CAMDEN EQUALITY IMPACT ASSESSMENT FORM

Camden

Introduction to this form

This is Camden's Equality Impact Assessment (EqIA) template, which should be used for all EqIAs carried out across the Council on a project, activity, change or decision (hereafter, 'activity'). Unless agreed with the Equalities Service in advance, no other template should be used for carrying out an EqIA.

Most activities that affect Council stakeholders (including residents and officers) will require an EqIA when they are in the planning stage. Many will also require an EqIA to monitor their impact on equality over time or if there is a significant change that prompts a review, such as in local demographics.

EqIAs will usually be required when a new activity affecting people who share the protected characteristics is being developed and when reviewing or changing such activities. They will also be likely required for any staff re-organisations.

EqIAs help the Council to fulfil its legal obligations under the Equality Act's Public Sector Equality Duty (PSED). The duty requires the Council to have due regard[1] to the need to:

- Eliminate unlawful behaviour, such as discrimination, harassment and victimisation;
- Promote equality of opportunity between those who share a protected characteristic and those who don't; and
- Promote good relations between people who share a protected characteristic and those who don't.

EqIAs are our chosen method at Camden for demonstrating that we have given due regard to these three aims, and therefore that we are complying with the PSED.

An EqIA should be started at the beginning of a new activity and developed in parallel with it. Activities, during and following implementation, should also be regularly reviewed for their impact. As part of this process, EqIAs should be revisited and updated to determine whether any planned positive impacts have been achieved and whether any identified negative impacts have been mitigated.

Following each version of an EqIA, this should be signed off by the relevant sponsor, director or Head of Service.

For advice, support, or to request a review of your EqIA, please contact equalities@camden.gov.uk.

[1] 'Due regard' is a legal requirement and means that decision makers have to consider the equality implications of a proposal before a decision has been made that may affect people who share each of the protected characteristics. Paying 'due regard' means giving a proportionate amount of resource to this analytical exercise relevant to the potential impact on equality.

Title of the activity	
Recommissioning the Reach Out Camden (ROC) Mental Health Alliance	
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Version number and date of version	
Final version one – 11/05/2026	

Section 1: Background

1.a. Is it a new activity or one that is being reviewed or changed?

☐ New
☒ Under review
☐ Being changed

1.b. Which groups are affected by this activity?

☐ Council staff
☒ Residents
☒ Contractors
☐ Other – please specify:

1.c. Which Directorate(s) does this activity fall under?

☒ Adults and Health
☐ Children and Learning
☐ Corporate Services
☐ Homes and Communities
☐ Investment, Place and Opportunity
☐ Multiple Directorates – please specify:

1.d. Outline the aims, objectives and scope of the activity

You should provide a summary rather than lots of detail copied from other reports or documents. This summary should always include at the least the following:

- Why is this work happening and why is it happening now?
- Is there any useful context about previous work linked to this activity which needs to be considered?
- Who will be impacted by this work? How, and why do we know this?
- What is going to happen as a result of the proposed activity?

The Council plans to retender the current contract for the Reach Out Camden (ROC) Mental Health Alliance, which is set to expire on 31 March 2027. This contract is for the delivery of a community-based, early mental health support offer, delivered by an alliance of local Voluntary and Community Sector (VCS) organisations.

The current service has been in place since the two-year contract commenced 1 April 2025. In early 2025, a 'stock-take' was undertaken to understand the alliance providers' performance half-way through the contract. This stock-take, which involved engaging with current users of the service, staff and coproduction partners, found that the service is performing well, particularly for the current users of the service who reported significant impact in their wellbeing after engaging with the service. Some improvements were identified in the stock take, notably around improving how coproduction is managed and around improved partnership working between alliance partners.

Between January and April 2026, to inform the recommissioning process, commissioners undertook an engagement process to understand both resident and system partners' priorities in a renewed Reach Out Camden service. Again, residents and partners reported that the service was an essential, transformational part of the wider mental health ecosystem in Camden. Residents who had engaged in the service reported improved sense of belonging and connection, and a space to prevent metal health relapse or deterioration. They emphasised the non-clinical, and non-statutory environment as being particularly helpful. Some improvements identified included better management of long wait times, better partnership working with the wider VCS system, particularly with organisations that represented or worked closely with culturally diverse communities in Camden, and improving the service's visibility with wider support and health system partners to open up more referral pathways.

The successful re-tender of the service would see the new contract commencing in April 2027, for a period of five years.

From April 2027, the service will mostly continue as is with some improvements, based on the stock-take (in early 2025) and the recent recommission engagement process mentioned above.

About the service

Reach Out Camden Alliance (referred to throughout as “Reach Out” or “The Alliance”) is an alliance of voluntary and community sector (VCS) organisations (Mind in Camden, Likewise, Voiceability Advocacy and The Advocacy Project) that work in partnership with the Council, North Central London Integrated Care Board and North London Mental Health Partnership.

Alliance contracting is a service delivery model where there is one contract between the commissioner and an alliance of parties who deliver the service. It creates a collaborative environment without the need for new organisational forms. By having one alliance contract, that includes commissioners alongside providers, all parties are working to the same outcomes and are signed up to the same success/outcome measures. There is a strong sense of ‘your problem is my problem; your success is my success’. Typically, there is a risk share across all parties and any ‘gain’ or ‘pain’ is linked with good or poor performance overall and not to the performance of individual parties.

Reach Out Camden provides a range of community-based early intervention and prevention support to people experiencing mental distress whose needs do not reach the threshold for statutory services. This support helps to prevent, reduce, or delay the need for people to access statutory services and forms an essential part of the wider mental health care and support 'ecosystem'. The offer is open to all Camden residents, there is no eligibility requirements or thresholds to reach, and people can be referred by their GP or other support services, or they can self-refer via a single point of access.

The current contract objectives are:

- Ensure help is available at an early point to stop problems getting worse
- Services are easy to access and work well together
- Reduce inequalities in mental health
- Ensure services are flexible and respond to what people need

As of 2025/2026 Quarter 3 figures, Reach Out Camden has supported a total of 1492 people so far. The demographic make-up of these residents is:

- 33% male, 58% female, and 1.2% are non-binary
- 35-64 year olds are overrepresented compared with census data; those in the 50-64 age bracket are underrepresented compared with census data
- Black and other ethnic groups are overrepresented compared to Camden population, which is against the national trend of Global Majorities being underrepresented in preventative services. Asian and white ethnic groups are underrepresented. Mixed ethnic groups are and similar to the Camden demographic.

The needs people present to the service with are typically emotional distress, social isolation and loss of connection, practical and socioeconomic pressures, identity, confidence and life transition, support gaps elsewhere in the system, and culturally responsive and inclusive support.

Once people are referred into the service, they are connected with a navigator to understand their needs and support preferences, who then connects them with one of the alliance offers that best fits their preferences. Once connected with a

key worker or a support group, that support is personalised to them as much as possible. Support tends to be short-term interventions to maintain independence, and includes, although is not limited to, a range of direct resident-facing and capacity building offers, such as:

- Navigation and social prescribing
- 121 emotional and practical support
- Group support and community activities
- Peer mentoring
- Cultural advocacy and addressing inequalities
- Service user involvement and co-production

Section 2: Evidence and data

In this section you should outline the evidence or data available to support your assessment of the potential negative and positive impacts of the proposed activity.

This should be evidence or data which is specific to the protected characteristics and the additional characteristics identified as priorities by the Council. It should not be generic data which cannot be linked to any specific characteristics. The evidence or data used should include or be one of the following:

- Demographic or representation data (e.g. Census data)
- Engagement or participation data relevant to the activity (e.g. user data, data on registrations, etc.)
- Findings gathered through feedback or complaints from relevant stakeholder groups (e.g. resident complaints, public consultations, engagement surveys)
- Research publications, evidence or policy documentation produced by Government, charities or research organisations (e.g. a publication by Age UK)

2.a. Evidence and data linked to the protected characteristics in the Equality Act 2010:

Please select each of the protected characteristics you have evidence or data for, then set out this evidence or data in the field below.

If evidence or data is not currently available, use the action plan (‘Section 6’) to describe how you will ensure you hold relevant evidence or data in the future.

Select all characteristics where evidence or data has been identified:

☒ Age
☒ Disability[2]

[2] The Equality Act defines a disability as a condition or experience which has a significant impact on someone’s ability to carry out day-to-day activities and which has a long-term impact (12 months or more over the course of a person’s life). This includes a diverse range of people with physical, mental and sensory impairments, long-term health conditions, mental health conditions and / or neurodivergence. Carers who provide unpaid care for a person who is disabled are also included in the protections of this characteristic.

☒ Gender reassignment[3]
☒ Marriage or civil partnership
☒ Pregnancy or maternity
☒ Race or ethnicity
☒ Religion or belief[4]
☒ Sex[5]
☒ Sexual orientation[6]

Age
Camden is experiencing unprecedented demand on support for mental health challenges in young people. Mental health disorders in children and young people have risen from 1 in 9 in 2017 to 1 in 5 in 2023. This is 33% higher than the national average.

Data from Camden's Mental Health Crisis Assessment Centre (MHCAS) and other emergency rooms has shown that 35% of young people (18 – 24 years old) who attend emergency services in Camden for mental health reasons have never received mental health care before. This suggests that about a third of young people's mental health needs in Camden are not being met until they reach a crisis point.

16% of people aged between 45 and 64 who attend emergency services for mental health reasons are unknown or have not received mental health care prior. For people over 65 years old, this increases to 22%.

The majority of people who access the current ROC service are aged between 35 and 64 (56%), while they only account for 37% of the population.

Young people between 16 and 24 account for 15% of Camden's population but only represent 4% of ROC's current service users. This could be because they are receiving support from Camden's Children's Services. Young people transition from Children's Services around the age of 25; 24% of ROC's service users are aged between 25 and 34, while they only account for 20% of the local population.

ROC currently disproportionally support people between 35 and 64, but we know that younger people need more support for their mental health before it reaches a crisis point, as this cohort is disproportionately represented in emergency contexts. Camden Council funds the Brandon Centre and The Hive to support young people in the borough.

Disability
15.2% of the Camden population reported being disabled under the definition of the Equalities Act (2010), meaning that they assessed their day-to-day activities as limited by long-term physical or mental health conditions or illnesses.

[3] This is the legal term in the Equality Act. This is understood to apply to people who may describe themselves as trans or transgender, who have undergone, are undergoing or are planning to undergo a process of transitioning from the sex they were assigned at birth to another sex.
[4] This characteristic covers religious or philosophical belief. The lack of religion or belief is also covered.
[5] This characteristic protects from discrimination on the basis of biological sex, rather than certificated sex or gender identity – specifically, this would refer to female and male.
[6] This characteristic refers to a persons sexual orientation toward a person of the same sex, opposite sex or either sex.

A mental health condition is considered a disability if it has a long-term effect on normal day-to-day activity as defined under the Equality Act 2010; the condition is classed as 'long term' if it lasts, or is likely to last, 12 months. An estimated one-in-seven adults in Camden (about 30,600) have been diagnosed in primary care with one or more mental health conditions, including common mental health disorders such as anxiety and depression (28,397), serious mental illness (3,668 people) such as schizophrenia, bi-polar disorder and dementia (1,071). Camden has the third highest diagnosed prevalence of serious mental illness in the country and the 8th highest diagnosed prevalence of depression in London.

People with a learning disability are more likely to experience poor mental health and have increased barriers to receiving help. 20-40% of people with a learning disability also have a mental health problem.

Carers for people with a disability experience high rates of mental health challenges in the UK. 35% rate their mental health as “bad” or “very bad” and 57% frequently feel overwhelmed (Carers UK, 2025). 43% of carers report worsening mental or physical health issues since taking on caregiving roles (MND Association, 2025).

ROC does not currently collect disability data on their service users. This will be improved in the recommissioned service from 2027 onwards.

Autism & Neurodivergence

It is important to note that autistic people have legal protections as autism is characterised as a disability, but autistic people will have different understandings of this – some autistic people consider themselves disabled by society (this is known as the ‘social model’ of disability) while some do not consider themselves to be disabled/have a disability. It is also important to note that some autistic people also have a learning disability (about a third of autistic people), and some do not. Autistic adults without a learning disability have told us, through engagement sessions with the Autism Hub (funded by Camden and Islington councils) as part of the recommission engagement process, that it is harmful for them when we do not understand the difference or when we group them with people with a learning disability as they can have very different needs.

If autistic people are likely to make up 2% of the population (based on the latest ‘official’ estimate of Camden’s resident population of 279,500 at mid-2020), there could be approximately 5,590 autistic residents in Camden. Population projections have suggested that this number will increase each year.

National data estimates that 7 out of 10 autistic people also have a mental health condition (Mental Health Foundation). A Camden study found that 71% of children and young people have reported needs related to their mental health and 80% of adults have identified a need related to their mental health. The study also found that 63% of autistic adults reported feeling lonely (Camden’s All-Ages Autism Strategy).

There are 1,410 autistic people in psychiatric hospitals in England (as of January 2025) and the number of autistic people without a learning disability detained in mental health hospitals has increased by 122% since 2015 (National Autistic Society, 2025).

Only 14% of autistic adults said there were enough mental health services in their area to meet their needs. Some autistic adults report difficulty in making GP appointments (often due to

reasonable adjustments not being made for them), and report encountering health staff who had a lack of understanding around autism and mental health which resulted in not being referred to specialist mental health care.

ROC do not currently collect data on autism and neurodivergence and this will be a priority for the new contract in 2027 onwards.

Gender reassignment
The Government Equalities Office estimate that around 0.3 - 0.8% of the UK population are transgender. In Camden, this would equate to between 700 - 2000 people.

People who identify as transgender have higher rates of mental health complications than those in the general population due to stigma and discrimination.

70% of non-binary people experience depression, 71% of trans people (including 79% of non-binary people) experience anxiety, 19% of trans people (including 24% of non-binary people) experience an eating disorder, and 88% of trans individuals across the UK showed symptoms of depression and 75% of anxiety compared with 20% of people in the UK general population. Data from 2015 shows that 48% of trans young people had attempted suicide.

In addition to a higher prevalence of mental health issues, transgender people typically experience barriers to healthcare, such as refusal of care, violence, and a lack of provider knowledge.

Around 3% of ROC's service users identify as transgender—higher than the estimated proportion of trans residents in Camden. This suggests that transgender people may experience mental health challenges at a disproportionately high rate. It is therefore likely that there are many more trans residents in the community who need support but are not currently accessing services.

Data is incomplete when it comes to trans people's needs. For example, NHS data on presentations at emergency services for mental health reasons only records data based on someone's sex rather than gender identity.

Marriage and civil partnership
In Camden, 70% of residents are single, separated, divorced, or widowed – which is higher than London (60%) and England (53%). According to Camden Council Public Health research on social isolation, relationships and social contact are essential in preventing isolation and loneliness. As there is a large proportion of the population who are single, separated, divorced or widowed, this suggests there is a large population in Camden at higher risk of social isolation, due to their marriage status.

According to the British Journal of Psychiatry (2018), married people, on average, report better mental health outcomes than unmarried people, including lower rates of anxiety, depression, and substance misuse. This is likely to do with people with good mental health being more likely to marry, rather than marriage having protective qualities. However, when studies control for previous mental health issues, results show that marriage can reduce mental health issues and risk of suicide.

Therefore, it is important that the future mental health service account for unmarried people, recognising that they are at higher risk of social isolation and may lack protective familial relationships – and in Camden, this group of people is disproportionately high.

Pregnancy and maternity
National guidelines suggest that around 1 in 4 women experience perinatal mental health issues (Camden Children and Young People's Health Needs Assessment, 2025).

In 2021/22, NCL has a lower rate of take-up for perinatal mental health services than the national target, as only 4.9% of pregnant women were assessed which is below the 8.6% NHS Long Term Plan ambition.

There is a clear link between deprivation and adverse maternal health outcomes. 60% of neonatal admissions at NCL sites are for babies in the 40% most deprived quintiles of the population (Camden Children and Young People's Health Needs Assessment, 2025).

Race
The highest prevalence of common mental health disorders in the UK are among Black ethnic groups. However, ethnic minority groups, especially Black people, receive mental health treatment at lower rates than White British people. This has also declined over the years, as the odds of receiving treatment for Black groups dropped from 0.68 in 2007 to 0.23 in 2014 (British Journal of Psychiatry).

Black people are over 3.5 times more likely to be detained under the Mental Health Act than people in white ethnic groups and they are also more likely to be placed on a community treatment order (CTO), where supervised treatment is given in the local community. For every 100,000 men receiving care for their mental health in hospital, 100 Black men had stays in hospital longer than 60 days compared with 25 white men who had the lowest length of stay. Restrictive interventions such as restraint or isolation are used against Black patients more than four times the rate of their White counterparts.

Black adults are disproportionately more likely to enter mental health services through the criminal justice system rather than through a GP.

NHS data from MHCAS and ER has shown that people from Chinese backgrounds are the most likely to attend emergency services in a mental health crisis with no prior contact with mental health services than other ethnic groups (43% of all Chinese people attending emergency services). This is followed closely by people of 'Any other Asian background', as 42% of this population attend emergency services in a mental health crisis with no prior contact. For comparison, White British people who attend with no prior contact is 14% of all White British people attending emergency services.

In a study of adults accessing NHS Talking Therapies, it was found that only 61% of Bangladeshi patients showed reliable improvement post-treatment, which was the lowest improvement rate among all ethnic groups tracked (NHS England). Bangladeshi men are amongst the lowest number of people referred to primary NHS Talking Therapies. Factors related to culture, religion, and gender create a sense of stigma and prohibits men from seeking the help they need (Alam, S, 2023).

ROC are seeing a higher representation of African, Mixed/Multiple Ethnic background and White/Black African and Arab communities being referred to their service compared with census data. This suggests that these groups have greater need for mental health support, likely due to issues such as structural racism, inequality, and barriers to accessing mental health care elsewhere.

People identified as being from 'Another White Background' are underrepresented in referrals to ROC.

Bangladeshi residents are underrepresented in those receiving ROC support. ROC are developing two new Bangladeshi peer groups with the aim of increasing engagement and take-up.

Religion or belief
2021 census data reported that 47% of Camden residents described themselves as having no religion compared to 37.2% nationally. 30% of Camden's population identified as Christian, fewer than the national average of 46.2%. 16% of people in Camden identified as Muslim compared with 6.5% of people nationally and 4.8% of people in Camden identified as Jewish which is ten times greater than the national rate of 0.5%.

According to Camden's Adults Mental Health needs assessment, religious and spiritual beliefs can both positively and negatively impact one's mental health. For some, religion can provide coping strategies and a sense of wellbeing that contributes to good mental health. Churches, mosques, and worship settings can provide social connection and prevent isolation.

However, religious discrimination and hate crimes (such as Islamophobic and antisemitic violence) can profoundly impact mental health. In the year ending March 2025, the Metropolitan Police reported 2,900 religious hate crime offences in London. This was an increase of 2% from the following year.

Camden's State of the Borough 2023 reported that there was a 400% rise in antisemitic incidents and a 270% rise in Islamophobic incidents in late 2023. (The 2025 State of the Borough report did not separate religions in its hate crime reporting, but it did note that recorded hate crimes had fallen by 8%, but for antisemitic hate crimes in particular, this continued to rise).

This data suggests that some religious groups are at higher risk of poor mental health due to discrimination and the risk of hate crime.

Sex
Camden has a slightly higher percentage of females (52.6%) than males (47.4%).

In England, 24.2% of women have a common mental health condition (depression and anxiety). This is higher than men, as 15% of men in England have a common mental health condition (NHS England, 2025).

In England, men die by suicide about three times the rate of women (74% of suicides registered in 2022 were males). London had the lowest rate of suicide for both sexes in England (7 deaths per 100,000).

Suicides in women is highest in those aged 50 to 54 years. For men, the age-specific rate was highest in those aged 90 years or over, followed by those aged 45 to 49 (ONS, 2022).

People who attend emergency services for mental health reasons with no prior contact with mental health services a slightly more likely to be male.

Participation in the ROC service for men and women broadly mirrors the Camden population. However, in the most recent quarters, a decline in men accessing ROC and an increase in women was observed.

Sexual orientation
In Camden, 6.9% of residents identify as a sexual orientation other than heterosexual. This is significantly higher than the UK average of 3.2%.

People in the LGBTQIA+ community are at a 2.5x higher risk of suicide than heterosexual people. 50% of LGBTQIA+ people reported experiencing depression and 60% reported experiencing anxiety.

Gay and bisexual men are 2.5x more likely to attempt suicide than heterosexual men (most common in those aged 35 and over). Lesbian women are three times more likely than heterosexual women to attempt suicide and bisexual women have the highest rates of self-harm compared to gay and lesbian people (24.5% have reported self-harm).

Discrimination, bullying and social isolation is a major contributor to the prevalence of mental health challenges among gay, lesbian and bisexual people.

Gay and Lesbian people account for between 4 and 7% of ROC's service users and bisexual people account for 2% of their service users. However, between 5 and 8% of ROC service users stated they were 'unsure' of their sexual orientation.

2.b. Evidence and data linked to the additional priority characteristics identified by Camden Council:

Please select each of the additional characteristics where relevant data has been identified and set out this evidence or data in the field below.

If evidence or data isn't currently available, use the action plan ('Section 6') to describe how you will ensure you hold relevant evidence or data in the future.

Select all characteristics where evidence or data has been identified:

☒ Foster carers
☒ Care-experienced young people[7]
☒ Low-income households
☒ Refugees and asylum seekers

[7] 'Care experienced' will apply to young people who have been 'looked after' at some point in their childhood and are entitled to receive services under the Children Act 1989, Leaving Care Act 2000 and the Children and Social Work Act 2017. As such, it does not include children who have been adopted as their support and services are covered under the Adoption and Children Act 2002.

☒ Parents / carers (of any gender, of young people aged under 18)
☒ People who are homeless
☒ Private rental tenants in deprived areas
☒ Single parent / carer households (of any gender, of young people aged under 18)
☒ Social housing tenants
☐ Any other (please specify):

Foster carers
National surveys have found that 58% of foster carers experience burnout or ill health related to their role, and 60% had considered resigning due to burnout and lack of support (The Fostering Network, 2024).

There is limited data on specific prevalence rates of mental health diagnoses in foster carers, but qualitative findings highlight a pattern of stress and ill health commonly seen in other caregiving roles.

Care-experienced young people
Looked-after children and care leavers are a significant concern as they often face higher rates of mental health conditions compared to their peers due to factors such as trauma, instability, and lack of consistent support systems.

As of 2024, there were 209 Looked After Children in Camden. One fifth of this population are unaccompanied asylum seeker children, which is the highest proportion in the NCL ICB. This population is also 'ageing,' with a higher proportion of adolescents than in previous years. The mental health needs of looked after children is a high priority for Camden Council, especially when they transition from Children's Services to Adult Social Care (i.e. when they become 'care leavers').

A national survey from 2024 found that 46% of care leavers had a mental health concern, and within this group, 65% received no services and only 9% were on a NHS waitlist (Research in Practice, 2024).

At present, the Reach Out Camden service does not assess whether the residents they support have a care experienced background. For the new contract, this can be included as a reporting requirement so that we can better understand care-experienced young people's engagement in, and experience with, the service.

Low-income households
Of the 133 local neighbourhoods in Camden, 32 are among the 20% most income-deprived in England, while 21 are in the 20% most affluent. This demonstrates that we have some of the UK's richest and poorest people living in our borough.

In Camden, 24% of its residents live within the 20% most deprived areas of England (Census, 2011). The impact of living in the most deprived wards also includes 83% higher prevalence of serious mental illness.

Young people from low-income families are likely to have worse mental health outcomes if they live in an affluent area (Camden Children and Young People Health Needs Assessment, 2025).

Social housing is home for 52% of Camden's children and young people, and young people living in social housing are twice as likely to have a mental disorder (Camden Children and Young People Health Needs Assessment, 2025).

Refugees and asylum seekers
Camden has the third largest inflow of international migrants in England from mid 2019 to mid 2020 – at approx. 20,000 people (The Migration Observatory). Research suggests that asylum seekers are five times more likely to have mental health needs than the general population, and more than 61% will experience severe mental distress (2011, Mental Health and Wellbeing in Leeds: An Assessment of Need in the Adult Population. NHS Leeds). However, data shows that they are less likely to receive support than the general population (2010, Refugees and asylum seekers: A review from an equality and human rights perspective. Equality and Human Rights Commission Research report 52, University of Kent). Feedback from stakeholders show that people with no recourse to public funds often experience barriers and delays access appropriate mental health support.

Parents or carers (of any gender, with children aged under 18)
There is limited data available on the mental health challenges of parents in Camden.

Approximately 68% of women and 57% of men with mental health problems are parents. Poor maternal and paternal mental health has been associated with poor outcomes in children (Mental Health Foundation).

ROC does not currently collect this data on their service users. They also do not currently collect data regarding whether the purpose of seeking help is to do with being a parent / parental challenges.

People who are homeless
According to CHAIN (Combined Homelessness and Information Network) there were 11,018 rough sleepers in London in 2020/21, and of these, 639 in Camden. Homelessness as measured by the total number of households assessed and owed a prevention or relief duty, has increased in Camden by 7% since 2018, from 1,026 to 1,098 in the 2020/2021 financial year. In London, the same figure has reduced slightly, by 3%, to 51,760.

Poor mental health is both a cause and consequence of homelessness, with the onset of mental illness triggering or being part of a series of events that can lead to homelessness. Housing insecurity and homelessness is stressful and traumatic and can cause mental health problems. 45% of people experiencing homelessness have been diagnosed with a mental health issue, rising to 8 out of 10 people who are sleeping rough (Crisis, 2023).

Private rental tenants in deprived areas
As of the 2021 Census, 33,012 households were renting privately in Camden, representing 35.6% of the borough's 92,758 households. This figure includes areas of varying deprivation within Camden but does not break down tenants specifically by levels of deprivation within the borough.

In the most deprived areas of Camden, private rental figures are not explicitly stated in available data, but these areas often see higher concentrations of renters due to housing affordability challenges. Camden's private rental market is one of the most expensive in London, with median rents in 2022 ranging from £1,550 for a one-bedroom flat to £3,575 for a four-bedroom property.

Many renters in Camden rely on housing benefits, though these often fall short of covering full rent costs.

Single parent or carer households
Data on the mental health experiences of single-parent households in Camden is limited, but there are some broader insights into challenges they face that can contribute to mental health difficulties.

Camden's data highlights that groups in socio-economic disadvantage, including single parents, are more likely to experience mental health challenges. National trends suggest that single parents often face higher levels of stress and mental health conditions, such as anxiety and depression, due to economic pressures, childcare responsibilities, and social isolation.

Single parents are disproportionately affected by issues like housing insecurity and financial struggles. For example, during the pandemic, many single parents in the UK, including those in Camden, faced significant discrimination and economic challenges, which worsened their mental well-being.

Although Camden offers mental health services and support groups, there remains a gap in services tailored to the unique needs of single-parent families, which can hinder their ability to access timely and adequate mental health support.

Social housing tenants
Housing tenure across Camden is split almost equally, with around a third of residents owning their home (30%), renting privately (36%), or in social housing (34%).

A qualitative study of social housing tenants from 2019 found that poor mental health was common, with stress and anxiety tied to damp conditions, slow repairs, low income and uncertain benefits (Journal of Public Health, 2019). The study also found that social housing tenants with stronger community ties reported better outcomes, and the study correlated social cohesion strategies within social housing with better mental health outcomes.

2.c. Evidence or data on intersectionality:

Please present here any evidence or data which indicates specific or different outcomes, experiences or opportunities arising for people who experience intersecting or overlapping forms of discrimination[8].

This is not necessarily about collecting or presenting different evidence or data to that already set out above. It is about ensuring that your analysis of the available evidence or data takes account of intersectional experiences – for example, the specific experiences of Black women, disabled parents or LGBTQ+ people who are homeless.

[8] Intersectionality is "the interaction and cumulative effects of multiple forms of discrimination affecting the daily lives of individuals". (Britannica)

An estimated 31% of disabled people in Camden have poor health, 61% are social renters and 64% are economically inactive. They are also likely to experience poor access to services and be disproportionately impacted by the cost-of-living crisis.

Homeless women are particularly vulnerable and typically experience multiple and complex issues related to their gender that result in or perpetuate housing and health crisis. Research conducted by Crisis suggests that 26% of people accessing homelessness services are women, and 12% of rough sleepers are women. The Homeless Link Health Audit identifies homeless women as more likely to have mental health conditions & to have used heroin or crack cocaine in the last month than their male counterparts.

Women with multiple disadvantages experience a combination of complex and overlapping problems including homelessness, substance misuse, mental ill health, poverty, and contact with the criminal justice system. But women often find themselves bounced between services or excluded because of the complexity of issues they face.

Agenda research (Agenda alliance) reveals one in 20 women have experienced extensive physical and sexual violence as both a child and an adult. These women face very high rates of problems like mental ill-health, addiction, homelessness, and poverty:

- 54% have a common mental health condition
- 52% have a disability
- 35% are in the lowest income tertile
- One in three have attempted suicide
- One in five have been homeless
- One in three have an alcohol problem

Rates of mental illness for people from Black, Asian and Minority Ethnic backgrounds are sometimes greater than for white people. Compared to white people:

- Black women are more likely to experience a common mental illness such as anxiety disorder or depression,
- Older South Asian women are an at-risk group for suicide,
- Black men are more likely to experience psychosis, and
- Black people are 4 more times likely to be detained under the Mental Health Act.

But more white people receive treatment for mental health issues than people from Black, Asian and Minority Ethnic backgrounds and they have better outcomes. Some of the reasons why there are different rates of mental illness for people from Black, Asian and Minority Ethnic backgrounds are due to:

- inequalities in wealth and living standards,
- bias, discrimination and racism,
- stigma about mental health, and
- they are more likely to have mental health issues identified in the criminal justice system

People from Black, Asian and Minority Ethnic backgrounds are more likely to be living in poverty than white people. People living in poverty are more likely to develop and experience mental health issues.

A 2024 national survey found that 58% of LGBTQI+ youth had seriously considered attempting suicide in the previous year, and 19% had reported a suicide attempt. Transgender and

nonbinary youth reported significantly higher rates of both suicidal ideation and suicide attempts compared to their cisgender LGBTQI+ peers.

Remember to use the action plan (‘Section 6’) to set out actions you will take to ensure that any gaps in the evidence or data you have available can be addressed and filled for future updates to this EqIA.

Section 3: Analysis of impact

You should use this section to outline the potential impacts you have identified which might occur for people on the basis of each of the protected and additional characteristics set out in this EqIA. Your analysis should be informed by the evidence and data considered and presented in 'Section 2' and you should clearly refer back to this evidence and data.

Potential impacts identified should only be those that are specific to any particular characteristics, rather than listing general positive or negative implications of the activity which would affect people regardless of their characteristics.

If you select 'No impacts identified' you must justify how you have reached this conclusion through your assessment. If you select 'Insufficient evidence', you should consider including an action in the action plan ('Section 6') to address this gap.

Protected characteristics (established by the Equality Act 2010)	**Is there a potential positive or negative impact on this characteristic arising from the proposed activity?** (Select all that apply)	**Describe the potential <u>positive</u> impact(s) which have been identified** (Please explain the evidence used to identify the **positive** impact(s))	**Describe the potential <u>negative</u> impact(s) which have been identified** (Please explain the evidence used to identify the **negative** impact(s))
Age	☒ Potential **positive** impact ☐ Potential **negative** impact ☐ No impacts identified ☐ Insufficient evidence	This service will be open access, with no threshold or eligibility to meet to access support. Residents can self-refer for help and will be connected to a range of support options that are flexible and person-centred. For these reasons, a person of any age can access support. The service also aims to be very accessible, with no fixed location for support delivery, which means people with limited mobility can be visited in their home. Conversely, the service in its current contract tends to employ younger people, which makes the service more appealing to young residents.	

Disability	☒ Potential **positive** impact ☐ Potential **negative** impact ☐ No impacts identified ☐ Insufficient evidence	The service is open access and does not require individuals to meet diagnostic thresholds or eligibility criteria, which removes a common barrier for disabled people, people with long-term mental health conditions, neurodivergent people, and unpaid carers. Support is flexible and person-centred, including one-to-one, group and community-based offers, allowing reasonable adjustments to be made based on individual need. Delivery is not tied to a fixed location, enabling home visits or community-based support for people with mobility issues, sensory impairments, or fluctuating health. The service's focus on early intervention and prevention supports disabled people to access help before needs escalate to crisis, and carers may benefit both directly (through emotional support) and indirectly through improved wellbeing of the person they support.	
Gender reassignment	☒ Potential **positive** impact ☐ Potential **negative** impact ☐ No impacts identified ☐ Insufficient evidence	The service provides non-judgemental, community-based mental health support that is open access and self-referrable, which can reduce barriers often faced by trans and non-binary people in statutory services. The alliance model includes organisations with experience of advocacy, co-production and addressing inequalities, supporting culturally competent and affirming practice. Flexible delivery and peer-led approaches can help trans and non-binary residents feel safer	

		accessing support, particularly those who may avoid traditional clinical settings due to discrimination or stigma.	
Marriage or civil partnership	☒ Potential **positive** impact ☐ Potential **negative** impact ☐ No impacts identified ☐ Insufficient evidence	The service supports residents regardless of relationship or household status, which is particularly beneficial in Camden where a high proportion of residents are single, separated, divorced or widowed. By offering group activities, peer support and community-based interventions, the service helps reduce social isolation and loneliness for those who may lack protective family or partner relationships. The preventative and relational nature of the service promotes wellbeing and social connection, supporting mental health outcomes for people who may otherwise be at increased risk due to isolation.	
Pregnancy or maternity	☒ Potential **positive** impact ☐ Potential **negative** impact ☐ No impacts identified ☐ Insufficient evidence		
Race or ethnicity	☒ Potential **positive** impact ☐ Potential **negative** impact ☐ No impacts identified ☐ Insufficient evidence	The service is delivered through a diverse alliance of voluntary and community organisations with strong local links and experience of working with communities that face structural inequalities and barriers to accessing mental health care. The focus on cultural advocacy, co production and peer led support increases accessibility for people from minoritised ethnic backgrounds, particularly those who are less likely to engage with	

		statutory services or who may enter support at crisis point. Open access and non clinical delivery routes support earlier intervention and help reduce inequalities in access, outcomes and pathways into mental health support. It is also expected that the provider will develop relationships with local VCS organisations and cultural groups to co-deliver peer support groups in different languages.	
Religion or belief	☒ Potential **positive** impact ☐ Potential **negative** impact ☐ No impacts identified ☐ Insufficient evidence	By operating outside of formal clinical settings and taking a person centred approach, the service can better accommodate religious practices and preferences, supporting equal access to mental health support for people of different faiths or beliefs, as well as those with no religion.	
Sex	☒ Potential **positive** impact ☐ Potential **negative** impact ☐ No impacts identified ☐ Insufficient evidence	The service is designed to be accessible and relevant to people of all sexes, offering multiple routes of support including one to one, group and peer based interventions. This flexibility can help engage people who may be less likely to access traditional services, including men who may be reluctant to seek clinical mental health support, as well as women who experience higher rates of common mental health conditions.	
Sexual orientation	☒ Potential **positive** impact ☐ Potential **negative** impact ☐ No impacts identified ☐ Insufficient evidence	The service provides inclusive, non judgemental mental health support that is open access and community based, which can reduce barriers faced by LGBTQIA+ residents due to stigma, discrimination or fear of disclosure. Peer support, group activities	

		and a strengths based approach can help reduce isolation and promote connection and belonging. The alliance's experience in co production and working with marginalised communities helps ensure that support is affirming and responsive, promoting equality of opportunity and improving mental health outcomes for LGBTQIA+ people.	

Additional characteristics (priorities for Camden Council)	**Is there a potential positive or negative impact on this characteristic as a result of the proposed activity?** (Select all that apply)	**Describe the potential <u>positive</u> impact(s) which have been identified** (Please explain the evidence used to identify the **positive** impact(s))	**Describe the potential <u>negative</u> impact(s) which have been identified** (Please explain the evidence used to identify the **negative** impact(s))
Foster carers	☒ Potential **positive** impact ☐ Potential **negative** impact ☐ No impacts identified ☐ Insufficient evidence	The service provides early, preventative mental health support that can benefit foster carers who may experience emotional strain, stress or isolation linked to their caring role. Flexible, community based delivery and open access allows carers to seek support without referral thresholds, supporting wellbeing and resilience and helping carers sustain stable placements.	
Care-experienced young people	☒ Potential **positive** impact ☐ Potential **negative** impact ☐ No impacts identified ☐ Insufficient evidence	The service offers accessible mental health and wellbeing support that may benefit care experienced young people, including care leavers who may not meet thresholds for specialist services. Community based, non	

		clinical support and early intervention can help address emerging mental health needs, reduce isolation and support transitions into adulthood, contributing to improved emotional wellbeing.	
Low-income households	☒ Potential **positive** impact ☐ Potential **negative** impact ☐ No impacts identified ☐ Insufficient evidence	The service's open access model removes financial and eligibility barriers that can prevent people on low incomes from accessing mental health support. All support is free. Community based and preventative provision supports earlier intervention for stress, anxiety and low level mental health needs associated with financial insecurity, helping to reduce escalation to crisis and improve overall wellbeing.	
Refugees and asylum seekers	☒ Potential **positive** impact ☐ Potential **negative** impact ☐ No impacts identified ☐ Insufficient evidence	The service's open access and voluntary sector delivery model reduces barriers for asylum seekers and refugees who may face language, cultural or trust based barriers to statutory services. Community based and preventative support can help address trauma, isolation and low level mental health needs, promoting improved access to early support and reducing escalation to crisis.	
Parents and / or carers	☒ Potential **positive** impact ☐ Potential **negative** impact ☐ No impacts identified ☐ Insufficient evidence	The service provides flexible mental health and wellbeing support that can benefit parents experiencing stress, isolation or emerging mental health needs related to caring responsibilities. Open access and community based delivery enables parents to engage at times and in ways that fit around family life,	

		supporting early intervention and improved emotional resilience.	
People who are homeless	☒ Potential **positive** impact ☐ Potential **negative** impact ☐ No impacts identified ☐ Insufficient evidence	The service's flexible, non clinical approach supports people experiencing homelessness or housing insecurity who may struggle to engage with traditional services. Open access, outreach and community based delivery enable earlier engagement with mental health support, helping to address emotional distress, reduce isolation and support overall wellbeing alongside other support services.	
Private rental tenants in deprived areas	☒ Potential **positive** impact ☐ Potential **negative** impact ☐ No impacts identified ☐ Insufficient evidence	The service supports private rental tenants living in deprived areas who may experience housing insecurity, financial stress and limited access to support. Open access community provision and voluntary sector delivery help reduce barriers to engagement, supporting early intervention for mental health needs and reducing the risk of escalation to crisis services.	
Single parent and / or carer households	☒ Potential **positive** impact ☐ Potential **negative** impact ☐ No impacts identified ☐ Insufficient evidence	The service's flexible and preventative approach supports single parents who may face increased pressures related to caring responsibilities, financial strain and isolation. Open access and community based support enables earlier engagement with mental health services, helping to address emerging needs, reduce stress and support parental wellbeing.	
Social housing tenants	☒ Potential **positive** impact ☐ Potential **negative** impact ☐ No impacts identified	The service supports social housing tenants who may experience higher levels of deprivation, social isolation or mental health	

	☐ Insufficient evidence	inequality. Open access, non clinical and community based delivery helps overcome barriers to engagement with statutory services, supporting earlier access to mental health support and promoting improved wellbeing within local communities.	
Any other (please specify)	☐ Potential **positive** impact ☐ Potential **negative** impact ☐ No impacts identified ☐ Insufficient evidence		

Please describe any potential positive or negative impacts you have identified as a result of the proposed activity on any intersectional groups Please describe the intersectional groups, the potential impacts identified and the evidence or data used in your assessment.
The proposed service is expected to have a positive impact on intersectional groups identified in Section 2c by actively addressing multiple and overlapping barriers to accessing support. Its open-access, preventative and community-based approach is particularly beneficial for individuals who experience compounded disadvantage, such as people from Black, Asian and minority ethnic backgrounds who are also on low incomes, disabled people experiencing social isolation, and LGBTQ+ individuals facing stigma alongside housing or financial insecurity. The culturally competent, co-produced and flexible delivery model is likely to improve engagement and outcomes for groups who experience both structural inequalities and poorer access to traditional services, including women from minoritised communities, older adults from diverse backgrounds, and transgender individuals. By offering early intervention in trusted community settings and reducing thresholds for support, the service is well positioned to reduce inequalities and improve mental health outcomes for people experiencing intersecting forms of disadvantage.

Section 4: Consultation and engagement

4.a. How have you consulted or engaged with those who will potentially be impacted by the activity (either directly or through engagement with organisations representing these groups)?

Consultation and engagement should be relevant to the specific activity being considered through this EqIA (although it may not have been carried out specifically because of the EqIA being carried out).

You should describe what the consultation process looked like, when it took place and how many people were involved. You should also be able to show how what you learned through this consultation or engagement has factored into your equalities thinking in this EqIA.

Group(s) engaged and details of engagement	Issues raised through the consultation or engagement, related to one or more protected or additional characteristics	Learning or impact for equalities thinking
Current services users Commissioners visited Likewise's community centre and Mind in Camden's Barnsley Street centre in February and March 2026 where service activities happen to meet with current service users one to one or in small groups to understand their experience and feedback of the service. A total of 25 current service users were engaged with in this process	• Many service users reported how the no-cost service offer was essential for them, which suggests that many may come from low-income households. Some service users reported that some opportunities were discontinued due to the providers not being able to make activities free (such as visits to the British Museum). These service users reported that community and cultural visits were the most impactful when it came to their sense of belonging and social inclusion. • Most current service users reported that access to free meals (via community drop ins) and cooking/baking classes made a significant impact to their wellbeing and sense of inclusion. They explained that free food was often a way for them to join a group that they would otherwise have felt too intimidated or anxious to join, and that they would not access healthy, cooked meals otherwise.	• This highlights the importance of ensuring the service remains free while also balancing the need for varied events and social prescribing offers. • This again suggests that the service supports people in low-income households and has a role in tackling food insecurity in the borough. • Current service users who were surveyed reported that language barriers were an issue in accessing the right kind of support.

Residents who do not currently use the service Commissioners offered library drop ins at Swiss Cottage and Queen's Crescent Libraries in March 2026 to engage with residents who had not used the service to understand their needs and preferences. Commissioners, as a result, had seven meaningful discussions with residents. Alongside this, an online survey was shared with Camden residents via council and partner newsletters. This was filled out by 61 people.	• Some survey respondents reported that language barriers exclude them from receiving personalised mental health support • One resident at a library drop in reported being excluded from the Autism Hub (funded separately to the Reach Out Camden service) due to having a co-occurring learning disability • Long wait times was reported as the biggest barrier to people accessing support. People whose needs are mostly met or people who have more experience navigating complex statutory systems will be better placed to manage long wait times, while people who are already excluded from support or underserved by the council will find long wait times particularly challenging, and may therefore be at risk of further deterioration	• Culturally responsive support services are essential in supporting those from culturally diverse backgrounds. This needs to go further than just language translation but should involve safe spaces coproduced with Camden's diverse communities • Camden's support networks are fragmented, which can result in people feeling excluded from certain places. Better navigation support could help with this
Autistic residents Three autistic residents who volunteer with the Autism Hub as support workers for other autistic residents were engaged with via an online meeting in March 2026 to understand their insight into the needs and experiences of autistic residents in accessing	• Residents engaged with shared that autistic people are at far higher risk of self-harm and suicide that neurotypical people, and that statutory services can be traumatising for autistic people and make things worse. • They emphasised the need for support being delivered out of safe spaces and that support should be tailored around the needs of autistic people. They emphasised the need for all support staff being trained in neurodiversity, and ideally, support for neurodivergent residents should be delivered by neurodivergent people	• The service should partner with existing autism-informed organisations so that support can be coproduced and delivered from safe spaces in the borough

mental health support.		
Mental health system partners (i.e. NHS, VCS organisations) Commissioners held two engagement sessions between February and March 2026 with 23 different mental health system partners, including NHS partners, drug and alcohol support services, VCS partners, and other council departments working in mental health support (e.g. the Social Prescribing team)	System partners reported an observed lack of diversity of front-line staff for the current service. This could make the service less accessible for some protected characteristics (i.e. race, sex, sexual orientation, gender reassignment, age, etc.) who may feel the service won't understand their needs.	This will influence the design of the next contract in that the providers are expected to partner with local organisations that support and represent Camden's diverse populations.

4.b. How have you engaged with other Council services or relevant external partners or suppliers who would be involved in the delivery of the activity?

This is essential where the mitigations for any potential negative impacts rely on the delivery of work by other teams.

- Public Health
- Community Partnerships Team
- Mental Health Social Work
- Adult Social Care Neighbourhoods Team

Section 5: Assessment

At this point in the form, you should have considered the available evidence and whether there are any potential positive or negative impacts identified against each of the protected and additional characteristics, and on the basis of any intersectional identities and experiences.

Using the analysis you have done so far, you are now asked to determine which of the below outcomes is most appropriate for this activity.

You should provide a clear, brief rationale for the conclusion reached in this section and should use the action plan in 'Section 6' to set out mitigating actions that need to be taken in response to the outcome of this assessment.

Please select one of the below assessment outcomes:

Assessment outcomes	
☒	**1. Activity can continue as it is:** No negative impacts have been identified, so the work can continue
☐	**2. Activity has justifiable negative impacts:** Negative impacts have been identified but these can be justified as a proportionate means of achieving a legitimate aim
☐	**3. Activity has negative impacts that can be managed:** Negative impacts have been identified but these can be balanced against identified positive impacts and / or can be addressed by changing the activity and / or introducing mitigating actions ('Section 6')
☐	**4. Activity cannot continue:** Significant negative impacts have been identified, or mitigating actions cannot be taken, meaning the work must be stopped

Narrative / justification for the above selection

The proposed recommissioned service is expected to deliver significant positive impacts by improving early access to mental health and wellbeing support and addressing known inequalities in access and outcomes. Its focus on prevention and early intervention will enable individuals to receive support before needs escalate, which is particularly important for groups who are less likely to engage with traditional clinical or statutory services. The open-access, community-based and non-clinical design helps remove common barriers such as stigma and eligibility thresholds, making the service more accessible to people who have been historically excluded from mental health support, such as people from Black, Asian and minority ethnic communities, LGBTQ+ individuals, and those experiencing socioeconomic disadvantage. Flexible delivery, including outreach and peer-led approaches, will further support engagement from people who may face additional barriers due to disability, language, caring responsibilities or social isolation.

The model's emphasis on co-production and holistic support is also expected to improve outcomes for those experiencing intersectional disadvantage. By involving people with lived experience in service design and delivery, the service can better reflect the needs of diverse communities and build trust with groups that have historically experienced poorer access or discrimination.

Section 6: Action plan

Use the template action plan below to set out actions that will be taken to address any potential negative impacts identified through this EqIA, or to support any potential positive impacts which have been identified. Be as specific and detailed as possible about the actions needed and how these will be carried out.

If other teams, services or partners would be required to support or input into the delivery of any actions, please ensure they are consulted prior to the EqIA being signed-off.

You should also make it clear through your action plan how you will ensure there is appropriate governance and oversight of your EqIA and the actions in this action plan, including how the EqIA will continue to be reviewed and updated.

Action	Responsible lead(s)	Delivery timeframe	Expected impact / outcome / measures
Require enhanced reporting requirements, so that providers must measure and report on protected characteristics (i.e. how many people access the service with each protected characteristic, and their outcomes achieved), as well as groups with “additional priority characteristics” that Camden has identified (i.e. foster carers, care experienced young people, etc.)	Commissioners (Catherine Schreiber and Louise Roberts)	Contract start, 1 April 2027 onwards	Better understanding of how the service is reaching out to people with protected characteristics, and greater understanding if the service is having a positive impact on these people
Include requirement for more coproduced support for autistic and neurodivergent residents and/or partnership working with local organisations supporting and co-lead by autistic residents in the contract specification. Consider focussing on neurodivergent residents on wait lists for diagnostic assessment, due to long wait times and risk of mental health deterioration.	Commissioners (Catherine Schreiber and Louise Roberts)	Contract start, 1 April 2027 onwards	More autistic residents supported to access autism-informed, non-clinical early mental health support and prevent things from getting worse, especially at times of greater emotional distress (i.e. waiting for assessment and health and social care input)

Support provider to build relationships with organisations supporting young people in Camden (such as The Brandon Centre and The Hive) to strengthen referral pathways and to build stronger support network for young people who are underrepresented in current service user make-up but have some of the highest needs in terms of mental health support.	Commissioners (Catherine Schreiber and Louise Roberts)	Contract start, 1 April 2027 onwards	When young people present to other organisations in Camden with mental health needs, they are quickly connected to Reach Out Camden to access mental health support, or vice versa.

Section 7: Review and sign-off

Once you have completed your EqIA, use this section to confirm agreement and sign-off from relevant parties.

Once this section has been completed, this version of the EqIA is finalised. At this point it should be saved as a PDF and sent to equalities@camden.gov.uk for performance monitoring.

Lead person completing the EqIA (author)	
Full name:	Julia Craig
Position:	Commissioning Manager, Mental Health, Learning Disabilities, and Autism
Date of sign-off:	11/05/2026
Person reviewing the EqIA (reviewer)	
Full name:	Jack Kilker
Position:	Equality Impact Quality Assurance Lead
Date of sign-off:	11/05/2026
Officer accountable for the EqIA (e.g. director or project sponsor)	
Full name:	Jon Horn
Position:	Head of Learning Disability, Autism and Mental Health Commissioning
Date of sign-off:	20/5/2026
Expected date of next review	
May 2031, as part of recommissioning process before five-year contract expires on 31 March 2032	