healthwatch Bath and North East Somerset

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From Crisis to Care: Strengthening self-harm support pathways in B&NES

Neighbourhood health and wellbeing insights – July 2026

Contents

Trigger warning

This report contains real stories and experiences from young people who have self-harmed and carers who have supported young people through difficult times. Anonymous quotes are used to highlight these experiences pertaining to seeking support for self-harm and mental health. While these quotes and paraphrased stories serve to represent real life experiences in their full colours, we recognise that this report could be hard to read.

Executive summary

People with lived experience of self-harm, carers, and professionals told us about the barriers that people face when trying to access care.

Access to support for people who self-harm in Bath and North East Somerset is often described as confusing and emotionally taxing.

Barriers to timely and compassionate care were reported to us as including long waiting times, inconsistent information about the services and organisations that may be able to support people, and the need for those who self-harm and their loved ones to advocate for themselves in order to receive support.

In some cases, individuals reported that they only received support for self-harm once they were in crisis, e.g. attending A&E for their injuries or attempting suicide.

While signposting is common, we were told that meaningful treatment is harder to access, particularly after age 18, where a clear 'cliff edge' into adult services is experienced.

Once a person receives support, experiences vary widely. Some have a positive experience, with continuity of care, flexibility, and an understanding of individual needs. Others have a negative experience, having to navigate different services, poor communication, and support that isn't right for them.

Carers also report feeling unsupported. They describe a lack of communication, clarity, and involvement during critical periods, particularly when services do not have the capacity to offer timely support where carers describe feeling like the burden falls on them.

Project aim

The aim of this research is to identify and address gaps in self-harm support services in B&NES in order to enable improved access and outcomes for individuals at risk, with a specific focus on children and young people. Proposed deliverables include mapping available services (from prevention to crisis), gathering perspectives from service staff and people with lived experience, identifying barriers to access.

In this context, the aim of this report is to:

- **Set out the local problem** of high levels of self-harm in B&NES and the populations most affected, drawing on available data and needs assessment evidence
- **Describe the availability of support**, including known pressures and challenges across referral pathways and service thresholds
- **Bring forward the lived experience and stakeholder perspective** on what helps, what hinders, and what gaps persist in the current system of support
- **Support partners to identify actionable improvements**—particularly those that strengthen early access, reduce avoidable escalation, and ensure that services are reachable and responsive for the groups experiencing the highest self-harm burden locally.

Co-produced recommendations

These recommendations set out the key changes required to improve access to, and experience of, self-harm support for young people in B&NES. They focus on strengthening pathways, enabling earlier support, improving continuity, and ensuring services are responsive to individual needs.

1. Improve access and navigation across the system

Outcome:

Young people and carers can easily find and access the right support first time.

Priority actions:

- Publish a single, public, visual directory of mental health and self-harm services, including referral routes, eligibility and waiting times
- Agree and maintain shared referral criteria and thresholds across services
- Introduce warm handovers at key points as standard between services (no signposting without onward contact)
- An "all doors are good doors" approach, so that every entry point can provide clear guidance and appropriate onward support.
- Improve information-sharing agreements so young people do not have to repeatedly retell their history. Strengthen mental health navigation support within primary care and community settings

Lead: ICB / Single Point of Access
Key partners: Primary care, CAMHS, AWP, school services, voluntary sector, further education providers
Addresses: Confusing pathways; fragmentation; poor coordination

2. Strengthen early help and prevention

Outcome:

Young people can access support early, before needs escalate.

Priority actions:

- Ensure consistent access to school-based counselling and trusted adults
- Ensure self-harm is recognised as a meaningful indicator of need, not dismissed
- Increase capacity of Mental Health Support Teams
- Increase awareness of the School Aged Health Service offer
- Expand community-based early help, including safe spaces and peer support
- Provide clear, age-appropriate information on mental health and self-harm in education settings
- Deliver trauma-informed training for staff across schools, primary care and community services
- Provide training for school staff on responding proportionately to self-harm (avoiding both dismissal and unnecessary A&E referrals)
- Improve responses to early disclosures, ensuring young people are taken seriously

Lead: Local Authority (Education / Early Help)
Key partners: Schools, MHSTs, School Aged Health, primary care, voluntary sector, further education providers
Addresses: Late intervention; gaps in early support; escalation to crisis

3. Ensure support while waiting ("waiting well")

Outcome:

Young people and carers receive consistent support while waiting for services.

Priority actions:

- Introduce or strengthen regular proactive check-ins for those on waiting lists, building on the approaches already used by some services Provide clear information on waiting times, next steps, and escalation routes
- Expand "waiting well" support, including emotional, practical and non-verbal support options
- Expand structured support for parents and carers, including guidance on risk and self-harm
- Provide a named point of contact wherever possible

Lead: Mental health providers
Key partners: Secondary care, school services, further education providers, voluntary sector
Addresses: Long waiting times; lack of interim support; carers holding risk

4. Improve crisis and post-crisis support

Outcome:

Young people receive timely, appropriate and relational support during and after crisis.

Priority actions:

- Develop alternatives to A&E, including crisis hubs and safe spaces
- Ensure routine follow-up after self-harm episodes or hospital attendance
- Strengthen crisis follow-up services and "bridge roles" to support transition into community care
- Improve out-of-hours advice and support for families

Lead: ICB / Commissioners
Key partners: Acute trusts, CAMHS, AWP, voluntary sector, local authority
Addresses: Crisis-driven access; gaps after discharge; reliance on A&E

5. Improve continuity of care and transitions

Outcome:

Young people experience support as stable, joined-up and relational.

Priority actions:

- Enable continuity of support from the same practitioner wherever possible
- Move towards flexible, longer-term support models beyond fixed-session approaches
- Strengthen transition planning between CAMHS and adult services, including clear routes to alternative adult support
- Ensure young people not meeting adult thresholds are not left without support
- Involve carers in transition, communication and safety planning where appropriate and with consent
- Introduce a step-down support offer to provide continued, lower-intensity follow-up for young people who disengage from specialist servicesImprove multi-agency coordination across services

Lead: CAMHS and Adult Mental Health Services
Key partners: Voluntary sector, further education providers, local authority, primary care
Addresses: Fragmentation; short-term interventions; transition "cliff edge"

6. Ensure support is tailored and inclusive

Outcome:

Support is responsive to individual needs, including neurodivergent and LGBTQ+ young people.

Priority actions:

- Improve practitioner confidence and training in neurodivergent and LGBTQ+ inclusive practice
- Adapt therapeutic approaches and environments to meet diverse needs
- Avoid over-attributing distress to identity alone, ensuring holistic understanding
- Involve young people and carers in service design and improvement
- Strengthen pathways for young people with complex or intersecting needs

Lead: Mental health providers and acute trusts
Key partners: ICB, education providers
Addresses: Mismatch between needs and provision; inequities in access and outcomes

Top priorities for action

1. Create clear, coordinated access pathways with warm handovers Introduce and expand consistent support while waiting to reduce risk escalation and disengagement.
2. Develop alternatives to A&E for crisis care.

Improve continuity of care and adapt support for neurodivergent and LGBTQ+ young people Strengthen early intervention and preventative support in schools, colleges, universities and community settings.

Introduction

Children and young people's mental health is a significant and growing concern in Bath and North East Somerset (B&NES). Self-harm is a key indicator of distress and unmet need, and local data consistently signals that B&NES as well as Swindon and Wiltshire (BSW) footprint experiences higher rates of hospitalisation for intentional self-harm than England overall. In B&NES specifically, rates of hospitalisation for intentional self-harm in 2023/24 was 235 per 100,000 population compared with 117.0 per 100,000 for England.

Local data from the Royal United Hospital also points to particular populations being disproportionately represented in high self-harm numbers and self-harm-related admissions. These patterns matter because improving access is not only about increasing capacity overall, but also about ensuring pathways and support models work for the groups at highest risk and those facing the greatest barriers.

Across B&NES, the people that are more likely to be admitted to hospital for self-harm are young females, people in more deprived communities, people with learning disabilities, neurodiversity, and those ranging 10-29 years. This reinforces that work to improve access should consider both universal and targeted approaches, so that the pathways intended to help are reaching those at highest risk and those living with overlapping vulnerabilities (including deprivation, disability, and co-occurring mental health needs).

Alongside high levels of self-harm, the wider system picture suggests significant pressure across referral routes, specialist services, and early intervention provision. According to the latest B&NES Wellbeing & Mental Health Needs from 2022, referrals to CAMHS have increased and waiting times have risen; locally, around 1 in 3 referrals are described as "not appropriate" for CAMHS support (not deemed a mental health issue after initial discussion). Referrals to Mental Health

Support Teams (MHSTs) working with school children are also reported to have doubled in the last year, signalling increasing reliance on school-linked support as demand rises.

Despite a clear strategic focus on reducing self-harm across BSW, there remains limited understanding of how accessible support is in practice for children and young people in B&NES. While data highlights high levels of need and system pressure, it does not fully capture how pathways are experienced or where they break down for those trying to access help. Feedback from local partners also suggests that barriers to access, thresholds, and variability between services are ongoing challenges. This gap between how the system is intended to function and how it is experienced in reality is a key reason for undertaking this work, with a particular focus on understanding access, identifying gaps, and highlighting opportunities for improvement.

Service providers commonly described self-harm as a coping mechanism or symptom of underlying mental health difficulties. Within this framing, support is generally oriented towards addressing the root causes - such as trauma or broader emotional distress - rather than the self-harm behaviour itself. Providers also noted that, unlike areas such as drug and alcohol use or eating disorders, B&NES does not have a dedicated self-harm service. Consequently, children and young people who self-harm typically access support through general mental health pathways, flagging a gap in the support landscape.

The overall picture of rising mental health need and rising system pressure to provide timely care, raise important questions about access: whether children and young people are able to find the right help at the right time; how well current pathways respond to escalating risk; and whether gaps in early support are contributing to later crisis presentations (including self-harm admissions).

This work aligns closely with wider system ambitions to reduce avoidable harm and improve mental health outcomes across BSW. The Population Health Board's recent 'deep dive' into self-harm admissions examined local data, including questions around potential over-recording in BSW, and highlighted evidence that consistency and sustained relationships are central to effective support. The Board has set an ambition to reduce emergency admissions for intentional self-harm by 740 per year across BSW—equivalent to 173 fewer admissions in B&NES—with a particular focus on young people, residents in Core20 areas, and people with learning disabilities or serious mental health difficulties, reflecting the groups most represented in high admission rates. The 'deep dive' document also highlights opportunities and good practice approaches such as educational campaigns to address stigma, prioritising early intervention, targeted self-harm and mental health awareness training for professionals and carers, clearer referral and support pathways, and stronger multi-agency collaboration involving people with lived experience.

By combining these strategic directions and the experiences gathered through this project, this report aims to contribute a grounded, practical evidence base for improving access to mental health support for children and young people in B&NES—particularly those affected by self-harm.

Definition of 'self-harm'

There is no single agreed definition of self-harm. Clinical, research, and lived experience perspectives differ in how self-harm is understood and categorised.

In clinical contexts (such as NHS and NICE guidance), self-harm typically refers to intentional self-injury or self-poisoning, regardless of suicidal intent. However, people with lived experience often describe a broader range of behaviours used to cope with distress.

For this report, we draw on the definition from YoungMinds, as it most closely reflects the experiences shared by young people and carers:

> "Self-harm is when you hurt yourself on purpose. It can be a way of dealing with overwhelming feelings, expressing distress, feeling something when you're numb, or trying to regain a sense of control."
>
> "It can take many forms... sometimes it's clear, but other times harmful behaviours may not be recognised as self-harm."
>
> Examples include cutting, burning, using alcohol or drugs to cope, disordered eating, over-exercising, or putting yourself in risky situations."

Source: www.youngminds.org.uk/young-person/my-feelings/self-harm/#Whatisselfharm

Self-harm can therefore include both direct physical injury and behaviours used to manage distress that may increase harm or risk, even if they are not always identified as self-harm by the individual or professionals.

Throughout this report, we use this broader, lived-experience-informed understanding. This is important because it captures forms of distress that may otherwise go unrecognised particularly among groups whose behaviours do not fit traditional expectations. How self-harm is defined in practice can influence whether individuals are recognised as needing support, and which services they are able to access.

Several service providers noted that patterns of self-harm may vary. Young women were described as more likely to direct harm inward, whereas young men were more likely to express distress through outward or risk-taking

behaviours. This has implications for identification and access to support, highlighting the need to recognise less visible or non-traditional presentations.

Support for this project

We would like to express our sincere thanks to the young people with lived experience of self-harm, and to the carers who shared their insights and reflections. Their openness and willingness to contribute have been invaluable in shaping this work.

We are also grateful to the organisations across B&NES that provided feedback and shared their perspectives. Their contributions have been essential in building a comprehensive understanding of the local mental health landscape and the challenges experienced across the system.

We extend particular thanks to the Healthwatch volunteers who supported this project and acted as trusted sounding-board partners throughout.

We would like to acknowledge the following organisations and groups for their support:

- The Diversity Trust, with special thanks to Tim Birkbeck for co-facilitating a workshop with LGBTQ+ young people
- The Carer Forum at Avon and Wiltshire Mental Health Partnership (AWP), which played a key role in supporting engagement with carers and enabling us to hear a wide range of caring experiences
- Bath Mind, for supporting engagement with individuals with lived experience
- Curo, for supporting engagement with individuals with lived experience

A full list of the 12 organisations who contributed to this project is provided in the appendix.

What we did

Hearing from people with lived experience of self-harm and their carers

We wanted to understand what it's like for young people in B&NES who have experience of self-harm, and for the parents and carers who support them. To do this, we worked with local organisations who already have trusted relationships with these groups. This included university providers, voluntary mental health organisations, a housing association, and carers' organisations.

People were invited to take part through these organisations. We used a mix of ways to hear from them, recognising that some people may feel more comfortable sharing in different settings. This included:

Methods of engaging included:

- A focus group with young people with lived experience
- One-to-one conversations with young people and carers
- Invitations to share feedback by email
- Attending a carers' forum to listen to wider discussions

Given the nature of the topic, we made sure to create opportunities for people to share their experiences in ways that felt safe and manageable. Participation was voluntary, people could choose how much they wanted to share, and they could stop at any point. We focused on listening without judgement, avoided asking people to revisit distressing detail unnecessarily, and ensured that follow-up support was available by trusted people from within the organisation. All contributions have been anonymised.

What we ask young people and carers

We asked people about their experiences of getting support for self-harm in B&NES, including their experiences with the service providers they have engaged with. We focused on the following key questions:

- What went well?
- What didn't work so well, or was missing?
- What would you change?
- Did services take your individual needs into account?

These questions were used as a guide, allowing conversations to be led by what felt most important for each person to share.

Who did we hear from?

In total, we heard from 16 people - 7 young people with lived experience and 9 carers.

Most of the young people we spoke to were aged 20–25. We did not speak directly to anyone under 18. While we would have liked to include younger voices, this wasn't possible within the time and safeguarding constraints of this work.

We took an approach that focused on depth rather than numbers, giving people space to talk through their experiences in detail and in their own words. It's important to note that most participants were already linked with organisations, so we are less likely to have heard from those who are not connected to support.

Hearing from service providers

Alongside lived experience, we also spoke to organisations involved in supporting people who self-harm. This helped build a picture of how the system is set up in practice, including where there are pressures and gaps.

We invited input from a range of services, including:

- Primary and secondary care
- Crisis and acute services
- Further education providers
- Voluntary sector organisations
- School Aged Health Service

We spoke to 12 service providers in total (See full list of service providers in the appendix). We gathered their views through:

- One-to-one meetings (online and in person)
- Written responses
- Local forums such as the Bath Mental Health Alliance and Population Health Board
- Self-harm and suicide prevention partnership meetings

What did we ask service providers?

We asked providers about:

- What support is currently available
- How people access their services
- Referral pathways, eligibility, and thresholds
- How self-harm is considered in their work
- Challenges within the system
- What they think could improve support overall

How is feedback used in this report?

We brought together everything we heard from young people, carers, and service providers and looked for common themes. This included where experiences aligned and where they differed.

These themes have shaped the findings in this report, along with the recommendations that follow.

Key issues

1. Confusing and fragmented access pathways

Lived experience and carers

Individuals and carers consistently described pathways into support as unclear, inconsistent, and difficult to navigate. Information about services was often contradictory or incomplete, with different professionals offering conflicting guidance about eligibility, referral routes, and available support.

This resulted in a fragmented journey across multiple services (GPs, secondary care, school services, voluntary sector, further education providers), requiring individuals to repeatedly start over in their search for support when they got rejected by one service without clarity on where they would ultimately receive treatment. Many described a system that felt disjointed rather than coordinated, though a small number recalled rare occasions where they encountered effective routes into meaningful support.

The burden of navigating the system was reported as frequently falling on the individual and carers, even during periods of distress:

> "Even when I tried to look stuff up it was really confusing. And no one would tell me anything useful, everyone that I spoke to told me different things and that's different GPs, like different specific doctors that I saw and then also every person who assessed me told me different things and every letter I got back told me different things and it was really confusing."

Someone else describes their experience as:

> "Everybody is signposting… but who actually gets to be seen by a professional?… for instance, talking therapies tell you 'this is not the right fit for you' and they just spit you back out. … They say, 'go back to your GP'. You go to your GP. Your GP has only been trained to do talking therapies referrals. So the cycle is really outlined in that. So actually seeing a professional, actually starting treatment is near enough impossible on the NHS."

There is a sense of frustration over the poor communication between services resulting in no service in particular taking ownership of the individual finding the appropriate support. Young people described this lack of coordination as emotionally draining, particularly when they had to repeatedly retell their personal history without knowing what information services had already shared with one another. This uncertainty left them unclear about what they were expected to provide and what professionals already knew. As a result, they often felt responsible for managing and communicating information that they felt should have been held consistently across services.

One young person explained:

> "Having accessed quite a lot of very different sorts of therapy, I've got notes everywhere. I've notes with the NHS, I've got notes with off the record. It's like, what notes do I need to bring to who? Can I gather them? Can they access them? I don't know who has what and who I should be giving what. I don't know if they need it or if I should be giving it to them."

Overall, individuals described cycles of referral, rejection, and redirection without clear explanations or onward guidance, contributing to feelings of frustration and disengagement.

Service providers

Most service providers identified fragmentation and a lack of coordination across the system as a fundamental structural issue underpinning many of the challenges described by individuals and carers. However, there also appeared to be a slight mismatch in expectations, with a few services operating under the impression that access points were relatively straightforward.

There is no shared system for accessing or tracking support or standardised referral process across all support services in B&NES. However, statutory services like CAMHS, AWP and GPs can link up to access background information and health records from an electronic system. Providers described a lack of integrated records and communication between organisations (including NHS services, voluntary sector, and universities), making coordinated care difficult to deliver in practice.

Providers described a lack of integrated records and communication between organisations (including NHS services, voluntary sector, and universities), making coordinated care difficult to deliver in practice.

Primary care professionals also highlighted difficulty staying up to date with available services and their varying eligibility criteria due to unstable funding arrangements, particularly in the voluntary sector where provision may frequently change.

This results in a system where both professionals and families lack a shared understanding of pathways, with coordination dependent on individual relationships rather than embedded structures.

Feedback from a system partner reinforces that navigation challenges are not only structural but relational. Evidence from their service showed that when young people are personally met and supported at the point of contact, engagement rates reach around 80%, compared with approximately 25% when support is offered only through referral or signposting. This highlights that clear pathways alone are insufficient; trusted relationships and warm handovers are critical mechanisms for helping young people move through a fragmented system.

2. Inconsistent threshold for treatment pushes individuals to crisis

Lived experience and carers

Young people and carers described a system where inconsistent thresholds, dismissive early responses, and crisis-based access are tightly interlinked. Many reported being excluded from support due to contradictory eligibility criteria—told they were either "not bad enough" to qualify or "too complex" to be accepted. This left them in a space where no service felt responsible for their care.

> "being signposted and referred was relatively easy, but then actually getting help was an absolute nightmare because you wait ages to be assessed and by that point your circumstances have changed or you're not bad enough for the services, which is always a real kicker or you're too bad for the services."

Early help-seeking, particularly through GPs or initial points of contact, was often experienced as minimising or invalidating. Some young people felt their distress was reframed as typical adolescent behaviour or something they should manage alone. These early interactions shaped a belief that moderate levels of self-harming were normal and that escalation was necessary to be taken seriously:

> "I think it's hard to self-advocate because I think with depression and with self-harm specifically, it's so competitive. It creates the sense that I need to try harder, I need to do worse to be seen."

Another young person describes how dismissal makes it hard to reach out for help:

> "when you're slightly younger, when you're told by the professionals that [self-harming] it not that big a deal, eventually I feel like you internalize that and so you stop wanting to kind of... reach out and advocate for yourself because if the professionals are telling you don't need to, then why do I feel like I'm any different? How many other professionals can I go to until one takes me seriously?"

Over time, many described a pattern in which meaningful access to support only occurred at crisis point—often through A&E or after significant deterioration:

> "And then I tried to kill myself. And that was all that got me help, that was the only thing that they actually cared about. I almost had to die to be taken seriously."

Another young person described the feeling of going to A&E for medical support for a self-harm injury:

> "It's absolutely terrifying going to A&E for self-harm, especially that you do feel like you're going to get dismissed or judged because I'm taking up medical time with something I did"

Carers echoed these concerns, describing how young people's needs intensified over time while waiting for services to respond. They expressed deep worry that waiting until crisis not only increases risk but also makes intervention more traumatic and less effective.

Experiences also varied widely depending on individual practitioners. Some young people felt heard and supported, while others felt dismissed or minimised. Meanwhile, medication prescribing practices were described as inconsistent—some received medication very quickly with no simultaneous offer for therapy, while others waited years despite repeated requests for medication. This variability reinforced the sense that access and response depend heavily on who a young person encounters rather than on need.

One person described their experience with the GP:

> "It was very much 'take this [medication] and go away'. And there was no more like, here's some other options or like, this is an [antidepressant] - here's how it works"

A general desire from many of the young people was about simply being listened to:

> "I understand that they are understaffed, underfunded, they can't really do much but the number one thing is to treat me like an individual human and take the time to listen to me because I don't think any of these services have."

Service providers

Service providers recognised these experiences and attributed them to system-level pressures, particularly the imbalance between demand and capacity. High demand mean that many services have decided to operate with elevated thresholds, prioritising those deemed at highest risk. As a result, many young people seeking help are not offered support because they are not considered suitable for respective services' high eligibility criteria despite self-harming behaviours as some do not treat self-harm alone as a sufficient indicator of need.

On the other side, some services view self-harm as an indicator of high-risk requiring specialist intervention and therefore consider it outside the scope of the support they can provide due to perceived complexity or risk. This inconsistency means that some services may automatically decline referrals where self-harm is identified, while others may not prioritise it. As a result, young people can "fall between services," where no single team feels both able and resourced to take responsibility for their care.

This inconsistency is compounded by variation in workforce confidence and training. Providers acknowledged that confidence in assessing and managing self-harm varies widely, especially in primary care. These variations shape how quickly people can be referred and accepted into services.

Providers also highlighted a broader system dynamic in which crisis pathways become the default route into care. With limited out-of-hours options and few community alternatives, GPs and teachers may advise A&E attendance as the quickest way to access support. Emergency departments—despite not being suitable environments for supporting mental health challenges—become the primary gateway to meaningful intervention.

Overall, providers described a system where risk management, capacity constraints, and inconsistent thresholds drive reactive rather than preventative responses. This reinforces a pattern in which young people access support primarily at crisis points rather than at earlier stages of need.

3. Insufficient early and preventative support

Lived experience and carers

Individuals described that access to support was significantly easier while in school settings. Provision of meaningful support within further education settings varied considerably between institutions. Beyond school systems, both individuals and carers described limited access to support at an early stage, with many experiencing difficulties in finding appropriate help before needs had significantly escalated. Early support was often perceived as unclear, variable, or not easily accessible, making it difficult for individuals to recognise where to turn when first experiencing distress.

One young person described uncertainty about what support was available at an early stage:

> "I didn't know where to go or what to do because I was so new to accessing mental health support."

Another individual described their experience of turning to the GP as a teenager but feeling that this was an ineffective entry for support:

> "And then when the kind of self-harm started, there was no change in the care. I feel like that would have been taken a bit more seriously, but I was just told 'come back in three months if you're still feeling this way, if you're still doing this'. In fact, I still remember the first time I saw a doctor specifically relating to self harm, his response was, 'Oh, that's not good'. And that was it. And it just felt very, okay, being mentally ill is just part of being a teenager. It just felt very dismissive of if for years I'm coming back to saying this is still progressing, this is still getting worse. I was just told to constantly come back."

Others also expressed that early disclosures were sometimes not responded to in a way that led to timely support. One individual described the experience as:

> "It's like if someone got diagnosed with stage 1 cancer and [healthcare professionals] are like, 'well, we'll just leave it until it gets really bad just in case you don't need the help'."

Meanwhile, social isolation and perceived lack of youth spaces contributed to difficulties forming friendships and mental health challenges, particularly for younger individuals.

> "There's not really many places… for teenagers to hang out."

Meanwhile, carers emphasised the importance of early intervention, particularly in education and community settings. They reported that by the time support was accessed, needs had often already intensified.

There was a consistent sense that opportunities for early support were missed or delayed, resulting in individuals reaching a point where more intensive intervention was required. Participants reflected that earlier, lower-level support could have helped them manage difficulties sooner and reduce escalation.

Carers also described the impact of limited early support on families, noting that in the absence of accessible early intervention, they were often left managing emerging concerns without guidance or reassurance. This created pressure to monitor situations closely without a clear sense of when or how support would become available.

Service providers

Service providers identified gaps in the availability and consistency of early intervention and low-level support, particularly outside of specialist services.

They highlighted:

- Limited provision of easily accessible, preventative services
- Inconsistent availability of school-based mental health support
- Reduced access to community-based support that can respond to emerging needs

Providers noted that early support is not always sufficiently developed or visible within the system, making it harder for individuals to engage at an earlier stage.

Schools often feel ill-equipped to manage self-harm, leading to: Overreaction and sending young people to A&E unnecessarily or underreaction through dismissal.There was also recognition that where early support is limited or difficult to access, individuals are more likely to seek help at a later stage, often when needs have become more complex and require more intensive intervention.

Overall, providers described early and preventative support as an area where provision is variable and not consistently embedded, limiting opportunities to respond to emerging mental health needs before they escalate.

4. Long waiting times and insufficient support while waiting

Lived experience and carers

We heard that system pressures contributed to extended waiting times for mental health support, often lasting several months or longer. A key concern was that support frequently arrived after the point of greatest need, reducing its relevance and effectiveness or impacted on mental health.

One young person described:

> "When I needed help, then they weren't available… now I don't need it."

During waiting periods, individuals and carers described feeling unsupported, particularly when there was little or no communication from services:

> "If a member of the team checks in with you throughout the waiting list period every couple of weeks or once a month, that would be good. I haven't had any communication."

Carers also highlighted uncertainty about waiting lists, including lack of clarity about position, timelines, or next steps. Young people described similar uncertainty when preparing to engage in counselling, noting that unclear expectations made it difficult to know how to participate, what issues to prioritise, or how best to present their experiences. This lack of clarity sometimes led to confusion about whether the support offered would meet their needs, alongside frustration at having waited a long time for something that might not be appropriate.

While some participants accepted long waits if prioritisation felt fair, the absence of interim support or reassurance significantly increased distress and anxiety during this period.

Young people also highlighted a lack of harm-reduction approaches for self-harm, both while waiting for support and during treatment. Harm-reduction strategies were described as realistic and supportive, offering ways to stay safer rather than expecting self-harm to stop immediately.

One young person noted:

> "I feel like that is such an important step in getting over self-harm and protecting yourself - is harm reduction. And I feel like not enough kind of mental health professionals or just health professionals in general kind of focus on that."

Service providers

Providers linked waiting times to rising demand, limited workforce capacity, and constrained resources. Insights from service providers in B&NES maintain extremely long waiting list typically from 4-12months, although it is typical for some services to turn down individuals expected to wait for more than 6 months.

Although some services offer support while people are on their waiting list, service providers generally identified a "waiting well" gap, where individuals and their families or carer who have been accepted into services receive little structured support before treatment begins.

5. Absorbing risk and taking the brunt of system gaps

Carers

Carers described a sustained experience of absorbing the risk created by gaps within the system, particularly where young people are unable to access timely or appropriate support.

This was reported as being most evident during periods of escalation or while waiting for services, where carers often felt they were "holding the crisis" at home, managing significant emotional distress and safety concerns without consistent clinical support or clear guidance.

One carer described feeling overwhelmed and mostly alone in managing the declining mental health of the child:

> "[Young people needing mental health support] got all this heavy baggage and that's how I have felt because I'm trying to manage [my son] and you can't just immediately hand that on to someone else."

Carers expressed concern that young people may sometimes be stepped down from CAMHS too quickly when they disengage, noting a belief that CAMHS holds a continued responsibility to maintain follow-up where possible. They highlighted that when support ends abruptly, carers often feel they are left managing increased pressures at home without sufficient guidance or oversight.

This experience is closely linked to wider system pressures, particularly high thresholds for statutory services and long waiting times, which mean that individuals are often unable to access support until their needs reach a critical level. As a result, families and carers are left managing increasing risk over extended periods.

Carers described a lack of communication and clarity from services during these times, including uncertainty about waiting lists, next steps, and who held responsibility for care. They highlighted concerns about where responsibility sits when statutory services are unable to provide support.

Service providers

Several service providers recognised that carers are carrying a significant share of the risk created by gaps within the system. They noted that this places families in an unsustainable position, where prolonged periods without adequate support can erode carers' capacity and wellbeing. Some services attempt to mitigate this by offering carers' support groups led by trauma-informed practitioners, or by delivering workshops for families in school settings to build knowledge and skills around mental health and wellbeing. While these initiatives were viewed as positive examples of practice, providers acknowledged that they remain limited in scale and are insufficient to meet the volume of carers and families requiring support.

Alongside recognising the pressure on carers, voluntary organisations offering lower-threshold or open-access support reported experiencing similar strain. Providers described routinely taking on individuals who had been turned away from statutory services due to eligibility criteria, risk thresholds, or capacity constraints. There was a consistent sense that services without strict thresholds were absorbing those rejected elsewhere and, in effect, operating as informal "catch-all" services for unmet need.

Overall, service providers reflected that both voluntary sector organisations without strict thresholds and carers are taking "the brunt" of system limitations, particularly in situations where statutory services are unable to respond because of thresholds or capacity. This displacement of responsibility underscores the need for clearer pathways, more consistent support, and a more balanced distribution of risk across the system.

6. Falling through the gaps while transitioning from children's to adult services

Lived experience and carers

Turning 18 was consistently described as a point where access to support becomes significantly more difficult, often referred to as a "cliff edge."

Individuals described a shift from more accessible, structured support in school or CAMHS settings to limited and harder-to-access adult services.

> "I think when you turn 18, it's much more difficult because you do hit a lot of brick walls when it comes to mental health in general."

Carers expressed concern about the lack of continuity during this transition, with some reporting that young people lost support entirely when moving between services.

Although signposting continued, access to actual treatment was seen as more restricted, with higher thresholds and fewer options available.

Service providers

Service providers acknowledged ongoing inconsistencies in how transitions between CAMHS and adult mental health services are managed. Although CAMHS has a transition programme in place, providers recognised that many young people still do not receive the support they need when approaching adulthood. In particular, those who are not accepted into adult services are often left without an alternative offer of support, creating gaps in care.

Providers highlighted that differing thresholds and eligibility criteria between children's and adult services contribute significantly to these gaps. Young people who would have been eligible for CAMHS may not meet the higher thresholds required for adult services, resulting in a loss of continuity at a critical stage.

There was a shared view among providers that more structured, consistent, and clearly defined transition pathways are needed to ensure continuity of care—especially for those who do not meet criteria for statutory adult services but still require ongoing support.

7. Insufficiently tailored support for neurodivergent and LGBTQ+ young people

Lived experience and carers

Neurodivergent and LGBTQ+ young people, along with carers, described support as often insufficiently tailored to their specific needs, both in terms of approach and understanding. Although services were often able to recognise identity-related needs (neurodiverse or gender identity), it was noted that some professionals lacked the knowledge or confidence to respond effectively, resulting in a gap between recognition and the delivery of appropriate support.

> "This is also not helping you know, it was very like obviously behavioural activation is very like functional and I was struggling to function but it was sort of planning your day and obviously with ADHD I'm not sticking to that plan."

A key issue raised was that standardised approaches to therapy were not always appropriate, particularly for neurodivergent individuals. Participants described difficulties engaging with common therapeutic models (such as structured talking therapies). This sometimes led to support feeling inaccessible or ineffective.

> "I feel like a lot of the time people just kind of default to CBT, which can be useful, but I've seen a lot of neurodivergent people don't tend to vibe very well with CBT."

Another young person describes an experience of effective therapy:

> "it was so clear that the positive [experiences] I've had have been with counsellors and therapists who are informed about neurodivergence and gender and sexuality stuff, even if they don't have those experiences themselves."

For LGBTQ+ young people, a further issue was the way in which identity was addressed within support. Participants described experiences where mental health difficulties were over-attributed to gender identity or neurodivergence, rather than understood in a broader context.

> "Once the GP discovered I was trans, it almost seemed like the shift of all of my mental health and self-harm experiences shifted to the fact, because I was trans. Dysphoria has an impact on your mental health and all of that, but I started [self-harming] before I realised I was trans. Not everything falls down to that, or the same with the autism, it seems to be like every single time I go to the GP, it seems to be a focus on the fact that my issues must be because I'm autistic and trans. You must be self-harming because you're trans."

This was experienced as reductive and, at times, dismissive, particularly where individuals felt that other contributing factors - such as trauma or wider mental health needs - were not explored.

> "I think it was always kind of beneficial to be like, listen, what are your issues? What do you want from this? Let's set goals, and then we will match you with a therapist."

Carers highlighted related concerns, particularly around:

- delayed diagnosis of neurodivergence, which affected access to appropriate support.
- lack of clear pathways for support that addressed both mental health and neurodiversity at the same time

Service providers

Service providers acknowledged that current models of care are not always well adapted to meet the needs of neurodivergent and LGBTQ+ young people.

They identified limitations in:

- workforce knowledge and confidence in supporting neurodivergence and LGBTQ+ identities
- the ability to adapt therapeutic approaches and communication styles
- service environments that may not be suitable for all individuals

One service provider noted that some autistic or otherwise neurodivergent individuals may not recognise when they are approaching crisis until after it has occurred, which can make it more difficult to seek support at the right time

There was recognition that while identity-related needs may be acknowledged, services do not always have the skills, flexibility, or resources to respond appropriately, leading to a mismatch between recognition and effective support.

Moreover, there is a recognition that a lot of individuals who are autistic or have ADHD are not getting the correct support from community mental health teams because they don't meet the criteria of the care assessment need framework, which means they don't get any additional support. There is also a risk that when individuals disengage from services, they may be discharged prematurely, particularly where neurodiversity affects their ability to attend appointments consistently. Current approaches often lack sufficient reasonable adjustments to support continued engagement. Not all service environments are accessible or suitable for neurodiverse individuals. This can impact attendance and engagement, resulting in discharge even where the individual still wishes to receive support but is unable to engage within the existing service setting.

In addition, professionals noted that where individuals present with complex or intersecting needs (e.g. neurodivergence alongside mental health difficulties), existing service structures may not align well with these presentations, especially primary care as well as acute and crisis services, making it more difficult to provide coordinated and tailored care.

8. Limited continuity of care and short-term therapeutic models

Lived experience and carer feedback

Young people and carers described a system where therapeutic support is often delivered in rigid, short-term blocks that do not match the complexity or duration of their needs. Many spoke about being offered six-session models or time-limited interventions that felt rushed or prematurely closed. These models were experienced as particularly misaligned for those dealing with self-harm, trauma, neurodivergence, or long-standing emotional distress -contexts where trust-building and relational safety take time.

> "there's no way I'd be able to undo everything in six hours so there is definitely a lot of pressure to have almost like a perfect session."

Young people frequently described the emotional disruption caused by abrupt endings, especially when they had only just begun to feel comfortable with a practitioner. Some felt "opened up and dropped," describing how short-term work surfaced difficult emotions without providing the continuity needed to process them safely. Others reported that the pressure to "make progress quickly" within a fixed number of sessions made them feel like they were failing therapy rather than being supported by it.

Carers echoed these concerns, noting that short-term models often left young people without support during critical periods. They described cycles where a young person would begin to engage, reach the end of a short intervention, and

then face long waits or unclear next steps. This created a sense of instability and unpredictability, particularly for those who struggled with transitions or needed consistent relational support.

> "I should not have been in so many services. There should be something more stable and unison."

Young people also highlighted the fragmentation between services, where each new referral required retelling their story, undergoing another assessment, and starting again with a new practitioner. This repeated resetting undermined trust and made it difficult to build momentum. Many expressed that what they needed most -continuity, familiarity, and a stable therapeutic relationship - was the very thing the system struggled to provide.

One person describes how they felt listened to only by people who had long-term involvement, such as school counsellors or private therapists:

> "it was beneficial because the same councillor was connected to the school and provided ongoing support".

Service provider feedback

Service providers acknowledged that short-term therapeutic models are often a function of structural constraints, not clinical preference. High demand, limited staffing, and funding tied to specific session-based models mean that services are frequently required to deliver brief interventions even when they know these are insufficient for many young people.

Providers described how commissioning frameworks and performance metrics often prioritise quantity over depth, incentivising short-term work and rapid discharge. This creates pressure to move young people through services quickly, even when their needs require longer-term engagement. Service providers expressed frustration that they are unable to offer the continuity they know is clinically appropriate.

Providers also emphasised the cumulative impact of fragmented pathways, where young people move between school-based support, voluntary sector services, secondary care, and crisis teams with little coordination. Each service may offer a short-term intervention, but without a shared plan or continuity, the overall experience becomes disjointed. Professionals noted that this fragmentation can lead to repeated assessments, duplicated work, and young people disengaging because they feel they are starting from scratch each time

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Additional areas of feedback

- Group-based support was often experienced as poorly structured, mismatched in age or need, and not psychologically informed
- Some young people expressed frustration that they feel that some mental health services misrepresent what they offer, particularly around access to one-to-one therapy and the suitability of group activities. While one service was seen as helpful, overall support was experienced as inconsistent, poorly matched to needs, and lacking clear, trustworthy information
- University services (Bath Uni and Bath Spa) were described as having clearer and more accessible information, including a one-stop shop structured signposting systems and visible resources
- Some young people described limited support for managing ongoing self-harm urges rather than behaviours.
- Assumption by some service providers that a good entry point to access support is the GP, yet this conflicts with experience from the people with lived experiences who report that GPs are not always a good entry point because they do not have up to date information.
- Young people experienced varying degrees of effectiveness of crisis phone lines with three people experiencing that these services were often inaccessible due to:
    - long wait times
    - lack of response
    - geographic limitations
- One person described that immediately after a self-harm episode, they don't want to be questioned by crisis staff about why it happened or what led to it. What they need in that moment is simple acknowledgement — someone recognising that it happened and reassuring them that it doesn't change how they're seen. They said the most helpful things A&E doctors have told them were along the lines of, "I can see that you're struggling. I hope things get better for you."

Next steps

Healthwatch Bath and North East Somerset will:

- Publish its findings and recommendations on its website, alongside a clear summary of key themes and priorities.
- Share the report widely with everyone who contributed to this work, including people with lived experience, carers, service providers, the Mental Health Alliance, Population Health Board, B&NES Council, and other relevant stakeholders who were unable to feed into the report.
- Produce accessible versions of the findings, including a concise and youth-friendly summary, so that children and young people, families and carers can clearly see how their feedback has been used and what changes are expected as a result.
- Facilitate a partner discussion bringing together service providers and system partners to reflect on the findings, explore the recommendations, and consider their feasibility and prioritisation.
- Share additional data and insight gathered through this work, including information that could not be fully included in this report, to support further understanding and inform ongoing discussions.
- Continue to centre lived experience by involving children, young people and carers—including those from underserved communities—in future engagement and follow-up work.
- Based on people with lived experience raising the issue, we will work with partners to better explore the role of "self-harm reduction" as an approach to responding to self-harm
- Follow up with service providers, carers and children and young people within 6–9 months to understand what difference this work has made, explore any improvements in experiences and outcomes, and assess whether further engagement or reporting is required.
- Capture and share learning more widely across Healthwatch BSW and TCF to support similar work in other areas.

Bath and North East Somerset Council have:

- Confirmed funding extension for another year of the ICB-funded Youth Worker Pilot scheme at Royal United Hospital to support young people in hospital going back into communities. This project has been highlighted by various service providers as working very well.

Healthwatch asks system partners to:

- Consider the recommendations in this report and how they can be taken forward within existing plans, resources and priorities.
- Work collaboratively to develop a shared response, including identifying lead organisations, potential timescales and measurable outcomes where appropriate.
- Align actions with wider system priorities and transformation programmes (such as mental health, SEND and early help) to ensure a joined-up approach.
- Provide updates on progress, where possible, through existing partnership structures to support transparency and collective accountability.
- Continue to involve children, young people and carers in the design, delivery and evaluation of services.
- Escalate any significant risks or gaps identified through this work within appropriate governance and decision-making structures.

Stakeholder response

Conversations with stakeholders who received this report are ongoing and any updates on the progress of our recommendations will be published on our website.

Appendix

To view or download the appendix, please go to:
https://healthwatchbathnes.co.uk/crisis-care-strengthening-self-harm-support-pathways-bnes

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