into_the_Tees_Esk_and_Wear_Valleys_NHS_Foundation_Trust_BPD_Protocol (Langley and Price 2022)

Langley and Price were especially critical of TEWV's Borderline Personality Disorder Protocol (BPD+)[28]. This was replaced in April 2021 by a new Harm Minimisation Clinical Risk Assessment Policy[29]. This stresses that 'positive risk taking' should not be used to deny people the care they need and that its use should be focussed on the person's wellbeing rather than the service's priorities. This new policy also emphasises that when 'positive risk taking' is used, it must be with the consent of the patient and risks should only be made in a collaborative manner.

Langley and Price found a recurrent theme in feedback on TEWV's services was that people were being refused care due to the assumption that they had the mental capacity to ask for it. Repeatedly people were told by mental health crisis services across TEWV that they had the mental capacity to ask for help, so did not actually need it.

In two reports to prevent future deaths from 2022[30], TEWV was criticised for its lack of understanding of autistic people. In both reports the death of the individuals was (at least in part) put down to a lack of suitable provision. The reports highlighted a need for increased holistic working and not to separate autism and mental health needs.

"Her death was contributed to by the actions and inactions of the mental health clinicians entrusted to keep her safe within a care system that was underdeveloped to manage an autistic individual with complex needs."

"Mr McLellan's distress and stressors before his death included his feelings that he was not getting what he saw to be the right help and that he would not lose his feelings of helplessness such that he took his own life."

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28 https://www.whatdotheyknow.com/request/672014/response/1633272/attach/2/BPD%20Protocol%202014.docx?cookie_passthrough=1

29 https://www.tewv.nhs.uk/content/uploads/2021/12/Harm-Minimisation-Clinical-Risk-Assessment-and-Management-Policy.pdf

30 https://www.judiciary.uk/wp-content/uploads/2022/04/Zoe-Zaremba-Prevention-of-future-deaths-report-2022-0117_Published.pdf
https://www.judiciary.uk/wp-content/uploads/2022/09/Antony-McLellan-prevention-of-future-deaths-report-2022-0207_Published.pdf

Both reports recommended that TEWV drastically improve its provision for autistic individuals with mental health needs.

The coroners' reports highlighted the stories of individuals who have died because of this lack of provision. However, they also acknowledged that this was a wider issue than just TEWV: "*statistical evidence indicated that autistic individuals are more at risk of suicide than those with no neurodevelopmental condition, and females at greater risk than their male counterparts.*"

Also in 2022, local councillors in Stockton called for a public inquiry into TEWV[31], citing accounts from staff and patients who felt they had been failed by TEWV. One patient's account said that TEWV had left them feeling "chronically suicidal".

Families of three young women, who died during or after being in the care of West Lane Hospital, added their voices to the call for a public inquiry into TEWV[32]. The families attributed the deaths to failures on the part of the hospital. David Moore, whose daughter died under the care of TEWV, said that the care was "substandard" and lacked compassion.

While a full public inquiry into TEWV did not go ahead, an independent investigation into the state of TEWV's West Lane Hospital in Middlesbrough (now closed) was conducted after the deaths of Christie Harnett[33] and Nadia Sharif[34], who were both 17, and Emily Moore[35], 18, who took their lives in an eight-month period in 2019 and 2020 while under the care of the

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[31] https://www.thenorthernecho.co.uk/news/19934620.tewv-trust-chief-faces-stark-accounts-let-down-staff-patients/

[32] https://www.bbc.co.uk/news/uk-england-tees-60569467

[33] An-independent-investigation-into-the-care-and-treatment-of-Christie-in-West-Lane-Hospital-by-Tees-Esk-and-Wear-Valleys-NHS-Foundation-Trust.pdf (tewv.nhs.uk)

[34] https://www.tewv.nhs.uk/content/uploads/2022/11/An-independent-investigation-into-the-care-and-treatment-of-Nadia-in-West-Lane-Hospital-by-Tees-Esk-and-Wear-Valleys-NHS-Foundation-Trust.pdf

[35] https://www.tewv.nhs.uk/content/uploads/2022/11/TEWV-response-to-NHS-England-independent-investigation-Emily-Moore.pdf

hospital. The report, published in March 2023[36], found that conditions at the hospital were "chaotic and unsafe".[37]

The report found significant staffing issues at West Lane Hospital, including a lack of relevantly and adequately trained staff, low staffing levels, often due to staff ill-health, and an over-reliance on agency staff resulting in a lack of continuity of care and increased stress on the young people in their care. The report cites staff attitudes as a theme from service user feedback and found that patients felt staff were judgemental and dismissive.

Moreover, the report raised inadequate risk management, a lack of safe practices within West Lane Hospital and a failure to learn meaningful lessons from mistakes. Culture and effective management are also raised as issues with suggestions that the TEWV area is too big to manage effectively. (On this last point, TEWV had already responded by carrying out an organisational restructure in March 2021 resulting in the creation of two care groups: Durham Tees Valley and North Yorkshire and York.

The report made a number of recommendations, including:

- complaints and feedback from service users and parents are taken more seriously
- decision making is evidenced and traceable
- oversight at a strategic level is increased
- Duty of Candour is consistently applied
- transitions are more effectively managed
- TEWV must make sure initiatives are being implemented effectively
- risk management is improved
- there is increased clarity of the role of high-level management
- safeguarding is improved.

[36] https://www.tewv.nhs.uk/content/uploads/2023/03/Independent-Review-of-Governance-at-TEWV-March-2023.pdf
[37] https://www.bbc.co.uk/news/uk-england-tees-65013550 21 March 2023

In March 2023, TEWV provided a public statement[38] following the production of the report and recommendations:

"….Our three big strategic goals in Our Journey to Change, which was launched in March 2021, confirm our commitment to listen to and act on the voices of our service users, their families and their carers, as well as to our staff and our partners. We use the term co-creation to describe that ambition. This helps us provide a better experience of high-quality, effective, and safe care to the people who use our services, offering clinical care that is person-centred, timely, compassionate, and kind. All of this is underpinned by our values of respect, responsibility and compassion, which are at the heart of everything we do.

We have employed two lived experience directors who bring their own knowledge, understanding and compassion to the strategic leadership of the Trust, to make sure that experienced voices are heard at all levels of the organisation, and that shared decision making is modelled from ward to Board. We now employ 28 peer support workers too.

These roles were developed as part of a wholesale organisational restructure which was put in place from April 2022, following a governance review in early 2021. Our new structure:

- *simplifies the governance processes – giving nurses more time to care, supporting clinical teams to make decisions with the people they care for and making it easier for everyone to understand their role and responsibilities,*
- *strengthens reporting from teams through our two care groups directly to the Board,*
- *embeds increased line of sight from ward to Board.*

This is all part of the journey the Trust is on to completely transform the services it provides, in parallel to our organisation-wide culture change

[38] https://www.tewv.nhs.uk/about/publications/independent-investigation-camhs-west-lane-hospital/#tewv-response-to-the-report

programme. We are seeing positive results with the most recent NHS staff survey showing we are the most improved mental health trust in England."

The various reports outlined above build a picture of a mental health service under severe pressure and of a Trust struggling to meet the needs of many of its patients.

The Local Picture

This period has been a time of significant change for mental health care provision in York:

- Bootham Park Hospital closed at short notice, following an unannounced CQC inspection in September 2015.
- The Retreat Hospital, which promoted 'moral treatment' based on 'humane and kindly psychological treatment' from 1796, closed in-patient services on 31 December 2018.
- The Haven, a telephone response and evening service for people to access seven days a week as an alternative to crisis care, opened in 2018.
- Foss Park Hospital, a purpose-built 72-bed hospital for people with mental health problems and dementia, opened in York in April 2020.

In 2021 the CQC carried out inspections on mental health hospitals under TEWV[39]. The inspections of the acute wards for adults of working age and psychiatric intensive care units were across the whole Trust area. They were rated inadequate for both 'safe' and 'well-led'. The inspections found that staff failed to manage and assess risks, resulting in patients being put at risk. A re-inspection in May 2021 took place over nine wards, including Ebor and Minster wards at Foss Park Hospital. The subsequent report[40] gave the rating 'requires improvement' and the CQC 'no longer had significant concerns relating to risk management of service users'. It was noted at a meeting of the City of York Council scrutiny committee on 2

[39] https://api.cqc.org.uk/public/v1/reports/ebdb75c1-e25b-44d4-a705-e3b772b7ad09?20210326010509
[40] https://api.cqc.org.uk/public/v1/reports/5f374c9c-17a7-43c1-9824-00d1df43813e?20221129062700

November 2021[41] that TEWV had committed an extra £5.4m and that North Yorkshire, including Foss Park, would use its allocation for extra staffing for inpatient wards and to secure additional administrative support, increase nursing capacity and support practice development. Four consultants were reported to have been recruited to address some of the challenges within the services and a new bed management system had been introduced.

According to the York Health and Wellbeing Joint Strategic Needs Assessment (updated in May 2023)[42], the suicide rate in York is currently in line with the national average but has been high in recent years. The rate in York is higher than many of York's statistical neighbours for both men and women. Self-harm is also identified as an area requiring improvement. The rates of York residents admitted to hospital for injuries relating to self-harm is higher than most of its statistical neighbours. The rates are particularly high for self-harm admissions in young people aged 10-24, but most notably in those under the age of 20. A high suicide rate and high rates of self-harm can be seen as an indicator of unmanaged serious mental illness and mental distress; however, it is important to note that these statistics do not show the proportion of people who present to any particular service.

People in York reporting high levels of anxiety is similar to the national and regional average. However, people in York were more likely to report high anxiety than the majority of York's statistical neighbours. Over the last five years the national trend has been stable, and York's data has either been similar to or slightly higher than the national picture.

What did we do?

In order to help shape, challenge and improve local health and social care services, Healthwatch York routinely gathers the views and experiences of people who use them. In May 2022 we focused on reaching out to adults

[41] https://democracy.york.gov.uk/mgAi.aspx?ID=60543
[42] https://www.healthyork.org/mental-health.aspx

who have experienced mental health crises, their carers, and front line mental health workers.

Qualitative research techniques were used for this report, which allowed people (including those with lived experience of the crisis care service) to tell us their stories. We acknowledge that in a service context of 15,000 contacts a year in the York and Selby Crisis Team (which excludes the assessments of acute hospital liaison in York District Hospital) the number of comments and the range of participants was narrow, and as a result some service areas have a low level of response. Nonetheless, qualitative analysis allowed us to capture the stories of people with all of the human subtlety, detail and complexity, uncovering topics that otherwise could have been missed by a quantitative approach. Whilst the limitations of this report are not insignificant, we have confidence in its results because we were able to achieve saturation within the data (the point at which no new information is gained from further data collection) and because findings were corroborated by data collected from different people over different times.

In total, we conducted 29 in-depth semi-structured interviews collecting 59,611 words and 410 specific statements about mental health crisis care: 55 positive (13%) 320 negative (78%) and 35 ideas (9%). We held five workshops, including with the TEWV crisis team, Acute Hospital Liaison Mental Health Team, York Carers Centre, a ‘drop-in’ style workshop and a York voICeS meeting to review the data gathered, inviting participants to comment on the emerging themes. In total we spoke to 67 People - 43 staff (seven male and 36 female) / 15 carers (one male and 14 female) / nine lived experience (three male and six female).

Key findings from our work

- Mental health services are under severe pressure throughout England, and have been for a long time
- 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's 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 for these recommendations in full)

Our findings in more detail

Accident and Emergency Department (A&E)

There were 15 statements from participants recounting their experiences of A&E including substance misuse, self-harm, anxiety and depression, suicidal thoughts and suicide attempts.
There seems to be a lack of understanding of mental health issues in A&E or the capacity to deal with them. We found people being discharged with their physical health issues treated, but without adequate treatment for their mental health concern. For example, we heard from people who had been admitted to A&E after self-harming but were essentially 'patched up' and discharged without any care relating to their mental health issues.

We found inconsistent and sometimes judgmental attitudes from healthcare providers, inadequate follow-up care, lack of communication and coordination between different healthcare teams, and dangerous assumptions made about patients' situations.

A carer also raised concerns about the lack of advice or instructions given to patients and their families when discharged from A&E after a mental health crisis. Some participants shared positive experiences with healthcare providers who showed understanding and were able to refer them to appropriate services.

"When she did eventually get through to the crisis team they took her into hospital to treat her physical condition, but in terms of her mental health, she was just discharged and they gave her a couple of numbers that were community based mental health support."

"Some doctors in A&E have been amazing with me, others have basically looked at me like a time-waster I suppose because things are 'self-inflicted'. It is very variable, I think it is the luck of the draw sometimes, unfortunately."

“When I presented at A&E, people would look at me and judge the situation rather than the individual. I’ve often had ‘sort yourself out, you’ve had too much to drink, go and sleep it off and you’ll be fine tomorrow’. They didn’t ask that second question because I was desperate for someone to ask just that second question: ‘are you actually ok?’”

“Discharge from A&E is one of our biggest sources of referral. We’ve worked with the liaison team for long enough that they have quite a good awareness of what homeless services are about. They are quite good at referring people who don’t have anywhere to go, because a lot of the time people are going in with anxiety and depression and suicidal thoughts, but when they dig into it, it can often be around social stressors, not having anywhere to live and things like that. They are one of the better teams at the hospital at referring people.”

“Improved training for A&E support is required; people are often not seen by the duty psych when they should and there is a lack of follow up. Police have arrested me to force me to go to A&E, to then be asked by liaison 'why are you here?' No one seems to know the process or who's job includes what, there is very little liaison or communication”

“Some people go to A&E because they are not safe and need to get admitted, but obviously there are pressures around beds. A few years ago when Bootham closed, we had everybody sent to Middlesbrough. They would stay in Middlesbrough for a day and be discharged, but the information wouldn’t always come with them. If you are in crisis the last thing you want to do is be sent 100 miles across the country.“

“So, I think initially he went to A&E and said ‘look, all I need is just some diazepam right now’, but they looked at his records and it's the GP’s fault because she’d coded it somehow so it came up that he had drug issues. It wasn’t down to the GP, but whatever he said to both A&E and crisis they just wouldn’t listen to him. So they were making all sorts of assumptions without even trying to talk to a GP to see if this is the case, and that’s what I

feel all the time, they are making these very dangerous assumptions about people's situations."

"And we've had carers say to us that they just don't ring the crisis team anymore and they end up ringing other emergency services or going to A&E which isn't appropriate, or police get involved, it's not a crime if someone is poorly, they need mental health help."

"Unfortunately, everything started to unravel again. I was self-harming a lot and I was overdosing a lot, but just as a form of self-harm and I was turning up to A&E and literally patched up and that was it. I was talking about trackers in my skin, which, you know, probably should have been a red flag."

"A carer raised a concern about something that happened five or six years ago when being discharged from A&E after her daughter's suicide attemp. Because her daughter was over 18 and it was classed as a mental health issue they weren't given any advice or instructions (in the way you might expect if someone had broken their leg or a similar non-mental health discharge) or any helpful/useful information that you would normally expect when taking someone home from A&E (e.g. take paracetamol for any pain, rest etc.). No information was shared with them of the details of what had happened, so I think she felt they weren't very well equipped."

"The police will take people experiencing crisis, who they suspect may be homeless, straight to A&E. They take a lot of people to A&E and leave them there and they just don't know what to do with them."

Addiction

There were 11 statements from participants recounting their experiences of addiction including substance misuse and mental health issues.
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. It seems that some service providers hold

misconceptions about addiction and may blame individuals for their problems, making it difficult for them to seek help. This can lead to a cycle of shame, self-hate and hopelessness. Additionally, there are challenges in dealing with people under the influence of drugs or alcohol; mental health assessments may not be possible at such times, and addiction services may struggle to engage with individuals who have poor mental health. This can create a 'chicken-and-egg' situation where people are unable to get the help they need.

Overall, it's clear that there is a need for more integrated and holistic approaches to treating addiction and mental health issues. Service providers need to have a better understanding of these issues and work together to provide comprehensive care and support for those who are experiencing them.

"I cannot understand how you can have mental health and addiction in different arenas as they are so connected. To separate those things to me just shows a fundamental lack of understanding of addiction, and addiction causes a lot of mental health issues. They are made separate when they should be one, it's never going to be possible to treat somebody with addiction if you separate those two things."

"It's 'a weakness' or it's 'about willpower' which is not the case, but it is framed like that. Sometimes you have an insight into systems where substance abuse is prevalent, but there is a lack of understanding which is extremely frustrating; 'stop doing that thing and you might receive some help' is the narrative."

"I have been through treatment myself and I haven't picked up a substance since I've been to Oaktrees so I am really grateful for it. I think the help is there, but I think York needs some more of it."

"There are disparities in treatment options for addiction as well, so sometimes it feels like you've got to navigate the different types of therapy."

“The idea that an addict can simply reduce the abuse of a substance by keeping a diary or simply stopping is counterproductive, it doesn't work; ‘why don't you go home and just lie about how much you drink?’”

“A couple of years ago now I went to hospital with a friend who was a drinker who was having a seizure. One of the liver consultants came out and said to her ‘I'm really disappointed in you, you're back here again’. I could see instantly in her face the impact that one sentence had on her. She's dead now, but I remember that, and I remember seeing her face and the brutality of that statement, when she had come for help. I think she left a couple of days later, she just couldn't cope with being spoken to like that, she was full of enough shame and self-hate to be told again ‘what a naughty girl she'd been’. It was shocking and these are people who are ‘experts’. It made me think that there might be a clinical approach to treating the symptoms but in terms of emotional or mental or psychological it seems to be really missing.”

“You've got to jump through hoops and for somebody who's maybe drinking a lot, it is very difficult. They are set up to fail, and then they reach crisis point and they go back to A&E and it's just the same cycle; it's really frustrating.”

“We get issues around dual diagnosis, so people who are under the influence of drink or drugs, we don’t always get the most holistic response from crisis contacts.”

“In general, one of the big obstacles does seem to be dual diagnosis. We’ve gone in phases with dual diagnosis over the years and I’ve been working with homeless people for 20 years now. We’ve had several phases where we’ve had a real effort to do dual diagnosis, and not to gate-keep people with substance abuse issues particularly. Of late there is quite a lot of gatekeeping around substance use whether it’s alcohol or substances. I’ve been in several multi-agency meetings about people who are very chaotic and quite high risk where the mental health input has been; ‘well they’re

drunk all the time so we can't do anything, so we're closing them. It has not always felt particularly supportive for workers within homeless services."

"I do understand that it is difficult to diagnose someone's mental health when they are under the influence, of course it is, but addiction is a recognised mental health condition. It feels like an excuse not to deal with that extra level of complexity. 'I can't assess this at this point, but when is the best time of day to see you so that I can?' should be the response, not I'm sorry when you've stopped taking drink and drugs and when you've stopped using amphetamines, that's when we'll do an assessment. Also substance abuse services really struggle to engage with a person because their mental health is so bad. But how am I supposed to stop using drugs when my mental health is so bad? It is chicken and egg."

"My son self-medicates with alcohol, but services will not attend if he is drinking. However, his drinking is because of his mental health, so he ends up in a full crisis as he has no help/support."

"I am fully aware of the constraints mental health services have, but there needs to be great improvements on dual diagnosis support for those people accessing substance services as it tends that we are the service that ends of having to lone work the people with mental health /substance misuse and we are not mental health trained. Regularly when a person who has been with mental health services accesses us, we see mental health services back off, this should not be the case so any report that can try and influence a more joined up approach I am happy with."

Communication

There were eight statements from participants recounting their experiences of poor communication between different services.

There appears to be a lack of communication and collaboration between various services and teams involved in mental health care. This can lead to a fragmented approach to treatment, where individuals' issues are not seen as a whole and are instead treated separately. This problem seems

to be prevalent across primary, secondary, community and statutory services.

The lack of communication is also hindering the implementation of strategic plans and initiatives. There seems to be a disconnect between what is being discussed at a strategic level and what is happening at an operational level; the clinicians and operational staff may not be aware of the strategic plans, which can lead to confusion and lack of 'buy-in' from staff.

Additionally, a lack of communication can lead to delays in accessing services, which can be detrimental to individuals' mental health. The longer the wait time, the more likely it is for individuals to lose faith in the process and not seek help when they need it. It is important to recognise that mental health care is not just the responsibility of specialists as 'experts', but everyone's business. It is crucial to involve people in the community who see individuals day-to-day and can provide support and conversations, especially when specialist services are under-resourced and cannot provide timely care.

"Lack of communication between services; especially primary and secondary care services."

"No communication between the Community Mental Health Team (CMHT), police and the hospital."

"There's no communication from the crisis team to other teams e.g. CMHT."

"There is a huge gap basically working with somebody who presents; they go to the crisis team then they might go to A&E and be seen by the team there. Then they are 'not at immediate risk' and referred back into the community and it just seems to be a gap and a breakdown in communication."

"There's a lot of people who have just lost faith in the process and the services. They've been through them so many times waiting for an

assessment and jumping through hoops that they just won't go near them even though they're really unwell. I think that is really problematic because we need all of those different aspects, that sort of social aspect, the friendships, the community support to work alongside and complement specialist services when people really need that. But we're not quite there with that. At a strategic level there's lots of noise, positive noise about getting there and that is what we want to achieve. We need to get staff at an operational level to get on board with that or it's never going to happen."

"I always raise the question that I don't know how aware a lot of the clinicians who are on the ground in these teams are of the work that is going on at a strategic level in TEWV. I think there's a real disconnect between that strategic level and the senior managers and the operational staff because you talk to them about connecting our city and they're like 'what's that'?"

"Complaints via PALS go nowhere because notes don't reflect that."

"It's those people in communities that will be having those conversations that make such a difference, they see people day to day. I always reflect to clinicians that they can sometimes have professional snobbery that 'we're the experts', 'we should be having these conversations'. Actually, it's everybody's business. There's a real danger in that narrative of 'we're the specialists, leave it up to us', especially since they are so under-resourced. It's like I'd love to leave it up to you, but you can't see that person until three months' time, so I think someone else should be having a conversation with them in the meantime."

Community Support

There were 16 statements from participants recounting their experiences of community support.

We found that community support services (including voluntary and community organisations and Local Area Coordinators (LACs) based at York City Council are highly valued by individuals who are struggling with

their mental health. These services are sometimes seen as understanding and relatable, as they are often run by individuals with 'lived experience' of mental health issues. The support provided by community services can play a key role in preventing people from reaching crisis point, and can also be vital in supporting people's recovery.

However, it can be challenging for individuals to know what support services are available to them, and this is where the support of social prescribers and Local Area Coordinators can be invaluable. These professionals can help individuals access the support they need before they reach crisis point, and can provide guidance on available services.

Connecting people with similar experiences also appears helpful in supporting good mental health, as it allows individuals to feel less alone and more understood. Stigma around mental health is still present, and this can make it difficult for individuals to seek help or talk openly about their experiences. However, the conversation around mental health is improving, and the work of community support services is helping to break down some of these barriers.

Different individuals will have different preferences when it comes to the types of support they need, and community support services should aim to provide a variety of different options. Some individuals may prefer more mental health-focused groups, while others may prefer more general support. The important thing is that individuals feel empowered to access the support that is most helpful for them.

Finally, it's clear that community support services can be very effective when they are delivered by individuals who have lived experience of mental health challenges. These individuals are often best placed to understand the needs of those they are supporting, and can provide a level of empathy and understanding that is difficult to replicate otherwise.

"It could be something that could be referred to as 'pathway to recovery' or somebody else in the voluntary sector, but actually in the meantime they

don't require crisis support. It's just that they need to hear a friendly voice, just somebody to talk to relieve that anxiety a little bit."

"There are other things we can put in place to stop, or at least reduce the risk of that crisis happening. Working as holistically as possible using the voluntary and charitable sector to do that."

"Quite often it is just knowing what's out there, quite often there are crisis support services, but they don't call themselves that, but they do provide that."

"What is on offer for people who aren't under a Community Mental Health Team to receive support before they reach crisis point?"

"...and LACs have flexibility, they are part of the system that seems to be able to work round it and they have the freedom to do that, so they are able to find ways that other parts of the system can't."

"Community support seems fundamental in a lot of people's recoveries. I've heard so many stories where it has been a community-based organisation, a charity or a couple of individuals who seem pivotal in them starting to get better."

"It is all about connection and connecting people seems fundamental, hopefully like-minded people and potentially people who have been through very similar experiences to you. Any sustainability in good mental health seems to be about getting that interaction with a specialist and also wider interaction."

"To some extent we've got a network of community hubs across the city. A lot of the LACS are involved in those. They're similar sorts of spaces. We find that what you need is a variety of spaces. Some people are keen to go to something that is really focussed on mental health and have those really focussed conversations. Some people who've had a lifetime of dealing with their mental health, they specifically say to us; 'I don't want any

mental health groups', 'I don't want anything to do with Mind'; they want something more general."

"Changing Lives is very much 'on the ground' and they get it, because a lot of them have been there and that's very similar with us, the majority of us with personal lived experience and still living with experience. Some of the best practitioners, they know and they get it."

"Voluntary services are available and stuff like that, I can't keep up with what's happening. The fact that social prescribers work locally, have knowledge of the local area, and what's available for people is just fantastic."

"They [York Mind] seem to take people seriously, they listen to people, didn't talk over you. Everyone was like, actually communicating, not treating us like, 'it's for young people' but they weren't doing the 'baby talking thing'. Really, they were just treating us like people and not like a problem."

Crisis After Care

There were 94 statements from participants recounting their experiences of the 'crisis after care' (i.e. after the initial traumatic crisis event and the first few steps along the path to recovery).

There are many problems with the mental health crisis after care that make it difficult for people to access appropriate support. One issue is the lack of clarity around when it is appropriate to call the crisis team, which may lead to inappropriate calls and a strain on resources. Another problem is that there is a lack of support available for those who are not yet in crisis, which means that people often call the crisis line when they need a lower level of support.

People also feel that the crisis after care is disjointed and inflexible, and that there is a lack of understanding that recovery is not a linear process. This can result in people being discharged too soon without adequate

support. There is also a feeling that the after care is not designed to meet the complex needs of homeless people.

In addition, there is a sense that people with a personality disorder diagnosis may be prevented from accessing appropriate support, and that the crisis aftercare is difficult to navigate. People may feel like they have to 'play the system' in order to get the help they need, which can be a barrier for those who are already unwell.

There is often a lack of sustainability in the support provided after the first point of contact, and people may be discharged from services when they are not yet fully recovered. This can lead to a rapid decline in their mental health and a need for further crisis care.

To improve mental health crisis after care, it may be necessary to provide more support for people who are not yet in crisis and to ensure that the crisis after care is more flexible and responsive to the complex needs of individuals. There may also be a need to address issues around 'gatekeeping' (withholding services) and to make crisis after care easier to navigate for those who need support. Finally, there is a need to ensure that support is sustainable and that people are not discharged too soon (from both Acute Hospital Liaison and Crisis Team) without adequate support.

We found that it was sometimes difficult for homeless people with mental health problems to access support when they need it. Some of these issues include a lack of follow-up after initial assessments, the complexity of problems faced by homeless individuals, digital exclusion, the need for face-to-face interventions, a lack of personal contact, and poor communication between different teams. This highlights the importance of improving communication between teams and working together to provide support to vulnerable individuals. It also emphasises the need for more personal contact and face-to-face interventions, as well as the need to address issues such as digital exclusion and day-to-day struggles faced by homeless people.

There are particular issues of concern for people experiencing personality disorders or complex Post Traumatic Stress Disorder (PTSD). It appears that some individuals are struggling to access appropriate support and are being passed between different services without receiving effective treatment. The availability of specialist services such as psychotherapy is also raised as a concern.

Some people are having trouble accessing the care they need, and there is a perception that the access team is acting as a 'gatekeeper' and preventing many from getting through to the Community Mental Health Team. Those who do receive care are sometimes not given enough sessions or coping strategies to deal with their issues. Discharge from care can be a difficult and abrupt process, with people being sent back out into the community without adequate support.

Referrals are not always met, crisis plans are sometimes ineffective, and communication is sometimes poor. Misdiagnosis and lack of continuity of care also appear to be issues. However, there are some friendly and helpful staff within the system.

Theme A: immediate post-crisis support

"In fact they <the Crisis Team> did come round one night and sat with her for a few hours, and she did get some support at that point, but that has dwindled and it's always a kind of one-off interaction, whilst at that moment in time it might be helpful because actually you are soothed because there is someone else in the room who knows what they are talking about and that is great, but as soon as they have gone and you are in that state, you know, the descent is rapid."

"It is the sustainability of help after the first point of contact which again seems to be missing."

"She was in absolute crisis. Picking up the phone to speak to people and arrange an appointment was really not the place that she was in at that point. Really, she was absolutely desperate to be sectioned, she just wanted to be somewhere else, but it wasn't going to happen. And I've

heard that too many times in terms of that one point of access crisis support."

Theme B: navigating longer-term support for after crisis care

"People talk about playing the system, and I absolutely see why. I think it is sinister because sometimes it makes recipients of services manipulative, not because they are inherently manipulative people, but because they want help, and if you don't know how to do that you tend to lose."

"I know people who have downright lied, by saying that they have reached this level of mental health crisis, and perhaps they haven't, or those suicidal thoughts aren't as prevalent. It seems to be an exaggeration of your symptoms, because they have the awareness that if they say they are feeling alright today, that is the end of that."

"Recovering from a mental health issue is never a linear process, but it seems to be framed or guided by the fact that a person gets better and better and better, but they don't necessarily. It is that lack of sustainability in help, or even the flexibility, without having to go through the whole formal process again of engaging, criteria meeting (I'm sorry you've already had your time)."

"In the community because they're struggling, people might not answer their phones or might not feel able to open letters so then they are discharged from the community team because they have not responded."

"To have more support for people during the day would be amazing; like a network of places that people could go."

"I really had to hit a crisis later on, becoming severely depressed, going into hospital and the experience in hospital wasn't really positive because it didn't impact on the severe depression, but I did get referred to an anxiety disorders unit, it took a year, but that was really helpful. But I had to hit that crisis before I got that help."

"It is all very well and good encouraging us to speak up and ask for help, but is the help there?"

"I think there is a problem with the system where we have to follow and chase things up when we are very unwell."

"I slowly saw that shift when they started to introduce the access to mental well-being team, almost the 'gate-keepers'; we often called them the 'gate-keepers' to mental health services and TEWV."

"So, the access team came in and then the crisis team alongside them, even though there had been crisis support home based treatment and things like that prior, it felt very much as if some process had been put in to stop people getting to the support that they needed."

"I know people who have contacted the crisis team to be told that their issues are 'not mental health', it's not something they can deal with. So we are working with a lot of people who have relationship difficulties, job losses through Covid, health issues, all sorts of things, and that impacts on their mental health to the point that they are maybe feeling suicidal to be then told by the crisis team that their issues are 'relational' or 'economic', so it's not their mental health, so they <the crisis team> are not there to help. Sometimes they are told IDAS will pick that up, or KYRA women's service will pick that up, so they seem to be very good at signposting back out into the community when you have people that are really on the edge."

"It would be good to have something for people that are in crisis that need that kind of emotional empathetic support from a professional that has time and can have a look at their staying well plan and their crisis plan and things, and talk them through it. But just to have that much more time."

"I think there can sometimes be a bit of a disconnect between somebody going to the hospital, seeing somebody, they don't need an admission, they've maybe been referred on to Huntington House or something like that, but then that follow up doesn't always seem to happen for people."

“For a lot of those clients, their lives are very day-to-day and things have to be tangible. If somebody actually opens up and expresses that they are in a mental health crisis in the middle of the night, if it’s 10 days before somebody trained in mental health care can speak to them about that, apart from somebody on the phone in the middle of the night (the crisis team) often by that point, not that they are not still in crisis, but they maybe don’t feel like anybody has responded.”

"Yeah, just none of it really makes sense. I mean, like xxx has just said, all this lady is wanting is to sit down with somebody wants to start PTSD therapy, and have a conversation about how she copes with the triggers, the system will have to adapt, because we'll keep fighting on behalf of people. And it will be the same, it will be another person saying no. And all these organisations start fighting on behalf of people, then the system, surely get tired of all these fights and will have to do something eventually. I suppose this is one sort of approach, as well as writing reports and saying, What are you doing? Where's the resource for this? And this and this, and this?"

“In terms of the crisis care pathway there is still a lot of work to be done around connecting all the different teams up. There is almost this quite negative culture of kind of handing off between the teams rather than a kind of fluid working alongside each other and working together and we find that as Local Area Coordinators. Some of the introductions that come through to us almost feel like a dump and run.”

“But I do find, particularly I think between the CMHTs and the crisis team, there often seems to be quite a fractious relationship. This kind of sense that it’s not my problem, go and talk to this person. It becomes really frustrating for us because we spend a lot of time on the phone, waiting to get through to somebody and then being told it’s not my issue, you need to go and ring someone else over there. And if that’s frustrating for us, I can’t imagine how frustrating that is for someone who’s experiencing a mental health crisis. So, it does feel like there’s a lot of work to be done about getting those teams to work together.”

“But then again, saying that, there are these odd cases where clinicians will go out of their way. I think it’s important not to lose those examples because they are under so much pressure and I imagine that it feels like quite a thankless task.”

“You get people that are sort of stuck in the assessment process. I was supporting somebody, a woman who was pregnant, who became really unwell with her mental health quite quickly and in pregnancy that can be really kind of catastrophic, women can end up experiencing psychosis and their mental health can deteriorate quite rapidly. I was really concerned about her, she was saying that she was really suicidal. She had already been referred to the perinatal mental health team by a midwife. So, I rang the perinatal team, knowing this, and said ‘I’m really worried about her, I’ve just got off the phone to her’ and they said ‘oh well actually she’s not on our system’ and I said ‘well I know she’s been referred’. And they sort of broke glass on their system to see that she was still with the access team and waiting assessment with the access team. I said ‘considering the situation she's in, is there any chance that somebody could give her a ring’, ‘oh no no it's not with us, you need to go and ring the access team, she's got an assessment on Friday could she not wait until then’. I said that she can’t. So then it was ‘well you need to ring the crisis team’. And that was quite a difficult conversation because I said ‘she’s pregnant so she’s gonna come through to you after this assessment with the access team, you know that could we instead of passing it around all these different teams could we not jump a step and have one of your practitioners give her a ring and have a chat with her’. It was just a very hard ‘no, no we can’t because of the bureaucracy’. Situations like that are very hard and it doesn’t feel very human and it doesn’t feel very compassionate. Some of the clinicians are a bit process driven. If that practitioner that I spoke to really wanted to, she could’ve just picked up the phone and had a conversation with this lady. I don’t think any managers anywhere in TEWV would’ve said ‘oh you shouldn’t have done that because it's not with your team yet.’”

“There have been some positives under TEWV in that the access team, they’ve done a lot of work into trying to make the referrals into the access team much more accessible.”

“That’s [community mental health transformation] working alright, there's been some really positive things from carers saying it’s made a huge difference to the people that they care for having had previous admissions and now following a recent admission, having a social prescriber involved for example to help someone go, there's no use having a list of places to go if you're really vulnerable and you’ve just come out of Foss Park. To walk through the door of an organisation and say that I need some support, it's really difficult.”

"Used to be Dialectical Behaviour Therapy and Psychotherapy, for people that have complex mental health conditions. But there's not even any access to that anymore."

“I don't want a group that is talking or helping me manage my emotions, I need to find coping strategies to deal with the flashbacks that I am having about things that's happened and nobody could offer that support.”

"So, people are at the moment jumping through loads of hoops to just basically pass the buck to you. The particular patient I worked with was quite upset about the fact that she had the access team appointment. They said the only thing we can offer you is an appointment with IAPT. They booked that appointment knowing that IAPT could not work with her because of her complex background.”

"xxx is really anxious about situations and has lots of sort of difficult thoughts to the point where she got really frightened about crossing the road because of OCD. If she crossed the road at a certain place, something bad was going to happen. And she was told by IAPT, 'that's not something we can help you with'. And again, directed to York St. John Counselling and Mental Health Clinic; redirected there to the trainees, basically, yeah, so that is kind of where it just seems to be happening. So,

we are at a meeting at the GP surgeries, and I flagged it up there, which was quite a shock to quite a few of the GPS, because they're assuming they're passing people on to certain services, which is maybe not correct. And the same with the access team, they feel that if they pass them people to the access team, they're gonna get some form of mental health support, but people are just getting passed back out again to Kyra, York St John, Mind, etc."

"Have discharge be less of a cliff edge."

"Services are discharging patients for being 'too high risk'; it makes zero sense. Who is the person that is the perfect level of complex and risky and what is actually offered to that person?"

"Discharged because 'too complex'."

"Suicidal plans and liaison – holds the door open to go and kill herself."

"Professionals meeting – no input."

"Not informed of own care pathway."

"Lack of continuity of care."

"Fed up of being treated like shit."

"Some friendly and helpful staff."

Theme C: navigating crisis after care for Post Traumatic Stress Disorder (PTSD)

"Had a couple of people that I'm working with who have a complex PTSD diagnosis and really struggling to get any of support. I've got two patients both very similar in presentation in that they have a complex PTSD diagnosis. They've had a history of some form of either sexual or domestic abuse in the past with lots of flashbacks, symptoms of PTSD, both of them try to access support. So, they're referred to the access team by the GP,

seen by the access team and basically kicked back out into the world, back out into third sector organisations. So, to Survive and IDAS. So, a lot of pressure was being put on those services. Both of them have seen these different services, and the services helped within their remit with the situation. So, it might have been a sexual incident or what have you, but we're not able to deal with a longer-term PTSD diagnosis and managing the kind of flashbacks and all the experiences."

"GP surgeries were left with two patients really struggling with their mental health, came through social prescribing one of them has gone down the route of putting in a formal NHS complaint, to say that they're not getting the support they need with their PTSD, the other one decided to put in an informal kind of complaint. Both were then seen again, given another assessment by access, both seen by the same clinician. I was at both the meetings with the patients. One of them's been referred through to CMHT support and he's now getting some one-to-one work around trauma and managing how to deal with flashbacks and coping strategies. The other one was denied access to CMHT and it's been passed through and was told; 'oh, we'll make a referral for you to IAPT'. So they've gone to IAPT, been assessed and given a statement to say that they only work with people who have single incident trauma and the staff there are not trained or funded to provide support to people with complex PTSD. So, they've signposted them to the counselling for mental health clinic at York St John."

"The access team is saying that they don't do trauma-based interventions, so who does? The amount of people that are coming through social prescribing at the moment who have complex PTSD or a form of trauma on their medical records, and they can't actually access anything. When it was the previous Trust in York, you had things like St. Andrews, you had The Retreat, which I know that was private, but you had The Retreat communities, you also had access to psychotherapists, and whereas I have to say, they don't have psychotherapists. So, what do they actually offer? It just feels like it's just got smaller the provision, but the GPs are

referring and signposting people through to IAPT because they are under the illusion that the services are available."

"People are sort of now seeing the access team are like the gatekeepers. So, it's like the access team will either give you permission to go into the CMHT or they won't and it doesn't seem to be that many people getting through to the CMHT. I've got a lady that I'm working with who has PTSD from different things, she's now self-harming, and she's been given six sessions with a psychologist at CMHT, but she's not been given any coping strategies to deal with some of the things that she has, and it's literally six sessions. You have six sessions, and then you're out; 'you'll be better by then'."

Theme D: The Haven

"We've had a few people present at the Haven and again I think there is that confusion about 'what can the Haven do?' Often people view it as a crisis service that you can go to, but that is actually not necessarily what it is supposed to be or is geared up to be, I think there is some confusion around that for people when they are looking for some support. It's a great thing for the crisis team, but again you are talking to somebody over the phone and it's not having somebody tangible who you can actually talk to and feel some kind of comfort from which is why some people still go to A&E."

"Going to the Haven I've had mixed messages where some people have had one-to-one, so they sat in a room with somebody and had some proper one-to-one time and others where they have just been invited to have a cup of tea and almost sort of just sit there in that space, but they have gone with that expectation that they'll get to chat to someone, but been told 'no', it's more of a sort of safe space to be if you're not feeling great. And then you've had other people who have had an intervention, so again it's really mixed as to what they do and where people go if they are in crisis."

Theme E: navigating crisis after care for people with personality disorders

"You have a PD… what do you expect."

"The attitude and stigma within services towards PD patients is awful. This is even worse when it's a misdiagnosis and is used to justify poor treatment or lack of input."

Crisis Line (Staff)

There were 12 statements from participants recounting their experiences of the staff crisis line (i.e. the alternative to the public crisis line telephone number offered to staff).

Some mental health professionals find that they cannot get through to the crisis team using the public line but can get through quickly using an additional internal 'staff' line. However, not all professionals are aware of this staff number and others who are aware of it do not find it to be any more responsive than the public line.

Some professionals have had positive experiences with the staff crisis line, reporting good support and successful outcomes for their patients. However, others have expressed frustration and concern when they are unable to get through to the crisis team and must deal with patients in crisis on their own.

Overall, it seems that there are both positive and negative experiences with accessing the crisis team on the staff number, and that there may be some variability in responsiveness depending on the specific circumstances and individuals involved.

"There is a different number for professionals and that is the one funnily enough that I did use last week and I got straight through."

"I had tried the public line first for half an hour with no answer, then used the staff line and got straight through."

“They <the crisis team> are very hard to get hold of even with professional numbers, it is very hit and miss.”

“That was the professional line I used, but I wasn’t working in a mental health team then and other workers I was working with weren't aware of the professional line.”

“There is a staff line. I got it as NHS staff, but it is not publicised because it would be inundated. I have used the professionals line all the time and I get straight through and they do an assessment. I used it last week, it is regular.”

“In my experience people have been referred on or discharged if it’s not a crisis, but to cover my back I would always phone them first.”

“I've had a couple of members of the team saying it's difficult to get through to the crisis line. Even on the ‘workers’ line.”

“We have heard some really positive experiences as well, and heard from some people that when they have got through and spoken to somebody they’ve got some really good support and it has really helped. I’m thinking of one case in particular and it was an older lady and the LAC said that the support from the crisis team when they came out was brilliant. She was experiencing psychosis and was acutely unwell and she was adamant that she didn’t really need much support from mental health services, but they managed to work with her to get her to agree to a voluntary admission to hospital rather than having to go down the route of sectioning first which is always much better.”

“We’ve got the staff number for the crisis line and email addresses for some of the practitioners as well, so with all those different options and ways of getting in touch we can usually get in touch with someone quite quickly if we need to.”

“We sometimes struggle to get through on the crisis line and we have the staff number.”

“It’s very frustrating when you’re concerned about someone you’re sitting with and you can’t get through to them <the crisis team>. As soon as you get through and as soon as you’ve got that progress, you’re relieved that you know someone else is dealing with it and you can hand it over to them, but when you can't get through to the service and you’ve got a busy clinic and you're trying to see other people at the same time. Reassuring this patient that help is on the way and trying to keep the patient in the surgery is often hard because of the concerns of what they’re going to do to themselves or others. It does impact on you psychologically, how you deal with your next patient or the patient afterwards.”

"That was properly scary, you know, something you dread most as a therapist. I wouldn't trust anybody who said that was easy to deal with; there and then to try to contact the crisis team and couldn't, it was so hard to do something, I literally couldn't get through. No, I just couldn't get through."

Crisis Line (Public)

There were 71 statements from participants recounting their experiences of the public crisis line (i.e. the alternative public crisis line telephone number).

Many people in crisis experience long waiting times and inadequate responses when calling crisis lines. People report having to ring many times and sometimes waiting for hours before the crisis team answers. This can have serious consequences for people's mental health; it is important that they receive timely and compassionate support. 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’.

It is clear that there are issues with the crisis lines in some areas, and it is important for these issues to be addressed. Providing adequate resources and training for mental health professionals who work on these phone lines is essential, as is ensuring that these lines are adequately staffed to meet the needs of the community. There is a recognition that crisis line staff are under a lot of stress and may not be adequately trained to handle the demands of the job. It is important that people who are experiencing mental health crises are heard and receive the support they need.

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. People also seem to have different ideas about what the crisis line is for, and some feel that the service is not working for them in their time of need. Some individuals report feeling unsupported and abandoned after reaching out to the crisis line multiple times without getting the help they need. Additionally, making sure that people are aware of alternative resources such as Samaritans and ChildLine can be helpful in providing additional support.

"One person tried to ring the crisis line 36 times about eight months ago. She tried to ring over the weekend and wasn't able to get through."

"I've had experience only on two occasions where I've tried to ring the crisis team and they haven't come through."

"In an ideal world you'd like to have that support for everyone all of the time when someone is in crisis. Just a simple phone call with someone there to support you and they can do it effectively."

"There are stories of people that we've worked with who have phoned 70 times in one night and you're thinking, well what happens?"

"Neither worker had referred people to the Samaritans line, it is a third sector entity."

“I have had success of calling the public number in the past.”

“I have heard that the crisis care line does not get picked up, and not just in York, e.g. Lancashire doesn't answer, so it is just a nationwide problem.”

“There was a lady I was talking to and she was in an absolutely awful place and she called me up one night and she had overdosed and she had self-harmed and the first time she tried to ring the crisis team no-one picked up.”

“Not getting through to the crisis line is a disaster. It is hard for the person making the call…if you've got to that point in life where you think ‘this is it’ and have had the courage to pick the phone up in absolute desperation and not get through; the knock-on effects of that are disastrous.”

“It just seems that they've gone through to the crisis team and unless they are actually well, it's really difficult I know, that everybody is really stretching under pressure but I know that the teams sometimes have phoned and get quite curt answers.”

“It could be that somebody is presenting over and over in a crisis but the crisis team is so used to that person that they say ‘well no, we're not going to do anything’.”

“It isn't acceptable to have a crisis line that isn't answered.”

“The crisis line is advertised as 24/7 but it doesn't get answered. It's wrong to offer crisis help and not answer the phone to somebody who is in crisis, whether that's staff or not, they've still got to provide a service.”

“I had mixed experiences of people accessing crisis. A lot of people had to access the mental health support line which was Council run rather than access the crisis service line and I think a lot of people found that really beneficial and helpful, but that has obviously disappeared so the only route now is via the crisis service and there doesn't seem to be much

'joined-upness' between the crisis service, the access team and the other services like IAPT etc."

"I've had quite a few people say that they call the Samaritans rather than the crisis team. One gentleman who I've been working with recently said he felt really patronised when he got off the call because they were questioning the fact that he should change his thought processes about things then everything would be ok. He almost felt like he'd been analysed on a call, but then not given any help at the end of it and ended up having to ring the ambulance because he was feeling like he was suicidal."

"We've a had a few people say they've had to ring and ring and ring <the crisis line> and not get through, but it sounds like some of the ones I'm speaking to have managed to get hold of somebody and talk to somebody; it's just that what they're left with at the end of it does feel like anything tangible. So, it's something about 'how do they deem something to be a crisis?' and 'what is their role in support?'".

"A lot of patients feel like if they're ringing them they are in desperate need for something, and they are not getting anything but a chat."

"When someone is ringing in a crisis I suppose their expectation is that someone is going to help, then they are asked lots and lots of questions and sometimes those questions have got no relevance to that person."

"What is the person's expectation on the end and actually what is this service going to offer and that is why quite a few people are just calling the Samaritans, but there isn't a proactiveness with that, no one is going to say right we're gonna call an ambulance or get you the help you need."

"I think one of the issues is when we lost the mental health support line, because I only really heard good things from patients when they were being supported over the mental health support line. It had more of an empathetic approach."

“It became worse (being on hold or in a queue) when they changed the crisis number to this one that covered the area because it used to be just York and you used to ring York’s direct crisis team, and I don’t think, well I haven’t heard of having to be in a queue. It seems to be much more when they changed to this number that covers the whole of TEWV.”

“If somebody tried to ring and couldn’t get through, put the phone down and ended up that they did end their own life, couldn’t that be investigated in a coroner's court? Would they be able to identify; ‘well actually they tried to get through to the crisis line?’”

“I spoke to a couple of my colleagues before I saw you and one was saying about a recent incident where somebody was supported to ring the crisis team during the night and it took about 40 minutes to get somebody on the phone to that person.”

“My son has given up and doesn't ring the crisis team anymore. He just calls the police or an ambulance.”

“There is quite a lot of feedback coming through around people trying to contact the crisis team because they have got that new number now. On the face of it that’s a really positive thing because they are offering that kind of general mental health support. I remember with the crisis line when you had to be with secondary care services or a professional had to ring on your behalf, so they have opened it up and made it much more accessible and taken away a lot of the exclusion criteria, but they haven’t necessarily got the staffing to support that, so we are hearing a lot from people who are struggling to get through.”

“People are ringing multiple times or are waiting a long time to get through because I think if you can hang on you will get through eventually, but it’s quite a long wait.”

“We have had a couple of horrendous experiences with the crisis line a few years back where there was absolutely nothing on offer.”

"Even if my daughter had a knife to my throat, I don't think I'd ever ring them."

"They reckon 10% of people who ring are in genuine crisis and therefore 90% could be accommodated in a much less acute fashion."

"We've had cases where the person is locked in a room, throwing chairs at an elderly parent, an absolute desperation kind of state and then they've phoned the crisis team and been told to tell them to have a bath."

"It's a simple thing, by saying recruit more staff. There's a limit to how that can be achieved but it would be good to know there'll be a response when we call that number. The staff I have always spoken to are well trained, really helpful and no hesitation, I haven't got any concerns about their ability to do their job. It's just having the numbers to do it but I don't know how they would do that, it's not a bottomless pit."

"All I remember is the fact that every single call to the crisis team has been the same level of patronising. There's sometimes where I'll go to the crisis team and I'll leave in more of a crisis than I was in already. I don't know how to explain this, there's a lot of times where they'll make you feel guilty for being on the phone with them."

"Even when I was under CAMHS, I was aware of the crisis line but I'd use ChildLine because they felt a lot less shitty."

"It feels like they're trying to get you off the phone as soon as possible so they can seem like they're doing a good job and they're not, they're doing an absolute shit job because you get better help from an AI generated script because that's all they do because an AI generated script wouldn't have, and this is no hate to them as people, they're dealing with young people who are calling you because they are dealing with suicidal thoughts or are a danger to themselves or others. An AI wouldn't have the same levels of bitchiness when you're like 'hey here are my problems' and

an AI wouldn't turn around and say 'why are you telling me this, what the hell do you expect me to do?'"

"I struggle with picking up cues, subtlety, I'm absolute shit at it all, but even I can tell that they're not happy to be there, they wish they could be somewhere else, and when you're sat there at your lowest point thinking everyone hates me, they are better off without me and someone on the phone that you're calling because you're thinking that is basically confirming that."

"One of my friends had it where they were talking to the person about it, they'd gone through 'three steps thing' and they were turning round and going to them, I've had people saying this to me before; 'it's not helpful can you give me some actual advice?', the person basically turned around and went; 'I don't appreciate your attitude I'm hanging up for my sake', after my friend had basically said 'I'm calling you because this is my last option before I try and kill myself.'"

"It's just an endless cycle of just, you speak to them once, you realise they're useless, you speak to them a second time, you realise they're more useless, you speak to them a third time, you're wondering why the hell you're still calling, you speak to them any time after that and you must be desperate as anything to have any help."

"They don't ask 'are you safe?', 'are you a danger to yourself?', which is an important question because if someone's sat there going 'hey I want to kill myself' your first response should be, 'okay are you safe?', 'do you need immediate 999?', 'do you need someone to come to your house to do a welfare check'?'. They don't do anything like that, just; 'have you tried having a cup of tea?'"

"I have reached a new low every time, to reach out to them and every time I've just been let down more and more."

“For me if I’ve got a whole set of skills behind me from being able to de-escalate and support you, so when we phone the crisis team, it's not willy-nilly because I’ve absolutely run out of all those techniques and I remember the first time I phoned up and it was; ‘this is the state we’re in we’ve done this, this, this’, and she was like ‘yeah you’ve been through everything we’d suggest, there’s nothing else you can do’. And in some ways it was reassuring, because I knew I’d done everything I should’ve done but then you also think, but what am I gonna do now, because I’m still in crisis.”

“And especially when people themselves are ringing and not being able to get through, it's just so off putting that they're in a point of really of desperation. And he just further added to that sense of abandon that no one else cares, by the fact that the crisis team isn't picking up. Also, as well, I think it's something about the way, the way they actually come across on the phone. This sounds horrible, because I know that they're under a lot of pressure. You know, from one sense, I can understand it, but they're very, there's no warmth, well, there's a lack of warmth, when they are on the phone. It's very clinical.”

“If somebody is in crisis, the closing and then it should be literally three or five rings and someone picks up, not 45 minutes.”

"Well, one of the things that came up with the name crisis is really quite misleading. It's not working for someone in immediate crisis. So, it's very hard to find what you say when you use the crisis line."

"It's a funny service of crisis line, it's not really what it purports to be, people are trying their best but it's, it's really a shame."

“I did start using a crisis line and they were just so unhelpful. They kept telling me I had capacity and it was my choice and stuff like that. Which I suppose is useful to some people because it makes them feel like they've got autonomy, but to me it was not useful. No.”

"I sometimes go non-verbal and a crisis line was useless to me."

"I spoke to someone a couple of weeks ago…the irony, I suppose irony of ironies was she'd rung them in extremis. She was young, really young and she was so angry with them, that she put the phone down and didn't do the things she was going to do out of sheer anger, it's a strange model, isn't it? I've heard recently people ringing up and being on hold for like half an hour. When you're in crisis, half an hour is bloody long."

"The overwhelming demand seems to be now, I'm not being completely nasty to the crisis line, I think that maybe they're not trained very well and they are definitely under a lot of stress at the moment, but so is the rest of you know, the health service."

"So, you've got different definitions of what the line is for."

"Neither of my daughters will speak to the crisis team anymore - they're placed on hold/automated messages to call back later and if on odd occasions you get through the advice is useless. You don't get through to York and don't seem to be able to access notes/care plans (like they should be able to). So, advice is quite general e.g. distract self, warm drink, go to bed. So, they don't ring, they don't see the point and think 'why bother'."

"My son has called me crying saying he has been trying for two hours to get through to the crisis team."

"Carer 1 - doesn't ring the crisis team because you can be on hold for two hours - she rings 999 or ambulance instead. Carer 2 - similar feedback - doesn't call."

"Shared an experience about five years ago when she felt her daughter was unsafe and contacted the crisis team on Friday evening, but because her daughter was already under the care of an early intervention team she was told she had to wait till Tuesday to speak to someone from that

team. The next night she called again but she couldn't understand what the person who answered the phone was saying, and he kept getting details wrong like her name, address etc. Because he repeatedly got the details wrong, she gave up and put the phone down."

"The phone line is not accessible to all and some of the advice is not applicable due to physical disabilities."

"If my son couldn't get through, he would take it personally/ become paranoid, so it is important that someone answers."

"It's a load of shit."

"Advice given is not appropriate to a person's needs. People can be suicidal and told to go have a hot bath or a cup of tea."

"If I really wanted to kill myself, I'd try harder" - hanging up on them."

"You have no reason to want to kill yourself, at least you're not in a war zone and dodging bombs."

"It's your choice if you want to kill yourself."

"You're not at risk of suicide else you'd be dead."

"Four hours and then hung up."

Crisis Team

There were 72 statements from participants recounting their experiences of the crisis line accessed directly by the public.

We found that the crisis team can be both helpful and ineffective, depending on individual experiences. 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 is a lack of clarity on what constitutes a mental health crisis, and there is a need for better follow-up after contact with the crisis team.

Some participants felt that the crisis team was understaffed and overwhelmed by the demand for mental health services, particularly during and after the pandemic. They suggest that there needs to be a shift in the demand for services to lower-level services, so that acute services can do a better job.

Others have expressed frustration with the way that personality disorders are perceived and treated by mental health services. There are concerns that people with personality disorders are being dismissed rather than being given the support they need.

Additionally, there have been concerns about the crisis team's ability to deal with complex diagnoses. Overall, it seems that there is a need for more clarity and consistency in how crisis teams are staffed and operated, as well as better communication with patients and their care-givers about what services are available and how to access them.

"Crisis care is always in crisis."

"I contacted the crisis team who did respond very well and responded very quickly, within an hour a doctor had come, then we did involve the police, and it went very well, within a couple of hours."

"He was then escorted informally by police, he was then assessed and has had treatment now, so that is a good story of this service working well. He is actually being discharged this week, he is a lot more well than he was when he came in here."

"I have seen first hand the crisis team work and the way it is set up is fantastic and they really do their best, but it's not infinite the amount of people that work within it or the capacity that they have."

“We then called the crisis team and said could you go in and check on this lady and I was quite surprised when they did pick up because I thought nothing was going to happen. But they were there when I turned up and they were offering crisis support and I was able to work with them because I knew the lady quite well, to see if she would agree with a formal admission. So that was a good response from them, very quick.”

“Going to the crisis team is not part of a normal induction process, it was a one off for the student placement, but it was a useful experience for her seeing it from that side. Our induction to what it is was all through word of mouth and experience on the job. We’d like to know too…”

“We need to know, what does ‘crisis’ mean?”

“It <crisis care> is in a dire place.”

“We've asked the crisis team to come to us at two team meetings, so that we know more and can define crisis more clearly and understand this service.”

“People are often left feeling much worse after their experience with the crisis team. The onus is put on the person to sort themselves out and they're not feeling well. There is a gap, something isn't right.”
“But we have had the odd positive but sometimes we’ve also been fobbed off there’s no other way of really describing it.”

“The crisis team were really helpful, they referred me on to the access team. They <the access team> introduced me to a department that I hadn’t heard of before; the department for psychiatric medicine and by speaking to my GP practice, they are working on getting me a referral via the access team to this new department. So, in my personal experience I’ve had really good mental health support from the NHS.”

“She has been passed to places like Survive and IDAS who can help with certain elements, but they are not here to offer long term support around PTSD. So she’s actually been ringing the crisis team on a regular basis and they have told her more about what is in her medical notes, what agreements have been made and what the criteria are that other services haven’t told her, so she has just had a letter that says ‘you can't have this, you don’t meet that.’ Whereas crisis have actually explained to her why she doesn’t meet that criteria. She is my first in a very long time that has had a really positive input and said that she’d spoken to the same people which felt quite comforting.”

“For patients with a personality disorder there would be a less empathetic response from crisis team. So much so that I think some patients would stop using it.”

“I guess the crisis team, well I know from working at TEWV as well, is grossly understaffed, and there is such a lot of pressure on the staff because it is so understaffed and there is such a lot of sickness as well, people off long term with stress and things, so that puts more pressure on. So, it seems the crisis team are very much assessing risk and directing from there, it doesn’t sound like the kind of support that patients are describing that they got is very therapeutic, it seems more kind of risk assessment.”

“I would have said before the pandemic I would probably have seen more follow up from crisis contacts.”

“We frequently ask questions and what we’d really like to do is a question on, ‘what is a crisis, what deems a mental health crisis?’ and ‘what does the crisis service do?’”

“We have quite a close relationship with the crisis team, we have our clinical supervision through one of the advanced practitioners on the crisis team and we have quite strong links with xxxxx who comes to our

practitioners' forum and he maintains a directory of online mental health resources which xxx shares with us and is now on Live Well York."

"We can see how much pressure that team has been under and we have quite a lot of empathy for that because the demand around mental health during the pandemic and post pandemic, the impact on people's mental health has been phenomenal and the demands that services and everyone finds themselves under has been really, really tough and I know that TEWV has got a bit of a staffing crisis, they've got lots of vacancies that they are struggling to fill, it's just such a challenging sector to work in at the moment and they've had so many people off sick with stress."

"We very much advocate for people in communities and where there are bad experiences and people have been struggling to get through, that's really awful, but I think you need to balance that with the pressure that staff are under, because they are people as well."

"The crisis team feel that 90% of the calls are not a real crisis. There should be triage and another service for people who feel lonely. The reality is that there is crisis care or A&E, there is nothing in between. The demand needs to be shifted to a lower-level service so that the acute service can do a better job."

"As a service who receives referrals from people still in crisis post-NHS emergency support, we are for low-mid level support run by volunteers and overrun with referrals with PTSD/EDs/attachment disorders/multiple suicide attempts/long term self-harm. Passing these people onto our services is inappropriate and potentially harmful for those clients; voluntary support needs to be preventative, not a sticking plaster."

"I've never heard one positive thing said to me about the crisis service."

"...as a member of staff and part of the mental health community in York and supporting friends and family, I am just appalled."

“There seems to have been nationally this whole shift around people with personality disorders; ‘it’s behavioural, they just need to knock it off’. I’ve been told things like I had a professional tell me when I had a client ring me up and it was a Friday and she was really distressed, ‘I don’t want to be here any more’, ‘I can’t do this’, ‘I just want to die’ and when I got in touch with mental health services they were like; ‘she’s just being emotionally abusive’, ‘that’s awful what she’s just done to you’, ‘if I was you I’d turn your phone off, pour a glass of wine and ignore her’. That was CMHT and the crisis team that said that.”

“I think there is a very common theme along the same lines that people go to the crisis team feeling suicidal and that not seeming to trigger any sort of response whatsoever. Almost like ‘well that’s how it is’, 'it's behavioural’, ‘they are choosing to do it’.”

“Many of my clients that come to me, as you’d expect with NHS complaints, it’s about not being able to access mental health services. Generally people <are> feeling very let down by mental health services in York and often before they get to me, they will have got to a crisis point and contacted the crisis team and basically not been given any support, generally <this> is really common thing. I get people saying to me over and over again different people saying, ‘I will never ring them up ever again’ and actually they felt worse because they contacted the crisis team because on top of their own crisis they are then being treated in such a way by the team that makes them actually feel worse, invalidated.”
“When I call <the crisis line> sometimes I get through, I phoned them 37 times until somebody answered the phone. My friend is coming off antidepressants, when you come off it, it’s like coming off an opiate, so it’s full on, you vomit. She’s never been aggressive in her life, she’d grabbed her counsellor by the throat, she was in a mess. So, she rang them 37 times, finally got through and explained the situation and they were like right I’m going to check this and get back to you within the hour. An hour and a half passed, <person 1 - that’s a very common theme, they say they’ll do

something and then it not happening> nobody rang back and my friend was escalating, so I rang back again 17 times (it's funny how I remember) and I got through and explained who I was and they had no record of my previous call. At this point my friend was just broken and couldn't take any more, she wanted to rip her own skin off, she went into the other room and … ended up in intensive care. That's the crisis team."

"Some of my clients will try A&E and feel rejected by A&E and not getting any support there and then they'll try the crisis team and the same thing happens with the crisis team, so that's quite a common thing for my clients; to try one and then try the other and just then where do they go after that? I had one client who would threaten to throw himself under a train because that was the only way, then the police would get involved, but at least somebody was reacting. That's how bad people can feel, like 'what do I do now?'"

"People feel they have no choice but to do something that forces professionals to look at them. It's desperation."

"I've lost clients. Xxxx died in from drug induced psychosis. I attended the inquest and was involved in the whole situation. He moved back to York <from London> and he really struggled, so he started drinking and had a bit of a problem with drink for a long time. He went off to xxxxx and by Monday he had completely lost his mind. Every single day at least three times a day until Friday he came into contact with the crisis team, he was going in and out of the police station, in A&E, the crisis team were going out and seeing him. He was running round York 'they're gonna kill me, they're gonna kill me'. They're going to put me into three pieces and chop me up. <He was> turning all the phones off 'they're listening, they're watching. They're coming, they're coming.' On Wednesday he begged the crisis team, I don't know if it was a moment of insight or what, he begged them; 'take me to hospital, I'm begging you, I'm begging you'. They gave him a 30% chance of killing himself, I don't know how you make that sum, and wouldn't admit him. They said he didn't need admitting. He needed to come down off the

drugs, but he hadn't actually taken any more drugs. They call it first episode, second episode, when you get to third episode they'll then look at sending you. By Thursday he'd given up, decided he wanted to take back control, he didn't want to be chopped into pieces, so his only choice was to xxxxxx. So, he took xxxx on Friday night and didn't expect to wake up, he was very surprised when he did. So he took xxxxx on Saturday morning and then crisis team turned up about lunch-time, and he was like 'it's all right now they're not coming for me, I've taken xxxxx, so I'll be dead shortly. Then they were like 'oh no, quick get him to the ambulance' and off they went and they were obviously trying to put drips, but he said 'oh no, no, you can't don't treat me, because if you treat me then they're going to come and I'll be chopped into three pieces. So, they had to sedate him and he was in a coma for 11 days and he spent his 37th birthday on a mortuary slab. They carried him to xxxxxx in a box; a year later on his birthday, scattered him on xxxxxx. We were at the inquest and the coroner was saying; 'why did you not intervene?' He begged you."

"Within mental health crisis services in York the fact that you are suicidal just doesn't seem to make a difference to the care. It's just like Russian Roulette. One of the things I've been really shocked by is that a client comes to you and says, I told them that I feel suicidal and still they are not offering any mental health support, so how bad does it have to get, can it get worse?"

"Clients who often end up in forensic hospitals, frequently have been in crisis, without intervention, despite asking repeatedly for help, and then feel they have to escalate to force reaction from emergency services, including eliciting "suicide by police" which leads to them being charged with an offence instead of receiving mental health crisis care they need."

"There was a point when he was convinced his neighbours either side were plotting to kill him and were talking about him and he was very, very afraid and very frightened. So, he's got an axe and then he was like, I've got this axe and he was crying down the phone; 'I don't want to hurt anybody', 'I'm

*not a bad person', 'I don't want to burn in hell', 'I'm so afraid, and they're plotting, they're gonna kill me'. Do you know what crisis team did? Absolutely f*** all. These neighbours had no clue, he was sat in that flat with an axe. Could you imagine that you were living in that flat and you had no idea that there was a man upstairs <with an axe> and he was ringing us, he was ringing crisis team, he was ringing the police, he was ringing ambulances, but guess what one of his diagnoses is? Personality disorder, so they won't <intervene>, oh 'this is what he does'."*

"Another thing is that crisis team agreeing to do something like call the person back or arranging stuff and then it just doesn't happen, so that's really common, and obviously you're at the point when you needed to ring the crisis team that is huge if someone has agreed to do something and it doesn't happen. That has a big impact on my clients. You have to be really, really desperate to get to that point and just being turned down or things being agreed and then not happening is the nail in the coffin."

"I am aware that a lot of people ring the crisis team when they're not in crisis and I think that's because of lack of other services like the preventative stuff that's really struggling so I know that it's really difficult for the crisis team to judge who is really in a crisis and who isn't. But I think that if you have a carer who's saying I've tried all these things and we are at this stage, that carer is also in a crisis, not just the person that they are caring for, it's the carer too that's also in a crisis. That's really demeaning to suggest things like go for a walk or have a bath which are really not helpful at that stage."

"In fact, we've had a couple of really positive ones, so we've had someone in complete and utter crisis and we've phoned the crisis team because they'd tried and not managed to get what she needed. The person we spoke to was brilliant and really good, they said we'll take this off you which is what we needed, we needed them to say we've got this now because it was far, far beyond really complex. And that was really positive, so we have had good experiences."

“So, we have major frustrations getting through to the crisis team when we have managed to identify a patient who is at risk and they become active in a patient’s life. Fantastic service, it’s just that initiation and getting the patient known to them but we have problems initially.”

“I’d rather just internalise it then have someone guilt trip me, tell me that I’m over exaggerating, that my issues are just on me, basically ‘it's your problem, you deal with it, I couldn’t give a shit, I don’t get paid enough to deal with you.’”

“I don’t think there’s actually anything positive that I have ever experienced with the crisis team besides, they’re funny to laugh at.”

“Whenever I’ve called, they’ve always been like, “is there someone else we can talk to?” basically. That always seems like they genuinely don’t wanna talk to me, they’re happy to talk to anyone else, except me.”

“And actually, it ends up being more unhelpful to individuals than helpful.”

“It's almost as if when you ring them from the point of contact, they're trying to get you off the phone, and they're trying to push responsibility back.”

“I'm not gonna say it's getting worse, because I don't think I've got actual evidence for that. But it's definitely not getting better.”

“It's the elephant in the room that they haven't got the resources that they need to deliver the service that's needed. And it does put pressure on the staff. Actually, what they do need is an investment, so that they've got the team to be able to do the job and their staff are not getting burnt out.”

"If it's not going to be a crisis service, then it needs to be more clearly communicated what it is."

“The underlying sense that I got was that they're very aware of the weaknesses, but don't have, or aren't granted enough resource by the top level to do it.”

“With the crisis team we're still getting issues around people. I'm still getting it all the time, I just put this call in to the crisis team because they don't have a phone to register. Even though I'm working within xxx, she really tries to ring a care coordinator at Huntington House. Nobody ever gets back to her until about two or three days later, by which time she's potentially self-harmed because she's not got through to the right person.”

“Sometimes they (crisis team) have been great, when I (carer) have spoken to them when there has been an issue or I’ve needed advice.”

“They didn’t seem to have the power to do anything or stop it going further (crisis team).”

“My daughter was becoming unwell and the care coordinator asked for CBT but they refused and then things went downhill so then a social worker, crisis team, consultant came - crisis team said she argued for my daughter to stay at home. But we were past that point and she was detained under section 2 of the Mental Health Act.”

“There have been times when they were needed but they weren’t able to step in (crisis team).”

“I am not quite sure what their role is (crisis team).”

“Carer - hadn't contacted the crisis team but was put off from making contact because of the bad things she has heard about them and worried what would happen if she did contact them.”

“A service sitting beneath the crisis team would be good - something more preventative (to stop things reaching crisis). xxxx from First Contact talked about the Durham model where there was a listening service which acted as a sort of triage to filter out those who needed to talk from those who were in crisis.”

“The length of time it took to process the paperwork for a crisis call, if unknown to TEWV.”

“There are certain complex diagnoses that services seem either to not understand or are scared of, so you get offered nothing at all – even crisis services when in actual crisis.”

“What is the definition of ‘crisis’? Lack of clarity of stages...”

“Support isn’t what we thought it was going to be...”

“Initial contact with crisis team and liaison team was okay – respectful.”

“Told police to leave her alone to kill herself - ‘she won't succeed so leave her to it’ - at least four times.”

“Crisis don’t offer solutions.”

“I don’t call the crisis team, I avoid the crisis team.”

Criteria Threshold

There were 24 statements from participants recounting their experiences of reaching, or failing to reach different ‘thresholds’ for treatment.
We found that people who are in crisis are often being turned away by mental health services because they do not meet the criteria threshold for support. The threshold for what is considered a crisis is described by many participants as being very high, which means that even people who are feeling suicidal may not be considered unwell enough to receive support.

This situation is problematic both for the individual and the system as a whole, because it means that people who are turned away may become more unwell in the future, which could be prevented by lowering the threshold for support. We also found that it can be difficult for professionals to judge whether someone is in crisis, and that families and carers feel better placed to recognise the warning signs.

The criteria threshold is not always clear or consistent across different services, which can make it difficult for people to know where to turn for help; some people may be denied support even when they are in genuine need, while others may be able to access support for relatively minor issues.

The text highlights the need for mental health services to be more flexible and responsive to the needs of people who are experiencing a crisis, rather than relying on rigid criteria thresholds that may not reflect the complexity of people's experiences.

"In terms of crisis care. Lots of people are waiting on mental health support, they haven't met the criteria for mental health support."

"A lot of people have asked for referrals and for whatever reason the criteria isn't met."

"It all seems to be about criteria; what is your criteria to access this service, what is your criteria to access the community mental health team, and that bar seems to have got higher going back to how it has changed with the Trust."

"It can be a bit hit and miss, because people are in crisis, or feel that they are in crisis, quite often it is not the same thing."

"It is difficult as a professional to make a judgement as to whether someone is in crisis."

“Families and carers know the warning signs so we should be listened to.”

“Boy, have I had to become very unwell to get some support.”

“I mean I haven't seen the bit of paper with the criteria as to how you access it, but I did speak to a LAC about criteria and they were telling me how ludicrous it is.”

“In terms of crisis care. Lots of people are waiting on mental health support, they haven't met the criteria for mental health support. Someone told me it was 18 weeks before they can get onto the first rung of potential mental health support, which is far too long if you’re struggling.”

“What I’m hearing from patients now is that they feel as if they go somewhere the door is shut, but there isn't a ‘joined-upness’ which says ‘you can go to this service’. Each of them have their own criteria for when they’ll help somebody, so it feels like if you don’t get through that one you have to try another route and another route.”

“I had my first positive chat with somebody about the crisis team yesterday. Somebody with complex PTSD is not able to access therapy support via TEWV, apparently they have been told that TEWV no longer offer that level of support, but they do offer it if you can get into the CMHT, so if you can meet the criteria for CMHT then they might give you some support around trauma, but if you don’t meet the threshold, and this lady has been told that she doesn't, then you can’t access any trauma support.”

“That lady who I mentioned who had had a good experience of crisis; she is at the point of wanting to make a complaint to TEWV because she’s been diagnosed with complex PTSD, had a long history of domestic violence and other kinds of abuse in her life and she’s having flashbacks, panic attacks, on a daily basis. She knows somebody from going to a kind of drop-in support place who had also been diagnosed with complex PTSD who has far, far fewer symptoms and is on far less medication, but is accessing the

Community Mental Health Team support, she has a psychiatrist a CPN who visits her. This lady has been told she doesn't meet the criteria for the Community Mental Health Team, so how….if you know people who are still working with those teams and now they are not able to even get through the door."

"Certainly even from the GP's perspective, this particular GP who is working with this lady is really trying to push the doors down, she keeps going back and saying you've referred her to IDAS, but IDAS has said they can only do this, so they are not able to give that level of input that she needs. You've now told us she needs to go to Survive, so she's going to Survive, so if Survive turn round and say 'we've done what we can do', where does she go? But the letter said that she doesn't meet the criteria for CMHT and that is where she might be able to get some trauma support, so she is just in crisis on a day-to-day basis. Luckily her crisis team experience had been positive, because there is somebody picking the phone up helping her to de-escalate when she's going into a complete state and trying to help reduce that, but they are still not giving her any input. So she's just in a crisis situation all the time, she is ringing the crisis team every day pretty much and having that contract, but she still doesn't meet that criteria, so it's hard to know what that criteria is; is it that somebody is presenting at A&E a lot, is accessing GPs a lot, or not, it seems really difficult."

"If a patient has a crisis outside of CMHT hours at weekends then they phone the crisis team, or if you were really concerned about a patient over the weekend you might put in a referral to the crisis team to see if they'd do a home visit to check their safety and support. Over time I found that the level of risk for the crisis team to actually accept a referral was rising and rising. For someone to get support from a CMHT they are raising the bar and for somebody to be admitted to hospital the bar is being raised again. This started happening about three years ago."

"One of my clients, I'd been working with her for a long time. She was 13 when she first started being unwell, she was adopted, <there was> abuse, a difficult start to life. She was at CAMHS and she had literally, like chicken

scratches, she said 'and I've done that to my arm'. They were superficial, she'd hear the doctor and her mum talking saying; 'I wouldn't worry about them, nothing more than superficial scratches'. Nothing to worry about. So, she went 'superficial, nothing to worry about, I'll show you'. This girl now is in her 30s, and has experienced an escalation to life threatening extremes of self-harm."

"He's like been in Huntington house, I've been involved, but on Friday he wouldn't leave the flat, paranoid psychosis, thought that York was full of demons and ghosts so won't go outside. Also thinks that he's going to die and he's going to burn in the middle of the sun and also that children were going past his window shouting "you're gonna burn in the sun". He told his sister to read the book of Revelation. So, she phoned the crisis team on Friday, they spoke to him and because he wasn't voicing active suicidal ideas, they said he was okay."

"Some of the carers are in their 70s, 80s, they're worrying about what happens when they're no longer here but when they are here, they're banging on the door asking what we do when I'm in a crisis. You know, I'm looking after someone 24/7 and no one's helping, no one's even listening and telling me what to do if things go completely wrong, what is gonna happen when they die."

"Not if you've attempted once but if you've attempted three times then you can reach out for help. But if you die on the third time, not their problem."

"People with mental health difficulties, particularly if there's risk involved, can end up slipping through the cracks where they're not severe enough for some services, and sometimes you're the only person who is going to see them who's going to check in on them, even though you shouldn't, and even though you're not a mental health professional, when you're made to feel like you're the only person in the service looking out for them, it's very hard to disengage, even if you're not the most appropriate person, because at least you're someone. Yeah. It's really hard. And we're all having to work on our own boundaries of that and how we handle it."

“Xxx is bi-polar and she’d come out of an appointment just really frustrated and she’d be like; what do I have to do? I wonder if I get up and wrap the phone wire round his neck.”

“It's a gatekeeping place, the same as IAPT even going on the form to fill in the online referral form for IAPT which is now the go-to, you’ve got to do that. The minute you start to say you have self-harming tendencies or you drink alcohol to excess it’s ‘no, no, no, not suitable for IAPT’. But then you get somebody like this lady who gets through all of that and they turn round and say we don’t offer specialist trauma support, you need to go to CMHT, so you go back to your GP from IAPT, GP then refers to CMHT; no you don’t meet our criteria, back out again to the access team, ‘oh we’re going to give you a five week managing emotions course’; she goes on a five week managing emotions course and it doesn’t deal with any of the PTSD and trauma, but helps in some ways with understanding emotions. So ‘we’ve done our bit, we can’t do any more’, so you’re back out again. And that person is just…it’s that revolving door thing again. So, she’s not going into hospital all the time, like when I first started working in advocacy, it was a boomerang in and out of Bootham. So now it's a boomerang around these services to try and get anywhere and that’s the difficult bit.”

Foss Park Hospital

There were 11 statements from participants recounting their experiences of Foss Park Hospital. Foss Park Hospital is a purpose-built, 72-bed hospital for people with mental health problems and dementia, it opened in York in April 2020.
We found that 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.

The first story mentioned is about a young woman who attempted suicide and was admitted to Foss Park only to be discharged and attempt suicide again. When the police found her, there were no ambulances available to

transport her, so she had to wait in a police van for hours before being seen by a paramedic. Another young girl who was discharged from Foss Park completed suicide shortly after leaving the hospital.

Some patients appear to have been neglected after being discharged from Foss Park.

Overall, these stories paint a picture of a hospital that has struggled to meet the needs of some patients and has failed in some circumstances to provide adequate care to people with acute mental health needs.

It is important to note that some of the cases detailed below are from the perspective of staff and reflect their perspective concerning particular incidents. Healthwatch York does not have the individual's perspective, but the statements below reflect the concerns of workers within the local system. Some of the incidents described have been the subject of subsequent in-depth investigations by multiple agencies at various levels.

"There was a girl and something really awful had happened to her, she made a massive suicide attempt and got admitted to Foss Park. She'd had to wait four and a half hours in a police van. Also, she was detained but they kept letting her out on unescorted S.17 leave. That situation repeated over the course of a week, with police bringing her back each day after they let her out unescorted from the ward."

"A young girl discharged from Foss Park got on the bus outside Foss Park....(went by bus to place where attempted to take her own life)....she died."

"I am currently at war, right now, for yet another unsafe discharge out of Foss Park. It's just relentless."

"There was a lady <with a> learning disability, mental health issues, she was outside the <shop> in <location in York> for a fortnight after being discharged from A&E, been in Foss Park for a while, they couldn't find a placement for her. They discharged her out of Foss Park, then she was in A&E then I was on the phone to hospital liaison as they tipped her out of a

wheelchair into the street. She then spent two weeks on the floor outside the xxxx in xxxx. For some reason the bottom half of her was completely naked, we are unclear why. She had ulcers on her legs, by the time we got her off the floor she had maggots crawling in her legs. We thought she was going to lose her legs. We had to use a guardianship order to be allowed to drag her off the floor. She was covered in urine, she was covered in faeces, her bank cards had been taken, jewellery had been taken, she told me that somebody had injected her with a drug, and a drug was found in her system, she is not a substance abuser. This lady required a specialist placement, but due to delays in finding/securing this for her, as she was informal, staff would allow her out unescorted, despite her vulnerabilities, and she'd disappear for a couple of days and turn up in A&E. This was happening repeatedly. This lady had a diagnosed personality disorder, as a result, it was felt her presentation was behavioural and she was discharged from Foss Park. Whilst in A&E, she began shouting and swearing, so was told to leave and present as homeless at West Offices. "She could have lost both her legs. She is now in a place where, she's very traumatised by what has gone on, she is very mistrustful, very frightened, but she is now doing quite well. It's scary, really scary. Whenever I do this job, I always think; 'that could be me' it is sheer chance, sheer luck. There is real compassion fatigue out there; but what would you do if that was your mother?"

Funding and resources

There were five statements from participants describing their views on a lack of funding and resources within mental health services locally. Funding is a significant issue in the provision of mental health services, particularly crisis support. Lack of funding and challenges in staff recruitment mean that the crisis service is struggling to cope with demand, which puts pressure on other services such as A&E and voluntary community support groups. The cuts to funding over the past decade have been described as 'shocking', and there is a perception that mental health has been neglected in favour of physical health during the pandemic. The lack of funding has also been blamed for inappropriate

referrals and limitations on the work of charities. There is a sense that more funding is needed to provide additional beds and support, and that mental health services require more attention from policymakers.

"A lot of it is about provision and about where the funding is and where it isn't, because everyone has got a huge case load."

"It's funding and the last 10-years of cuts have been shocking."

"More beds needed, if there were more beds this would take pressure off crisis and A&E."

"Funding, or lack of, seems to be used as an excuse to offer nothing."

"We're never going to have enough crisis support, particularly in the last two years, when most of the funding has gone on the physical health and quite rightly so in the pandemic, but now we are realising mental health has been bubbling away in the background, I think that there is an assumption that people are back to normal now, but they are not."

Mental Health Services

There were 19 statements from participants describing their views on broader mental health service issues.
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, which are also facing increased demand. People are calling for a mental health service that is more holistic, similar to the Trieste model. There are also concerns about the lack of services for children, autistic people, and older people.

Many believe that mental health is not given enough priority compared to physical health, and there is a need for better training for professionals to assess and refer mental health patients. There are some positive examples, such as the Papyrus service in the UK and the preventative

approach taken in Scotland. Some suggest that the entire system needs to be overhauled to reduce stigma and improve communication.

"If you look at the Trieste model, which is something that York is trying to bring in, it is that open access to mental health services at the point that the individual thinks that they need it."

"I mean the mental health system is in a mess isn't it?"

"There are many people in absolute crisis with their mental health."

"We do get lots of carers ringing us after they've tried the crisis team and after they've tried lots of others, they've tried GPs, they've tried the crisis team, they've tried the mental health services. Then they ring us, but we are not mental health specialists, we do not know the answer, but we end up dealing with a lot of issues that are far beyond what we should be doing as a voluntary organisation."

"We have very few places to refer them to, we have very little in bed situations in York, we have absolutely very few services for people with eating disorders for example or you know psychosis and things like that."

"I think closing some of the services in York has been particularly detrimental to people. We just don't have that place of safety to refer people into. You can send them to A&E, but they are busy with other things as well as mental health. We just send anyone who's actively injuring themselves or psychosis to A&E."

"So, I think instead of triaging the patient, I think it would be better to have further training in surgeries to make sure that the quality of referrals is correct. It's time, it's a heart sink situation, we're all trained in physical health 100 times over, so if someone comes in with a pain of the stomach we're happy to assess that, we can assess that we've got our referrals we can get that sorted and we know how urgent it is, if someone's talking

about mental health, it's not a 10 minute appointment it takes us a while to dig deep enough to understand how distressed the patient is."

"And it's just like a revolving door, I think with a lot of people is the fact that they're in crisis, because there's a lot of stuff outside their control, whether it's work, housing, you know, difficult family relationships, past trauma. But when we've got them out of immediate crisis, there's no kind of, oh, but they're still in crisis. And we need to work holistically."

"I think mental health, and to be honest care for the elderly, are always bottom of the list. And it continues to be the case. And that's a fact that I think that's because they've got less of a voice and less power and they're easily ignored."

"Somebody said a whole lot of people are finding Papyrus really useful."

"Scotland's very different mental health wise anyway. I mean, it was a while ago, but it seemed like it was very aimed at preventing crisis, rather than in England, where it kind of feels like they wait as long as physically possible and then swoop in at the end."

"In Scotland, I could get treatment. In England, I can't because my BMI is not like dead."

"Scrap the entire system and start over without the intrinsic stigma and assumptions and with improved communication."

"Services for people with autism?"

Police

There were three statements from participants about the police in York. The police in York appear to be involved and well-trained in dealing with mental health crises. It's important for all frontline workers to have an understanding of mental health and be prepared to respond with flexibility and compassion. It's also encouraging to hear that the police are taking

steps to improve their skills and knowledge in this area. Collaborative approaches between different services, such as the police and mental health services, can be effective in providing better care for individuals in crisis.

In response to discussions about the publication of this report North Yorkshire Police offered the following statement to help gain context of their work in crisis care:

North Yorkshire Police, Force Control Room Mental Health Team

The team are mental health clinicians, employed by TEWV and working within the NYP control room. The team are part of the network of mental health crisis service, and work with NYP to help NYP deliver the most appropriate response to mental health crises being reported to police.

Over the last decade, it has been seen that the number of mental health crises to police have increased dramatically. One response has been 'street triage', where a mental health clinician can attend crises with police officers. There is no national model for this type of service, and its application nationally is patchy. The North Yorkshire model now has no street triage, and the clinicians in the control room attempt to meet this demand remotely – as the large geography of North Yorkshire is such a challenge to be able to attend in a timely way.

The aims of the team are to ensure that people presenting to NY Police in mental health crisis receive the most appropriate mental health response in a timely way. They also aim to minimise the number of unnecessary Section 136 MH Act detentions, and reduce mental health demand upon the police, by resolving issues or getting people to the correct place. The team work to their aims by giving advice to police and carrying out mental health triages by telephone.

"The police in York are a lot more understanding and prepared to work with staff than they were 20 years ago around things like mental health. Officers seem to have a bit better knowledge around mental health issues and tend to be a bit more prepared and flexible. They turned up in our old

hostel with an attitude that these are the worst people in the city and we're here to arrest them, or we're not coming. Whereas now they do tend to respond, it does depend upon the individual officer, but we have had one or two circumstances where we have sat down with an officer and said, 'right how can we deal with this?' to get the person the help they need."

"I'm a trainer for this thing called assisted suicide prevention; the police have been sending more people on that, because they're often the frontline for mental health increasingly, you know, think that they've always had to do that stuff. So, it seems to be as if there's a willingness or recognition to improve their own skills."

"First contact was good – police triage involvement, knew her well."

Prevention

There were five statements from participants about the role of prevention in mental health services.

Prevention has been a theme in this research and there is recognition of the importance of prevention in mental health. Early intervention and proactive support can help to prevent people from reaching crisis point and can ultimately lead to better outcomes for individuals and less strain on mental health services. However, there are also challenges around funding and resources for preventative measures, and it can be difficult to shift the focus away from crisis management towards prevention.

Nonetheless, it's encouraging to see that there is a growing awareness of the need for prevention and that there are calls for more investment in low-level support and early intervention services.

"We need things that reduce the likelihood of crisis because people don't just wake up in crisis, it's a build-up."

"Peer support is brilliant, having an avenue there that is pre-crisis, that for me is an obvious thing, be proactive and put something in pace before we get there, then we can alleviate the crisis team."

"Community support should be more preventative and less reactive."

"Going down the road of talking about prevention, and that is an arena that need to be talked about, but that seems quite unfathomably difficult as clearly the funding is problematic around the crisis point, so trying to look at trying to help someone not get to that place in the first place seems like a vastly difficult conversation."

"Preventative/low level NHS support before people's mental health deteriorates to crisis (turning young people away from CAMHS as 'not at risk' is negligent) and means more money/resources down the line."

Reduction in Services

There were three comments concerning a perceived reduction in mental health services.

This perception may result in people not being able to access the care they need. It also increases reliance on the voluntary and community sector, which may not be always be equipped to handle high-level needs.

There was also a feeling that access to emergency support and second-tier support, such as community mental health teams, trauma therapy support, and psychiatry input, have been scaled back. This may leave individuals struggling to manage their mental health conditions without the necessary support and resources.

"With Leeds and York Partnership Trust there seemed to be much more access to crisis support and mental health support in general, even though at that point people said there wasn't enough mental health support. When we're looking at what we've got now, compared to what we had, you can really see that difference in the access to emergency support and also the access to 'second tier' support; access to the

community mental health team, trauma therapy support, psychiatry input, so it's really scaled back."

"I started working with xxxx in 2005 and at that time the access in the 'in' to mental health services seemed to be more there, you had Bootham, I know people had issues with Bootham Hospital, but the services were all there in one place and it felt more accessible."

"Now it is resulting in people needing to complain, making an NHS complaint because they are not getting any help. I think that people thought when TEWV came in that they are supposed to be a mental health trust and obviously you've got projects all over in the North East, so people thought that they would be coming in and improving what was already there rather than stripping it back. It does seem to push a lot of pressure onto the charity sector."

Staff

There were seven comments concerning mental health staff.

Despite negative experiences with mental health crisis care shared as part of this research, many of the participants recognised that there is more of a system issue rather than an issue with individual staff members. It's 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.

Some healthcare professionals who do not work in the crisis team also feel they need more training in knowing where to send people when they are in crisis. This highlights the need for a comprehensive approach to mental health training that extends beyond crisis care teams to all healthcare professionals.

Many individuals working in the system go above and beyond to provide support to those in crisis. However, some feel that the level of support for

workers is very low, and more support is needed to prevent burnout and ensure staff can provide the best possible care.

Some felt that there were not enough trained people to deal with mental health issues and that there is a lack of support for individuals who need it. This highlights problems around recruitment and the need for increased resources and funding to address the mental health crisis and ensure that individuals can receive the care and support they need when they need it.

"The majority of feedback that I have had about individuals within the system has been amazing, some of the examples I've heard of how support workers are absolutely… they have done everything and put aside their own time to help people has been extraordinary, so it feels like such systems are full of wonderful human beings, but as soon as you look at it from a system level it becomes problematic. It is almost like you want to say to people, please don't take this personally, this is the system's problem not you, you are awesome."

"I've probably had as many tears from people working within the system as I have from people trying to access the system. I think the level of support for workers is very low, so sometimes there is peer support and sometimes a telephone line and occasionally people have access to professional support for an hour or so, but generally the support is very low."

"The root of the problem is that there are not enough trained people to deal with this. There is a public narrative around talking more about mental health, which is a good thing, but there is nothing to support people when they do."

"We had a case here; he said: 'this is my last day here and if I don't get help this is what I'm going to do' and for somebody who's not trained or not clinical to make that decision is very difficult. More training or more intermediate support would have been much better."

“It’s difficult with the social prescribing because we are supposed to be working with people with mild to moderate mental health problems, but there are people coming through that are more severe and I’m finding that, even though it’s not part of the role, I am having to draw on some of my mental health nurse training, un-officially really. I think I would struggle a lot more if I hadn't had that training, I really would, so I feel for people on the social prescribing team who haven’t had a lot of mental health training.”

“A lot of pressure on staff and we could earn more without this stress.”

“We’re all concerned, you’ve always had that case where it was a patient that you didn't think was severe or something like that but, ultimately, we did something and we’ve all had that situation where you’ve got someone sitting there going ‘oh we’ll be alright’ and then a few days later you hear that they’ve, you know. So, I think it's also that fear and how comfortable you are at saying, well off you go now.”

TEWV

There were 13 comments concerning mental health staff.

TEWV (Tees, Esk and Wear Valleys NHS Foundation Trust) was criticised by many participants for becoming less person-centred and overly focused on discharge and processes, often making assumptions about patients that limit access to support.

Some staff members have also expressed frustration with TEWV's standardised and model line approach, which they feel limits their creativity in working with patients. Some patients have been hopeful for change but remain sceptical, citing broken promises.

However, some have been optimistic about recent investments in funding for early intervention and support, which they hope will have a positive impact on reducing demand. TEWV's approach is to show patients that they have a choice in their recovery, which may be well-intentioned but

may not be suitable for all patients. Patients have expressed frustration with the difficulty of making complaints and accessing support, with some feeling that TEWV actively ignores their concerns.

"I was working with the xxxx team when TEWV took over from the Leeds and York Partnership Trust (LYPT), there were quite a lot of staff that left because they were unhappy with the changes. But it felt to me that the way TEWV worked with model lines and very systematic way of working, as a member of staff you lost that creativity that you could have with patients because everything had to be done in a certain way, it was very standardised; a certain staying 'well plan' had to be done and at each meeting in the morning you'd have to say what you did with the client the day before and how you'd moved them forward on the pathway, so it was very much about moving people forward in the process and then discharging, whereas before with LYPFT you felt like you had more creativity and more space, so you could have an appointment with somebody and the goal could be 'building therapeutic relationships', but therapeutic relations wasn't one of the processes, so it kind of, to me, it felt like that was being removed and in my nurse training the big part of mental health nurse training is that the therapeutic relationship is absolutely key, but the reality I found with TEWV is that is hard because you just don't have that time and the pressure is on targets, processes and 'moving people on'. So, it feels very different to what I thought I was signing up for when I trained to be a mental health nurse."

"One of the positive things for my team is, we've recently got some funding in from TEWV and the CCG which comes from a pot of funding called alternatives to crisis care. Where they are looking to invest in early intervention and upstream support for people, to prevent them from getting to the point where they are in crisis and keep people well. They've recognised that we work with so many people in the community, supporting them with their mental health and that has had a bit of an impact on reducing that demand. So, we've been given a little bit of funding to increase the capacity of our team. That's like really positive partnership working."

“A general theme is making a lot of assumptions about people very quickly and often that assumption means they’re not gonna give them any support. I don’t know if they work that way because they are under-resourced.”

“They don’t want people to become what they call a career patient, a revolving door patient, and this becomes their entire life. They want to show them that they can be their own heroes, they can save themselves, they do have a choice, you don’t actually have to cut your wrist, you could do something else instead, you could treat yourself with kindness, you could stop hurting yourself because you deserve better than that. The theory of it is great, it’s coming from a place of good intention, but some people with certain conditions, things like Emotional Intelligence, <without> social support, family support, some people don’t have that. There is a massive assumption there.”

“Some people might always need that support worker and that’s ok. Let’s be realistic about that and don’t pretend these people don’t exist.”

"I keep hearing things, you know, 'we're on a roadmap to improvement', but this has been almost a year of watching in quite some detail a system that feels like it's getting worse."

“I’ve had some serious situations with my son (complaint level) - when my son is in crisis, he has to come first. I don’t have time to write letters etc.”

“It's very difficult to make a complaint - I do not have time or energy due to my caring role. If I do then nothing comes of it, and the procedure doesn’t work.”

“During the day you’re supposed to ring your team’s duty worker but this is a voicemail.”

“You have capacity – it's up to you – you have choice.”

"TEWV took on care but openly actively ignored Retreat plans."

"Package of care – funded with old home team 1% and TEWV ongoing – agreed – nothing happened."

"Notes not accurate, information missing, discrepancies between experience and what's written."

The Haven

There were six comments about The Haven.

There is support for The Haven (which offers mental health support to anyone aged 16 or over in York) as it provides a valuable service that is not necessarily offered by crisis care. People feel that the Haven provides a place where they can be heard and listened to, which is not always the case with crisis care services.

The accessibility and drop-in nature of the Haven/hub model is also appreciated, as it promotes community support and a more preventative approach to mental health care, rather than a reactive one.

Some people are even suggesting that the community mental health hub model should be the way forward for mental health care services. However, there are also some concerns about whether the community mental health hub is simply filling gaps in the current system, rather than fundamentally changing it.

"The Haven provides something that crisis teams can't provide, which is both a place and people to listen, I don't think crisis is there to listen, they are there to respond."

"We've got the Haven that you can go to in the evening and we've got a 'staying safe number' so we've got Samaritans and support like that."

“Crisis team should not really be signposting to the Haven without assessing the safety of the client/patient. Haven is not designed for or have capacity for very high risk.”

"The Haven/hub model was good, and this was because it was accessible and you could just drop in."

“Mental Health Hub - <we need> everyone to buy into this and TEWV to put emphasis on this being the new way forward.”

“Community Mental Health Hub, what will this achieve? Is it gap filling?”

Waiting Lists

There were 11 comments about waiting lists for mental health services. 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.

“The GP is often the place that people refer to, but can you get hold of a GP when you need it? Certainly not, or you can book in something in two weeks’ time.”

“The waiting time for mental health care through a doctor is another bit of gatekeeping.”

“I’ve just walked in having built up the courage to ask for help and I’m told, actually you’re not that important, come back three weeks on Thursday.”

“Someone told me it was 18 weeks before they can get onto the first rung of potential mental health support, which is far too long if you’re struggling.”

“Getting some kind of aftercare from the mental health service takes 12 weeks, this seems to be a bit of a standard timeframe, but still that is not enough.”

“Initially on the call <to the access team> the person said, ‘it is a 20 week waiting list’, but then she said ‘it is urgent’, and I said yes ‘I think it is’. So I hung up and five minutes later I was called up by a consultant.”

“Waiting lists have always been a problem, but they seem to be getting worse. Often when you need help you need it soon, not in six months or a year's time, that’s no good really.”

“I’ve certainly had; ‘come back and see us in three weeks on Thursday’, so is that the help? ‘What do I do between now and three weeks on Thursday?’ ‘Well, you just have to manage’, and that has been quite consistent. I might be in deeper trouble by the time I get to you, or I might not get to you because I’ll think, you know, ‘I’ve had enough’. I have actually considered taking my own life.”

"I don’t think that people who don’t have a mental illness or condition realise how long that two or three weeks or months actually is, and very sadly some people don’t make it to that time, because they make a different choice which we know very sadly does happen."

“They’ve been promised that they’ll have an appointment within a week, but a week is a long time when you’re in a mental health crisis.”

“We’re creating more mental health crises, the system can’t cope with what we’ve got anyway and then we’ve got a backlog of waiting lists, creating even more for the crisis team which is already snowed under.”

Case Studies

Case study of a person admitted to A&E in York Hospital after a suicide attempt.

My neighbour had found me and called the ambulance to get me to hospital. The usual long wait in A&E. Eventually I got seen to. While the doctor was stitching my wrists up, my hands, the crisis team turned up.

<The> attitude was that 'it's another who's tried again' - I overheard <them> talking to the nurses and the doctor stitching my arms. Then s/he went off. After a while s/he came back and shoved a leaflet in my hand and said, 'we're going to discharge you, and if you have any problems, ring the crisis line'.

It didn't matter what their personal thoughts were, they should have been more caring, not as abrupt and taken more time to see whether I was fit or not. <Assess> when can I go home, keep me for a few hours or a day. <It was> just the pure bluntness, I felt like saying 'do you treat all your patients like this?'

I had lost that much blood I could hardly walk, and I was trying to tell them I wasn't well. But that chap seemed to give me the all clear, that I was capable of managing at home. Even the taxi driver got a wheelchair for me and said; 'I want to wheel you back straight to A&E; you're not fit'.

Nothing happened <after the taxi took me home>, it was just; 'go down to your doctor and get your dressings changed the next day'. I cleaned up some of the blood as best I could and slept on the spare bed.

I rang the crisis line and tried to explain what happened. Someone was supposed to come and see me. I explained I needed someone to

come and see me as soon as possible. By dinner time they turned up. They were a right nice couple. They were doing their best to get me round but slowly I was drifting away.

Then eventually, by 9pm, an ambulance had turned up and they wheelchaired me downstairs. I told them what had happened and they said I shouldn't have been sent home. They were in two minds whether to take me to A&E or to Foss Park. This just isn't the way you want things; they swan in 'I'm from the crisis liaison team' and looked at me as if to say it was my fault because I tried to finish it.

I got to Foss Park and they put me on xxxx ward. The following day / evening, they wanted to weigh me and measure my height. I don't know how I got to the end of the corridor, but they didn't have any wheelchairs to wheel me. A hospital without wheelchairs!

I was as white as a sheet and my blood pressure was 70. On the way back, I collapsed and they called an ambulance and rushed me to A&E. I could hear the ambulance staff asking why they had let me out. They were really nice. I remember the crisis team were in and out, on the phone trying to sort things out. They were really good. I can't remember a wrong word. They were really supportive trying to find somewhere for me to go.

<I spent> three days in the hospital and then back to Foss Park.

Case Study of a person's experiences in Foss Park Hospital and another psychiatric hospital

I had an assessment and then the doctors wanted another one done, because he said, 'he might be alright to stay in the community'. I had another meeting and turned up at Foss Park just thinking it was like another one-to-one, and my mentor was there, his boss and six other people, and I wasn't kind

of prepared for it. And then it was in that meeting, it was kind of said 'I'm off to hospital'.

I remember the assessment, but the sessions I'd had before was like a one-to-one. So, I turned up and I'm like <makes surprised face>, I went to the toilet and came back out and there were even more, so it was a bit daunting really. I went out for ten minutes and basically I had a choice to go voluntary and they kind of let me go home of my own accord, so I just went to my car, they didn't really check, I could have easily gone and done something, I left and went to the car, but then because of the fact that I was going to hospital, in that moment I was quite impulsive.

Well, I left and went home, it was a bit of a rush around and said, look, we'll come and check on you. And then it could be tomorrow. It could possibly be Scarborough or whatever, shouldn't be far away. Then on Saturday morning they rang and the woman said 'you're off to xxxx' <a city over 200 miles away>. I got picked up at 12 and taken <there>.

I was in xxxx for three and a half, four weeks and then I got moved back to York for like a week and a half and then I had two sessions with the home-based treatment team and then back to the community team. Then they sent me to the early intervention and psychosis team. And then they've just sent me back last week to the community team again. So, it's like change of a lot of personnel.

The whole hospitals palaver was quite weird, because it didn't really get explained. So for example, when I got to xxxx, they took all my bags sat me in a room, and it was all because it was the weekend, I literally got left in my same clothes and they said we're leaving your jogging bottoms with string in it, you can have your phone, but no one explains anything. I hadn't even been given a toothbrush. It was a good 24 hours after that I actually got my belongings back, because obviously they note everything down that you've got belongings wise.

I kind of just stood in that in a kind of communal kitchen area where you learn a lot more stuff. It's like being in prison you just kind of pick up on the routine and what you can and can't do, but it's not explained. And then I came to York and York was completely different. I was allowed my razor, my charger and stuff like that. It's odd because you go and sit outside and then staff will come and bug you, for like, 'why are you sat there? Come inside', but then they wouldn't do that if you're just sat your room. So, it's a bit like 'I can't do right or wrong' sometimes. I think a lot of it is just explaining, it's like moving teams and stuff, it isn't really explained what's happening.

I got transferred back to York and it was completely different because the rules were different. I got a leaflet at least when I got into York. But then it felt weird trying to sign out and stuff because again, it was different because you got a strip search every time, but in York it was a bit like they just let you in. I could have brought something in to be honest. I sat in my room, but a lot of people, it put them on edge and seemed a bit more erratic when I got to the York, and one time some lad had a fight and ran off and come back with some sort of wood. I could have easily snuck something in as a protective weapon if I felt that way, not that I would. It seemed extreme at the time in xxxx, like the whole like checking, but you could see when you got to York it's for the right reason.

Case study of a family's experience of crisis support

Woman raised concerns about failure to provide care for people with autism. Son has twice had an autism diagnosis. The family had to pay to go through Tuke Centre diagnosis after initial diagnosis from Sheffield was taken off him. He was in Willow Tree House in Haxby before the pandemic. Family were told he needed to be discharged to home during the pandemic. Family

were assured care would be put in place, but essentially no care was provided.

Autism Plus were meant to be involved so he could live in the community. There was no care plan in place, no structure, no meaningful activities, no routine. Son relies on structure to get through the day and manage anxiety. Did get him independent housing, but still no care - two years four months without real support. Son believed someone was going to kill him. Family believe this is all linked to his anxiety.

He ran away, got on a bus then a train. Family kept calling, eventually tracked him to a nearby town. Police kept an eye out, but family had to pay for a taxi at 3am to fetch him home. Called crisis team, they said they'd see him in a few days. He ran away again twice in that time. Family by now gravely concerned. Took him to Foss Park for help. He didn't want to go in, so TEWV contacted police for assistance. Three cars turned up with lights flashing. Son screaming as carried in. Family feel this was more traumatic than needed to be.

Still no structure on ward. Family felt the ward was not a sensory sensitive environment. Local authority now saying he doesn't need night care when he's discharged. But he doesn't take his medication if someone doesn't tell him to before bed. He has run away three times and is in a worse place than ever. Family feel no-one listens until there is a carer breakdown, they are otherwise expected to just keep it all going. No one is involving them.

Family has a Health and Wellbeing Power of Attorney in place, but TEWV staff keep discussing whether he has capacity, and not involving the family in discussions. Invited them to a meeting that started at 11am, family brought in at 11.30am but no one would tell them what was decided and the meeting was over. Family feel that "autistic people should not be in hospital"; that "there is no autism service in York"; and

that when it comes to crisis care "nothing happens till you get the police involved." They also feel "there is no integration - the local authority let things get bad enough for health to pick up the problem and the tab."

Case study of seeking help from the Crisis Team in York

In early 2022 he went into crisis in York. The crisis team came round, and he had an assessment with a psychiatrist. In the next few days he had multiple visits from the crisis team but did not find them to be very useful. The crisis team was not able to deal with the fact that he was also physically disabled. Being in mental health crisis pushes him into physical health crisis due to increased stress on the system. But the crisis team's response to him being in bed wanting to hurt himself was to tell him to get up and go for a walk. Their response to him saying that he was not capable of this was "Oh well now you're just being difficult."

The psychiatrist came back a few days later with a completely changed manner. The psychiatrist told him that he was a drug addict and that he had a personality disorder – neither of which were true. The psychiatrist claimed that he was addicted to diazepam which he had been put on whilst hospitalised in xxxx and he had never used it outside of what he had been prescribed. However, the psychiatrist claimed that since he had been on it for a year, he must be addicted despite him not displaying any signs of dependency. The psychiatrist also claimed that he had emotionally unstable personality disorder because he had self-harmed since childhood – which he hadn't.

Psychiatrist informed him that he would be taken off diazepam in two weeks despite guidance saying that if you have been on diazepam for over a year you should be taken off slowly.

He has PTSD from a previous situation where he couldn't get emergency treatment that he needed when he was very ill – this situation was identical as he was in a life-threatening situation and being refused medical care.

The psychiatrist then told him that he did not have PTSD.

"I just felt like I'd been run over by a train."

Psychiatrist didn't listen to him or his parents when they told him that he didn't have emotionally unstable personality disorder.

After that he stopped eating and drinking - "I was just broken."

Crisis team didn't believe that he wasn't eating or drinking they thought he was just after attention.

xxxx from the crisis team was kind and was able to get him to drink something.

Crisis team was a culture shock from xxxx as they treated him without empathy or professionality; they did not seem to know what they were doing.

He feels like the personality disorder is to deny him help; he requested a second opinion and was told he would get one at CMHT.

He also went to the psychiatrist to try and convince him with reasons that he did not fit the criteria for PD – the psychiatrist said that he would withdraw the diagnosis but a year later he requested to see his medical notes which say that the psychiatrist only said that he would withdraw the diagnosis to preserve the therapeutic relationship and all subsequent interactions with the crisis team still included the PD diagnosis.

In Autumn 2022 things got bad again and his care coordinator referred him to the crisis team, but the crisis team just thought that he was after drugs and attention.

CMHT did not work with the PD and drug addiction diagnoses; they use the correct diagnoses of PTSD and autism.

CMHT recommended a couple of days of diazepam but the crisis team refused as they believed that he was a drug addict – this triggered a sever dissociative episode.

This led to attempting xxxxxx, he was helped passers-by; they gave him a lift to A&E.

Psychiatric liaison in A&E made his father leave the room against his wishes and then told him that he was just after drugs and that there was nothing wrong with him. The psychiatric liaison didn't ask what happened or how he was.

The psychiatric liaison had security escort him out without warning – this made him extremely distressed and A&E doctors were confused about why liaison had left.

Chucked out onto the street and his father took him home in a taxi.

The next day he told his parents that he was planning on killing himself and that there was no point in contacting the crisis team as they wouldn't believe them. He didn't kill himself at the weekend and on the Monday his parents were able to get in touch with his care coordinator and he was voluntarily admitted to Foss Park.

Foss Park was good until they accessed the notes which had his PD diagnosis – psychiatrist's notes from Foss Park said that the hospitalisation would not help; this was before s/he had even met him.

He discharged himself from Foss Park after one week – they ignored his physical disability and said he was a drug addict.

He needed diazepam which his GP had given him for emergencies to help with physical pain caused by phycological stress. Foss Park said he could only use it for one day even though when you reduce diazepam when in crisis he becomes physically very ill.

Three days later he couldn't get out of bed so he could not eat for two days until a healthcare assistant came with some stew.

Healthcare assistant told him to talk to the nurses as he wanted to kill himself, but the nurses told him he was just a drug addict.

This led him to throw his bowl out of the door which ended up shattering windows; then he went "to pieces" and huddled in his bathroom but he was told that the doctors had said not to give him anything because he is an addict and just wants attention, so they left him in the dark and screaming and nobody came. He still can't sleep with the lights off.

Very few staff there the next day as it was the Queen's funeral, and he was easily able to discharge himself and the doctor said there were no concerns with very few questions asked.

His friend kept him alive until the arrival of the CMHT care coordinator.

In early 2023 – care coordinator set up a crisis plan that did not involve the crisis team – CMHT psychiatrist tested him formally for substance dependency and he did not meet the criteria – notes now say that he

used to be an addict even though he never has but the new psychiatrist cannot change anything retrospectively.

CMHT has never gone down the PD or addict line but have also never given treatment for PTSD – psychologist for PTSD left and there has been no replacement.

Crisis plan without crisis team was set up which included an emergency drug kit and the Haven, but the GP refused to prescribe this emergency kit. The emergency kit including the Haven had been set up by his care coordinator who subsequently left and the new one did not seem to care.

A bad appointment with CMHT where he was told that he would not get emergency kit or PTSD psychologist led to a dissociative state – he tried to leave the building but didn't manage and ended up throwing chairs around reception – care coordinator told him just to get out despite knowing that this was a PTSD trigger which mean that he "lost the plot entirely".

CMHT staff called the police, and the police were brilliant – "they were absolutely fantastic; I cannot speak highly enough of them. The police know that you cannot rely on the crisis team." Staff at CMHT were useless at de-escalating his crisis, they just stood around.

The police knew exactly what to do, they told him they wouldn't leave him and sat in the van and listened to him. They told CMHT to do their jobs and helped mediate.

With mediation by police, the CMHT manager then agreed to contact the GP to try and sort out emergency meds kit and to try and sort out the replacement psychologist.

He felt that it was hopeless and no one would help him because they just think he's an attention seeking drug addict, so he made plans to attempt suicide. He texted his friend to say goodbye and fortunately they worked out where he would be. A police search party was sent out and he was found in Whitby.

He was taken to Scarborough Hospital – the crisis team there was amazing and really compassionate. They understood that he was going through a terrible time; the policeman who found him in Whitby was also amazing.

Everyone at Scarborough was amazing until he spoke to a psychiatrist who had seen his notes. This psychiatrist told him to go home as he was low risk but the rest of the staff did not think he was safe to drive so they put him in a taxi.

York crisis team aren't providing a crisis service they are making crises worse; he has not been able to work since his first interaction with the crisis team.

Participant recommendations

During the interviews participants identified how the system could work better for them. This included:

Recommendation	Made to
Increased provision of preventative care so that fewer people end up in crisis in the first place	York Health and Care Partnership / York Health and Wellbeing Board
Lower level support; decrease the threshold for support so that people don't have to end up in crisis before they get support	York Health and Care Partnership / Tees Esk and Wear Valleys NHS Foundation Trust
Improved follow up after discharge or after calling the crisis line so that crisis is not a revolving door and people do not repeatedly find themselves in crisis	Tees Esk and Wear Valleys NHS Foundation Trust
Strengthening the crisis line alongside promoting the second line for those who need support but are not in crisis	York Health and Care Partnership / Tees Esk and Wear Valleys NHS Foundation Trust
Clarify what constitutes 'crisis' for both service users and professionals.	Tees Esk and Wear Valleys NHS Foundation Trust

Recommendations

Recommendation	Made to
Reinstate and strengthen the Mental Health Crisis Care Concordat to clarify care pathways, provide clear minimum performance standards for all those working in services, and make sure members of the public can access the right help and support at the right time delivered by appropriately trained professionals.	NYP, TEWV, CYC, Y&SHNHSFT, voluntary sector partners, YAS
Review existing resources, support services and gaps in the pathway and identify the most effective ways to deliver support and fill gaps, including those best provided by the VCSE sector.	YHCP, TEWV, CYC
Restructure approaches to coproduction to make sure everyone's views and experiences are heard and influence service design and delivery. This must include working with external partners to facilitate involvement for those who cannot engage directly. Consideration must be made of the resource implications for VCSE organisations to make this possible.	TEWV
Learn from schemes improving people's experiences of crisis response / changing the system to identify ways to invest in and maintain those that work (for example, the positive feedback about police street support).	YHCPEC / MHCCC
Make sure workforce plans reflect the specific challenges for attracting health and care staff to York (including lack of affordable housing, transport). Work together locally to learn from historical examples such as the Rowntree Housing model and how this fits with Local Plans.	HNY ICB

Embed a compassionate culture towards all people experiencing mental ill health.	YHCPEC / YHWB

Initial response from TEWV

Tees, Esk and Wear Valleys
NHS Foundation Trust

It's incredibly important that we listen and act upon people's experiences. This will help us, along with our partners, to drive forward improvements and make sure that everyone receives safe and kind care.

In common with elsewhere in the UK, there continues to be an unprecedented demand for mental health services. In 2021/22 we received 267,150 calls to our crisis lines across our trust geography, which was a 12.5% increase on the previous year.

We're absolutely committed to providing a better experience for people in our care and there is a great deal of work underway to improve crisis services, as well as preventative care in York.

This includes:

· Our crisis response and home treatment team in City of York and Selby which supports people to continue to live at home in their local communities. The team also help people during times of crisis to keep them safe. They are available 24 hours a day, 7 days a week.

· First contact mental health workers, introduced through the Community Mental Health Transformation programme, to support people in the community. This is part of primary care, proving early mental health support to reduce need for crisis or secondary care.

· The launch of mental health hubs in City of York and North Yorkshire, the first of which is now open in Clarence Street, York. This has been done in partnership and provides a range of social and health support to in a local accessible hub which is easily accessible and provides ongoing support when people need it.

· Mental health team presence within the police force control room supporting an increased number of frontline police officers where there is a mental health need.

· Working in partnership with the third sector we've increased telephone response to the all age mental health support and crisis line. This has resulted in a wider range of support and increased response rate to people across City of York and North Yorkshire.

· Joint working with City of York Council to support the homeless and the provision of bespoke mental health housing.

Whilst we know there is more to do, we have continued to make significant progress and over the last year we have put patients, carers and families at the heart of the way we plan and deliver care.

Conclusion

Our aim in doing this work was threefold:

1. To provide a voice to those who feel unheard in the current system.
2. To understand what crisis care can feel like for those individuals as well as the carers and organisations who try to help them.
3. To identify what people think would improve the support available.

This is not an easy report to read, and in truth has not been an easy report to write. We have, throughout, been mindful of the need to honour the experiences of those who trusted us to hear them. Some of these experiences are historical, but it is clear through our conversations that these poor experiences live long in the memory.

We subtitled this report 'a recent history' very deliberately. Because we want to help play a role in shaping the future, we believe that the best way to do that is in partnership with those experiencing mental ill-health and the system that is trying to help them. Our experience in peer research has reminded us that before you can start to work together on what comes next, you need to capture the experiences people live through – in essence, people need to get this stuff off their chests, and feel listened to and validated when they do. We hope this report can help capture their truth, and allow us all to draw a line under what has happened and begin to focus on what comes next. We are committed to helping make that happen.

No one individual or organisation can make that change. This has to be a partnership effort. Those responsible for buying health and care services must continue to invest in the transformation of community mental health services. Those helping plan our future workforce must address the challenges that stop people wanting to work in health

and social care. Those delivering services must work together to make sure people can access the right help at the right time.

There are many seeds of hope for a better future in York. The Connecting our City project has given us a shared vision for community mental health services. Coproduction has been an underpinning principle of all Connecting our City work. Inspired by Trieste's model, we are working to create a new approach here in our city. This includes:

- the introduction of new support services for people with eating disorders
- better multi agency support planning on leaving Foss Park hospital through Pathway to Support
- the creation of community mental health hubs with multiple partners providing a range of support.

Our major provider of statutory mental health services, TEWV, has also been working on its own transformation, with significant changes to its senior leadership and a commitment to a 'journey to change' and investment in increasing the role and understanding of lived experience within the organisation. TEWV has already identified significant areas for improvement including in crisis care.

In Primary Care, we are seeing an increase in mental health support roles. These aim to provide earlier access to help and prevent people's mental health deteriorating, as well as providing support for those being discharged from mental health hospitals.

There are renewed commitments to improving mental health within York's refreshed Joint Health and Well-being Strategy and from York Health and Care Partnership.

We understand how difficult this report is to read, and we are mindful of the impact on existing staff, and the potential impact on those who may be considering a health and care role. We must say again thank you to all those working in services who worked with us on the report. Making life harder for anyone working in services is not our intention. We want to say very clearly that we do not believe this report highlights a people problem, but a system issue. One quote from our report sums this up best:

"The majority of feedback that I have had about individuals within the system has been amazing, some of the examples I've heard about support workers are absolutely incredible.... They have done everything and put aside their own time to help people. It has been extraordinary, so it feels like such systems are full of wonderful human beings. But as soon as you look at it from a system level it becomes problematic. It is almost like you want to say to people, please don't take this personally, this is the system's problem not you, you are presumably awesome"

We hope that this report can be a further catalyst for the partnership work to improve mental health support in the city.

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