Mental health crisis support

What are we hearing in Kent and Medway?

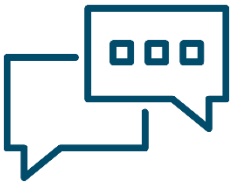
healthwatch Kent

Mental Health Voice

healthwatch Medway

Contents

About us



Healthwatch Kent, Healthwatch Medway and Mental Health Voice are your local independent champions for health and social care. Our aim is to improve services by ensuring local voices are heard – we want to hear about health and social care experiences to influence positive change for communities across Kent and Medway. We have the power to make sure NHS leaders and other decision makers listen to your feedback and improve standards of care.

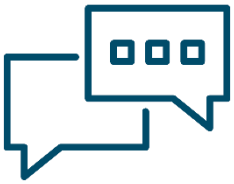
We use your feedback to better understand the challenges facing the NHS and other care providers, to make sure your experiences improve health and care services for everyone. It is really important that you share your experiences – whether good or bad, happy or sad. If you've had a negative experience, it's easy to think there's no point in complaining and that 'nothing ever changes'. Or, if you've had a great experience, that you 'wish you could say thank you'. Your feedback is helping to improve people's lives, so if you need advice or are ready to tell your story, we're here to listen.

Notice on Healthwatch England changes announcement:

As part of the Dash Review published in July 2025, Healthwatch England and the local Healthwatch network were recognised for their work in listening to and raising the voice of the people who use health and social care services across the country. The review highlighted the government's desire to streamline bodies contributing to patient safety and consequently local Healthwatch responsibilities will be transferred to NHS integrated care boards and local authorities. This transformation will take time and therefore, here in Kent and Medway, we will continue to work with the public and stakeholders to achieve change for local people. We also recognise that since the announcement, while the current body Healthwatch will cease to exist, there has been an acknowledgement of the need for high-quality, independent voice to remain.

Healthwatch Kent, Healthwatch Medway and Mental Health Voice are hosted by EK360.

Get in touch



If you or a loved one would like to share your experiences of health or care services, please get in touch – Have your say | Healthwatch Kent or Have your say | Healthwatch Medway.

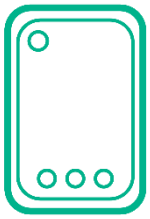
Or call our freephone number on 0808 801 0102.
Text 'Need BSL' to 07525 861 639 for our British Sign Language communicator to contact you.

If you work in or alongside health or social care and would like to discuss how you might use the insights in this report, we would love to speak to you – please get in touch via info@healthwatchkent.co.uk.

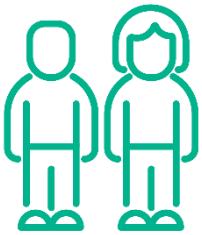
Support information

In need of support now?

- Mental Health Wellbeing Information Hub – Help and support if you are feeling anxious or stressed, down or low.
- Children and young people – specific services to support you are just a text, call, or click on a website or app away.
- Kent and Medway Mental Health Crisis Line – Anyone experiencing an urgent mental health crisis can call 111 and select the option for mental health to speak to a specially-trained mental health practitioner. If there is a risk to your life or someone else's, please do not call 111. Dial 999 instead.



- Release the Pressure have a highly trained and experienced team available 24/7 to provide expert support no matter what you are going through. Don't suffer in silence. You can call the helpline on 0800 1070 160, text the word SHOUT to 85258, or use Rethink's webchat service.
- Kent and Medway Safe Havens offer people aged 18+ free mental health and crisis support in a welcoming, comfortable, non-judgmental, and non-clinical environment. This is a drop-in service, with no referral or appointment required, via face-to-face or virtual support.



- Samaritans – Call us any time, day or night. Whatever you're going through, from any phone for free on 116 123.

Summary

From September 2024, we started to receive more feedback on people's experiences of support in a mental health crisis. We heard some positive feedback where people had accessed support that had helped them prevent or recover from a mental health crisis. We did, however, also hear from some people sharing experiences in which individuals had tragically died.

In December 2024 and February 2025, we presented summary reports to key stakeholders in the Kent and Medway mental health system (see Appendix 1) on what people had told us about support in mental health crises. They took action to improve awareness of and access to crisis care (see Responses section). We also called for the improvement of care coordination and continuity within and between services, particularly for people reaching out in a mental health crisis.

To understand in more depth what people were telling us, we analysed 489 related experiences from January 2024 to February 2025. These emerged from what people had told us through Mental Health Voice, Healthwatch Kent and Healthwatch Medway without any targeted prompts for mental health crisis. People told us about understanding, supportive and helpful care and how positive interactions had enabled them to manage their mental health, keep them safe and help them to recover. When people had less positive experiences, key issues included waiting times for crisis support, ineffective crisis response, and unsuccessful coordination or continuity of care between services.

> I had been feeling very depressed and I rang 111 to get some support as I did not know where to turn, although I waited a long time for them to get back to me. I spoke to [a doctor, who] was very reassuring and listened to me and suggested some ideas to calm me down, I would like to say thank you as it makes such a difference when somebody takes the time to listen to you.

This report provides further detail on people's experiences of crisis support, analysis of the underlying themes and trends for key services (see Findings section) and recommends next steps (see Recommendations section).

In June 2025, we shared a draft version of this report with the mental health team at the NHS Kent and Medway Integrated Care Board, who initiated positive changes (see Responses section). From October 2025, we shared this end report with them and the executive team, plus the Kent and Medway suicide prevention programme team, senior and operational leaders at Kent and Medway Mental Health NHS Trust, Public Health teams, key members of adult social care in Kent and Medway, all four health and care partnership leaders, safe havens, and general practice leadership, with a call to action for further positive change.

Methods

Engagement

Mental Health Voice and the Healthwatch Kent and Healthwatch Medway signposting, information and research services receive a continuous and ongoing flow of insights from people sharing their experiences of health and social care. We invite feedback from anyone living in Kent or Medway. Mental Health Voice is a forum for people with lived experience of mental health issues.

Engagement in Mental Health Voice and the Healthwatch signposting, information and research service was both solicited and unsolicited and was conducted by online webform, email, social media, text message, telephone and in-person methods. As much of the feedback was unsolicited, there was a bias towards negative sentiment.

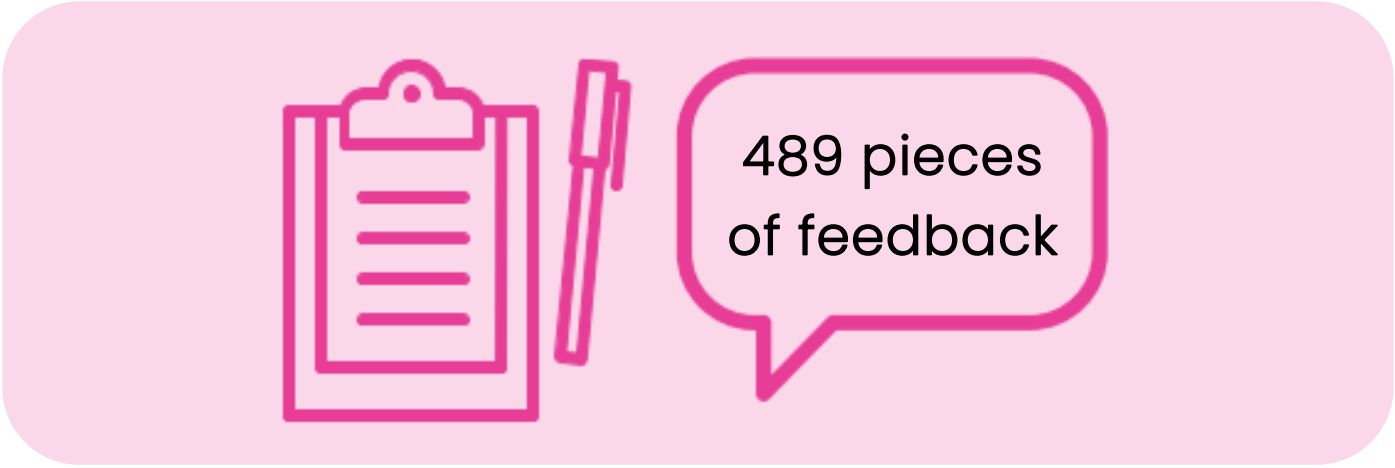
Wherever possible, a member of staff contacted the individuals providing feedback to support them to tell their story and to ensure high quality engagement and data capture. Feedback received from January 2024 to February 2025 via these engagement methods was considered in this report.

Measures

The survey questions were open and invited people to tell us about their or their loved one's health or social care experience, providing detail on what happened, where it happened and when. There were no targeted prompts for feedback about mental health crisis support.

Sample selection

Within all of the feedback shared with Mental Health Voice and Healthwatch Kent and Healthwatch Medway signposting, information and research services between January 2024 and February 2025, we identified 489 pieces of feedback about mental health crisis support.



All feedback received had been assigned a service type and organisation. Feedback on crisis support was identified by filtering for items relating to mental health care from urgent, emergency or crisis services including A&E, ambulances, home treatment and rapid response, the police, liaison psychiatry, crisis lines, safe havens and urgent treatment centres, and other organisations relevant to crisis care. Word searches were also used on the feedback itself to identify pieces outside of these services that contained terms related to mental health crisis, which were then checked manually for relevance.

Analysis

All feedback was assigned topics from our topic bank (see Appendix 2). Feedback relevant to crisis support was then grouped by service and topic before being analysed further thematically. Demographics were also explored to identify any trends or patterns.

Demographics

Demographics were captured in all engagement methods by using closed question sets (see Appendix 3). The amount of feedback from the demographic groups of the people who gave the feedback is shown in Figure 1. For feedback about crisis support, 74% was about the person who gave the feedback and 26% was about someone else.

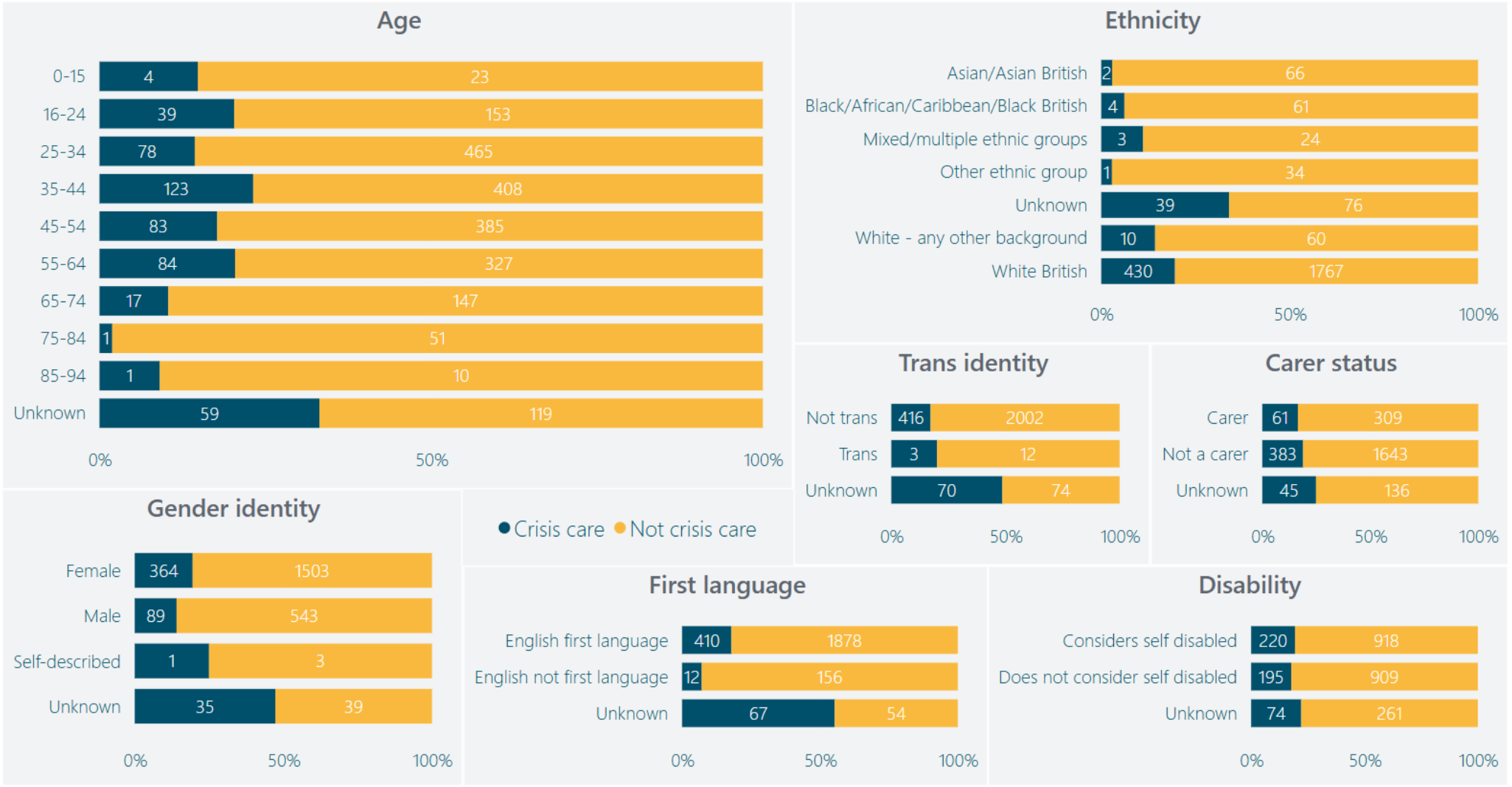


Figure 1. Demographics of people who gave feedback by the amount and percentage of feedback about crisis care vs. any other care.

Findings

Were there any changes over time?

To identify if there were key periods for feedback on crisis support, the amount of feedback on crisis support over time is shown in Figure 2, in both number and as a percentage of the total amount of all feedback about any care or service.

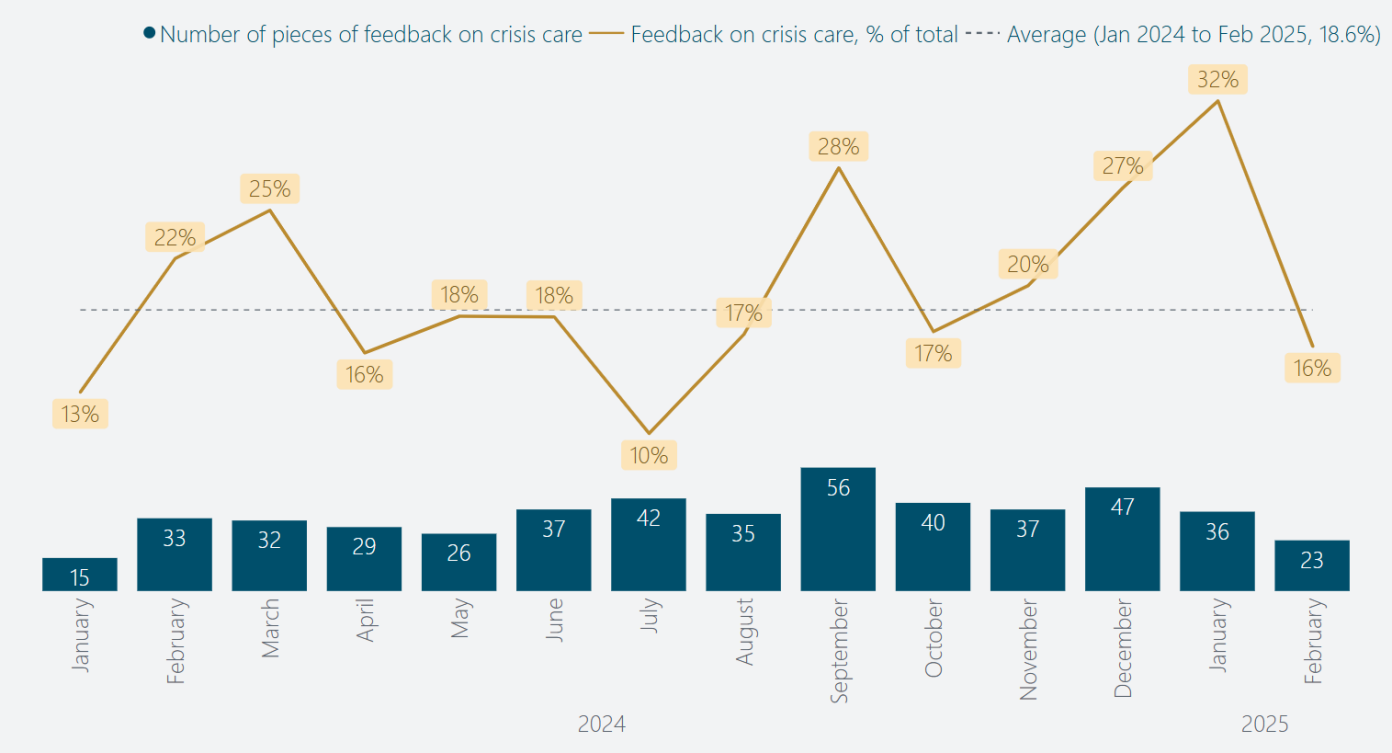


Figure 2. Amount of feedback on crisis support over time, in number of pieces and as a percentage of the total amount of all feedback about any care or service.

The percentage of feedback on crisis support was above the average of 18.6% in February, March and September 2024 (22%, 25% and 28%, respectively), showing that a greater proportion of the people we spoke to were telling us about crisis support at these times. Between October and December 2024, this percentage increased three times in a row (from 17% in October to 32% in December), showing an escalation in how much people were telling us about crisis support during these months. These observations underline recent findings that indicate the importance of considering time of year, as well as time of day and day of the week, in the planning and provision of services for mental health (Bu, Bone and Fancourt 2025).

Was age a factor?

To understand if we heard more about crisis support for people of certain ages, the age of the person the feedback was about is examined as a factor in Figure 3. In terms of the percentage of feedback that was about crisis support, we heard the most about people aged 16 to 25, 35 to 44 and 55 to 64 (23%, 22% and 20%, respectively), compared to the average of 18.6%.

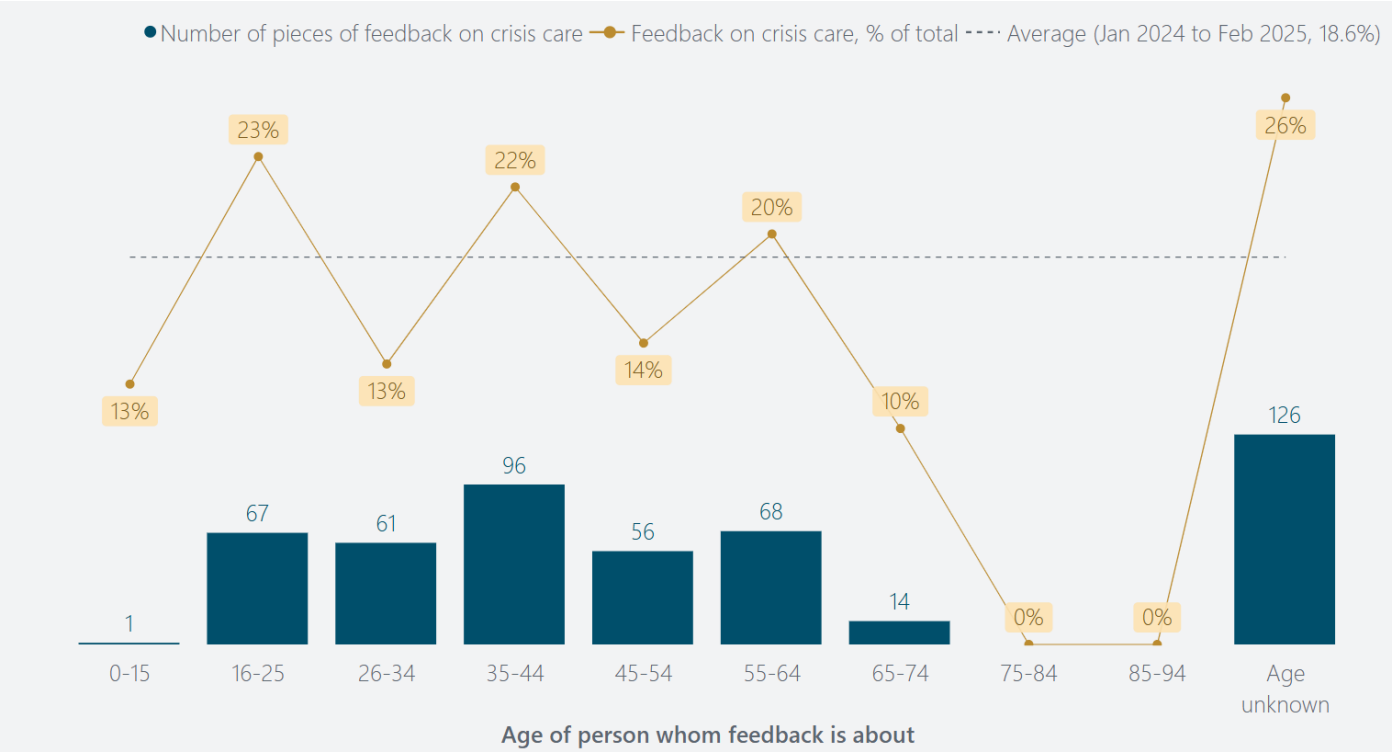


Figure 3. Amount of feedback on crisis support by the age of the person it was about, in number of pieces and as a percentage of the total amount of all feedback about any care or service.[1]

Were there times when we heard more about crisis support for key ages?

As we heard the most about crisis support for those aged 16 to 25, 35 to 44 and 55 to 64, we looked for any variability over time for these groups (see Figure 4).

For people aged 16 to 25, the percentage of feedback that was on crisis support peaked in February, April and May 2024 (39%, 50% and 31%, respectively, see Figure 4) to levels higher than for all other age groups or those of unknown age. Levels rose again in October 2024 (39%), staying high until January 2025 (33%), a peak that was both higher and started a month earlier than for feedback not filtered for age (33–39%, Figure 4 vs. 20–32%, Figure 2, respectively). These observations echo recent evidence that time of year, particularly the autumn season, can be linked to trends in young people's mental health (Jack, et al. 2023).

1. Figure 3 and Figure 4 are limited to the feedback for which we were told the age group of the person the feedback was about, which made up 19% of all feedback and 26% of feedback about crisis support.

For people aged 35 to 44, the percentage of feedback that was on crisis support peaked around February, March and April (29%, 56% and 25%, respectively, see Figure 4), then September and December 2024 (48% and 26%, respectively). The February and April 2024 peaks were most notable in the 35 to 44 (29% and 25%, respectively) and 16 to 25 (39% and 50%, respectively) age groups, although did not repeat in February 2025. The March peak, at a high level of 56%, was most notable in the 35 to 44 age group. The September 2025 peak was most significant in the 35 to 44 and 55 to 64 age groups (48% and 39%, respectively).

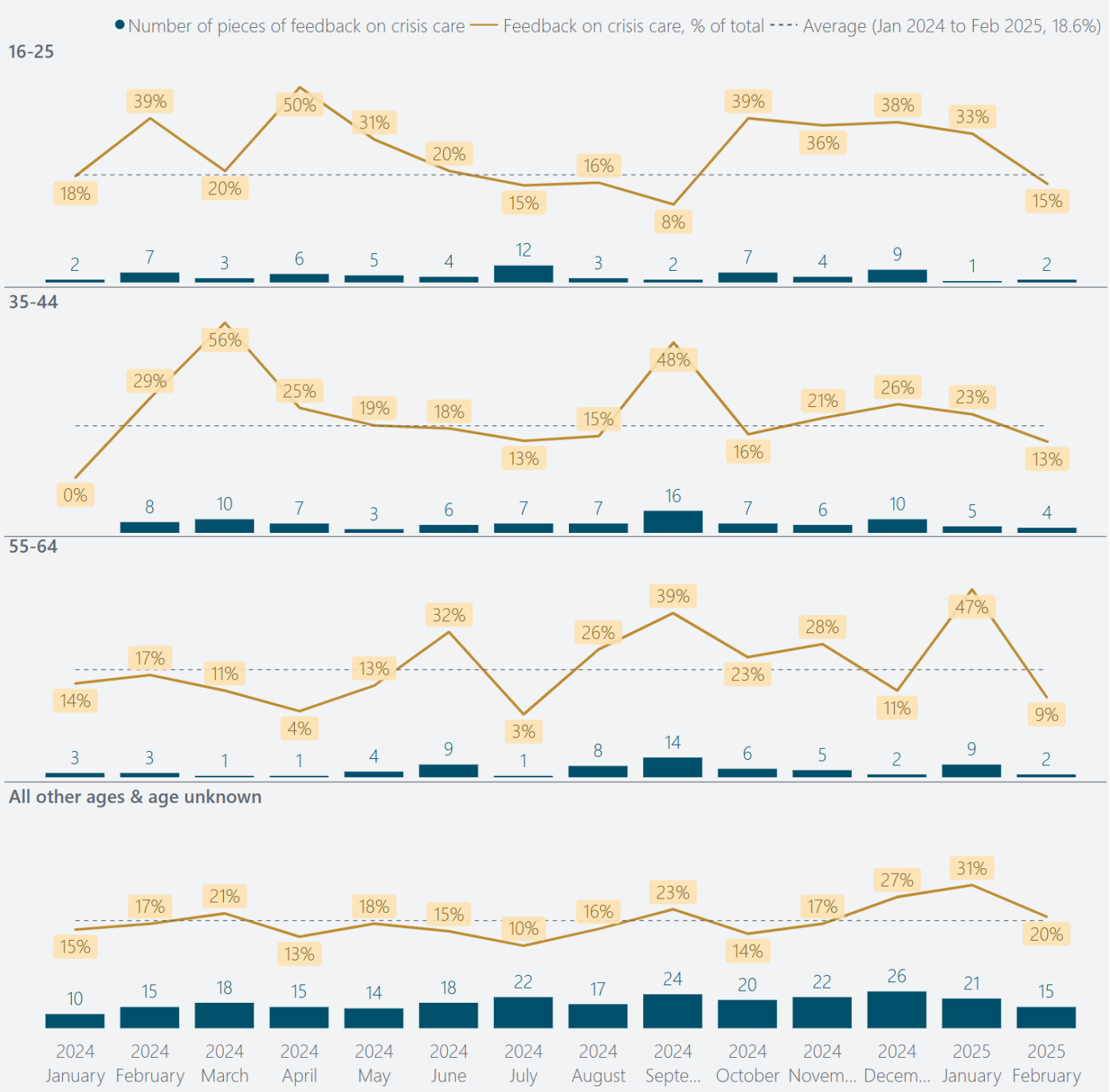


Figure 4. Amount of feedback on crisis support over time for the key age groups of the person it was about, in number of pieces and as a percentage of the total amount of all feedback about any care or service.[1]

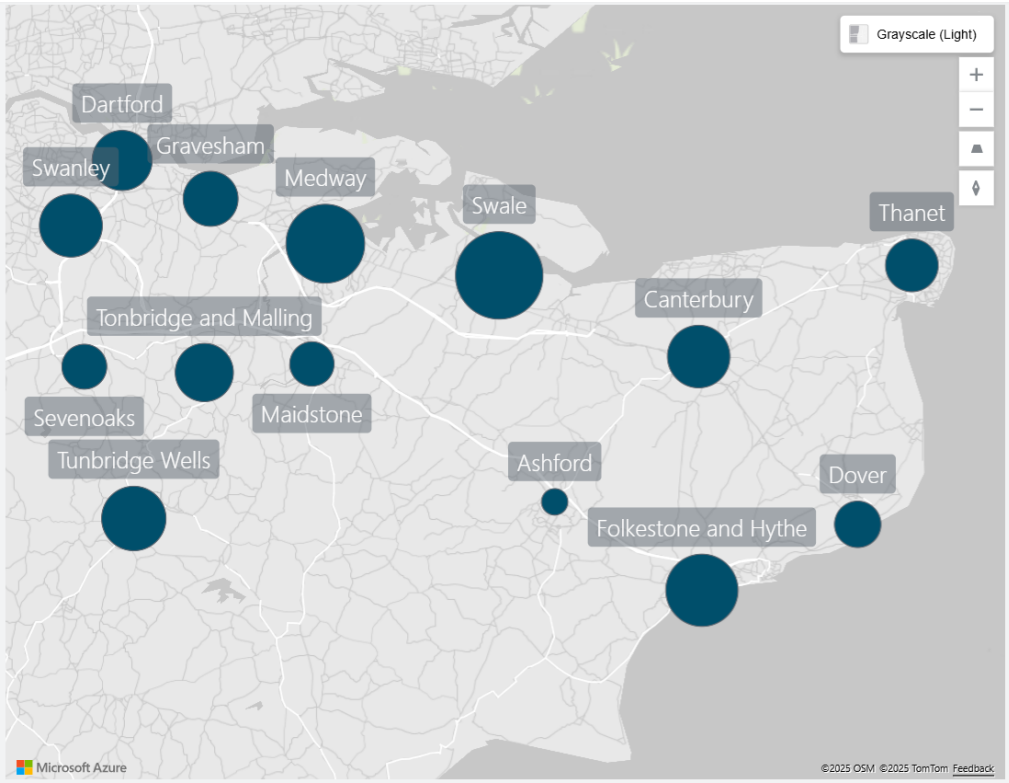
For people in the 55 to 64 age group, the percentage of feedback on crisis support peaked in June, August, September and November 2024 and January 2025 (32%, 26%, 39%, 28% and 47%, respectively). The June and August 2024 peaks were most notable for the 55 to 64 age group. The September 2024 peak was shared with the 35 to 44 age group and the November 2024 peak with the 16 to 25 group. The January 2025 peak, whilst common across age groups, was most pronounced for the 55 to 64 age group.

Whilst the percentage of feedback on crisis support for people in the 45 to 54 group was overall below average (14% compared to the average of 18.6%, see Figure 3), it also peaked in January 2025 at 32%.[2] Notably, the 45 to 54 and 55 to 64 age groups represent many people in Generation X, aged roughly 45 to 60, who have been identified in research as the generation most likely to die by suicide and drug poisoning (Office for National Statistics 2019).

2. Based on seven pieces of feedback on crisis support.

What were people's experiences in different districts?

The proportion of people's feedback that was about crisis support and the sentiment of the feedback by district are shown in Figure 5 and Figure 6.

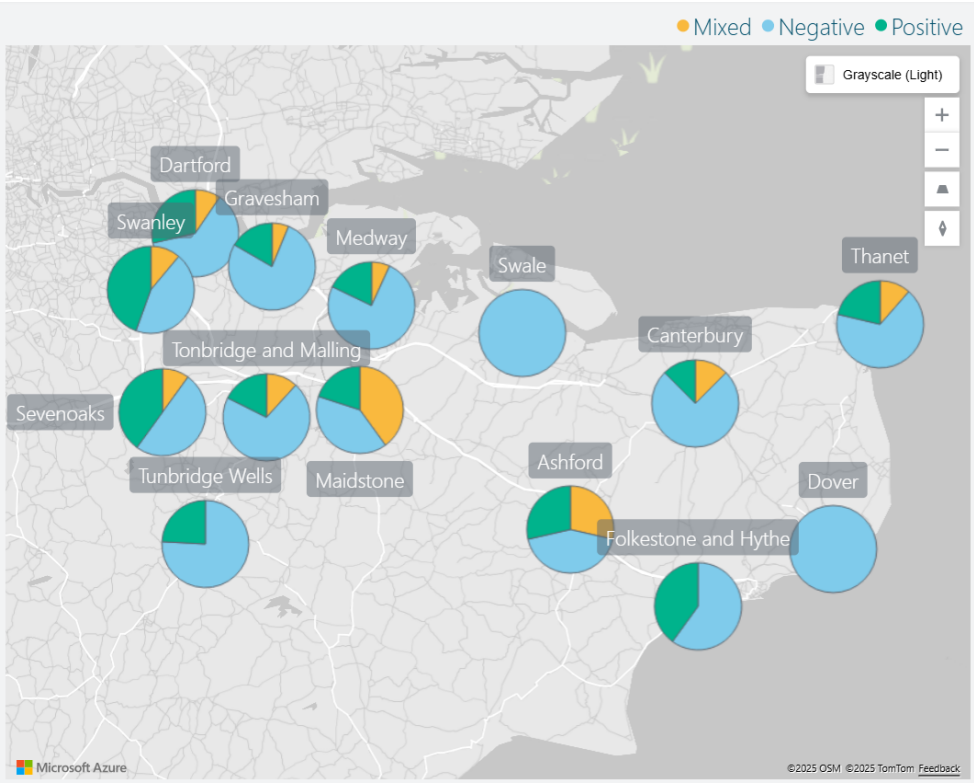


District	Percentage
Swale	42%
Medway	33%
Folkestone and Hythe	26%
Tunbridge Wells	20%
Swanley	19%
Canterbury	19%
Dartford	17%
Tonbridge and Malling	16%
Gravesham	14%
Thanet	13%
Dover	10%
Sevenoaks	10%
Maidstone	10%
Ashford	6%

468 pieces of feedback on crisis care

2553 pieces of feedback in total

Figure 5. Percentage of feedback that was about crisis support in each district. Feedback from people who did not specify which district they lived in was excluded.



District	Positive	Negative	Mixed
Ashford	4	6	4
Canterbury	2	12	2
Dartford	6	13	2
Dover	0	12	0
Folkestone and Hythe	2	3	0
Gravesham	8	37	3
Maidstone	2	4	4
Medway	34	143	13
Sevenoaks	4	5	1
Swale	0	14	0
Swanley	4	4	1
Thanet	13	41	7
Tonbridge and Malling	3	12	2
Tunbridge Wells	7	22	0

457 pieces of feedback

Figure 6. Proportion of positive, negative and mixed feedback by district. Feedback about our engagement partners' services was excluded to avoid bias.

Swale, Medway, and Folkestone and Hythe districts had the highest proportion of feedback about crisis support (42%, 33% and 26%, respectively) compared to the average of 18.6% (see Figure 5). Within Swale, all 14 pieces of feedback were negative; in Medway, 143 of 190 were negative (75%), 34 positive (18%) and 13 mixed (7%); and in Folkestone and Hythe, three of five were negative (60%) and two positive (40%), however, the latter is based on a limited sample size (see Figure 6).

Whilst the proportion of feedback from people living in the Dover district that was about crisis support, at 10%, was less than the average for Kent and Medway (see Figure 5), all of this feedback was negative (12 pieces, see Figure 6). Whereas in Sevenoaks, the same proportion of feedback was about crisis support (10%), but four of these ten pieces of feedback were positive (40%) and five negative (50%). In Swanley, the proportion of feedback that was about crisis support was average (19%), with four out of nine pieces positive and four out of nine negative (each 44%).

Of the eight pieces of positive feedback in the Sevenoaks and Swanley districts, four were about Samaritans. There was one piece each about private therapy, NHS 111, West Kent Mind and the Kent and Medway Mental Health Crisis Line.

In the Dover district, five of the 12 pieces of negative feedback were about a community mental health team or Mental Health Together, two were about acute hospitals and two about safe havens. In Swale, two of the 14 pieces of negative feedback were about a community mental health team or Mental Health Together and two about Kent Police.

This variation in sentiment by district, when broken down by service, is relatively consistent with the overall sentiment of feedback about services (see Figure 7). For example, voluntary, community and social enterprise services received more positive feedback than community mental health teams. An exception to this was the lack of positive feedback about safe havens from people living in the Dover district, with one negative feedback linked to the lack of a safe haven in Dover. Notably, in Swale, the two pieces of negative feedback for Kent Police were about a lack of support for children experiencing suicidal ideation or intent.

What did we hear about different services?

Sentiment of feedback about services

The key service types we heard about regarding crisis support were community mental health teams (CMHTs) or Mental Health Together (22% of feedback), Kent and Medway Safe Havens (13%), voluntary, community and social enterprise (VCSE) services (10%), general practice (10%), home treatment and rapid response (8%), Kent and Medway Mental Health Crisis Line (6%), A&E (6%), children and young people's mental health services (5%), counselling, psychotherapy and talking therapies (5%), liaison psychiatry (4%), and mental health hospitals (3%).

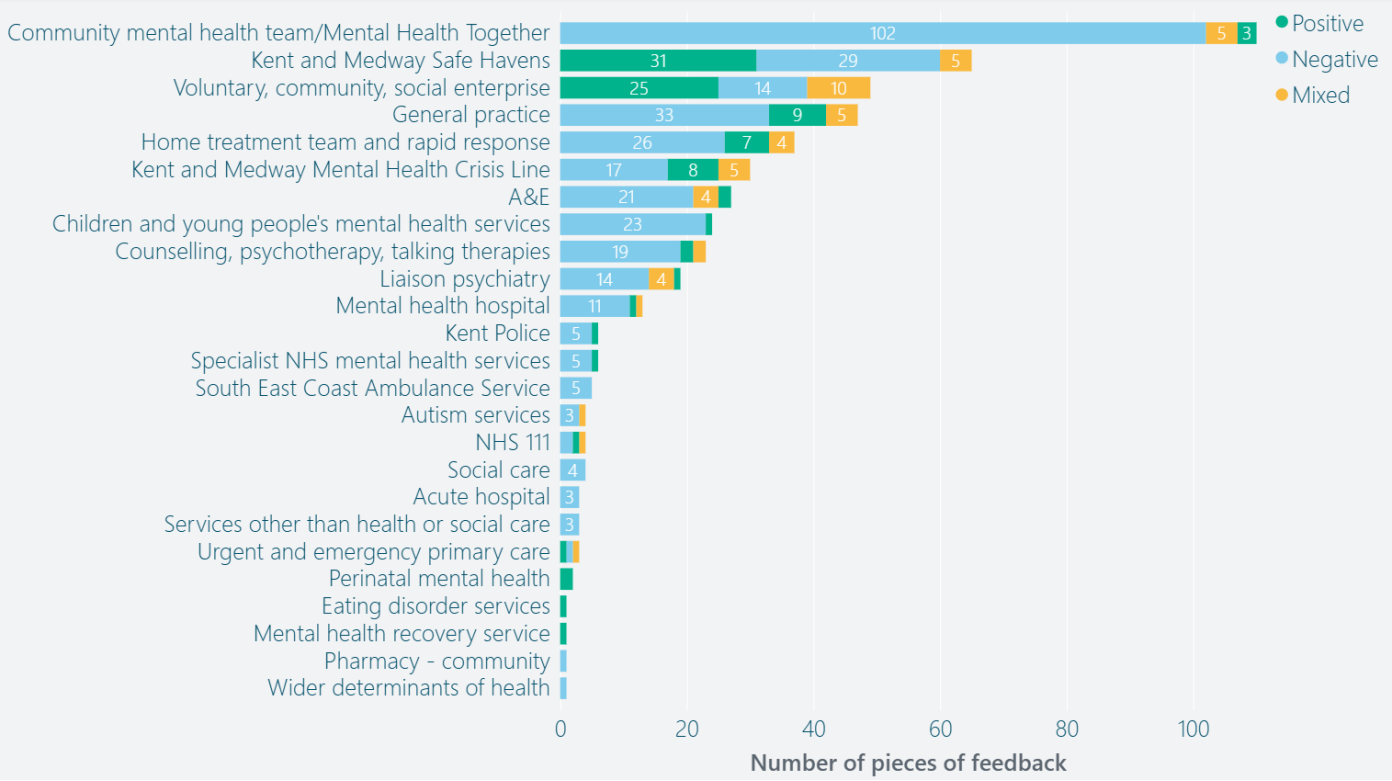


Figure 7. Number of pieces of feedback by service type and sentiment.

The service types with the most positive feedback were VCSE services (51%) and Kent and Medway Safe Havens (48%), suggesting that we can learn from what is going well in these services.

Case study involving multiple services

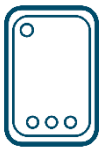
We heard about Nat's experiences with crisis services.[3] Nat's story involves multiple services and highlights issues of access, coordination and continuity of care, and response to crisis situations.

3. Pseudonyms and they/them pronouns are used to protect identity.

Nat

> The experience I had … and the way I was treated … made me feel so much worse at a time in my life when I already felt at my lowest. Since then, I have not engaged with any mental health services or accepted any help from my GP practice and if I were to experience another crisis in the future, I would be extremely reluctant to reach out for help.

‘ [In early] 2024, I had a mental health crisis. A family member called 111 and was advised to take me to hospital, where I was given a number for a crisis line and sent home. At home, I called this number to discover it was no longer in use.



I ended up calling [an out-of-county] home treatment team, which I had been receiving treatment from before this. They gave me the number for [my local] home treatment team, who told me they could not help me and to call 111 again.

This time, 111 told me to attend [the] hospital. I ended up staying there for six days. During this time, I stayed in a room with at least five other patients at once, having to sleep on a chair. I didn’t leave this room for six days, except from the attached bathroom and assessment rooms, and I was told I couldn’t shower because there was not enough staff. This room and the attached bathroom were not cleaned during the time I was there.

There were many issues with medication, causing me and other patients to experience withdrawal symptoms. One evening, I was given the wrong medication but when I tried to explain this, I was dismissed and I took the medication. … I was put into one of the assessment rooms attached because I was upset. This room had faeces smeared on the walls from another patient the day before and it had not been cleaned. When I tried to leave the room, I was told I wasn’t allowed and that I needed to calm down. I was eventually allowed to leave after other patients argued with the staff and advocated for me.

I was later transferred to [a mental health inpatient unit] and then discharged to [the home treatment team]. Throughout this process, I felt very ignored and dismissed, like I was wasting time. [In the mental health inpatient unit], a doctor told me they were treating people who were ‘actually sick’, which felt very invalidating. **I want to share my story to highlight that mental health services are not only underfunded but lacking empathy and compassion. ’**

Community mental health teams and Mental Health Together

93% of feedback about CMHTs and Mental Health Together was negative, 3% positive and 5% mixed.[4] People giving positive feedback about CMHTs or Mental Health Together described effective coordination and continuity of care.

> I have recently been in crisis and … expressed my need to just get away, which I did. During this time [the CMHT] liaised with the [CMHT in another part of the country] where I was staying to ensure continuation of care.

> I phoned the [CMHT]. I was having really dark thoughts and feeling suicidal. I asked to speak to my worker, and I was told that someone has signed me off from their mental health service. [The CMHT] said no problem and that they will refer me back in right now. She transferred me to a [member of staff] who did all the forms, and it was all easy. It was one phone call, and I was back on there. I am very happy about this. I would just like to say thank you to how quickly they sorted this out for me.

The most frequent topics in negative feedback were impact on lifestyle and wellbeing, coordination and continuity of care, and communication between staff and patients (see Figure 8). Care given by staff, medication, discharge, and triage, assessment and admission were also frequently mentioned. These issues were identified in CMHTs in all four health and care partnership areas.

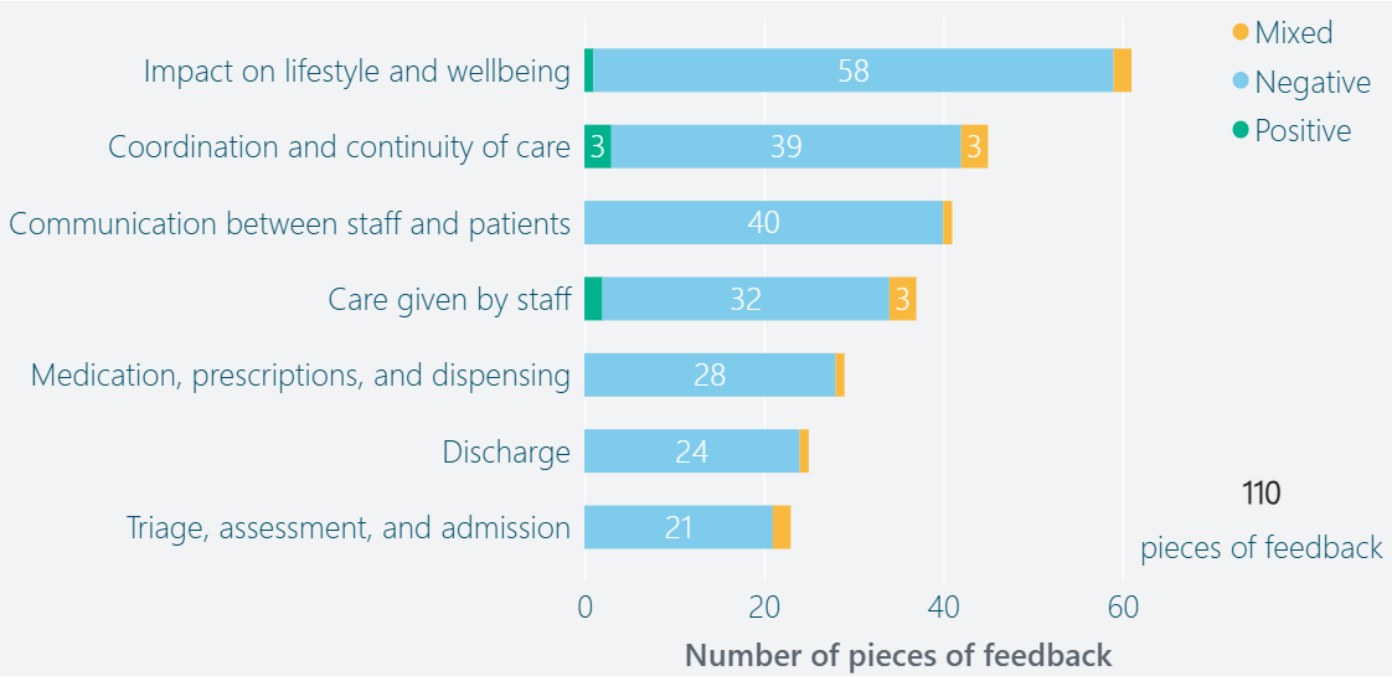


Figure 8. Top seven topics in 109 pieces of feedback about CMHTs.

4. These percentages total more than 100% because they have been rounded to the nearest whole number.

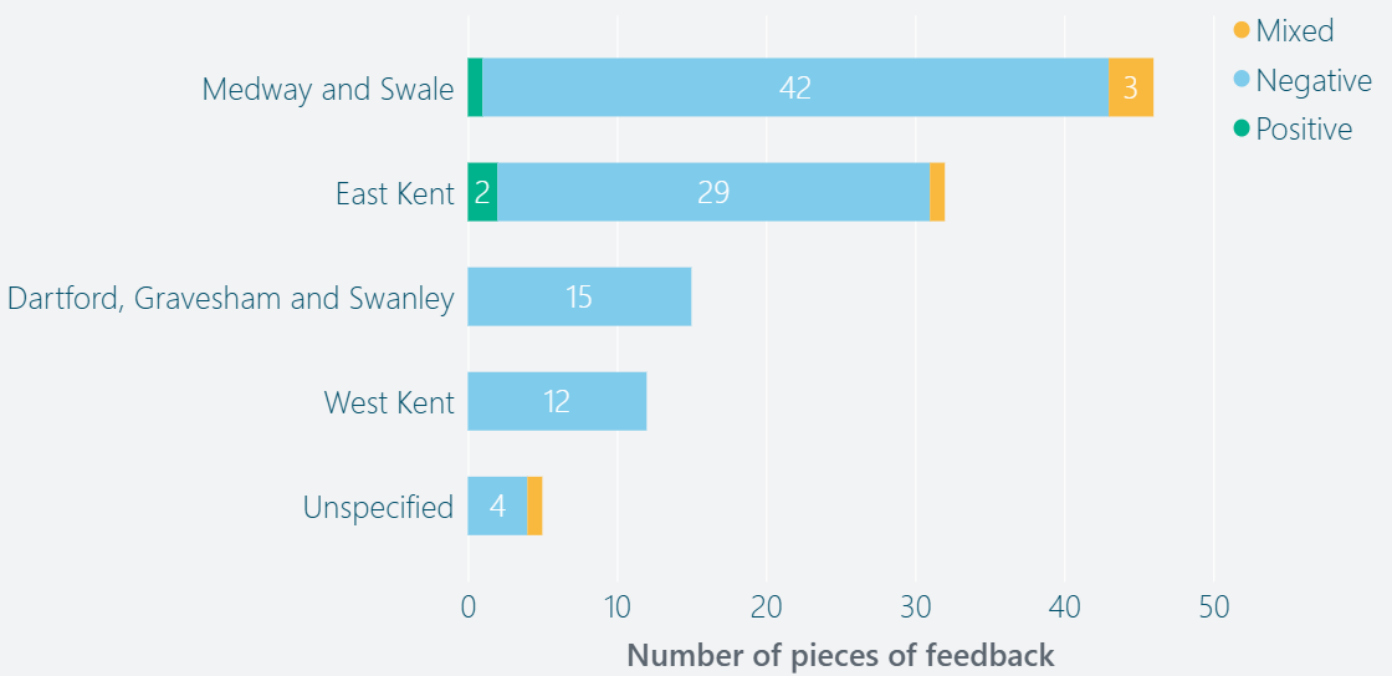


Figure 9. Sentiment of feedback about CMHTs in each health and care partnership area.

Impact on lifestyle and wellbeing: Of the 61 pieces of feedback on this topic, the most common theme was people describing how their interactions with CMHTs had left then feeling more unwell or had tipped them into crisis.

> I became a lot more anxious, depressed and suicidal after my dealings with them.

Coordination and continuity of care: The most common theme in the 45 pieces of feedback on this topic was from people with ongoing mental health conditions that caused them to occasionally reach crisis point. They shared how they felt unsafe with a lack of oversight or ongoing check-in support from the CMHT. They were instead in a cycle of referral, assessment, discharge and re-referral, during which we heard cases of people not receiving effective support.

> As a result of the wait times to be referred back in and receive an appointment for a medication review, it has resulted in two admissions to [the mental health] hospital, which could have been prevented had [Mental Health Together] kept me under their service.

Communication between staff and patients: Within the 41 pieces of feedback on this topic, people most commonly told us they had been unable to access timely or effective support when they contacted their CMHT. People also told us of instances where they did not receive planned or promised phone calls from the CMHT, including for follow-ups and remote appointments.

> I originally contacted the CMHT [a few months ago] as I was in crisis and felt very unstable. … I waited ten weeks before anyone contacted me. … I went on to self-harm after a week. … I have now been signposted on to a [mental health] course and informed of a few more things that may be of help – this shouldn't have taken ten weeks.

Care given by staff: Within the 37 pieces of feedback that mentioned this topic, whilst we heard about responsive and understanding care, people also described feeling dismissed or that they were not being listened to.

> I found [them] unsympathetic and felt like [they weren't] listening or understanding.

Medication, prescriptions and dispensing: The most common theme in the 29 pieces of feedback on this topic was of people having difficulties getting medication reviews or changes.

> I recently contacted [the] CMHT and asked them for their help and to review my [mental health medication]. This was completely ignored and I was told basically I'm going to get discharged from their service. This is despite basically saying I'm planning to [die by] suicide.

Discharge: Within the 25 pieces of feedback that related to discharge, people referred most often to being discharged without follow-ups or support.

> I was referred by 111 to the CMHT during crisis as I was actively suicidal. I had a one-hour consultation and then was discharged back to the care of GP without any follow up. This has had a detrimental effect as they acknowledged how bad things were during my assessment and then did nothing to support me.

Triage, assessment and admission: Within 23 pieces of feedback on this topic, the most common theme was that people who had reached crisis point or had identified that they were approaching it described not being accepted into the CMHT for support because they were not unwell enough.

> I was told by [the CMHT] that I wasn't suicidal enough to have their support and was turned away.

A professional also told us of the exclusion of people with a dual diagnosis, an issue we have reported on previously (Healthwatch Kent and Healthwatch Medway 2024).

> The CMHT refuse to work with anyone who is self-medicating with substances despite this being an area covered extensively within the dual diagnosis and co-occurring conditions act.

Next steps for community mental health teams and Mental Health Together

We recommend community mental health teams and Mental Health Together to consider the following.

Timely and effective support for people in or at risk of mental health crisis

- Maintain systems and plans to ensure that if people contact their CMHT in crisis, they access timely and personalised support.
- Ensure that callbacks, follow-ups and appointments take place. If there is an unavoidable need for cancellation, ensure that these are rebooked at the point of cancellation and communicated clearly to the individual.

Breaking the cycle of referral, assessment, discharge and re-referral

- Review re-referral rates to understand opportunities for more effective support systems.
- Review why people referred into the CMHT due to mental health crisis are not being accepted for support, including people with co-occurring conditions, and communicate this back to the referrers.
- Facilitate regular check-ins with people diagnosed with mental health conditions, those on mental health medication and/or those at greater risk of mental health crisis.

Responsive and understanding care

- Celebrate and promote responsive and understanding care where people feel listened to by all staff, with ongoing training as required.

Support for people on waiting lists

- For those on waiting lists, put in place signposting and updates for all, and check-ins or support plans for those at higher risk.

Discharge practices

- Ensure that people are discharged with coproduced and personalised support plans and receive follow-up check-ins for a tapered discharge.

Kent and Medway Safe Havens

48% of feedback about Kent and Medway Safe Havens was positive, 45% negative and 8% mixed.[4] The two most common topics of care given by staff and impact on lifestyle and wellbeing were also the topics with the most positive feedback (see Figure 10). Communication between staff and patients was the third most common theme and the one with the most negative feedback. Other common topics included quality of treatment, service change or closure, coordination and continuity of care, and health inequalities.

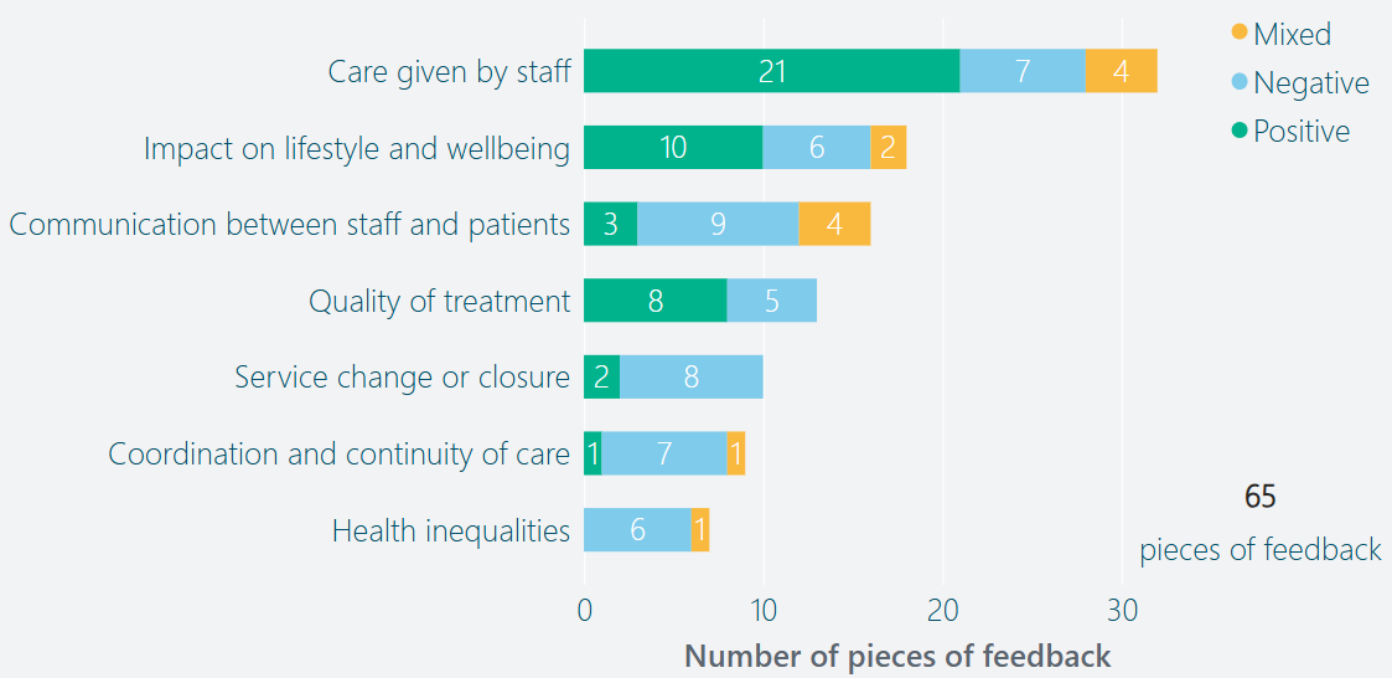


Figure 10. Top seven topics in 65 pieces of feedback about Kent and Medway Save Havens.

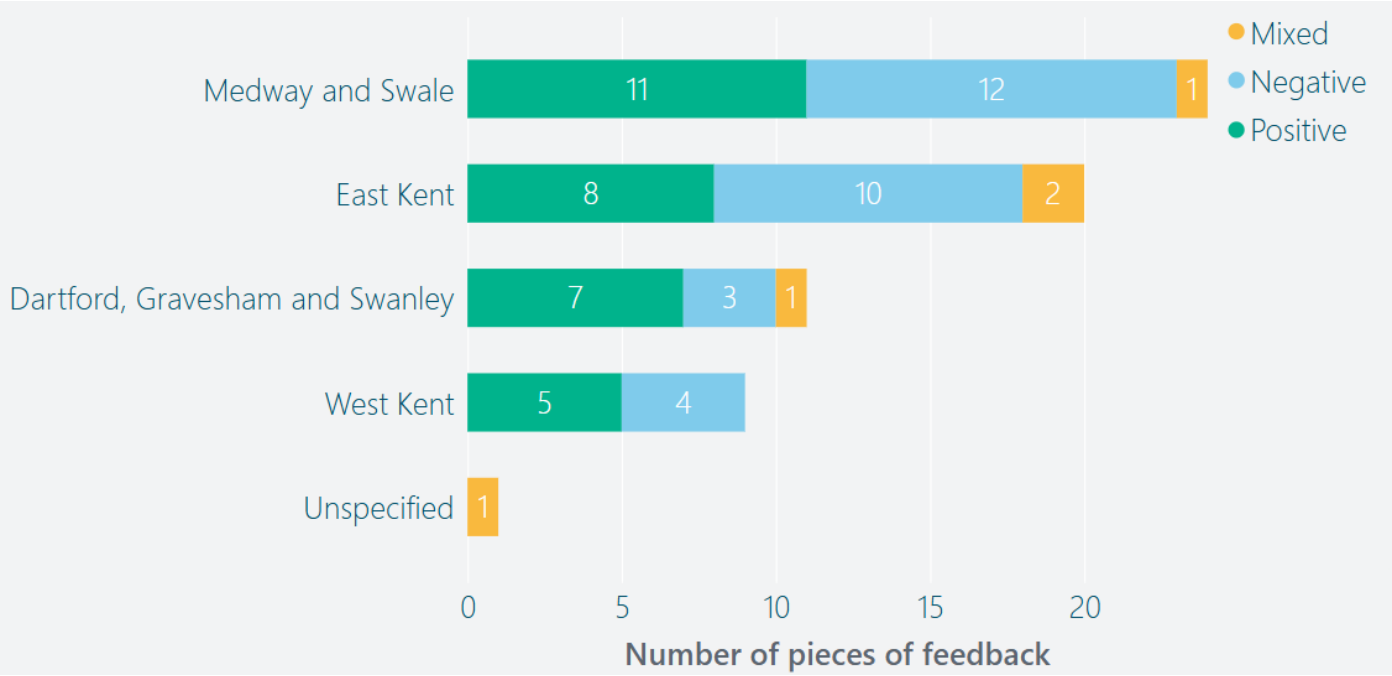


Figure 11. Sentiment of feedback about Kent and Medway Safe Havens in each health and care partnership area.

Care given by staff: Within 21 pieces of positive feedback on this topic, the most common theme was of people experiencing a welcoming and safe atmosphere and feeling listened to without pressure or judgement.

> The safe haven[s] … are great. They will listen. I was in crisis back in November and they gave me the time to just be.

However, ten people relayed that they ended up feeling they had been wrong to attend the safe haven or that the interactions with staff had not helped.

> The first time, I didn't feel like the [member of staff] I spoke with was taking me seriously. … The second time I spoke with [another member of staff] who seemed to listen more and took me seriously.

Impact on lifestyle and wellbeing: Ten people told us how their attendance at the safe haven had had a positive effect on them. In eight cases, this was tied in with the care given by staff theme, suggesting that positive interactions had a direct impact on people's wellbeing.

> Everyone was really helpful to get me through the nursing baby phase. I am okay now.

One person reported how a chaotic atmosphere at a safe haven had a negative impact on their wellbeing.

> It was chaotic up there. There were all these people wanting help, some of them were under the influence of drugs or alcohol, and it was loud. … I came away feeling more traumatised than when I arrived.

Communication between staff and patients: People described accessing safe haven support via email, phone and text, which they found helpful. Others mentioned that useful information had been given to them at the safe haven.

> The [member of staff] who got in touch with me said I could text, which we did for a bit, and it helped having someone there on the other end when I couldn't speak.

Some people were concerned that there was not enough public awareness of the support offered at safe havens, including the peer support groups, or of the fact that locations had changed.

> I am concerned that so few people in Thanet know about the safe havens here. … If they knew sooner, they could have benefitted from this support service.

Quality of treatment: People felt that the support offered, including the groups, were good quality and helpful.

> The safe havens is a brilliant service and I don't know what I would do without it.
>
> Safe havens are really good. I use them all the time.

Others felt the support they received at the safe haven was not as thorough as they needed it to be. For example, two people stated that a 20-minute time limit on phone calls was not long enough.

> It was an activity evening, but I wanted something less informal where I could meet people and gain peer support.

Service change or closure: Whilst one person cited the longer opening hours of the Tunbridge Wells Safe Haven as helpful when compared to the previous crisis café offer, others mentioned issues with the change to the service offer in Thanet, Tonbridge, Ashford and Medway. Two people felt the support at the Thanet Safe Haven was not as good as in its previous location and two others experienced confusion around its move, with one arriving during the advertised opening hours only to find it closed. Two others expressed concern at the lack of service in Ashford. People who had attended the former crisis café in Tonbridge were disappointed that the service was only being replaced in Tunbridge Wells and one person described staffing issues at the Medway Safe Haven.

> I rang 111 option 2 and they suggested that I go to the safe haven instead of A&E. I got a taxi and found out it had closed, I had no knowledge of this at all.

Coordination and continuity of care: People described challenges when it came to coordination of their care between safe havens and CMHTs. People also identified continuity of care issues as they had been offered welfare checks that then did not take place.

> [After being referred by the CMHT], I attended the safe haven. … I went there in a high level of crisis … but it was not what I had hoped for at all. … The support I received was minimal, and it was explained to me that the safe haven was actually more of a social community place, offering weekly group classes.

Health inequalities: People described issues with the location of some safe havens, especially due to limited transport links. For example, people in Tonbridge and Swale were unable to access their nearest safe haven as public transport stopped at 8pm. Others shared issues linked to Ashford, Sandwich and Dover, with one identifying it was unsafe to drive if in a mental health crisis.

> We don't even have a safe haven in Dover, so I can't even use this service.

A person with a disability felt that their needs had been accommodated well.

> They made me feel comfortable by adapting the environment to my needs.

However, others with disabilities or neurodiversities shared mixed experiences in accessing the safe havens. For example, one person with autism and communication difficulties said she would be unable to access safe havens without support. Another benefitted from the sensory room but felt misunderstood as an autistic person, as did an individual with mutism.

> Autistic individuals can be more sensitive to rejection, have a strong sense of right and wrong, and dislike breaking rules or making mistakes. It's important to choose words carefully to avoid making them feel they've done something wrong.

Next steps for Kent and Medway Safe Havens

We recommend Kent and Medway Safe Havens to consider the following.

Responsive and understanding care

- Celebrate and promote responsive and understanding care where people feel listened to by all staff, with ongoing training as required.
- Ensure that planned welfare checks reliably take place.

Effective signposting and awareness of service

- Share good practice in providing appropriate signposting information.
- Engage in public and community outreach to raise awareness of the support offered at safe havens, including peer support groups.

Accessibility and reasonable adjustments

- Share and develop good practice in meeting diverse needs, including for people with disabilities, neurodiversities and communication differences.

Locations

- Pursue facilities for communities in underserved locations, for example, Tonbridge, Swale, Sandwich and Dover.

Support offer

- Continue to offer a broad range of engagement options, including email, phone, text, walk-ins and support groups.

Integrated care

- Work with community mental health teams and home treatment and rapid response teams to develop good coordination of care between services, for example signposting and referral processes.

Voluntary, community and social enterprise services

51% of feedback about VCSE services was positive, 29% negative and 20% mixed. The two most common topics of care given by staff and impact on lifestyle and wellbeing were also the topics with the most positive feedback (see Figure 12). Other common topics were quality of treatment, communication between staff and patients, and service change or closure. Access to services was the sixth most common theme and the one with the most negative feedback.

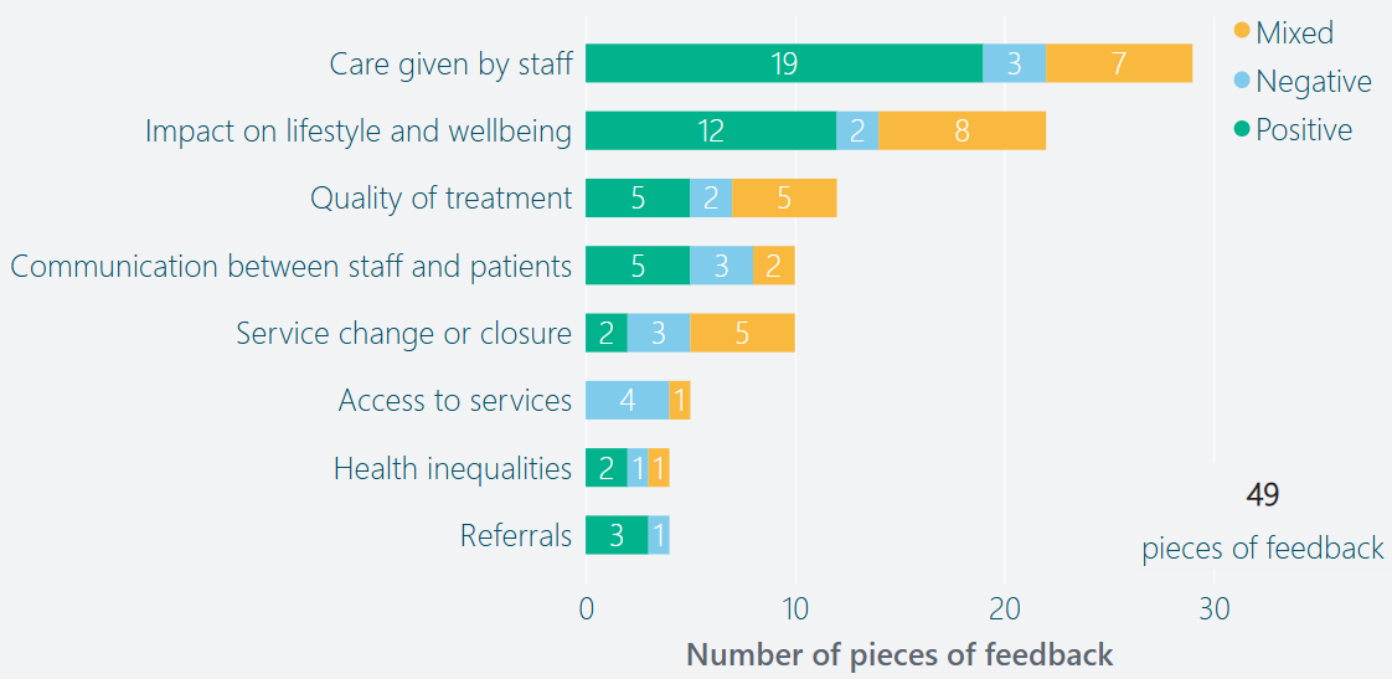


Figure 12. Top seven topics in 49 pieces of feedback about VCSE services.

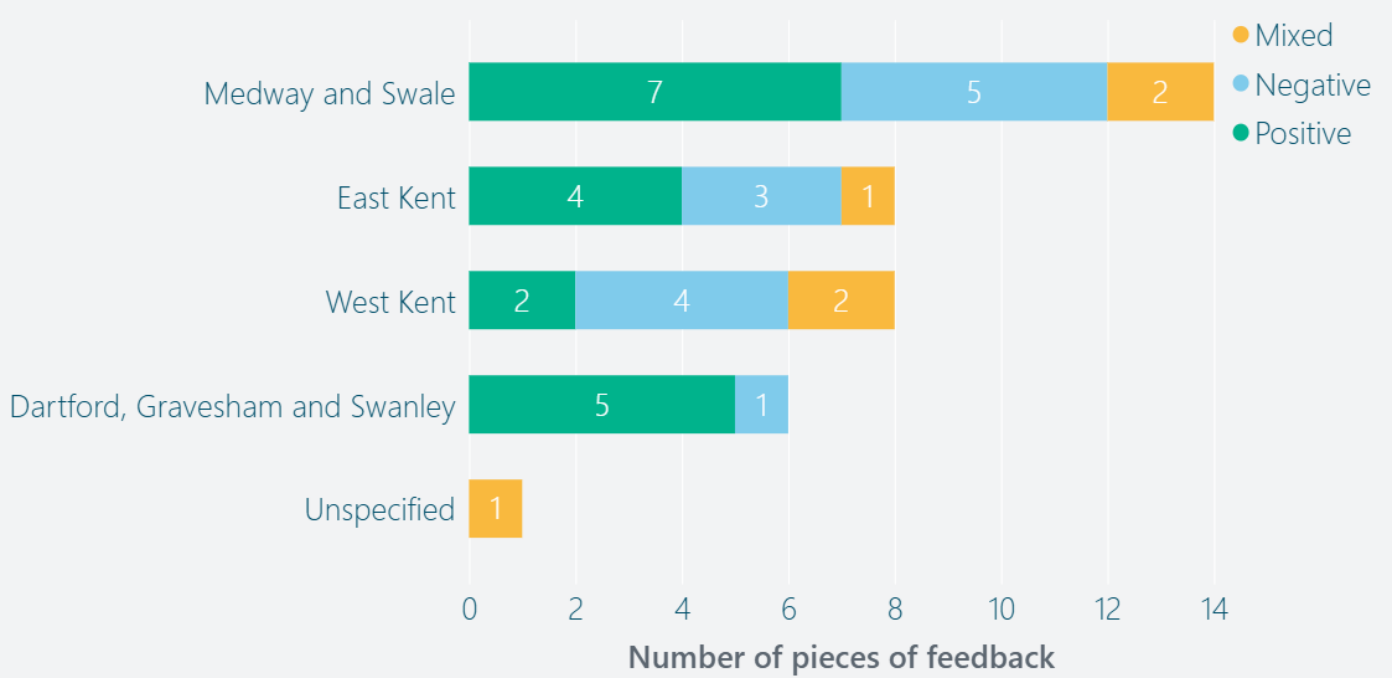


Figure 13. Sentiment of feedback about VCSE services in each health and care partnership area. Feedback about our engagement partners' services was excluded to avoid bias.

Care given by staff: Staff who treated people with understanding and compassion were mentioned, particularly on the Samaritans helpline. As were a range of other VCSEs, including peer support organisations, charities and a church.

> Each time I've spoken with [Samaritans], they have been absolutely incredible in helping me gain clarity and perspective. I called them after self-harming on a few occasions, and they responded with such understanding and compassion. They made me feel supported and ensured my safety, guiding me to seek the care I needed at A&E, who also treated me with respect and understanding.

Impact on lifestyle and wellbeing: People reported being able to manage their mental health or navigate further support as a result of the support provided.

> In three weeks, I've started accessing the church and other things alongside [the peer support organisation] and no longer feel in crisis.

Two people, however, told us of the danger of not receiving timely or effective support when in crisis.

> [A] telephone assessment [with Live Well Kent] took place [nine days after my GP referred me to the crisis team], but there was nothing they could offer me other than going back to [a mental health support service] and paying for one-to-one counselling. … This constant rejection makes me feel completely inadequate and worthless.

Quality of treatment: People felt that the support available in the voluntary sector was good quality. Two people compared this to NHS services.

> The voluntary sector is far more underfunded than the mental health teams but will do more to support.
>
> Services such as the [crisis café] take pressure off the NHS and work to prevent crisis, rather than responding to it.

Communication between staff and patients: People described effective signposting practices that helped with crisis treatment and recovery.

> Fortunately, via [a peer support organisation], I have been given details about the Kent Enablement [and Recovery] Service and I am going to contact them in the hope that they can accept and support my [loved one].

However, two people described being given advice they did not find helpful.

> They told me to talk to family and friends. I had no family or friends at the time.

Service change or closure: People who were accessing support from personality disorder peer support groups were concerned about the potential impact of these services being replaced by the Service User Network, particularly for people in crisis.

> This has the potential for suicidal thoughts to overrun.
>
> I worry I'll end up in psychosis through the ending of the group.

Access to services: Four people reported issues with accessing support via the Samaritans phoneline and one via the Release the Pressure helpline.

> I wouldn't try to call any helplines again for support after trying to call Samaritans on a few different occasions and not getting an answer.

Health inequalities: One person identified good practice in supporting an autistic young person.

> My [loved one] has been really happy to engage with the [member of staff] supporting her, which is rare for my [loved one], as she is autistic and finds engaging with support agencies really hard.

Next steps for voluntary, community and social enterprise services

We recommend that voluntary, community and social enterprise services consider the following.

Timely and effective support for people in or at risk of mental health crisis

- Identify and share good practice in the provision of timely, targeted care.
- Review and address why some helpline calls are not answered.
- Fast-track people at risk of mental health crisis on waiting lists.

Responsive and understanding care

- Celebrate and promote responsive and understanding care where people feel listened to by all staff, with ongoing training as required.

Effective signposting

- Share good practice in providing appropriate signposting information.

Accessibility and reasonable adjustments

- Share and develop good practice in meeting diverse needs, including for people with disabilities, neurodiversities and communication differences.

General practice

70% of feedback about general practice was negative, 19% positive and 11% mixed. The two most common topics of care given by staff and impact on lifestyle and wellbeing were also the topics with the highest proportion of positive feedback (see Figure 14). Other common topics were medication, prescriptions and dispensing, communication between staff and patients, coordination and continuity of care, booking appointments and referrals.

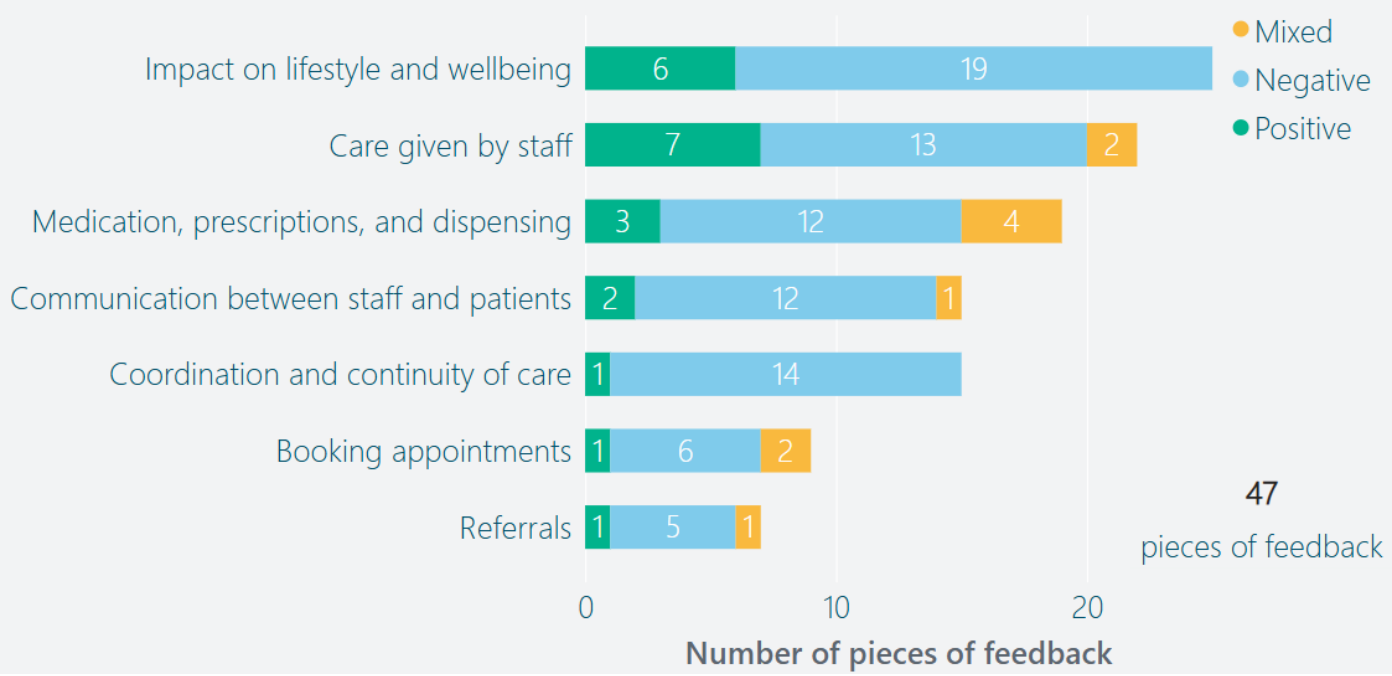


Figure 14. Top seven topics in 47 pieces of feedback about general practice.

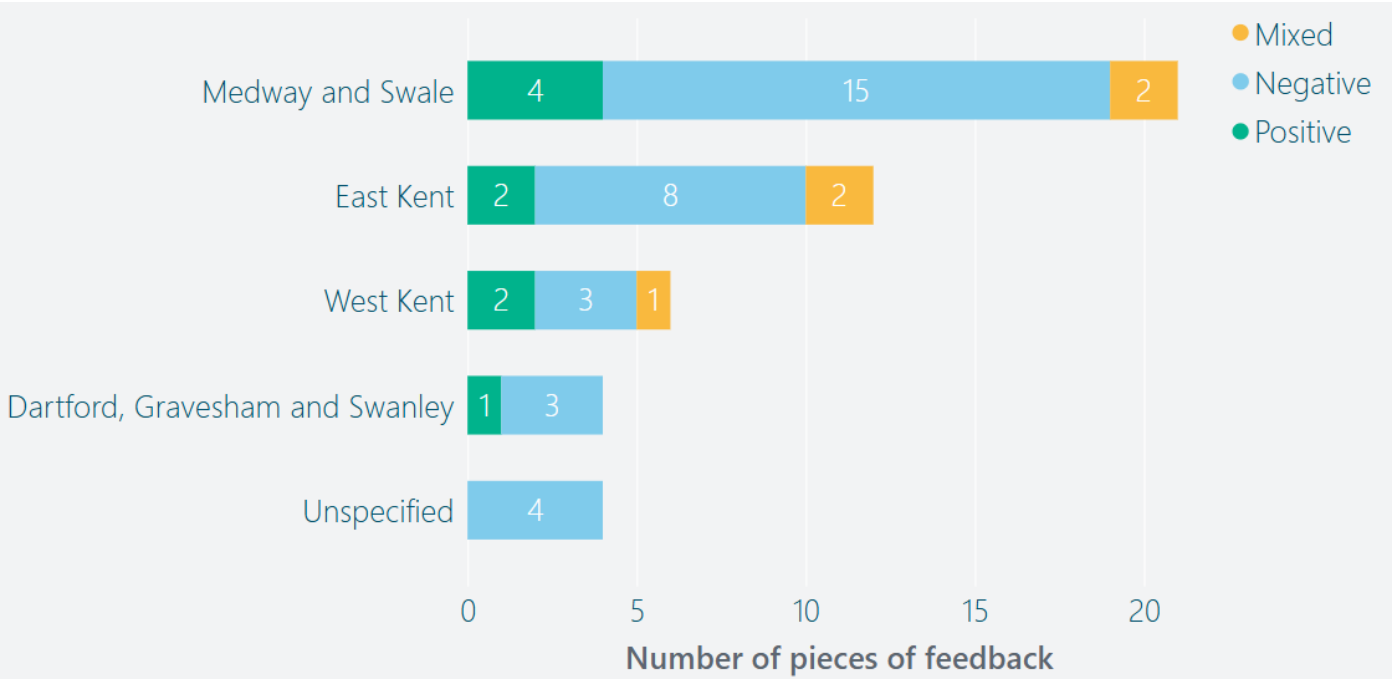


Figure 15. Sentiment of feedback about general practice in each health and care partnership area.

Impact on lifestyle and wellbeing: People described how effective and timely care from GPs or mental health nurses had kept them safe and helped them to recover. One young person was able to return to work as a result.

> I have been very suicidal at times and [my mental health nurse] has literally kept me going.

However, general practice professionals telling people they could not help them or no help was available, making ineffective referrals, forgetting to refer, not supporting with medication, cancelled appointments and being dismissed directly contributed to people's mental health becoming worse.

> He has appointments [at the GP surgery] that get cancelled and rebooked, which impacts him even more because he mentally prepares for these appointments to then be let down.

Care given by staff: People described understanding and supportive care from their GP or mental health nurse.

> The doctor she saw … was very understanding.

> We had been doing a lot at home with our amazing GP. The GP had managed to get my [child] into a better place mentally.

However, people also described dismissive attitudes from professionals when they disclosed how they were feeling.

> The doctor I last saw laughed when I said I was feeling suicidal.

> In the end, I tried going into the surgery and explaining, but the receptionist tutted and laughed at me.

Medication, prescriptions and dispensing: Four people received a prescription for medication within two days of contacting the GP. This was after two of these had been let down by children's or adults' mental health services.

> I got an appointment with a doctor that same day who was stunned at my [loved one's] presentation and immediately prescribed her antidepressants and talking therapies.

We heard of two people struggling with crises who were not having medication reviews from their CMHT and were finding their GP support insufficient. People also told us of GPs not following their CMHT's prescription recommendations.

> I'm not under the care of a psychiatrist, no one checks if my medication is still suitable, and the only way I get to see someone is if I get referred back into the CMHT by my GP because I have gone to him in crisis.

Others described medication being changed without enough support.

> I brought in some of my medications from my home country, registered with the GP when I arrived, went in for medical review where the medical team cancelled my medications without any proper review.

Communication between staff and patients: One person said it had been helpful to receive fortnightly follow up calls, which reliably took place on the scheduled date, although it would have been better to know what time the calls would be.

> [The GP] offered me follow-up consultations every two weeks, which they kept to. It was a little annoying not to know what time they were going to call me – they told me what day, but they didn't say a time – so sometimes I had to leave a meeting or worry about going to the loo and missing the call, but they always did call on the day they said they would and that was reassuring and I felt heard and taken care of.

Two people told us that their GP had told them they could not or did not know how to help them. Two others mentioned ineffective signposting, where out of date or incorrect information had been provided.

> When I again said I wasn't coping, [the GP] said, 'I can't help you.'

> I was given a telephone appointment where I was told they had no idea how to help and that they would refer me to another organisation.

Coordination and continuity of care: Two people described the positive impact of having consistent support from their mental health nurse.

> I have [the mental health nurse's] direct email and so when I need help/support, I am able to contact her rather than having to go through the GP surgery. To be able to speak with the same person and have that consistency means the world.

However, one person had the opposite experience when a cognitive behavioural therapy course at their GP surgery was run by three different practitioners. Three others described how they or their child had been passed between their GP surgery and other services without receiving effective care.

> What would a good service look like? A single person responsible for my care. Let me know who they are and what to do if I don't hear from anyone. Joined up care across services, without me having to make dozens of GP appointments.

Booking appointments: Two people mentioned the positive difference easy appointment booking experiences had made. Two others were satisfied with the appointment booking procedure.

> An individual phoned his GP at 9:30am because he was feeling "very low and depressed". His GP made an appointment for him at 11am that day. On another occasion, this individual was feeling suicidal and the GP phoned him that evening. He felt the service he received was very good and felt very supported by his GP.

However, people also told us of struggles to book an appointment for a mental health crisis: two could not get an appointment for two weeks, another was given a telephone appointment for their child only after visiting the practice 13 times, and another was asked to download an app to book an appointment, but the triage system deemed they did not need one. Two people in mental health crisis due to physical health issues also described issues obtaining appointments.

> Mental health crisis, police involved, completely unable to get a face-to-face GP appointment. Initially offered nothing, then an appointment in two weeks. Eventually got a phone call and meds prescribed.
>
> When I eventually got through, they told me to download an app. Not what you want to hear when you're feeling this way.

Referrals: One person was referred promptly to the crisis team by their GP, only to then not hear from the crisis team. Two others told us of a referral being forgotten and delayed or of struggling to be considered for a referral at all.

> I had a very strong urge to take my own life. … My GP was supportive and did an urgent referral to the crisis team and said that someone would call me within the next 24 hours. It was totally ignored.
>
> His GP took weeks and weeks to get a mental health referral sorted and nothing happened. The GP actually forgot to do it twice.

Next steps for general practice

We recommend that general practice considers the following.

Timely and effective support for people in or at risk of mental health crisis

- Ensure that urgent mental health appointments are easy to book and that all staff including receptionists recognise their importance.
- Make it possible for people to make contact throughout the day for booking urgent mental health appointments.

Responsive and understanding care

- Celebrate and promote responsive and understanding care where people feel listened to by all staff, with ongoing training as required.
- Promote delivery of care by the same professional to people experiencing mental health issues wherever possible.

Mental health medication

- Facilitate prompt care for issues involving mental health medication.
- Promote face-to-face appointments for medication changes and reviews.

Holistic approach for people experiencing mental health issues

- Consider how physical health issues such as chronic pain, weight and mobility may increase mental health risk factors.

Integrated care

- Work with community mental health teams to develop good coordination of care between services, for example, referrals and medication plans.
- Ensure mental health referrals are dealt with promptly and patients are updated when they are completed and provided further contact details.

Signposting and awareness of mental health services

- Promote accessible and up-to-date mental health signposting information, for example, the Kent and Medway Mental Wellbeing Information Hub[5] and local community and peer support groups.

5. https://www.kmhealthandcare.uk/mental-wellbeing-information-hub

Home treatment and rapid response

70% of feedback about home treatment and rapid response was negative, 19% positive and 11% mixed. The topics of care given by staff, impact on lifestyle and wellbeing, medication, prescriptions and dispensing, and quality of treatment had the most positive feedback at two pieces each. The impact on lifestyle and wellbeing theme had the most negative feedback (see Figure 16). Other common topics were care given by staff, coordination and continuity of care, and quality of treatment.

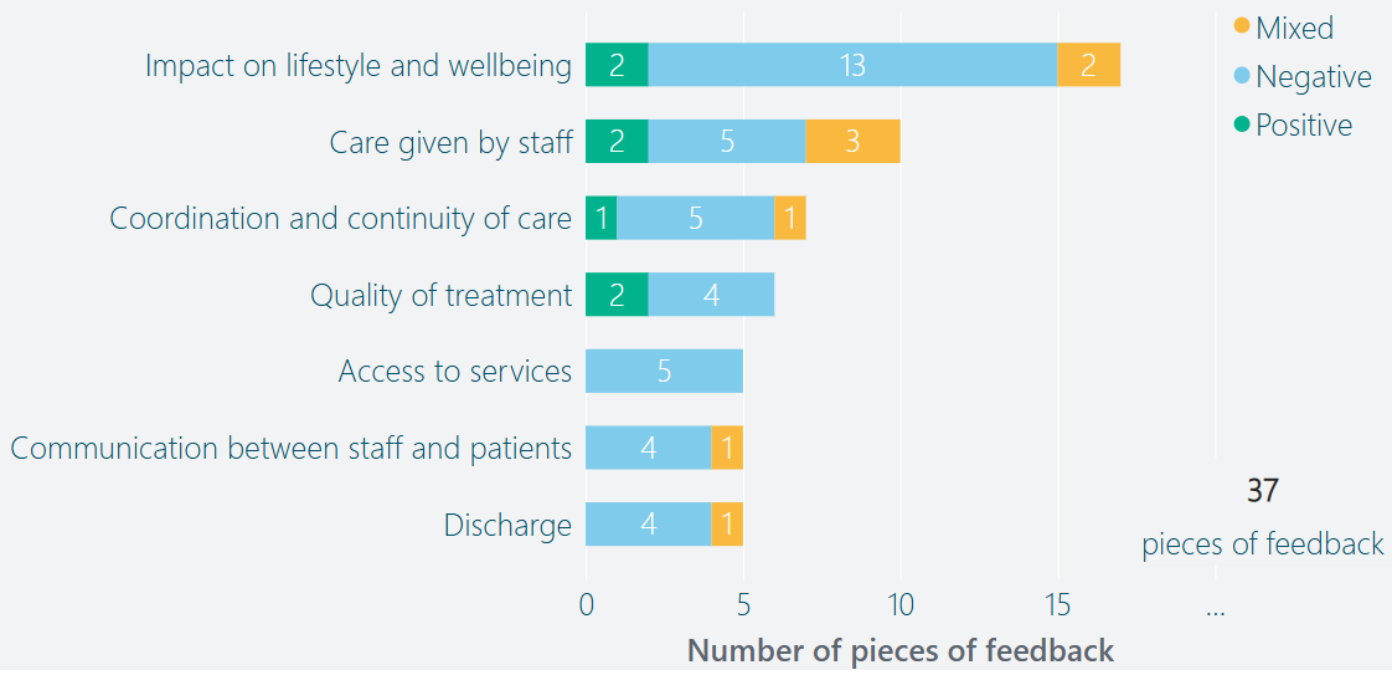


Figure 16. Top seven topics in 37 pieces of feedback about home treatment and rapid response.

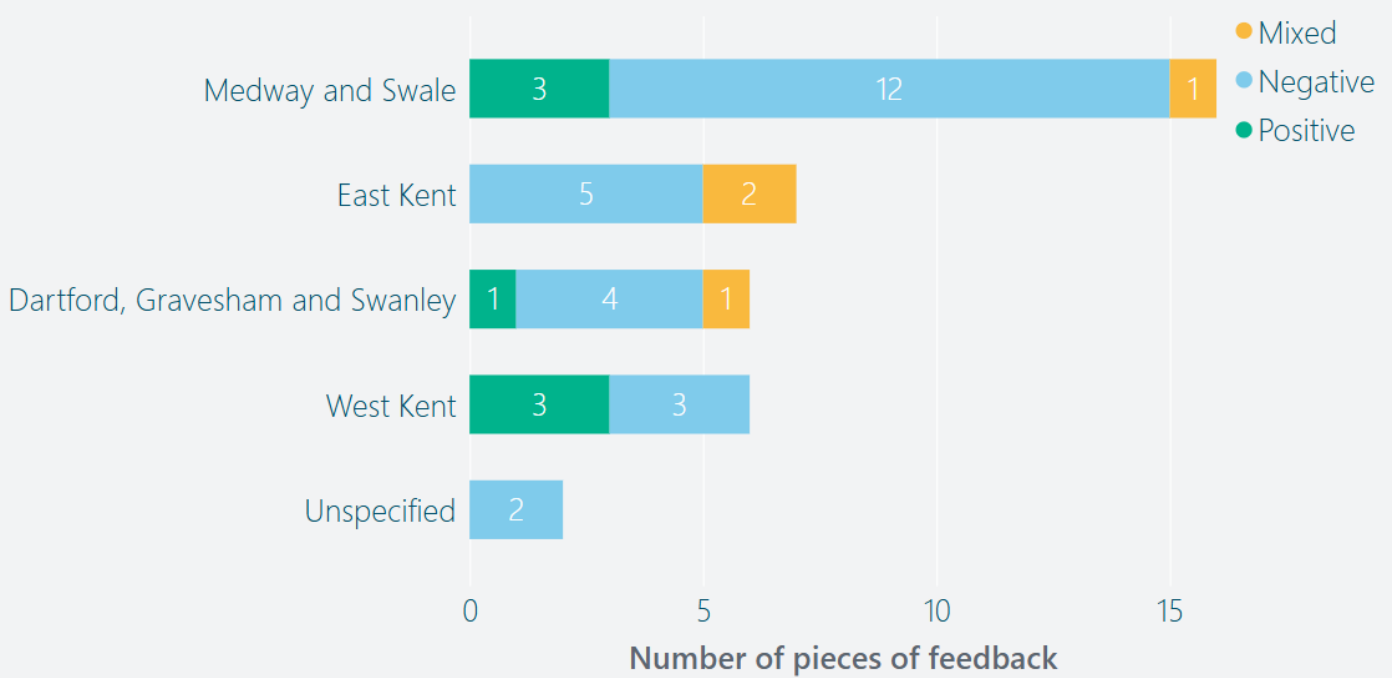


Figure 17. Sentiment of feedback about home treatment and rapid response in each health and care partnership area.

Impact on lifestyle and wellbeing: One person said that the home treatment and rapid response team had helped them to avoid a mental health crisis.

> The rapid response team were really good with me when I needed them in hospital. They helped me avoid a mental health crisis, which I'm very grateful for.

Two people told us of the home treatment and rapid response team not offering direct support to their loved one, which had a detrimental effect on their loved ones' mental health, with one nearly losing their life and being placed under section 136. Others described losing their trust in the service.

> So, through their lack of support, although they tell me I'm not a burden, their actions show otherwise and there just isn't any help and why people end up ending their life. … It's made my mental health worse as I said I won't reach out to anyone when in crisis, which is daily.

Five people told us of the impact of being discharged from the service, with people left feeling worse, unable to cope with their mental health or back in a crisis. One of these had experienced multiple prompt discharges without treatment plans being followed and three were discharged without a plan.

Care given by staff: Positive feedback was about people feeling helped and supported by the home treatment and rapid response team.

> I recently received support from the crisis resolution home treatment team, which was very good. I found the support to be very helpful.

However, others felt described indifference or rudeness. Two people had mixed experiences, depending on which staff they were being supported by.

> Some of the crisis nurses are fantastic. Others shouldn't have a job like this.
>
> The [other team] were much kinder and better at the job in general. They asked questions and seem like they care.

Coordination and continuity of care: An individual whose loved one was admitted to hospital praised the service for their support in his transition.

> I can only praise the team who eventually came with police support as they managed to get him to leave the house calmly and be taken by ambulance for the help he so clearly needs.

However, three people described ineffective referrals or care transfers from the GP or hospitals to the home treatment and rapid response team, resulting in them not receiving sufficient support.

> Each time she has been referred to the home treatment team … this team has ignored the hospital instructions and discharged her after one visit.

Access to services: Five people told us that their calls to the home treatment and rapid response team were not answered or they did not get a callback as promised. Another was referred by their GP but did not hear from the team.

> The phone just kept ringing and ringing, and nobody answered; I was holding on for nearly an hour and finally gave up.

Next steps for home treatment and rapid response

We recommend home treatment and rapid response teams to consider the following.

Timely and effective support for people in or at risk of mental health crisis

- Ensure that people are provided direct support.
- Ensure that callbacks take place within the timeframes stated.

Integrated care

- Work with GPs, A&E, liaison psychiatry and mental health inpatient services to improve referral processes into home treatment and rapid response.
- Review and address why mental health treatment plans from other services may not have been followed.

Discharge practices

- Review and address the negative impact of discharge practices on people's mental health and make improvements.
- Ensure that people are not discharged too soon and have robust, personalised and coproduced support plans in place.

Responsive and understanding care

- Celebrate and promote responsive and understanding care where people feel listened to by all staff, with ongoing training as required.

Kent and Medway Mental Health Crisis Line

57% of feedback about the Kent and Medway Mental Health Crisis Line was negative, 27% positive and 17% mixed.[4] The two most common topics of care given by staff and impact on lifestyle and wellbeing were also the topics with the most positive feedback (see Figure 18). Other common topics were access to services, coordination and continuity of care, and communication between staff and patients.

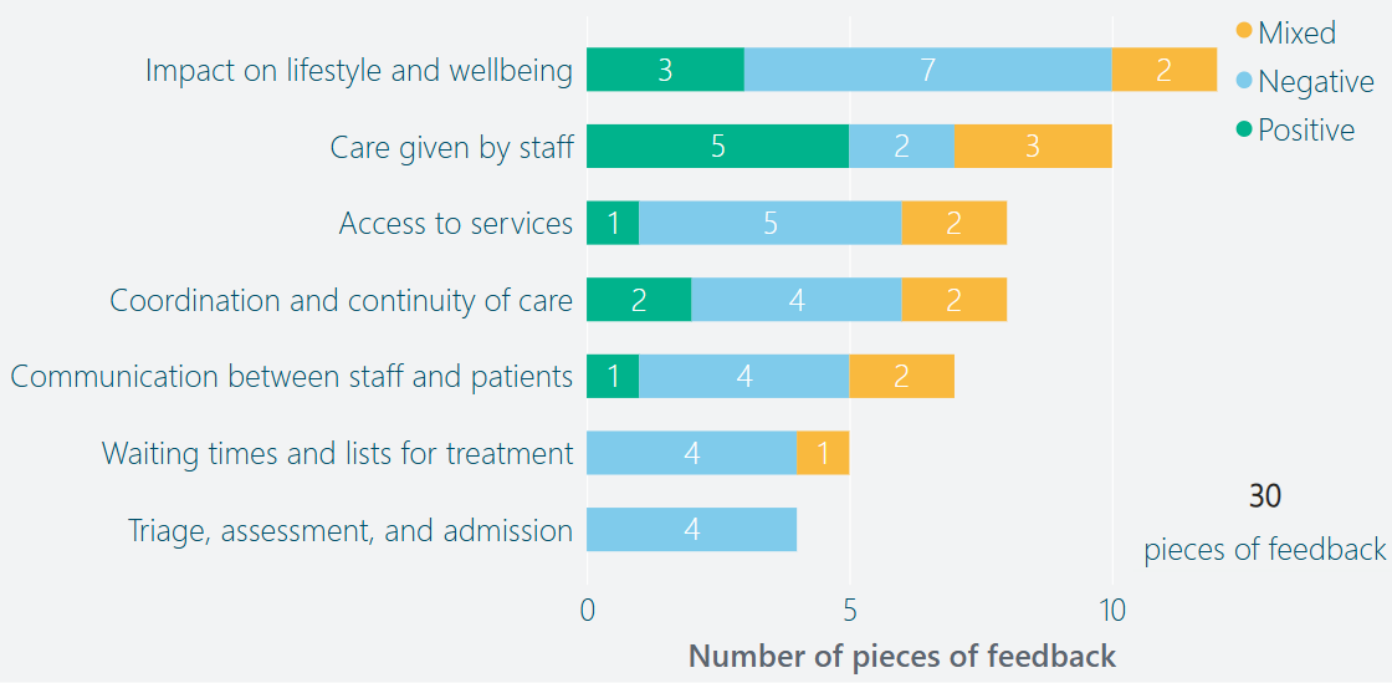


Figure 18. Top seven topics in 30 pieces of feedback about the Kent and Medway Mental Health Crisis Line.

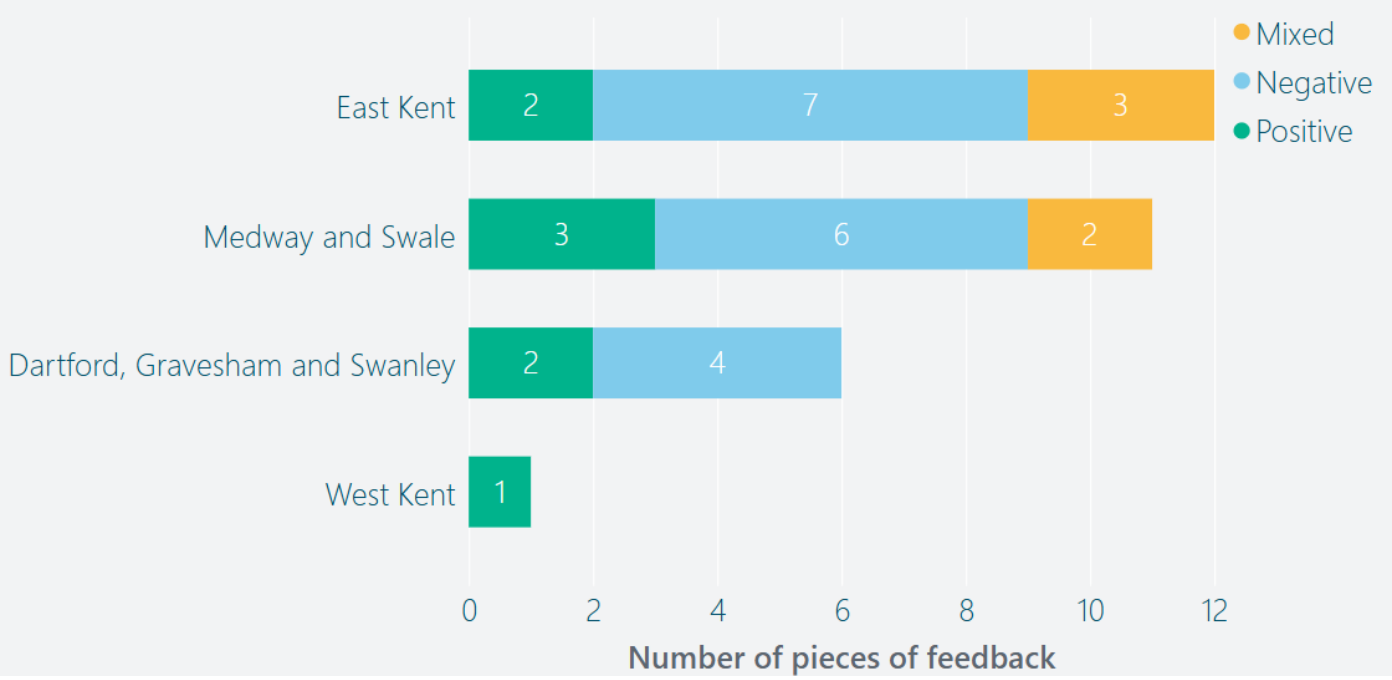


Figure 19. Sentiment of feedback about the Kent and Medway Mental Health Crisis Line in each health and care partnership area.

Impact on lifestyle and wellbeing: Two people told us about the positive impact of the support from the crisis line.

> They spoke to me like I was human and I could tell they genuinely cared. It really helped to calm me down and pick me back up again.

> It was decided that [a person I was supporting] would be contacted by [the crisis line] within the next 72 hours. I informed [the individual]. … It was immediately apparent [they] felt instant relief because of this.

However, four people told us they had become more distressed or had self-harmed as a result of their call to the crisis line. One of these people had waited for a 72-hour callback that did not happen, two were waiting for their call to be answered and one person felt dismissed by the call handler.

> I was placed in a queue. Unable to wait any longer, I self-harmed as a result.

Care given by staff: Six people described call handlers as helpful, understanding and caring. They also described how this contributed to effective support.

> I dialled 111 option 2 and spoke to a really understanding woman. She totally got what I told her.

However, two people felt judged, dismissed or that the call handler was reading from a script.

> She kept interrupting like she was following a script. At point[s] of the conversation, it felt like she was judging me and trying to get me off the phone.

Access to services: Three people told us they had received the care they needed from the crisis line after being unable to access GP support. Five others reported positive experiences accessing the crisis line, including two professionals raising safeguarding concerns. Two people told us of effective support for their urgent medication needs.

> I decided to call 111 option 2 and ask for an emergency prescription. They helped me a huge amount to get it done.

However, four people waited a long time for an answer from the crisis line, ranging from 15 minutes to over two hours, which aligns with known challenges in the delivery of the service in Kent and Medway (NHS England 2025). Three people did not receive the callbacks they had been told to expect.

> I contacted 111 option 2 last week and they told me somebody would call me back within two hours. 24 hours later and nobody had called. I rang them again and they had no record of my previous call, but said I would get a callback within the next hour. Still never got called back, so I just gave up and went to A&E for some help.

Two people who got through to the crisis line felt they did not access direct support, being told instead to attend A&E or await their planned CMHT appointment in two to three weeks. Another was told there was no help available for a person in crisis on the street as they were too distressed for A&E and there were not enough staff at the crisis line to handle the situation.

Coordination and continuity of care: Two people also felt that 72 hours was too long for an urgent callback. One of these people also told us that, whilst the crisis line had coordinated police and paramedic home visits, they did not get to speak to a mental health nurse, which is what they felt they needed most. Two others had referrals made to adult social care by the crisis line, however were then left waiting for that support.

Next steps for Kent and Medway Mental Health Crisis Line

We recommend the Kent and Medway Mental Health Crisis Line to consider the following.

Timely and effective support for people in or at risk of mental health crisis

- Improve call answer times.
- Ensure that callbacks take place by the planned timescale, if not sooner.
- Facilitate more direct support by mental health professionals for people in crisis rather than signposting to A&E.

Responsive and understanding care

- Celebrate and promote responsive and understanding care where people feel listened to by all staff, with ongoing training as required.

Integrated care

- Maintain a clear pathway for professionals to raise safeguarding concerns at the first point of contact, whether an individual is known to services or not.
- Work with adult social care to ensure people referred into their service by the crisis line are clear on timelines and details for further contact.

Recommendations

Recommendations are based on the feedback people gave about the services they accessed for mental health crisis support and any suggestions they made for improvements to these services.

Next steps for Kent and Medway Integrated Care System

We recommend the Kent and Medway Integrated Care System to consider the following.

Continuity of care

- Provide a consistent professional for the care of individuals at risk of mental health crisis, based on a caring and understanding relationship.
- Support families and loved ones who care for people at risk of mental health crisis, seeking their input and including them in care plans.

Preventative support for people in or at risk of mental health crisis

- Support access to local and accessible daytime, evening and weekend support groups and wellbeing activities, both online and in person.
- Improve access to preventative support that does not require people to book a GP appointment first.
- Reinforce the mental health support offer for periods of high demand, with consideration of time of year, time of day and day of the week.

Integrated care

- Facilitate joined-up care across services that does not rely on people making GP appointments.
- Support a simple means of inter-trust digital patient record sharing.
- Progress community care centres that enable holistic health support.
- Support services, including prison and probation, to provide up-to-date and accurate information on the mental health support available.
- Facilitate means for patients and professionals to track the progress of referrals, both into and out of mental health services.

Wider determinants of health

- Improve access to supported housing for people with severe mental illness.
- Improve transport to safe havens and community centres.
- Subsidise access to wellbeing facilities such as sports centres.
- Improve access to counsellors and support networks in schools.

Conclusions

We analysed 489 experiences related to mental health crisis that people had told us about from January 2024 to February 2025. We found that:

- People told us about understanding, supportive and helpful care from professionals and how positive interactions had enabled them to manage their mental health, keep them safe and help them to recover.

> It makes such a difference when you're supported by people who understand and treat you as a person and things are explained to you.

- We heard the most positive feedback about voluntary, community and social enterprise services and Kent and Medway Safe Havens.
- Other key service types were: community mental health teams, general practice, home treatment and rapid response, the Kent and Medway Mental Health Crisis Line, A&E, children and young people's mental health services, talking therapies, liaison psychiatry and mental health hospitals.
- Key issues were waiting times for crisis support, ineffective responses and unsuccessful coordination or continuity of care between services.

> There needs to be room to deviate from a script in order to fully understand a person.
>
> It was better when you could call the crisis team and speak to people who know you who can help calm you.

- We heard the most about crisis support for people aged 16 to 25, 35 to 44, and 55 to 64.
- Time of year was an important factor for consideration in the provision of services that support mental health.

We have made a range of recommendations throughout this report (see Recommendations section), both for key services and the wider integrated care system. These align with the draft Kent and Medway suicide and self-harm prevention strategy for 2026 to 2030, in terms of the priorities of supporting efforts to improve support for those in crisis and maximising our collective impact (NHS Kent and Medway, Kent County Council, Medway Council 2025).

Responses

In December 2024 and February 2025, we presented summary reports on what people had been telling us about mental health crisis support to key stakeholders in the Kent and Medway mental health system. NHS Kent and Medway Integrated Care Board took swift action to ensure that:

- Clear messaging and signposting on the different ways of accessing crisis support was issued via their public newsletter in time for the winter season.

Kent and Medway Safe Havens engaged proactively, implementing the following.

- Working with staff teams on the management of and messaging around telephone support.
- Improving the pathway for people accessing Thanet Safe Haven who need a full mental health assessment, managing this in the haven wherever possible and working with the hospital liaison psychiatry service to improve coordination and continuity of care for those who need to be assessed by them.
- Ensuring clear and prominent messaging about safe haven opening times over the festive period and increasing social media visibility.
- Increasing local promotion of safe havens to the public and professionals, including in primary care.
- A marketing campaign for community crisis alternative services based on the Stop Think Choose campaign.

A draft version of this report was shared with the mental health leads at the NHS Kent and Medway Integrated Care Board in June 2025. NHS Kent and Medway have made the following changes so far, which include:

- Working with Mental Health Matters to develop information videos about Kent and Medway Safe Havens to promote awareness of the services with both public and professionals, including police and ambulance staff.
- Improvements to the triaging of the mental health advice line to ensure that safe havens are offered as an option.
- With regards to providing a consistent professional for the care of individuals at risk of mental health crisis based on a caring and understanding relationship, the integrated care board is supporting providers to deliver services in alignment with NHS England's recently drafted Personalised Care Framework: The Modern Care Programme.

- Preventative support for people in or at risk of mental health crisis: The ICB is expanding the safe haven model to a third operating 24/7, with all 11 interoperable, ensuring a 24/7 community crisis alternative, and is also expanding community crisis recovery beds.
- To improve access so GP appointments are not required: Safe havens and the urgent crisis line are open access and both services can help service users access more help if required, signposting or referring where appropriate to other clinical commissioned services.
- Plan to incorporate Healthwatch feedback into future commissioning intention.

A further response and next steps from NHS Kent and Medway is detailed in Appendix 4.

Kent and Medway Safe Havens also responded:

- They will review people's feedback about underserved locations with the integrated care board. They also promote to these areas, offering virtual and telephone support.
- Regarding welfare checks, these are done on a needs basis and if consented to by the individual where there is a threat to life or the individual has requested this as part of their safety plan. Safe havens will endeavour to ensure that these reliably take place.

In October 2025, a draft version of this report was shared with the Kent and Medway suicide prevention programme team. They felt the report aligned with the priorities of the draft Kent and Medway suicide and self-harm prevention strategy for 2026 to 2030 (NHS Kent and Medway, Kent County Council, Medway Council 2025) in terms of maximising collective impact and supporting efforts to improve crisis support, and are interested in joining next-step discussions.

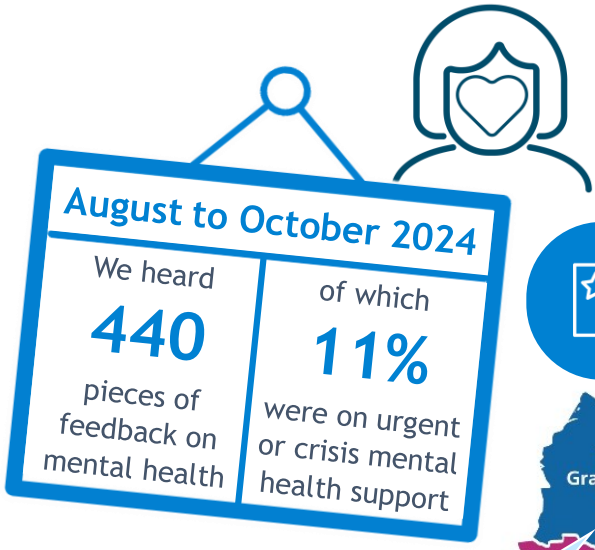
Kent and Medway Mental Health NHS Trust received this report in October 2025 and responded with details of the improvements they are making, which include:

- Addressing waiting times and crisis support.
- Enhancing coordination and continuity of care.
- Fostering compassionate care.
- Bridging service gaps and inequalities.
- Improving crisis line performance and integrated care.

Full details can be found in the response from Kent and Medway Mental Health NHS Trust in Appendix 4.

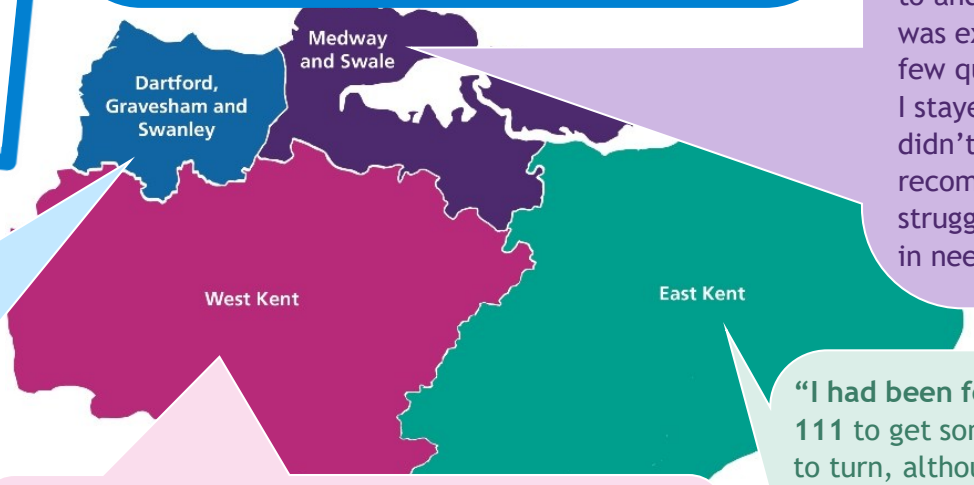
Appendices

Appendix 1: Excerpt from November 2024 summary report – positive experiences



Mental Health Voice

What positive experiences did people have of crisis support?



"I am so thankful to [the peer support organisation] for informing me of the Medway Safe Haven. I went to the Safe Haven the other night … . The Safe Haven was warm and clean. The [member of staff] I saw was welcoming and understanding. I felt safe, listened to and most importantly heard. Nothing was expected from me, I was asked a few questions for clarification purposes. I stayed in for about two hours and didn't feel rushed to leave. I really do recommend this service to anyone struggling with their mental health and in need of someone to listen."

"I had to take my [loved one] to the minor injuries unit at [the hospital] after he had self-harmed. It wasn't bad enough for A&E and the staff were so good with us both. They were helpful and advised he goes back to his GP and discuss his mental health so that's our next step."

"We contacted Kent Police last week as a client [communicated suicidal intent] …. We notified the police … and they acted immediately - they found the person in time and stopped the plan. An amazing outcome. They also phoned us back with the update."

"I had been feeling very depressed and I rang 111 to get some support as I did not know where to turn, although I waited a long time for them to get back to me. I spoke to [a doctor, who] was very reassuring and listened to me and suggested some ideas to calm me down, I would like to say thank you as it makes such a difference when somebody takes the time to listen to you."

Appendix 2: Topic bank

Topics	How to use them
Access to services	Use for access to services, e.g. NHS dentistry, as well as registering or deregistering with a GP; and services picking up the phone. Include positive experiences of access.
Accessibility and reasonable adjustments	Feedback regarding if and how people's additional needs are met, e.g. no email options for deaf people. Includes physical access.
Administration	Use for administration or letters, including the length of time it takes for letters to be sent, fit notes (sick notes) and results communicated. Not including referral administration and patient records.
Booking appointments	Use for the ease or means of booking appointments, including changing the date and time.
Buildings and facilities	Use for issues about the building the service is situated in, e.g. suitability for purpose, facilities and access to toilets. Not relating to physical access. Includes issues regarding health and safety.
Cancellation	Use for cancelled meetings, appointments, procedures or operations.
Care given by staff	How staff interacted with people when delivering care or treatment or in general interactions, e.g. giving respect or dignity, being friendly or helpful.
Cleanliness, hygiene and infection control	Use for all issues related to general hygiene and cleanliness, including for Covid, e.g. keeping venues covid-secure, social distancing, hand sanitiser, mask wearing.
Communication between staff and patients	Use for feedback regarding communication: both the content that is communicated, and the timeliness of communications, including a lack of communication. Does not include administration processes.
Complaints procedure	Use for feedback regarding the process of complaining or when the organisational complaints process is not being followed.
Consent to care and treatment	Use for all issues about consent, including do not resuscitate orders (DNACPR, DNAR, DNR).
Coordination and continuity of care	Use for issues where people do or do not get the same professional every time or must explain themselves afresh every time they have an appointment with a different professional on an issue. Also use for someone being passed from service to service and lack of communication between services.
Cost and funding of services	Cost and provision of funding to the individual; e.g. social care; NHS charges, e.g. dental; or having to pay for private care.
Diagnosis	Feedback received regarding diagnosis or lack of diagnosis.
Discharge	Use for all issues about being discharged from a service, including support put or not put in place as part of the discharge.
Food, drink and nutrition	Use for all issues about food, hydration and catering, e.g. quality of food served in hospitals or care homes, and whether people's preferences and special dietary needs are met.

Health inequalities	Experiences regarding disadvantages or advantages relating to: socio-economic factors, e.g. income; geography, e.g. region or whether urban or rural; specific characteristics, including those protected in law, such as sex, ethnicity or disability; socially excluded groups, e.g. people experiencing homelessness.
Impact on lifestyle and wellbeing	Use when an individual states their lifestyle or wellbeing has been impacted.
Medication, prescriptions and dispensing	Use for issues around medication, prescriptions or vaccinations, including efficacy. Use this for healthcare professionals being willing to prescribe and pharmacies being able to dispense it.
Parking and transport	Use for availability and location of car parking spaces. Use for the cost of parking, including penalty charges for contravening parking rules. Includes public transport and patient transport.
Patient records	Use for issues about accuracy of information on patient records and data protection issues.
Quality of treatment	Use for issues about people's perceptions of the efficacy of treatment they have received that does not include detail allowing it to be themed into the other categories.
Referrals	Use for all issues about referrals, including administration and making the case for a referral.
Service change or closure	Use for all closure issues, whether temporary or permanent. Use when there is change in the way in which a service is delivered, e.g. location.
Triage, assessment and admission	Relating to the process required to access a service or treatment, e.g. the assessment to become an inpatient within a hospital setting, including mental health, or resident within a care home or short stay bed.
Waiting time to be seen once arrived at appointment	Use for length of waiting time on arrival to the service before being seen or treated by a healthcare professional. Not including transport.
Waiting times and lists for treatment	Use for waiting times and lists to get treatment, e.g. for elective care or NHS dental care, waiting time for a residential bed.

Appendix 3: Demographics

1st box: About You □□ **2nd box:** About person receiving care, or information is for, if not you

Relationship to person receiving care/info:
□ **Individual** □ **Family** □ **Friend** □ **Carer** □ **Professional**

Postcode:

What district do you live in?:

□□ Ashford
□□ Canterbury
□□ Dartford
□□ Dover
□□ Folkestone and Hythe
□□ Gravesham
□□ Maidstone
□□ Medway
□□ Sevenoaks
□□ Swale
□□ Swanley
□□ Thanet
□□ Tonbridge and Malling
□□ Tunbridge Wells
□□ Out of county
□□ Prefer not to say

Ethnicity

White

□□ English/Welsh/Scottish/Northern Irish/British
□□ Irish
□□ Gypsy, Roma or Irish Traveller
□□ Any other White background - please describe:

Mixed/multiple ethnic groups

□□ White & Black Caribbean
□□ White & Black African
□□ White & Asian
□□ Any other mixed/multiple ethnic background - please describe:

Black/African/Caribbean/Black British

□□ Caribbean
□□ African
□□ Any other Black/Black British background please describe:

Asian/Asian British

□□ Indian
□□ Pakistani
□□ Bangladeshi
□□ Chinese
□□ Any other Asian/Asian British background - Please describe:

Other ethnic group

□□ Arab
□□ Any other ethnic groups - please describe:

□□ Prefer not to say

Gender

□□ Male
□□ Female
□□ Prefer not to say
□□ Prefer to self-describe

Sexual Orientation

□□ Heterosexual/straight
□□ Bisexual
□□ Gay/lesbian
□□ Prefer not to say
□□ Other (please describe)

Do you identify as trans?

□□ Yes □□ No
□□ Prefer not to say

Age

□□ 0- 15
□□ 16-24
□□ 25
□□ 26-34
□□ 35-44
□□ 45-54
□□ 55-64
□□ 65-74
□□ 75-84
□□ 85-94
□□ 95-99
□□ 100+
□□ Prefer not to say

Disability

□□ No
□□ Prefer not to say
□□ Yes

Disability Type

□□ Physical disability
□□ Learning disability
□□ Mental health condition
□□ Long-term health condition
(Please specify below if you wish)

Are you a carer?

□□ carer
□□ Young carer
□□ No
□□ Prefer not to say

Appendix 4: Responses

Further response from NHS Kent and Medway

NHS Kent and Medway Integrated Care Board (ICB) will use the insights from the crisis care report to better understand the experiences and needs of people across Kent and Medway. The ICB is committed to working in partnership with Healthwatch, service users, and carers to coproduce solutions that are informed by lived experience and local priorities, ensuring meaningful improvements to mental health services.

The ICB is committed to sharing timelines and progress updates through the Local Mental Health Networks, where appropriate. This approach will ensure that partner organisations remain informed about changes, have an opportunity to provide feedback, and work collaboratively towards more integrated care.

NHS England has now published a Strategic Commissioning Framework;[6] Strategic commissioning is now the central purpose of ICBs, focusing on long-term, evidence-based planning, purchasing, monitoring, and evaluation of services to improve population health, reduce inequalities, and ensure equitable access to high-quality care.

This involves ICBs being more data-driven and focused on long-term strategic planning based on population health and strong contract management. ICBs will use joined-up, person-level data and intelligence (including user feedback, such as this report) partner insight, outcomes data, public health resource and insight to understand the local population of Kent and Medway.

The ICB will look to align with the Lived Experience Engagement and Employment Framework (LEEEF). Aligning with the content of the framework will help with the inclusion of lived experience and removal of barriers. The ICB recognise the importance of working with people who live in local communities and/or use services.

Full response from Kent and Medway Mental Health NHS Trust

Sheila Stenson, Chief Executive of Kent and Medway Mental Health NHS Trust responded to this report with the following letter.

6. https://www.england.nhs.uk/publication/nhs-strategic-commissioning-framework/

NHS
Kent and Medway
Mental Health
NHS Trust

Robbie Goatham
Manager | Healthwatch Kent
Leanne Trotter
Manager | Healthwatch Medway
By email

Sheila Stenson
Chief Executive
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www.kentmedwaymentalhealth.nhs.uk

10 December 2025

Dear Robbie and Leanne,

Healthwatch Kent and Medway Mental Health crisis care report

On behalf of the Trust Board and all our staff, I want to write to acknowledge and confirm receipt of your detailed report into crisis mental health care in Kent and Medway.

I would like to thank you and your team for the thorough work involved in compiling this report and I am grateful for the inclusion of direct patient views and lived experiences within the report. Understanding the reality of care from a patient's perspective is essential for us to drive meaningful, patient-centred improvements.

We value our partnership with Healthwatch and appreciate the vital role you play in giving voice to the patients and service users within our community.

The findings presented, while challenging and certainly not what we aspire to hear have been reviewed carefully by our clinical and operational leadership teams. I want to acknowledge your findings and be transparent. The findings were consistent with what we have heard from the Care Quality Commission (CQC) inspection, which was published in October and our own independent report, which we undertook earlier this year.

Please be assured that we are committed to listening to feedback, and addressing systemic challenges. We have a robust quality plan in place, and while we recognise there is much to do, we have started to see some improvements. It is imperative we take forward these improvements with our partners, which includes Healthwatch.

I have set out some of the headlines below:

Addressing waiting times and crisis support

- **Rapid response:** Our Rapid Response service attends to those in crisis within 4 hours, achieving this benchmark for over 90% of referrals over the past year.
- **Waiting times:** We have successfully implemented reductions in waiting times by 10% for Mental Health Together (MHT) services. We have also improved our memory assessment waiting times. People are receiving a first contact following referral within four weeks and the average wait for an intervention is just over 11 weeks - up to two months faster than the national average.
- **Crisis line monitoring:** Ongoing, concentrated work is focused on monitoring and reducing call abandonment rates on the crisis line to ensure timely access to support.
- **Long wait reviews:** We conduct weekly reviews for patients waiting over 52 weeks, providing regular contact and ensuring they receive appropriate, stepped-down support where clinically indicated.

Enhancing co-ordination and continuity of care

- **Standardised planning:** All people referred to our service receive a DIALOG Plus intervention that underpins care planning and we are soon to launch this being completed within 4 four weeks of referral as part of the first contact proceed - early in the calendar year.
- **System collaboration:** In addition, we continue to build relationships with our VCSE providers to meet the holistic needs of people. As part of our Mental Health Together developments we will roll out ‘Better Understanding’ sessions to support effective care navigation. This is following a successful pilot in Medway.
- **Community Mental Health services transformation:** Through the second phase of our Community Mental Health Framework (CMHF) and as part of our quality plan, we are revising our model of care to ensure a partnership approach, getting people to the right support, with the right agency/partner, more quickly. We aim to launch this early in the new calendar year with a phased approach.

Fostering compassionate care

- **Culture and values:** We recognise that we have some work to do to improve our culture, and in March 2025, we introduced our new identity and values – to help us strengthen our culture and live our values. We are embedding our values through staff engagement initiatives, the Doing Well Together programme, and the Value in Practice Awards.

Bridging service gaps and inequalities

- **Safe havens and access:** We work in partnership to deliver the safe havens, and have contributed significantly to expanding Safe Haven hours and locations, and we are actively reviewing underserved areas for targeted support.
- **Dual diagnosis support:** We are working with our partners including the local authority to role a group-based intervention further.

Improving crisis line performance and integrated care

- **Crisis line improvements:** We have set clear improvement targets for our crisis line, refining triage processes and improving signposting to ensure direct support from mental health professionals where needed. In the last two months we have seen a 50% improvement in abandonment rates.
- **Digital integration:** We are improving outcomes through enhanced digital record sharing and referral tracking for community services.

While not an exhaustive list of the improvements we're making, I hope this provides an overview of the work we have already done to respond to the findings in your report. We are committed to complete transparency, and over the coming weeks we will be sharing information about ongoing improvements that are making a difference to the people we care for.

I am delighted that in July this year, our Board agreed to recruit a team of Co-Creation Facilitators, who are working with our Patient Experience team and partners, to listen to the views of our patients. Their work will be invaluable so we can make future improvements to our services through a lived experience lens.

I am confident that their work, together with the continued insights from Healthwatch will help us to monitor the impact of the progress we're making – and guide us as we continue to improve the services we deliver.

Should you wish to discuss our improvement work in further detail, please do contact my Executive Assistant, Sharon Tree and we will arrange for you to get an in person briefing from clinical and operational leaders.

Yours faithfully,

S. Stenson.

Sheila Stenson
Chief Executive

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