LONDON BOROUGH OF CAMDEN	**WARDS:** All

REPORT TITLE
2000 Tomorrows North Central London community intensive mental health pilot - award of a grant to the Tavistock and Portman NHS Trust (AH/2026/03)

REPORT OF
Cabinet Member for Best Start for Children and Families

FOR SUBMISSION TO Cabinet	**DATE** 25 February 2026

STRATEGIC CONTEXT

We Make Camden aims to ensure that Camden is a borough where every child has the best start in life. This proposal will help us to achieve this through supporting the development of an innovative team which will trial a new preventative approach for some of our most complex adolescents. By funding specialist mental health nursing and occupational therapy for complex adolescents, the pilot addresses health inequalities and promotes early intervention, enabling young people to thrive and reducing the risk of long-term adverse outcomes.

The way we work sets out how we will take a relational approach, working with partners and the community to deliver services that improve wellbeing and tackle inequality. This initiative exemplifies that approach by bringing together local authorities, NHS partners and community stakeholders to provide integrated person-centred care.

SUMMARY OF REPORT

London Borough of Camden has agreed to lead a test and learn pilot across North Central London (NCL). A new clinically led team will be based in Camden and provide intensive, therapeutic, community-based support to adolescents aged 13–18 with a history of complex trauma and escalating behaviours that cannot be managed within existing service structures.

The pilot will involve developing and hosting a small multi-disciplinary team to support families of children with complex mental health and/or behavioural presentations/needs. This team will be based within the Directorate for Relational Practice and will consist of 5.5 posts with two posts employed by the Tavistock and Portman Trust and the rest by LB Camden. The proposed grant will fund the posts seconded in from the Tavistock.

In the first phase, the pilot will be delivered across the London Boroughs of Camden, Islington and Barnet, funded through £500,000 of NHS funding in

2025/26 from NHS North Central and East London (NCEL) CAMHS Provider Collaborative. The NCEL Collaborative is made up five NHS Provider Trusts and an independent service provider. It provides Child and Adolescent Mental Health Inpatient / Child and Adolescent Mental Health Services (CAMHS) to children and young people aged 13-18 years living in North and North East London. The London Borough of Newham is leading a parallel pilot across North-East London.

The pilot will be operational initially for one year, with the potential to extend into a second year should funding be available and the outcome of an independent evaluation being carried out by University College London Partners (UCLP). Each test and learn site is expected to work with circa 10 children each over the course of the first year - 20 in total for year 1 across both pilots. The intention in the longer term, is that NCEL Provider Collaborative identify further funding to roll out to all five North Central London (NCL) boroughs, if there is merit in this model. In NCL this will mean expanding to work across the London Boroughs of Enfield and Haringey.

This report seeks Cabinet approval to award a grant of £231,007 to the Tavistock and Portman NHS Trust for the recruitment of a specialist mental health nursing and occupational therapy posts as part of the North Central London Complex Adolescent Intensive Pilot.

The decision is required because the grant value exceeds £100,000 per annum, which is above the threshold for delegated authority under the Council's Constitution.

Local Government Act 1972 – Access to Information

No documents that require listing were used in the preparation of this report.

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RECOMMENDATIONS

The Cabinet is asked to:

1. Approve that Camden enter the pilot as the lead Local Authority of the new North Central London complex adolescent intensive 2000 Tomorrows pilot.

2. Approve the award of a grant to the Tavistock and Portman NHS Trust, amounting to £231,007 for the delivery of specialist mental health nursing and occupational therapy posts. These posts will be part of the North Central London 2000 Tomorrows pilot.

3. Delegate authority to the Director of Relational Practice, following consultation with the Cabinet Member for Children and Families, to finalise and enter into the grant agreement amounting to £231,007.

Signed
Director of Relational Practice:
Nana Bonsu

Date: 11th February 2026

Director of Health and Wellbeing
Kirsten Watters

Date: 11th February 2026

1. CONTEXT AND BACKGROUND

1.1. This report seeks Cabinet approval to award a grant to the Tavistock and Portman NHS Trust to fund specialist mental health nursing and occupational therapy posts as part of the North Central London (NCEL) Complex Adolescent Intensive Pilot.

Need/demand for the service

1.2. National and local evidence shows a growing number of young people admitted to acute hospitals with complex needs, where mental health is the primary presenting issue. These young people often experience suicidal ideation, self-harm and behaviours that challenge.

1.3. These young people usually have multiple other complexities such as exposure to exploitation, involvement with complex safeguarding and youth justice systems, neurodiversity, severe self-harm, disrupted education, complex family histories, multiple placement breakdowns and going missing from care, and they may have been held in secure care or subject to Deprivation of Liberty Safeguards (DOLS). All of which also limits their capacity to establish trusting relationships with adults.

1.4. In 2023/24 young people from North Central London (NCL) experienced at least 1,212 days (a total of 3.3 years) of delays to discharge from acute mental health inpatient beds due to a lack of onward placement.

1.5. This lack of sufficiency of provision, combined with increasing complexity and increasing costs, has left the social care placement sector more challenged than ever before. This results in poor outcomes and experience for young people with additional complexity, despite exceptionally high costs to both health and care.

1.6. Breakdown of the occurrence of delayed discharges across NCL and associated costs shows that:

- Overall, 92 children and young people were admitted to mental health in-patient settings in NCL. Out of those, 17 (or 18.5%) of children and young people experienced delayed discharges at a total of 1,212 bed days.
- The highest number of total clinically ready for discharge (CRFD) bed days was in Barnet (660 days) for nine young people, at a total cost of £805,800. Barnet also had the highest number of children and young people's admissions generally.
- The most common reason for a delay was the need for a social care placement (66.7%), because families and other pre-existing care arrangements were not able to manage the child's needs with the support available to them.

1.7. One of the indicators of need is the number of children on the dynamic support register (DSR). The DSR is a mechanism for local health and social care and education systems to identify children and young people who have been diagnosed with a learning disability and/or autism with mental health needs and/or challenging behaviour and are at risk of being admitted to mental health inpatient settings. NCL Integrated Care Board's (ICB) analysis shows that there were 167 children from this cohort of children across NCL who were at risk of being admitted to mental health in-patient setting.

1.8. Cabinet approval is required because the grant exceeds £100,000 per annum, which is above the threshold for delegated authority under the Council's Constitution.

1.9. An agreement between Camden Council and NHS North Central and East London (NCEL) child and adolescent mental health (CAMHS) Provider Collaborative is in place for the funding of the overall pilot, of which this grant is a part. The one-year agreement will run from February 2026 and require funds to be spent within 24 months, allowing Camden to carry funds across the financial years.

2. PROPOSAL AND REASONS

Complex adolescent intensive community support pilot

2.1. Camden is leading on the development of this pilot, which aligns with We Make Camden ambitions to promote health equity and early intervention. In its first year, the pilot will focus on Barnet, Islington and Camden, as analysis of Tier 4 (children's mental health inpatient) bed usage by NCEL over the past five years shows these boroughs have the highest spend per child in North Central London.

2.2. This unique, clinically led team will be based in Camden and provide intensive, therapeutic, community-based support to adolescents aged 13–18 with a history of complex trauma and escalating behaviours that cannot be managed within existing service structures.

2.3. The proposed two new posts will be part of a new multi-agency, multi-disciplinary team which will work intensively with young people and families to address barriers that often delay discharge or lead to avoidable hospital admissions. These barriers include family relationship breakdown, parental mental health challenges, need for respite, housing concerns, medication reviews and breakdown in relationship with professionals. Other roles in the team will include a clinical lead, a family early help worker and youth worker.

2.4. There will be a focus on supporting the development of expertise in the care team, working with the clinical/social care system to develop and share complex formulations to enable system wide shared understanding and collaboration to foster shared safety planning and therapeutic risk taking. The team will work alongside existing clinical services to develop inclusive support plans for children and young people, whether they are living with their families or in care placements.

2.5. The core aim of the proposed new pilot is to maintain or create stable living arrangements and prevent traumatising and damaging family and placement breakdown as well as avoidable hospital admission because of unmet need. Intensive short-term support will be provided to prevent admission or placement breakdown for young people with highly complex presentations. In parallel, we have successfully secured £1,203,500 capital funding from the DfE to develop a new children's home for children who are looked after, with the same complex needs. This will open in December 2027. The new team will provide learning to help inform development of our new home, and if this pilot is extended, provides an opportunity for the team to work across children both in our home and the community – helping us maintain placement stability by supporting children's local connections to health and care systems.

2.6. The new service will provide additionality and will not be case managing on behalf of other boroughs. Lead responsibility for each family will remain with the home borough and the new team will work alongside the local network. This service will not replicate any existing services, as it will work intensively with a very small number of cases that are not currently receiving an intensive enough service to prevent escalation. This because the

current services do not have the scope/remit to offer a whole system intensive approach.

2.7. The pilot aims to:

- Enable young people to receive personalised care in the community, closer to home.
- Reduce preventable admissions to CAMHS inpatient services and acute hospitals.
- Minimise delayed discharges and avoid high-cost, out-of-area social care placements.
- Support approximately 10 highly complex young people and their families in NCL in year one.

2.8. Equivalent funding is being provided by NCEL to North-East London boroughs. The pilot is being led by the London Borough of Newham.

2.9. NCEL have commissioned an independent evaluation of both pilots to inform their future funding decisions. We will also seek to both share and apply learning about what works in supporting residents with highly complex needs across the life course with colleagues doing related work with adults, such as through our neighbourhoods work. The Centre for Prevention provides a means to capture, consolidate and disseminate this learning.

3. OPTIONS APPRAISAL

3.1. Option 1: Do nothing. Continue existing provision without making use of NCEL's additional investment. However, as section two above notes, given we know there are a significant number of children at risk of mental health inpatient admissions, turning down this opportunity to trial new approaches to supporting children in their communities means this option is not recommended.

3.2. Option 2: The Council recruits the specialist mental health nurse and occupational therapy posts directly
While this option would give the Council direct control over recruitment, it is not recommended. The Council does not have the required clinical expertise or infrastructure to provide professional supervision for these specialist roles. Recruiting in-house would also increase risk, reduce quality assurance and limit access to established clinical networks.

3.3. Option 3: Award a grant to a supplier through a competitive process to provide the specialist mental health nurse and occupational therapy posts
A competitive process would provide the Council with the ability to test the market and assess suppliers' responses on how they would provide the posts in a way that supports the achievement of the pilot's objectives. The primary risk of conducting a competitive process is that the time and resource required would likely lead to a lengthy delay in the delivery of the pilot, thereby delaying the potential to improve the health and wellbeing of Camden's young people. Consultation with CAMHS providers by the Provider Collaborative across the three boroughs has shown that they are supportive of the Tavistock and Portman NHS trust leading on this recruitment, therefore there is also a high chance that only one submission would be received, and should other submissions be received (albeit unlikely), the nature of the requirements needed from the grant recipient would mean it is likely that the grant would be awarded to the Tavistock and Portman NHS Trust. This would not be a good use of Camden resources given the focus needs to be on mobilising the pilot as soon as possible.

3.4. Option 4: Directly award a grant to a supplier to provide the specialist mental health nurse and occupational therapy posts **(RECOMMENDED OPTION)**
Given this is a pilot, this option ensures that the roles are delivered by an experienced

NHS provider with the necessary clinical governance, supervision and expertise in local service infrastructure. Tavistock and Portman NHS Trust have a strong track record in delivering specialist mental health services and have worked closely with their fellow NCL mental health trusts and the NCEL provider collaborative to shape this pilot. As there are already clinical staff from the Tavistock seconded into Camden teams, they are best placed to speedily mobilise and integrate these posts into the wider care pathway. This approach offers best value, minimises risk and supports the pilot's objectives of early intervention and reducing avoidable admissions.

4. WHAT ARE THE KEY IMPACTS / RISKS? HOW WILL THEY BE ADDRESSED?

4.1. The recommended option of awarding a grant to the Tavistock and Portman NHS Trust for the funding of two posts carries risks that could affect the pilot. A range of mitigation measures will be implemented to address these risks as set out in the table below.

Risk	Mitigation
Recruitment There is a risk that there may be delays in recruiting a suitably qualified mental health nurse and occupational therapist as there are a limited pool of clinicians with the skillset we will seek for these roles.	• Tavistock and Portman NHS Foundation Trust have agreed to recruit clinical posts, in line with our existing joint working arrangements such as the Whole Family and Growing with You teams. This means staff will experience the benefits of being part of a well-regarded NHS Trust, making the roles more attractive. • Existing job descriptions will be used where possible, to speed recruitment. • The Tavistock has a good track record of recruiting to specialist posts.
Partnership working The success of the pilot depends on effective collaboration between Camden Council, NHS partners and other stakeholders. Poor integration could reduce impact and create duplication. Barnet and Islington do not engage with the new team or hold unrealistic expectations of case working capacity	• A joint governance structure will be established, including regular multi-agency meetings and clear escalation routes. Roles and responsibilities will be defined in the grant agreement. • A detailed mobilisation plan is in development, and Islington and Barnet are involved in the mobilisation and governance arrangements so that expectations are clearly understood. • Regular reports and updates will be provided to the NCL Directors of Children Services to ensure there is oversight of progress and engagement at the chief officer level.
Clinical risk Working with highly complex adolescents involves safeguarding	• Robust clinical protocols, multidisciplinary collaboration and strong supervision arrangements will

concerns and potential escalation of behaviours that challenge.	be in place to manage risk effectively. The Tavistock has considerable expertise of working with this cohort of children and young people.
Sustainability NCEL are not satisfied with Camden's delivery or do not sustain funding within contract.	• We will ensure the agreement includes sufficient notice for us to terminate staffing contracts and/or secondments. • Governance arrangements with NCEL are in place and regular updates will continue to be provided, working in partnership together.
Funding is not sustained beyond the end of the pilot period.	• All staff will be retained on fixed term arrangements • All families will have clearly defined planned exits from engagement with the team within the timescales of the pilot. • Evaluation evidence will be used to build a strong case for continued investment and explore alternative funding streams if required.

5. CONSULTATION/ENGAGEMENT

5.1. Extensive multi-agency stakeholder engagement has informed the development of this pilot. A collaborative approach is being taken with engagement focused on ensuring the pilot reflects the needs of young people and families, promotes partnership working, and aligns with Camden 2025 ambitions for health equity and early intervention.

5.2. Feedback from stakeholders has shaped the service design and informed risk mitigation strategies, this includes co-production work that the Provider Collaborative had carried out with young people. Other key activities included:

- Stakeholder workshop - A dedicated workshop was held with representatives from Camden, Barnet and Islington Councils, NHS partners and other agencies to co-design the service model and agree priorities for implementation.
- Mobilisation meetings - A series of mobilisation meetings have taken place to plan operational aspects of the pilot, including governance arrangements, referral pathways and integration with existing services. These meetings involved senior leaders and practitioners from Camden, Barent and Islington and health services.

5.3. Further engagement will continue throughout the pilot, including regular multi-agency governance meetings and opportunities for stakeholders to review progress and contribute to the evaluation of the pilot.

5.4. An Equality Impact Assessment (EqIA) has been undertaken in accordance with Camden's equality duties. This is attached at Appendix 2. The assessment considered the potential impact of the proposal on all protected characteristics under the Equality Act 2010, as well as the additional characteristics that the Council is concerned about. The EqIA concluded that there are no adverse or disproportionate negative impacts arising from the proposal. The assessment did not identify any groups who would be

disadvantaged as a result of the decision. Mitigating actions in section 6 of the EqIA relate to data monitoring, quality assurance and review of the pilot. This is to ensure that any emerging issues relating to equality characteristics are identified early and addressed through continuous improvement actions.

6. LEGAL IMPLICATIONS

6.1. This report seeks Cabinet approval to award a grant of £231,007 to the Tavistock and Portman NHS Trust for the recruitment of a specialist mental health nursing and occupational therapy posts as part of the North Central London Complex Adolescent Intensive Pilot.

6.2. The decision is required because the grant value exceeds £100,000 per annum, which is above the threshold for delegated authority under the Council's Constitution and therefore requires a Cabinet decision on how this grant value can be awarded.

6.3. The Council must be mindful that it must comply with the public sector equality duty and the requirements of Section 149 (1) of the Equality Act 2010. This means that they must have due regard to the need to eliminate discrimination, harassment, victimisation, harassment, victimisation or other prohibited conduct and advance equality of opportunity between persons who share a relevant protected characteristic and those that do not share it.

7. RESOURCE IMPLICATIONS

7.1. Camden has successfully been awarded £500,000 health grant funding from NHS North Central and East London (NCEL) CAMHS Provider Collaborative to support the delivery of the North Central London community intensive mental health pilot.

7.2. This report seeks approval for the award of a grant to the Tavistock and Portman NHS Trust, amounting to £231,007 for the delivery of specialist mental health nursing and occupational therapy posts.

7.3. The grant conditions permit project management costs up to £50,000 to support the delivery of the programme and joint working across the North Central London pilot boroughs. The remaining cost of this post will be funded from existing resource within the Council's General Fund.

7.4. The grant funding is for one year provision commencing from the 1 February 2026 to January 2027. There is the potential of a further one-year extension subject to the outcome of an independent evaluation.

7.5. The estimated timing of the grant income and expenditure is summarised below.

	FY 2025-26	**FY 2026-27**	**Total**
Grant income from NCEL Trust	£250,000	£250,000	£500,000
Grant awarded to Tavistock for 2 clinical NHS posts	£231,007	£0	£231,007
Pilot team (LBC posts)	£0	£235,036	£235,036

Project Manager – part time	£0	£33,957	£33,957
Total grant usage	**£231,007**	**£268,993**	**£500,000**

8. ENVIRONMENTAL IMPLICATIONS

8.1 The proposals will not have any environmental impacts.

9. TIMETABLE FOR IMPLEMENTATION

9.1 The indicative timetable for implementation is set out as below:

Key activity date	Key task
December 2025 – January 2026	• Recruitment process for LBC roles • Finalise service descriptor, referral criteria and referral pathways
February 2026	• Cabinet approval sought • Post Cabinet approval - Finalise grant agreement with Tavistock and Portman NHS Trust, including governance arrangements and mobilisation plan.
March – April 2026	Recruit specialist mental health nurse and occupational therapist posts through Tavistock and Portman NHS Trust, using existing job descriptions to accelerate the process.
April – May 2026	Team induction and training; establish clinical protocols, supervision arrangements and referral pathways.
May 2026 onwards	Service goes live; begin working with first cohort of highly complex adolescents and families across Camden, Barnet and Islington.
Throughout 2026	Ongoing multi-agency governance meetings, stakeholder engagement, monitoring of pilot delivery and evaluation.
March 2027	Final report of the independent evaluators commissioned by NCEL to assess impact and inform decisions on future funding and potential expansion to all five NCL boroughs.

10. APPENDICES

Appendix 1: Need/demand for the service
Appendix 2: Equality Impact Assessment

REPORT ENDS

Appendix 1 – Need/demand for the service

1. Tier 4 Discharge data

Table 1 – The number and duration of delayed discharges in each NCEL borough against the cost to health providers (2023/24)				
Borough	**Number of CYP admitted**	**Number of delayed discharges**	**Total number of Clinically Ready for Discharge (CRFD) bed days (2023/24)**	**CRFD cost to health** (approximate)
Barnet	41	9 (21%)	660	£805,800
Enfield	12	1 (8.3%)	39	£25,350
Haringey	19	3 (15.8%)	264	£176,550
Camden	11	1 (9%)	191	£124,150
Islington	9	3 (33.3%)	59	£38,350

Table 2: Common causes for delays to discharge from NCEL Tier 4 CAMHS (2023/24)			
	1st most common	**2nd most common**	**3rd most common**
Reason for delay	66.7% - need for a social care placement	12.8% - need for a package of care in the home	12.8% - lack of social care support

Appendix 2: Equality Impact Assessment

Camden Council Equality Impact Assessment Form

Camden

Camden Council Equality Impact Assessment Form

Title of the activity	
2000 Tomorrows North Central London community intensive mental health pilot	
Officer accountable for the EqIA (e.g. director or project sponsor)	
Full name: Position: Directorate: Email:	Nana Bonsu and Kirsten Watters Director of Relational Practice/Director of Health & Wellbeing Adults & Health Nana.Bonsu@camden.gov.uk; Kirsten.watters@camden.gov.uk
Lead person completing the EqIA (author)	
Full name: Position: Directorate: Email:	Daxa Kotecha Strategic Commissioning Manager, Children's Commissioning and Health Partnerships Team Adults & Health Daxa.Kotecha@camden.gov.uk
Person reviewing the EqIA (reviewer)	
Full name: Position: Directorate: Email:	Jack Kilker Equality Impact Quality Assurance Lead Homes and Communities Jack.Kilker@camden.gov.uk
Version number and date of update	
Version 1 - 28/01/2026	

Step 1: Clarifying aims

1.a *Is it a new activity or one that is under review or being changed?*

☒New

☐Under review

☐Being changed

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

☐Staff

☒Residents

☐Contractors

☐Other (please detail):

1.c *Which Directorate does the activity fall under:*

☒Supporting People

☐Supporting Communities

☐Corporate Services

☐More than one Directorate. Please specify:

1.d *Outline the aims/objectives/scope of the activity. (You should aim for a summary, rather than copying large amounts of text from elsewhere.)*

Camden is leading on the development of a pilot across North Central London (NCL), which aligns with We Make Camden ambitions to promote health equity and early intervention. The pilot will be funded through £500,000 of NHS funding in 2025/26 from NHS North Central and East London (NCEL) CAMHS Provider Collaborative.

In the first phase, the pilot will be delivered across the London Boroughs of Camden, Islington and Barnet. The intention in the longer term, is that NCEL Provider Collaborative identify further funding to roll out to all five North Central London (NCL) boroughs, if there is merit in this model. In NCL this will mean expanding to work across the London Boroughs of Enfield and Haringey.

This unique, clinically led team will be based in Camden and provide intensive, therapeutic, community based support to highly vulnerable children and young people aged 13–18, with a history of complex trauma, and who have complex needs and circumstances, and their families, where there are challenges to returning home. These young people are often demonstrating escalating patterns of behaviour, which cannot be adequately contained within existing service structures so that they are viewed as high risk, high harm (to self or others) and high vulnerability and this leads to increasing levels of professional anxiety in the system. The pilot aims to:

- Enable young people to receive personalised care in the community, closer to home.
- Reduce preventable admissions to CAMHS inpatient services and acute hospitals.
- Minimise delayed discharges and avoid high-cost, out-of-area social care placements.
- Support approximately 10 highly complex young people and their families in NCL in year one.

A new multi-agency, multi-disciplinary team will be set up to work intensively with young people and families to address barriers that often delay discharge or lead to avoidable hospital admissions. These barriers include family relationship breakdown, parental mental health challenges, need for respite, housing concerns, medication reviews and breakdown in relationship with professionals. The roles in the team will include a clinical lead, a family early help worker, youth worker, mental health nurse and mental health occupational therapist.

This team will be based within the Directorate for Relational Practice and will consist of 5.5 posts with two posts employed by the Tavistock and Portman Trust and the rest by LB Camden. The Council are proposing to provide funding for the mental health nurse and mental occupational therapist to the Tavistock and Portman NHS Trust. This will be subject to the decision of the Cabinet on 25 February 2026.

The team will work alongside existing clinical services in each borough to develop inclusive support plans for children and young people, whether they are living with their families or in care placements. The new pilot will provide additionality and will not be case managing on behalf of other boroughs. Lead responsibility for each family will remain with the home borough and the new team will work alongside the local network. This service will not

replicate any existing services, as it will work intensively with a very small number of cases that are not currently receiving an intensive enough service to prevent escalation.

The service/pilot is being commissioned by the Provider Collaborative, who have developed the service description and referral criteria. Young people referred to the pilot will typically have multiple and overlapping complexities, including exploitation, involvement in complex safeguarding or youth justice, neurodiversity, severe self-harm, disrupted education, complex family histories, repeated placement breakdowns and episodes of going missing from care. Some may have experienced secure care or Deprivation of Liberty Orders. These factors often make it difficult for young people to form trusting relationships with professionals. All referrals will be considered on a case-by-case basis through a multi-agency, multi-disciplinary and multi-borough panel. Indicative criteria include young people aged 13–18 who are supported by children's social care, whose statutory responsibility sits with one of the participating boroughs, and who are on the edge of care or in care with unstable placements, presenting with escalating risks such as absconding, severe self-harm, exploitation, risk of harm to others, or high-risk behaviours that remain poorly contained despite involvement from CAMHS and local authority teams.

The pilot will work with a diverse range of young people and families, providing intensive, trauma-informed and culturally competent support that adapts to individual needs and life circumstances. This approach aims to promote equitable access, improve outcomes and strengthen whole-family support across participating boroughs. An independent evaluation of both pilots has been commissioned by the Provider Collaborative to inform future funding decisions.

Step 2: Data and evidence

What data do you have about the people affected by the activity, for example those who use a service? Where did you get that data from (existing data gathered generally) or have you gone out and got it and what does it say about the protected characteristics and the other characteristics about which the council is interested?

Is there currently any evidence of discrimination or disadvantage to the groups?

What will the impact of the changes be?

You should try to identify any data and/or evidence about people who have a **combination, or intersection, of two or more characteristics.** For example, homeless women, older disabled people or young Black men.

2.a *Consider any relevant data and evidence in relation to all Equality Act protected characteristics:*

☒Age

☒Disability, including family carers[2]

☐Gender reassignment[3]

☐Marriage and civil partnership

☐Pregnancy and maternity

☒Race

☒Religion or belief

☒Sex

☐Sexual orientation

Age
The pilot will support children and young people aged 13–18. Camden's population is approximately 218,000 people, according to the ONS mid-year estimates in 2022 (Census 2021). 74,555 (34%) of Camden's residents are ages 0–25, and 40,000 are 0-19. 17% of Camden's population are aged under 18, and more than half (57%) of 0–25-year-olds are aged 16-25.

The Big Mental Health Report by MIND (2024) states that 11% of 8–16 year olds in England with a mental health difficulty had missed more than 15 days of school in 1 term, compared to nearly 2% of those without.

In Camden (as of June 2024) it is estimated that 1 in 5 children and young people aged 11-16 have a mental health condition, and almost a quarter (23%) of 17–19-year-olds. Among younger children, results from the Camden Health related Behaviour questionnaire (HRBQ 2021) showed 38% of year 5 and 6 children were worried about their mental health.

Disability, including family carers
Nationally, data shows a steep decline in the mental health of children and young people, and unprecedented demand for support, with mental health disorders rising from 1 in 9 in 2017 to 1 in 5 in 2023 (NHS digital - Mental Health of Children and Young People in England, 2023 - wave 4 follow up to the 2017 survey).

The Big Mental Health Report by MIND (2024) states that 1 in 5 children and young people in England have a mental health problem but only a third were able to access treatment in 2023. And waiting for support often leads to worse mental health for individuals.

The 2023 Camden Public Health annual report states that:
- 6,810 additional people aged under 25 in Camden are predicted to seek help from mental health services over the next 2-3 years as a result of the pandemic in 2020.
- Proportion of referrals categorised as urgent/emergency in Camden has increased from 11% in 2018/19 to 38% in 2020/21.

The young people in Camden who may be at greatest risk of mental health conditions include children with SEND, young carers, children living in social housing, and children in care or care leavers:
- Nationally, over half of children with SEND have a probable mental disorder, compared to just over 1 in 10 children without SEND

- In 2021, 51 children in Camden had an identified social, emotional or mental health need as a part of their educational health and care plan (EHCP).

North Central London

Across North Central London, mental health needs among children and young people are high and rise sharply through adolescence. (draft NCL CAMHS JSNA 2025) Emotional disorders, self-harm and eating disorders are most prevalent, particularly among girls and young women, while neurodevelopmental conditions frequently co-occur and contribute to complex presentations. Recorded prevalence varies by borough but is widely recognised as an underestimate, with need strongly shaped by poverty, housing insecurity, SEND and care experience.

Barnet

Children and young people in Barnet experience a high prevalence of emotional and eating disorders, with levels above the NCL average, while prevalence of neurodevelopmental disorders is broadly in line with other boroughs (draft NCL CAMHS JSNA 2025). Barnet has the second highest recorded prevalence of mental health conditions in NCL for both 0–17 year olds (around 5%) and 18–25 year olds (around 7.3%), though true prevalence is likely higher than recorded. The borough also shows high levels of acute mental health need, with historically the highest rates of inpatient admissions and A\&E attendances among children and young people in NCL, indicating increased risk of escalation, particularly linked to self-harm and emotional distress.

Islington

Islington has the highest recorded prevalence of mental health conditions in NCL, at around 7.3% for both 0–17 year olds and 18–25 year olds, across emotional, neurodevelopmental and eating disorders, although this remains an underestimate compared with survey evidence (draft NCL CAMHS JSNA 2025).
Neurodevelopmental need is particularly pronounced, with almost one in four pupils identified with SEND and a high proportion having autism as a primary need, contributing to co-occurring mental health difficulties. High levels of poverty, housing instability and declining pupil resilience are key drivers of emotional distress and mental health need among children and young people in Islington.

Camden

Camden shows a higher prevalence of emotional disorders and eating disorders than the NCL average, particularly among adolescents presenting with anxiety, low mood and school-related stress (draft NCL CAMHS JSNA 2025). A large proportion of children and young people have SEND and neurodevelopmental needs, contributing to complex and overlapping mental health presentations. Camden education data indicates rising demand for EHCPs and increasing pressure on families, schools and mental health services, with parental stress and system complexity further compounding risk. Although the use of crisis pathways is relatively low compared with some other boroughs, Camden has consistently high demand for community CAMHS and specialist mental health services, indicating substantial underlying mental health need that is often identified earlier through community and school-based routes.

Enfield

Enfield has the lowest recorded prevalence of mental health disorders in routine

health data across NCL, particularly for emotional and neurodevelopmental disorders, but this is widely considered to underestimate true prevalence (draft NCL CAMHS JSNA 2025). Mental health need is strongly concentrated in areas of high deprivation and among groups experiencing overlapping risks, including poverty, SEND, care experience and ethnic inequality. Enfield also shows high levels of crisis-related need, with elevated rates of crisis calls, crisis referrals and A&E attendances, suggesting later presentation and gaps in early identification and access to support.

Haringey

Haringey has a rising prevalence of mental health difficulties among children and young people, particularly emotional and eating disorders, with increasing complexity driving demand for services (draft NCL CAMHS JSNA 2025). Rates of mental health-related A&E attendance are higher than in some other NCL boroughs, especially among teenage girls and children and young people from black ethnic groups, highlighting both gendered and ethnic disparities. Self-harm is the most common reason for crisis referral in Haringey, indicating significant levels of acute risk and escalation during adolescence.

Gender reassignment

There is limited local data on the representation of trans or gender non-conforming children and young people in Camden and for NCL, as this information is not routinely or consistently collected for under-18s. However, a report by Mermaids (2025) states that trans youth are experiencing poor mental health and a study published in the British Medical Journal states that over half of the young people who spoke to their GP about being trans had a record of anxiety, depression or self-harm at some time before reaching the age of 19. The study also revealed that 1 in 5 young people that GPs recorded as having gender dysphoria had a history of self-harm. Amongst all young people aged 17-19 years old, it is estimated that around 17% have a mental health disorder. This is compared to 55% of the same age group of trans youth included in this study.

The pilot is therefore expected to have a positive impact by providing inclusive, trauma-informed and non-judgemental community based support that is responsive to the needs of all young people. By creating safe and affirming therapeutic relationships and reducing barriers to engagement, the pilot will help promote equitable access to intensive mental health support regardless of gender reassignment.

Marriage and civil partnership

Officers do not consider that the new pilot will have any negative impact on marriage and civil partnership.

Pregnancy and maternity

Officers do not consider that the new pilot will have any negative impact on pregnancy and maternity.

Race

In Camden, around 45% of pupils are White, 20% Asian, 15% Black, 15% Mixed and

5% from other ethnic groups (JSNA 2023, Census 2021). Eligibility for free school meals has risen across all ethnic groups but remains highest among Black children: 54% of Black adolescents are eligible for FSM compared with 33% of White adolescents, and in 2021/22 over half of Black children in Camden were eligible for FSM. These patterns indicate that Black and some Asian communities experience greater socioeconomic disadvantage, which is closely linked to higher emotional distress.

Evidence from the NCL CAMHS Strategic Needs Assessment shows clear inequalities in terms of race in both prevalence and access. Camden has higher proportions of CYP from Asian backgrounds, particularly Bangladeshi communities, where the recorded prevalence of mental health conditions is lower than expected—suggesting under-identification rather than genuinely lower need. Black children in Camden report greater concerns about safety and have fewer opportunities for social interaction outside the home, factors which are associated with increased emotional stress and mental health vulnerability. Analysis across NCL also indicates that children and young people from Black communities in boroughs such as Haringey and Enfield are more likely to present in crisis and through A &E rather than through planned or early intervention pathways.

Further NCL CAMHS data shows that crisis presentations are not evenly distributed: Haringey has high A&E attendance for mental health among Black teenage girls, and Enfield has the second-highest rate of crisis calls and referrals in NCL, affecting CYP from minority ethnic groups disproportionately. In contrast, multilingual families in Barnet and Islington may experience barriers related to language, trust and system navigation, which can delay help-seeking and lead to late presentation. Camden Children's Sufficiency data further shows that Black children are over-represented among Children Looked After in Camden, reflecting wider inequalities in need, access and outcomes. Taken together, the evidence shows persistent ethnic inequalities in both mental health need and service pathways across Camden and NCL, with Black and some Asian communities experiencing higher barriers to early support and a greater likelihood of presenting in crisis.

The pilot will help address these inequalities by providing trauma-informed, culturally competent and flexible community based support that improves engagement for young people who currently face barriers to early identification or planned care, particularly those from Black, Asian and multilingual families.

Religion or belief

There is no available NCL, Camden or DfE data on mental health service presentation or access by religious group, as this information is not routinely collected in CAMHS, crisis pathways or children's social care datasets. This reflects a wider national gap. UK mental health and educational datasets do not record service use by religion. While national literature shows that religious beliefs can influence help-seeking behaviour and perceived stigma, there is currently no quantitative evidence on presentation or access patterns by religious group in NCL or Camden. But we know that according to the 2021 Census 61% of Camden residents have a religion (29% no religion, 10% did not respond). 3 largest religious groups, Christian 38%, Muslim 14% and Jewish 5%.

The pilot will be supporting children and young people from a broad range of demographics, reflecting the diverse make-up of the Camden and NCL population.

Sex

Evidence across Camden and North Central London shows clear sex-based differences in the prevalence, presentation and escalation of mental health difficulties among children and young people. Adolescent girls and young women are more likely than boys to present with emotional disorders such as anxiety, depression and low mood, and are significantly more likely to present with self-harm, eating disorders and school-related stress. These patterns are reflected in higher use of crisis services and A and E attendance for mental health among teenage girls across several NCL boroughs.

Boys are more likely to present with behavioural difficulties and neurodevelopmental needs, including ADHD and autism, particularly in younger age groups, but may be less likely to access support for emotional distress until difficulties escalate. Evidence also suggests that boys may experience greater stigma around help-seeking, increasing the risk of delayed access to appropriate support.

In Camden and neighbouring boroughs, these sex-based differences intersect with other factors such as poverty, SEND, care experience and ethnicity, increasing the likelihood of crisis-led pathways for some groups. Without targeted intervention, there is a risk that girls and young women will continue to experience repeated crisis escalation related to self-harm and emotional distress, while boys with emerging mental health needs may continue to be under-identified until difficulties become acute.

The 2000 Tomorrows pilot is expected to have a positive impact on addressing sex-based inequalities by offering intensive, trauma-informed and relational support that responds to different patterns of need. By working flexibly with young people and families in the community, the pilot could help reduce crisis presentations among girls and young women and improve earlier engagement and emotional support for boys, contributing to more equitable access, experience and outcomes across Camden and North Central London.

Sexual orientation

There is limited local data on the sexual orientation of children and young people in Camden, as this information is not routinely or consistently collected for under-18s. However, national data from the Office for National Statistics (ONS) shows that young people who identify as lesbian, gay or bisexual are at significantly higher risk of poor mental health outcomes. ONS analysis of people aged 16 and over found that those identifying as LGB+ had 2.5 times higher rates of intentional self-harm and more than double the suicide risk compared with heterosexual people, with the greatest relative increase in self-harm risk seen among 16–24-year-olds.

The pilot is therefore expected to have a positive impact by providing inclusive, trauma-informed and non-judgemental community-based support that is responsive to the needs of LGBTQ+ young people. By creating safe and affirming therapeutic relationships and reducing barriers to engagement, the pilot will help promote equitable access to intensive mental health support regardless of sexual orientation.

Intersectional Groups
Children and young people in Camden experience multiple, intersecting forms of disadvantage, particularly those living in low-income households, eligible for Free School Meals, living in social housing, from minority ethnic backgrounds, with SEND, or with migration-related vulnerabilities. These overlapping factors are strongly associated with higher prevalence of mental health need, increased risk of crisis presentation, school absence and barriers to accessing timely support.

They are more likely to come from low income or benefit dependent households, live in Camden's most deprived wards, and belong to ethnic groups that face structural barriers, including Black, Bangladeshi, Somali, and some Asian communities (Trust for London – Camden Poverty Indicators; DfE FSM/Ethnicity dataset).

Many have English as an additional language, come from single parent or larger families, or have Special Educational Needs and Disabilities, all of which increase vulnerability to economic strain (DfE FSM, Ethnicity & Language by SEN dataset; Camden SEND JSNA 2024).

Prevalence estimates for mental health disorders in Camden are around 33% higher than the national average according to OHID fingertips child and maternal health profile with social risk factors playing a significant role. Young people most at risk are:

- Children living in social housing are twice as likely to have a mental disorder according to Mental Health of Children and Young People in England 2017 and social housing is home for 52% of Camden's children and young people.
- 1 in 3 children live in poverty in Camden, and young people from low-income families are likely to have worse mental health as well.
- 1 in 3 young carers estimated to have a mental health issue, and there are estimated to be 1,370 young carers (aged 5–24) in Camden.

There are also particularly strong links locally between housing tenure type, child poverty and other related risk factors for mental health conditions (Camden Public Health Report 2023). Children and young people living in social housing are significantly more likely to have a mental health disorder than average, and over twice as likely as those living in a house owned by their parents or caregiver. Prevalence estimates for Camden are 33% higher compared to the national average, giving an estimated prevalence of over 19% in 11–16-year-olds (3,080) and 23% (2,110) in 17–19-year-olds (OHID fingertips child and maternal health profile).

Raise Camden Child Health Equity Data Audit (2025), Department for Education FSM and SEND datasets and ONS Census 2021, shows that SEND frequently overlaps with poverty, social housing, care experience and from Black and minority ethnic backgrounds, creating layers of disadvantage associated with higher mental health needs and barriers to timely support.

Across North Central London, children and young people experiencing mental health difficulties also often face multiple, intersecting forms of disadvantage that compound risk and barriers to support. Evidence shows that mental health need and crisis presentation are highest where factors such as poverty, housing insecurity, ethnicity, sex, SEND and care experience overlap, for example among girls and young women from Black and minority ethnic backgrounds experiencing self-harm,

children with SEND living in low-income households, and young people from migrant or multilingual families affected by trauma and system complexity. These intersecting characteristics are associated with later identification of need, greater reliance on crisis pathways and poorer outcomes within standard service models. Intensive, trauma-informed, culturally competent and whole-family approaches are therefore particularly important for addressing inequality and improving outcomes for intersectional groups across NCL.

Part of the role of this team is to think creatively about ways to support young people with very complex social and emotional needs. This will need to include responses that meet young people's needs in terms of religion, culture, disability, gender, sexuality or any other individualized characteristic. We will ensure the new team has appropriate training around equality and diversity but also that as part of their onboarding they receive training to understand the landscape of statutory, community and VCS assets in each community that can support each young person's needs. The NCL Waiting Room directory lists a wide range of services in each borough and will form the basis for this training.

2.b *Consider evidence in relation to the additional characteristics that the Council is concerned about:*

☐Foster carers

☒Looked after children/care leavers

☒Low-income households

☒Refugees and asylum seekers

☒Parents (of any gender, with children aged under 18)

☒People who are homeless

☒Private rental tenants in deprived areas

☒Single parent households

☒Social housing tenants

☐Any other, please specify

Foster carers

Foster carers in Camden and across NCL support children and young people with complex trauma, emotional dysregulation, self-harm risk and neurodevelopmental needs such as autism and ADHD. These needs contribute to placement stress, unplanned moves and school disruption and carers frequently report gaps in timely, trauma-informed and out-of-hours support. Placement instability is often linked to escalating risk between CAMHS appointments, delayed multi-agency responses, carer burnout, and unmet daily living or sensory needs, with additional pressures such as poverty, housing and transport barriers limiting carers' ability to access planned support.

Local evidence reinforces this picture. The NCL CAMHS Strategic Needs Assessment highlights high and rising levels of emotional disorders, eating disorders, anxiety, low mood and school-related stress, particularly among young people with SEND, those in social housing and those from minority ethnic backgrounds. Camden's Children's Sufficiency Strategy (2025–28) shows increasing numbers of older adolescents entering care with complex emotional and behavioural needs, high levels of SEND and trauma, alongside increasing placement instability. These pressures are also reflected in national data showing that many children enter care due to abuse, neglect or acute family stress, with high rates of probable mental disorders among children and young people.

Taken together, national and local evidence shows that foster carers are supporting some of the most complex young people in the system. Officers therefore do not consider the new pilot and proposed grant to Tavistock to have any negative impact; rather, the pilot's trauma-informed, flexible and community-based model is expected to reduce escalation between appointments, strengthen relationships, improve placement stability and address unmet need that currently places significant pressure on carers.

Looked after children/care leavers

Looked after children are more likely than their peers to experience emotional and behavioural difficulties, self-harm, neurodevelopmental needs and poor emotional wellbeing, and are more likely to access support through crisis pathways rather than planned care. Transitions, including placement changes, moves to semi-independent living and step-down from inpatient care, are periods of particularly high risk for escalation and disengagement from services. Care leavers may face additional challenges related to instability in housing, education and support networks, increasing vulnerability to deterioration in mental health. Without intensive, coordinated and relational support, these young people are at increased risk of placement breakdown, hospital admission and poor longer-term outcomes. Department of Education (DfE) data shows that 40% of looked-after children aged 5–16 have emotional and behavioural health scores that are a cause for concern, and they are over twice as likely to have special educational needs as their peers. NCL crisis data also shows that boroughs such as Enfield and Haringey experience high levels of crisis calls, A and E mental health attendances and self-harm, indicating late escalation when needs are unmet. Camden's Children's Sufficiency Strategy confirms that more teenagers with complex trauma, high SEND levels and behavioural needs are entering care, and that children looked after are disproportionately Black and more likely to experience poverty and housing stress before entering care.

DfE data acknowledges that looked-after children require timely and effective mental health intervention, but many face barriers accessing CAMHS at the right time. Combined with wider pressures such as poverty, housing instability, waiting times and inconsistent multi-agency responses, foster carers often shoulder significant emotional and practical burden while supporting children whose needs exceed what services can provide.

The pilot's trauma-informed, flexible and community based model is therefore expected to have a positive impact by reducing crisis escalation, strengthening placement stability and improving access to coordinated support for young people and their carers.

Low-income households

There is extreme and widening socio-economic inequality in Camden. Half (56%) of households with children have at least one measure of deprivation (Raise Camden, 2025).

Deprivation and poverty are associated with poorer health outcomes, whereby people living in more deprived areas typically experience worse health than those living in less deprived areas (MHCLG 2019 ONS). Deprivation is associated with poorer health outcomes including a greater risk of poor mental health, chronic pain, cardiovascular disease, lung disease and diabetes, lower access to healthcare services and premature mortality (Kings Fund 2024).

Across North Central London, a substantial proportion of children and young people live in low-income households, with poverty identified as a key structural driver of poor mental health, unmet need and crisis escalation. The NCL CAMHS Strategic Needs Assessment highlights high and rising levels of child poverty across several boroughs, including Camden, Islington, Enfield and Haringey, with many families experiencing the combined effects of low income, high housing costs, overcrowding and housing insecurity.

Camden still has significantly higher levels of child poverty than London and England. In 2022/23, 14.8% (n=4,756) of children aged under 16 years in Camden were living in absolute low-income families, compared to 12.3% in London and 15.6% nationally. Meanwhile, during

the same time period, 19% (n=6,085) of children in Camden were living in relative low-income families, compared to 15.8% in London and 19.8% nationally.

Evidence shows that children and young people from low-income households are more likely to experience emotional distress, anxiety, behavioural difficulties and neurodevelopmental needs, and are more likely to present later with higher level of need and through crisis pathways. Poverty also creates practical barriers to accessing support, including difficulties attending appointments, navigating complex systems and sustaining engagement with services, particularly for families managing multiple pressures. These factors contribute to inequalities in access, experience and outcomes, underlining the importance of intensive, community-based and whole-family approaches that reduce reliance on crisis care and support families to sustain stability for children and young people living in low-income households across NCL. The pilot will accept referrals for young people identified as vulnerable who would benefit from this support.

Refugees and asylum seekers

Young refugees and asylum seekers in the UK have much higher rates of poor mental health than their peers. A Refugee Council survey (2022) found that 61% of asylum seekers experience serious mental ill-health, making them five times more likely to have mental health needs than the general population. It also shows high levels of depression, anxiety and PTSD in refugee and asylum-seeking groups, driven by pre-arrival trauma and post-arrival stressors such as long asylum waits, poverty and poor housing.

The Office for National Statistics (2024) reports that displaced young people in England experience stress, anxiety and low wellbeing due to disrupted education, language barriers, poor accommodation and past experiences of conflict and family separation.

Clinical guidance from the Royal College of Psychiatrists highlights that displaced children and young people show high rates of distress, grief and PTSD, and face barriers to accessing timely mental-health support.

Camden has a higher-than-average proportion of refugee and asylum-seeking families and is a long-standing resettlement borough with significant refugee support infrastructure (Camden Refugee, Asylum Seeker and Migrant Support Services, 2024).

The pilot will accept referrals for young people identified as vulnerable who would benefit from this support.

Parents (of any gender, with children aged under 18)

Local Public Health and children's services data set out in this assessment, including the Camden Annual Public Health Report (2023) and Raise Camden Child Health Equity Data Audit (2025), show that parents of vulnerable children and young people often experience high levels of stress linked to caring for complex mental health needs alongside poverty, overcrowded housing and financial insecurity. Camden data indicates that adolescent mental health need is rising and that families experiencing deprivation face additional strain, affecting parental wellbeing, family stability and engagement with services.

The pilot is therefore expected to have a positive impact for parents by providing coordinated, trauma-informed, whole family support that strengthens relationships, reduces pressure on parents and supports families to sustain care for their children within the

community.

People who are homeless

There is no routinely collected data in Camden or across North Central London (NCL) that links homeless or temporarily accommodated young people with CAMHS referrals, access or outcomes, as CAMHS datasets do not record housing status for under 18s. However, local evidence shows that around 600 children and young people in Camden are currently living in temporary accommodation, highlighting the scale of housing instability among families in the borough. Evidence presented to Camden Council shows that temporary accommodation creates significant stress, disruption, overcrowding and instability for children and families, all of which negatively affect emotional wellbeing and mental health. Although no formal CAMHS linked dataset exists, these sources indicate that young people experiencing homelessness or temporary housing are likely to have higher mental health needs and face greater barriers to consistent engagement with services. In the absence of direct CAMHS data, it is reasonable to state that the pilot is likely to be particularly beneficial for this group because it provides flexible, community based, relational support that can reach young people whose housing circumstances make it harder to access traditional services.

Private rental tenants in deprived areas

Families living in Camden's private rented sector—especially in the borough's most deprived areas—face high housing costs, financial insecurity, and greater reliance on benefits, which means they are significantly more likely to meet the income-based criteria for Free School Meals compared with families in other tenures (Trust for London – Camden Poverty & Inequality Indicators).

Single parent households

Camden Public Health and children's services evidence, including the Camden Annual Public Health Report (2023) and the Raise Camden Child Health Equity Data Audit (2025), shows that single-parent households are significantly more likely to experience poverty, financial insecurity and Free School Meal eligibility than couple-parent households. Local analysis indicates that single-parent families are over-represented in Camden's most deprived wards, where high housing costs, overcrowding and limited informal support networks are more common. These factors are strongly associated with increased parental stress and poorer mental health outcomes for children and young people, contributing to higher risk of emotional distress, behavioural difficulties and escalation to crisis services.

Young people living in single-parent households are more likely to experience compound disadvantages that increase vulnerability to mental health escalation. An intensive, community based, relational model could therefore reduce pressure on parents, improve engagement and support family stability for households with less capacity to absorb crisis without additional help.

Social housing tenants

Local and national data referenced in this assessment, including the Camden Annual Public Health Report (2023), ONS Census 2021 and the Raise Camden Child Health Equity Data Audit (2025), show that families living in social housing are more likely to experience low income, benefit reliance and Free School Meal eligibility. Camden-specific evidence demonstrates that children and young people living in social housing have a higher prevalence of mental health difficulties than those in owner occupied housing, with overcrowding and

housing instability contributing to increased parental stress and reduced emotional wellbeing. Public Health analysis identifies housing tenure as a key structural driver of inequality in Camden, with strong links between social housing, deprivation, school engagement and mental health outcomes for children and young people.

Young people living in social housing are more likely to experience multiple layers of disadvantage that increase mental health risk and reduce resilience at times of escalation. The pilot's flexible, trauma-informed, community based approach is therefore expected to improve access, engagement and continuity of care for families whose housing circumstances can otherwise act as a barrier to sustained support.

Any other, please specify
N/A

2.c *Have you found any data or evidence about intersectionality. This could be statistically significant data on disproportionality or evidence of disadvantage or discrimination for people who have a combination, or intersection, of two or more characteristics.*

Local evidence set out in this assessment demonstrates that many children and young people in Camden experience multiple, intersecting disadvantages, which together increase the risk of complex mental health needs and escalation beyond the reach of existing services. Data from the Camden Annual Public Health Report (2023) and OHID Fingertips child and maternal health profiles show that prevalence of mental health disorders among children and young people in Camden is around 33% higher than the national average, with risk concentrated among those living in poverty, social housing and deprived wards. The Raise Camden Child Health Equity Data Audit (2025) highlights that poverty, housing insecurity and overcrowding frequently coincide with other vulnerabilities, including SEND, ethnicity, migration-related disadvantage and parental mental health difficulties, creating layers of disadvantage that compound risk.

Education and deprivation data referenced in this assessment, including Department for Education FSM, ethnicity, English as an additional language and SEND datasets, show that children eligible for Free School Meals are more likely to belong to Black and minority ethnic groups, have SEND and live in lower-income households, all of which are independently associated with poorer mental health outcomes. Local housing evidence drawn from the ONS Census 2021 and Camden Public Health analysis indicates that children and young people living in social housing are significantly more likely to experience mental health difficulties than those in owner-occupied housing, with overcrowding and housing instability further amplifying risk. These disadvantages frequently overlap with care experience, with local data showing that looked after children and unaccompanied asylum seeking children are more likely to have experienced trauma, disruption and unmet mental health need.

Evidence in this document shows that children and young people most likely to benefit from this pilot are those experiencing intersecting pressures across poverty, housing, ethnicity, disability, care experience and family stress, rather than any single characteristic alone.

These overlapping factors are strongly associated with higher levels of complexity, barriers to engagement, increased crisis presentation and poorer outcomes within standard service models. The pilot's focus on intensive, relational, trauma-informed, community based support aligns directly with this evidence base by responding to complexity arising from intersectionality, rather than treating disadvantages in isolation.

Step 3: Impact

Given the evidence listed in step 2, consider and describe what potential **positive and negative impacts** this work could have on people, related to their **protected characteristics** and the **other characteristics** about which the Council is interested.

Make sure you think about all three aims of the public sector equality duty. Have you identified any actual or potential discrimination against one or more groups? How could you have a positive impact on advancing equality of opportunity for a particular group? Are there opportunities within the activity to promote "good relations" – a better understanding or relationship between people who share a protected characteristic and others?

3.a Potential negative impact on protected characteristics

Protected Characteristic	Is there potential negative impact? (Yes or No)	Explain the potential negative impact
Age	No	No negative impact is expected because the pilot increases support for adolescents aged 13–18 and does not reduce or replace any existing age-related services.
Disability including carers	No	No negative impact is expected because the pilot adds flexible, trauma-informed support that complements existing provision for young people with mental health needs and carers.
Gender reassignment	No	No negative impact is expected because the pilot is intended to be inclusive, non-judgemental and responsive to individual identity, and should not introduce any barriers that could disadvantage trans young people.
Marriage/civil partnership	N/A	
Pregnancy/ maternity	N/A	
Race	No	No negative impact is expected because the pilot aims to be culturally competent, trauma-informed and responding to individual need rather than stereotypes about the type of support needed by the young person and family.
Religion or belief	No	No negative impact is expected because the pilot will be flexible and person-centred, enabling support to be provided in ways that respect religious or belief-based needs without limiting access.

Sex	No	No negative impact is expected because the pilot will be responding to individual need rather than gendered assumptions.
Sexual orientation	No	No negative impact is expected because the pilot will provide inclusive, trauma-informed support that does not restrict access or create any barriers for young people based on sexual orientation.

3.b Potential positive impact on protected characteristics

Protected Characteristic	Is there potential positive impact? (Yes or No)	Explain the potential positive impact
Age	Yes	The project aims to support young people aged 13-18 who have a range of complex needs including mental health needs. The pilot and the proposed grant to Tavistock will provide support to help to manage the young person and improve their emotional well-being.
Disability including carers	Yes	The project aims to support young people aged 13-18 who have a range of complex needs including mental health needs. The pilot and the proposed grant to Tavistock will provide support to help to manage the young person and improve their emotional well-being.
Gender reassignment	Yes	The pilot will have a positive impact on young people undergoing gender reassignment by providing inclusive, trauma-informed and non-judgemental community based support that removes barriers to engagement. By creating safe and affirming therapeutic relationships, it will help reduce barriers to engagement and support equitable access regardless of gender.
Marriage/civil partnership	N/A	
Pregnancy/ maternity	N/A	
Race	Yes	The pilot will support children and young people from diverse backgrounds by providing culturally competent, trauma-informed community based mental health support. By working flexibly with families and alongside

		local networks, it will help reduce barriers to engagement and promote more equitable access for young people from black and minority ethnic groups, who are more likely to experience structural disadvantages and unmet need.
Religion or belief	Yes	The pilot will be taking a person-centred and relational approach allows support to be adapted to families' faith, belief and cultural contexts. This flexibility will support inclusive engagement and ensure that children and young people can access appropriate mental health support in ways that respect individual values and beliefs.
Sex	Yes	The pilot will respond to differing mental health presentations by focusing on individual need rather than gender stereotypes. Its trauma-informed, community based model will be promoting equitable access, engagement and outcomes for all young people regardless of sex.
Sexual orientation	Yes	The pilot will provide inclusive, non-judgmental and trauma-informed support that is responsive to the needs of LGBTQ+ young people, who face higher risks of poor mental health outcomes. By creating safe and affirming therapeutic relationships, it will help reduce barriers to engagement and support equitable access regardless of sexual orientation.

3.c Potential negative impact on other characteristics

Characteristic	Is there potential negative impact? (Yes or No)	Explain the potential negative impact
Foster carers	No	There is no negative impact because the pilot adds intensive, flexible support designed to reduce pressure on carers and improve stability for the young people they look after.
Looked after children/care leavers	No	There is no negative impact because the pilot strengthens support around young people in care and does not remove or reduce any existing services.
Low-income households	No	There is no negative impact because the pilot aims to reduce barriers linked to poverty and provide additional community-based support.

Refugees and asylum seekers	No	There is no negative impact because the pilot offers trauma-informed and culturally competent support that is intended to improve engagement.
Parents (of any gender, with children aged under 18)	No	There is no negative impact because the pilot will work with parents and provide whole family support that helps to reduce stress and improve access to help.
People who are homeless	N/A	
Private rental tenants in deprived areas	No	There will be no negative impact because the pilot will take into account issues related to housing and will aim to improve access and continuity of support without reducing existing services.
Single parent households	No	There is no negative impact because the pilot's coordinated and flexible support aims to improve access to services including young people who come from single parent households.
Social housing tenants	No	There will be no negative impact because the pilot will take into account issues related to housing and will aim to improve access and continuity of support without reducing existing services.
Any other, please specify.	N/A	

3.d Potential positive impact on other characteristics

Characteristic	Is there potential positive impact? (Yes or No)	Explain the potential positive impact
Foster carers	Yes	The pilot is expected to have a positive impact on foster carers by providing intensive, trauma-informed mental health support to young people with complex needs who may otherwise experience placement instability. By working intensively with young people and families, including those in foster placements, the pilot aims to reduce escalation linked to unmanaged mental health needs, strengthen relationships and improve emotional wellbeing. This approach is expected to contribute to

		greater placement stability, reduce the risk of placement breakdown and help minimise new care entries arising from family breakdown associated with unmet mental health need.
Looked after children/care leavers	Yes	The pilot will be supporting young people from a broad range of demographics, reflecting the diverse make-up of the Camden population including looked after children and care leavers. The pilot will be seeking both to support those in care with greater placement stability and minimising numbers entering care as a result of family breakdown arising from unmanaged mental health need.
Low-income households	Yes	The pilot is expected to have a positive impact on young people and families living in low-income households, who are disproportionately affected by housing insecurity, financial strain and barriers to accessing timely mental health support. By providing intensive, community based and trauma-informed support, the pilot may reduce reliance on crisis and inpatient services, improve engagement with care and mitigate the cumulative effects of poverty on mental health outcomes. This may also reduce barriers to access and help families sustain caring arrangements within the community.
Refugees and asylum seekers	Yes	The pilot is expected to have a positive impact for those children, young people and families who may experience additional barriers related to trauma, migration related stress, language, cultural differences and system navigation. Through its trauma-informed, culturally competent and relational approach, the pilot may improve access to mental health support, reduce disengagement and help stabilise family relationships. By addressing unmet mental health needs early and intensively, the pilot may also reduce the risk of escalation that can contribute to family breakdown, placement instability or crisis presentations for this group.
Parents (of any gender, with children aged under 18)	Yes	The pilot will support parents by working with them as partners in care, providing coordinated, trauma-informed whole-family support that reduces stress, strengthens relationships and helps families navigate complex systems more effectively. The pilot could also act as a gateway to wider support services, helping families who may be isolated or unsure where to seek help.

People who are homeless	Yes	The pilot would support young people and families experiencing homelessness by providing flexible, trauma-informed whole family support that takes account of housing instability, reduces barriers to engagement and works alongside housing and social partners to promote stability, safety and continuity of care. The pilot could also act as a gateway to wider support services, helping families who may be isolated or unsure where to seek help.
Private rental tenants in deprived areas	Yes	The pilot would support families with children and young people living in private rental tenants in deprived areas by providing flexible, trauma-informed mental health support that takes account of housing instability, needs of the young person and parental stress, and reduces barriers to engagement. The pilot could also act as a gateway to wider support services, helping families who may be isolated or unsure where to seek help.
Single parent households	Yes	The pilot would support single parent households with children and young people by providing flexible, trauma-informed co-ordinated support that reduces pressure on parents and improves access to services. The pilot could also act as a gateway to wider support services, helping families who may be isolated or unsure where to seek help.
Social housing tenants	Yes	The pilot could support children, young people and families living in social housing by providing flexible, trauma-informed co-ordinated support that recognizes the impact of poverty and housing related stress and improves access to services. The pilot could also act as a gateway to wider support services, helping families who may be isolated or unsure where to seek help.
Any other, please specify	N/A	N/A

3.e Consider intersectionality. Given the evidence listed in step 2, consider and describe any potential **positive and negative impacts** this activity could have on people who have a **combination, or intersection, of two or more characteristics.** For example, people who are young, trans and homeless, disabled people on low incomes, or Asian women.

Children and young people living in low-income households are more likely to experience factors associated with poor emotional well-being, including housing insecurity, overcrowding, financial strain, parental stress and reduced access to early help. These pressures can contribute to the development or exacerbation of mental-health difficulties and increase the likelihood of crisis presentations, school absence and escalating behaviours. Financial hardship can also create practical barriers to accessing and sustaining engagement with support, such as difficulties attending appointments or navigating systems.

By working flexibly and collaboratively with families and wider services, the pilot could improve access to timely intervention, strengthen family stability and help mitigate the cumulative effects of poverty on mental-health outcomes. Many young people affected by the pilot may experience intersecting disadvantages, including low household income, care experience, complex mental health needs and SEND by providing intensive, community-based, trauma-informed support that reduces reliance on crisis and inpatient care. The pilot is therefore expected to have a compounded positive impact for those experiencing multiple, overlapping risks.

2 Intersectionality refers to the interconnected nature of social categorisations such as race, class, and gender as they apply to a given individual or group, regarded as creating overlapping and interdependent systems of discrimination or disadvantage.

Step 4: Engagement - co-production, involvement or consultation with those affected

4.a How have the opinions of people potentially affected by the activity, or those of organisations representing them, informed your work?

List the groups you intend to engage and reference any previous relevant activities, including relevant formal consultation?[5]	**If engagement has taken place, what issues were raised in relation to one or more of the protected characteristics or the other characteristics about which the Council takes an interest, including multiple or intersecting impacts for people who have two or more of the relevant characteristics?**
Young people	The NCEL Provider Collaborative who are providing funding for this pilot has an established approach to co-production with children and young people, using participation groups and lived-experience feedback to inform service design, quality improvement and decision-making. Engagement with young people, families and carers is embedded across Provider Collaborative services, ensuring that care models are shaped by lived experience and responsive to diverse needs. Feedback highlighted that children and young people wanted support that was more accessible, less fragmented and delivered closer to home, with greater continuity of relationships and fewer transitions between services. Young people consistently reported that hospital-based care and highly segmented pathways could feel disruptive, intimidating and disconnected from their everyday lives, particularly where trust with professionals had broken down. Young people also highlighted the need for support that recognises trauma, family context and cultural identity. This learning shaped the pilot's emphasis on trauma-informed, culturally competent practice and whole-family working, ensuring that interventions are responsive to lived experience rather than narrowly focused on symptoms alone. The feedback has directly informed the pilot's design principles of being a community-based and a multi-disciplinary model.

3 This could include our staff networks, advisory groups and local community groups, advice agencies and charities.

4.*b. Where relevant, record any engagement you have had with other teams or directorates within the Council and/or with external partners or suppliers that you are working with to deliver this activity. This is essential where the mitigations for any potential negative impacts rely on the delivery of work by other teams.*

Extensive multi-agency stakeholder engagement has informed the development of this pilot. A collaborative approach has been taken with engagement focused on ensuring the pilot reflects the needs of young people and families, promotes partnership working, and aligns with Camden 2025 ambitions for health equity and early intervention. This feedback from stakeholders has shaped the service. Other key activities to engage and work collaboratively through a stakeholder workshop and other discussions within the Council, NCEL Provider Collaborative, Barnet Council, Islington Council and NHS partners, including the Tavi, other providers and CAMHS clinicians and other agencies to co-design the service model and agree priorities for implementation. A series of mobilisation meetings have taken place to plan operational aspects of the pilot, including governance arrangements, referral pathways and integration with existing services. These meetings involved senior leaders and practitioners from Camden, Barent and Islington and health services. Further engagement will continue throughout the pilot, including regular multi-agency governance meetings and opportunities for stakeholders to review progress and contribute to the evaluation of the pilot.

Step 5: Informed decision-making

5. *Having assessed the potential positive and/or negative impact of the activity, what do you propose to do next?*

Please select one of the options below and provide a rationale (for most EqIAs this will be box 1). Remember to review this and consider any additional evidence from the operation of the activity.

1. Change the activity to mitigate potential negative impacts identified and/or to include additional positive impacts that can address disproportionality or otherwise promote equality or good relations.	N/A
2. Continue the work as it is because no potential negative impacts have been found	The pilot has been developed using available evidence, engagement with children and young people through established NCEL Provider Collaborative's co-production arrangements and learning from existing service gaps. Its trauma-informed, community based and culturally competent approach, alongside planned monitoring and mitigation measures, provides assurance that the risk

	of unintended discrimination is low as the pilot is likely to advance equality of opportunity by supporting those who may not currently receive adequate support which accounts for their full experience through existing systems. Ongoing data collection, quality assurance and review will ensure that any emerging issues are identified early and addressed through continuous improvement.
3. Justify and continue the work despite negative impacts (please provide justification – this must be a proportionate means of achieving a legitimate aim)	N/A
4. Stop the work because discrimination is unjustifiable and there is no obvious way to mitigate the negative impact	N/A

Step 6: Action planning

6. *You must address any negative impacts identified in steps 3 and/or 4. Please demonstrate how you will do this or record any actions already taken to do this.*

Please remember to add any positive actions you can take that further any potential or actual positive impacts identified in step 3 and 4.

Make sure you consult with or inform others who will need to deliver actions.

Action	Due	Owner
Establish the minimum equity data set and data collection methodology with the Pilot Steering Group which includes Barnet and Islington Council reps and in discussion with the independent evaluators	June 2026	Pilot Steering Group
Review uptake data against localised population demographics	October 2026	Pilot Steering Group
Engage with stakeholders to establish possible reasons for underrepresentation	November 2026	Pilot Steering Group
Develop a quality improvement plan to adapt provision to better meet the needs of underrepresented groups	January 2027	Pilot Steering Group
Ongoing review of impact of quality improvement plan based on uptake data and service user feedback	Ongoing	Pilot Steering Group
Review data collection of the minimum equity data set for completeness and accuracy	March 2027	Pilot Steering Group

Step 7: EqIA Advisor

Ask a colleague, preferably in another team or directorate, to ‘sense check’ your approach to the EqIA and ask them to review the EqIA form before completing it.

They should be able to clearly understand from what you have recorded here the process you have undertaken to assess the equality impacts, what your analysis tells you about positive and negative actual or potential impact, and what decisions you have made and actions you have identified as a result.

They may make suggestions for evidence or impacts that you have not identified. If this happens, you should consider revising the EqIA form before completing this version and setting a date for its review.

If you feel you could benefit from further advice, please contact the Equalities service at equalities@camden.gov.uk

Step 8: Sign-off

EqIA author	Name: Daxa Kotecha Job title: Strategic Commissioning Manager Date: 19/1/2026
EqIA advisor / reviewer	Name: Julia Mills Job title: Head of Children's Commissioning and Health Partnerships Date: 20/1/2026
EqIA advisor / reviewer	Name: Jack Kilker Job title: Equality Impact Quality Assurance Lead Date: 28/1/2026
Senior accountable officer	Name: Kirsten Watters Job title: Director of Health & Wellbeing Date:29/1/2026