

# Challenging Inequalities Self-Assessment Toolkit - Disabilities

For Improving Access to  
Mental Health Services



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# Introduction

This toolkit is designed for health and social care organisations to assess and review their practices related to service provision at the intersection of mental health and disability. It has been developed and co-designed with Islington residents, particularly those with lived experience of both mental health challenges and disability, as well as local professionals.

The Islington toolkit project has been running since the Covid-19 pandemic, a time when health inequalities became especially visible. Racialised minorities were disproportionately affected in terms of both infection and mortality rates. The first toolkit focused on race and ethnicity, followed by one on LGBTQI+ inclusion. Both were identified as priority areas by Islington's All Age Mental Health Partnership Board under the Equality Act.

Throughout the project, managers from local organisations have taken part in face-to-face peer learning events to share and develop their Equality, Diversity and Inclusion (EDI) pledges, and explore opportunities for growth. Disability was then chosen by the majority as the next key area of focus.

According to the Office for National Statistics, 2021 census data shows that 10.4% of Islington residents identified as “disabled and limited a little” and a further 10.0% as “disabled and limited a lot”, at a total of 20.4% identify as being disabled. This is higher than the national average of 17.8%.

Under the Equality Act 2010, a disability is defined as:

“A physical or mental impairment which has a ‘substantial’ and ‘long-term’ negative impact on a person’s ability to carry out normal daily activities.”

According to the Equality Act, while some conditions constitute a disability on diagnosis, such as cancer, an HIV infection and visual

impairment, having a long-term condition does not always constitute a disability. The definition above highlights two key aspects, significant impact and long-term effects. Usually this means conditions which have an impact over a year or longer.

In mental health services, not all service users are considered disabled, but mental health disability is often invisible to others, and it can be difficult to address, especially when service users do not request adjustments explicitly. While this disability toolkit centres around mental health conditions, it is important to consider physical health conditions as the comorbidity is high (more in Part 1.2).

Additionally, although neurodivergent conditions do not always constitute a disability, the Equality Act includes them when they create disabling barriers. As such, disability encompasses a wide range of needs and health conditions.

Organisations are legally and ethically obligated under the Equality Act to deliver equitable services to all service users and to provide an accessible environment for everyone, including service users, staff, volunteers and visitors. Recognising individual needs and required adjustments, this toolkit includes responses to the needs of neurodivergent people. These often overlap with other disabilities, especially when considered through the social model of disability.

In line with the approach taken in the previous two toolkit chapters, this edition also aims to address intersectionality. People's needs are complex, and multiple identities and labels can compound the challenges they face. This toolkit acknowledges and responds to that complexity.

This toolkit also aims to make suggestions on how your organisation's practice can be adapted to meet the needs of disabled people with mental health conditions (Part 1), followed by widening the lens to examine practices and approaches within the context of the UK system (Part 2). Parts 3 and 4 focus on organisational governance and disabled

staff inclusion and Part 5 is on working in partnerships across the sectors.

Throughout the toolkit, recommendations and questions for self-assessment are in yellow boxes.

The best practice shared by organisations and further resources are in blue boxes.

There are numerous useful toolkits already available. For broader mental health support resources in Islington and how to have conversations about mental health, comprehensive guidance<sup>1</sup> has been published.

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<sup>1</sup> <https://www.islington.gov.uk/social-care-and-health/support-for-professionals/mental-health-support-toolkit>

# For providers of services

## 1. Welcoming and inclusive services

### 1.1 Social model of disability

The shift from the medical model of disability to the social model may offer a useful perspective for this toolkit. The medical model focuses on impairments associated with a condition, such as blindness, and emphasises what a person cannot do. In contrast, the social model of disability recognises that it is the barriers within society, for example attitudes and environment, that disable people with impairments. Inclusion London, a leading disabled-led campaigning organisation, has published a fact sheet<sup>2</sup> explaining this approach.

Our society should provide equitable access for all, without excluding or discriminating against particular groups of people. The social model of disability is a key concept for disabled-led organisations and inclusion campaigns, and has its roots in activism during the 1970s, when disabled people fought for the right to live in the community rather than institutions.

Each disabled person has their own unique needs, and it is crucial that services ask what those needs are and make reasonable adjustments to ensure equal access to the support provided.

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<sup>2</sup> [https://www.inclusionlondon.org.uk/wp-content/uploads/2015/05/FactSheets\\_TheSocialModel.pdf](https://www.inclusionlondon.org.uk/wp-content/uploads/2015/05/FactSheets_TheSocialModel.pdf)

## 1.2 Types of disabilities and overlapping mental and physical conditions

Disability can take many forms and may involve physical, sensory, cognitive, neurological, neurodivergent, or mental health-related conditions. Many individuals experience overlapping conditions, where mental and physical impairments coexist and interact, often compounding their impact on daily life. Although there is no exhaustive list of disabilities, there are conditions closely linked to disability. The focus is on the effect of the condition on day-to-day functioning and the barriers encountered, rather than the diagnosis alone.

Common types of disabilities include:

- Physical disabilities and long-term health conditions
  - Musculoskeletal or neurological conditions that affect mobility or chronic pain conditions
  - Long-term conditions such as diabetes, cardiovascular disease and obesity
  - For some mental health patients weight gain and above metabolic syndrome conditions are caused by side effects of antipsychotic medication
  - Chronic fatigue, breathing difficulties, long Covid, fibromyalgia and other fluctuating or energy-limiting conditions
  - Acquired memory impairments following brain injury, stroke, infection, or neurological illness
  - Epilepsy and other seizure conditions
  - Autoimmune and inflammatory conditions (e.g. lupus, multiple sclerosis, rheumatoid arthritis)
- Sensory impairments
  - Blindness and partial sightedness
  - Hearing loss, including people who are Deaf or with hearing impairment
  - Sensory processing difficulties, which may occur independently or alongside neurodivergent conditions
- Learning disabilities
  - Conditions from birth, such as Down's syndrome and other genetic conditions, some people with cerebral palsy and autism
  - Mencap research shows double the rate of mental health conditions among people with learning disability, compared to general population<sup>3</sup>

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<sup>3</sup> <https://www.mencap.org.uk/learning-disability-explained/research-and-statistics/mental-health>

- Neurodivergent conditions
    - Autism, with around 50% of autistic people experiencing depression<sup>4</sup>
    - Attention Deficit Hyperactivity Disorder (ADHD), approximately 50% experiencing anxiety<sup>5</sup>
    - Dyslexia, dyspraxia, dyscalculia, and other specific learning differences and difficulties
    - Tourette's syndrome and tic disorders
  - Mental health conditions, which may be considered a disability depending on
    - The severity, duration and fluctuation of symptoms
    - The impact on daily functioning, employment, education, relationships and self-care
    - Conditions such as depression, anxiety disorders, bipolar disorder, psychosis, PTSD, complex trauma, eating disorders and personality disorders
- It is also important to note:
- Experience of the Covid-19 pandemic has had a lasting negative impact on people's mental health, especially for women and young people<sup>6</sup>
  - Not all people with a diagnosed mental health condition are disabled
  - Not all people with a mental health diagnosis identify as having a condition and/or disability.
  - High prevalence (70%) of mental health issues among people who seek drug and alcohol addiction treatment<sup>7</sup>
  - Some people on antipsychotic medication long-term experience severe side effects including cognitive dysfunction, short-term memory dysfunction, apathy and emotional instability<sup>8</sup>
- Speech, communication, and cognitive impairments, including
    - Speech and language disorders
    - Cognitive impairments affecting concentration, executive functioning, planning or processing speed

It is important to recognise that disability is not always visible, may fluctuate over time, and often involves multiple, intersecting conditions. Inclusive and accessible approaches should therefore be flexible, person-centred, and responsive to both mental and physical health needs.

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<sup>4</sup> <https://www.autism.org.uk/advice-and-guidance/topics/mental-health/depression>

<sup>5</sup> <https://www.autism.org.uk/advice-and-guidance/topics/mental-health/anxiety>

<sup>6</sup> <https://democracy.islington.gov.uk/documents/s41972/Islington%20Joint%20Health%20and%20Wellbeing%20Strategy%2020252030.pdf>

<sup>7</sup> <https://stats.islington.gov.uk/wp-content/uploads/2025/07/Islington-Mental-Health-Joint-Strategic-Needs-Assessment-March-2025.pdf>

<sup>8</sup> Breggin, P. (2013) *Psychiatric Drug Withdrawal: A Guide for Prescribers, Therapists, Patients and Their Families*. Springer Publishing Company.



## Co-existence of physical and mental health<sup>9</sup>

People living with mental health conditions often experience co-occurring physical health problems. According to the Centre for Mental Health data, 46% of people with mental health problems have a long-term physical condition, highlighting how frequently these challenges overlap. Factors such as the physiological effects of chronic stress, barriers in accessing support services and the side effects of some psychiatric medications can all contribute to poorer physical health, resulting in premature death of about 15-20 years earlier for those with severe mental illness than those without. In turn, long-term physical illnesses can intensify symptoms of anxiety, depression or other mental health difficulties, creating a cycle that makes recovery more challenging. One of the risk factors for suicide is a long-term physical condition<sup>10</sup>. To improve this cycle, Islington Council created a toolkit<sup>11</sup> to help physical activity providers to guide inclusion of people with mental health needs.

Similarly, the same data suggests 30% of people with physical health conditions have mental health problems. A case study from the Stroke Association illustrates the impact of a physical health condition on mental health.

### Case study – Stroke Association

*Stroke Association's Islington service offers various support to stroke survivors and their families and carers, including casework support after a stroke, communication support, emotional support, stroke education, prevention and signposting to social activities. Having a stroke can be life changing for many, which is why mental health needs increase among those affected. Many stroke survivors experience emotional changes including anxiety, depression, anger, grief and frustration, and may also struggle with controlling their emotions or mood, such as sudden crying or laughter or irritability. These might be caused by changes in the brain or responses to changes in life and relationships. Stroke Coordinators at the Islington Stroke Recovery Service fully understand the emotional impact of a stroke and offer holistic and person-centred one-to-one services.*

[www.stroke.org.uk/finding-support/support-services/islington-stroke-recovery-service](http://www.stroke.org.uk/finding-support/support-services/islington-stroke-recovery-service)

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<sup>9</sup> <https://www.centreformentalhealth.org.uk/co-morbidities-physical-health-and-mental-health-problems-together/>

<sup>10</sup> <https://mentalhealth-uk.org/suicide/#section-3>

<sup>11</sup> [http://search3.openobjects.com/kb5/islington/directory/service.page?id=z4SyJs8xh\\_w](http://search3.openobjects.com/kb5/islington/directory/service.page?id=z4SyJs8xh_w)

## 1.3 Physical access

To ensure accessibility for people with mental health and other needs, services should consider both the physical environment and how they communicate with service users. Many organisations now publish access information on their websites, such as parking, step-free access, lift availability, doorway and corridor widths, toilet facilities, and interpreter services, often supported by user-friendly accessibility widgets. Islington's local football club Arsenal publishes extensive access information<sup>12</sup>.

While face-to-face contact may be preferred by many, for a better sense of connection when receiving support, sometimes it is just too difficult for individuals to leave home. The Covid-19 pandemic enabled organisations to equip digital access in many parts of services. Remote appointments should be offered when needed. This also brings to light the issue of digital exclusion, highlighted by research by Healthwatch Islington<sup>13</sup>. The e-consult systems used to book GP appointments are inaccessible for some, especially due to the number of questions. Similarly, while offering convenience and control, the NHS app can create difficulties, from registering to navigating contents. Some don't have an email address which can create considerable difficulty. The app also requires a lot of practice for some individuals to be able to use it properly. Healthwatch Islington historically offered short-term intervention to teach people how to use technology to access healthcare.

For some users of mental health services, the barriers can be around remembering appointments, travelling to/from a new location and difficulty communicating with a care professional. For further details of communication, see the next section. See box below regarding a service that fills a gap in travelling support for people with mental health needs.

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<sup>12</sup>

[https://www.arsenal.com/sites/default/files/documents/Emirates\\_Stadium\\_Access\\_Statement\\_2021\\_22\\_newforweb\\_v2.pdf](https://www.arsenal.com/sites/default/files/documents/Emirates_Stadium_Access_Statement_2021_22_newforweb_v2.pdf)

<sup>13</sup> <https://www.healthwatchislington.co.uk/news/2021-05-13/what-are-people-telling-us-about-e-consult>

### Case study – Hand in Hand Peer Travel Buddy service

*Hand in Hand Peer Travel Buddy service offers one-to-one support to Islington residents with mental health needs in accessing appointments, activities and green spaces. The service is delivered by trained mental health peer volunteers with lived experience, who offer practical and emotional support while travelling. Volunteers remind service users of upcoming appointments, accompany them where needed, and provide reassurance and encouragement to help reduce anxiety and increase confidence when leaving home. The benefits are mutual where clients gain independence and confidence, as well as volunteers maintaining wellbeing on their way to recovery and for some, a paid employment in peer work. The service bridges the gap.*

<https://www.islingtonmind.org.uk/hand-in-hand-service/>



## 1.4 Predictable environment and psychological safety

Taking a first step in accessing a mental health support service can be daunting for service users, especially for those who experienced marginalisation or discrimination in the past. In addition, many people with mental health needs find it difficult to access a new service due to increased anxiety traveling to a new place, meeting new people or not knowing what to expect. Long waiting time or perceived long waiting time for mental health support creates uncertainty around when support will become available, causing further anxiety. We can apply the concept of providing psychological safety when communicating with our service users to ensure we address various needs from the stage of booking an appointment to the day of an appointment. This approach is based on principles including trauma-informed care and psychologically informed environment.

In your written or verbal communication when booking appointments;

- Is there clarity on the purpose of the appointment?
- Do you clearly state who the appointment is with?
- Do you state how long the appointment lasts? Do you state what sort of questions will be asked in the appointment? Do you explain the medical procedure the appointment carries out, and do you provide supplementary information about it and any information on preparation?
- Do you provide clear information on how to find the location of the appointment? If a link to a website is provided, is your website accessible to all types of disabled people?
- Do you provide access information?
- Do you ask if a reasonable adjustment is needed? Can your service offer flexibility in how you communicate with service users (text, phone call, email, letter, large print letter)? Can your service offer options for an AM or PM appointment and different locations?

- Do you provide information on how to contact the service if the appointment needs rescheduling, or a service user has questions?
- Do you clearly provide information on discharge from the service, if the service user does not or cannot engage?

### Case study – Healthwatch Islington research on Moorfields Eye Hospital

*In a report about appointment letters and signage in the Moorfields Eye Hospital, Healthwatch Islington spoke with over 100 patients and 4 hospital staff. While many respondents found the letter and navigating in the hospital clear, quite a significant proportion of respondents addressed issues at different stages. The main recommendations from this report were to ask all patients their accessible information needs. Patients had not been offered a large format letter even when they would have benefited from it, or access to a pager to manage a long waiting time in the hospital. Some respondents also found signage to certain floors poor or inconsistent with the rest, making it harder to reach the destination. Many reported volunteers and kiosk around the entrance helped them to navigate. This report highlights the need for accessibility in many layers.*

<https://www.healthwatchislington.co.uk/sites/healthwatchislington.co.uk/files/Moorfields%20Enter%20and%20View%20visits.pdf>

## 1.5 Neurodiversity

Although neurodiversity is included under “disability” in the Equality Act, not all neurodivergent people identify as disabled, and not all forms of neurodivergence meet the legal definition of disability. As with many other disabilities, neurodivergence is not always obvious or visible, which makes it harder for service providers to respond unless inclusive provisions are already built into how services are delivered. For this reason, the kinds of adjustments that support neurodivergent people should be co-designed into services from the outset with neurodivergent people and made available to everyone, rather than only offered on request. These adjustments should only be seen as a guideline as each neurodivergent person requires different adjustments. These can change over time, so flexibility and understanding of the individual is paramount.

RIBA, the Royal Institute of British Architects, offer guidance on building design through their checklist<sup>14</sup>. In their extensive resource to meet needs of neurodiversity, they ask questions to ensure buildings address sensory processing differences and various neurodiverse conditions.

Examples of questions relevant to mental health services include:

- Is there an opportunity for people to obtain information prior to visiting?
- Are there preview guides showing routes to the premises from transport links and key features?
- Are there walk-through videos or plans available on a website?
- Can entrance(s) easily be identified?
- Does the entrance appear welcoming without features which may cause sensory overload, such as clutter or glare from reflective materials?

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<sup>14</sup> <https://www.riba.org/media/4eohbp5h/28-neurodiversity.pdf>



A local theatre, Sadlers Wells, offers a visual guide<sup>15</sup> with photographs of navigating the venue. Videos and photographs of the venues are increasingly available for neurodivergent audiences, which is also beneficial for all.

During an appointment or activity, there are other aspects and considerations needed to be inclusive of neurodiverse individuals. Always ask individuals what they prefer and be ready to adjust. Some individuals may not know what adjustments they need so attempting to understand the individual and listening / talking them through what adjustments might be helpful to them should be the considered approach.

- Lighting: fluorescent lighting and harsh lighting which create glare are uncomfortable for people who have sensitivity to light
- Noise: Can you provide an appointment in a quiet room?
- Provision of quiet space: To help regulate sensory stimulation, after travelling or a difficult meeting
- Fidget / sensory toys: To be made available during a meeting to help people regulate sensory system and calm anxiety
- Autism friendly language: An autistic person may likely understand language literally. For example, if you ask “Can you get dressed in the morning?”, a person might answer simply yes. What the question should ask is “Do you have any difficulty getting dressed in the morning? What are the difficulties? How long does it take you to get dressed?”
- Longer appointment time allocation for people who need extra time for processing and answering. This is especially helpful for a GP appointment where a standard is 10 minutes.

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<sup>15</sup> <https://www.sadlerswells.com/your-visit/accessibility/getting-to-our-theatres/sadlers-wells-theatre-visual-guide/>

- Lateness: This should be approached with understanding, rather than automatic discharge. Services should explore possible causes such as difficulties with sleep, timekeeping, or travel, and adopt good practice such as offering a reasonable grace period for arrival.
- Timing of the appointment: Many neurodivergent individuals experience sleep disorders so scheduling appointment in the morning should be avoided, or offer an option for afternoon.

Part of the difficulties for neurodiverse people is that their disability is not always obvious to others and others making assumptions about their behaviour. Examples of ADHD Babes highlight “invisible disability” and intersection with race.

### Case study – ADHD Babes

*ADHD Babes is a peer-to-peer support organisation specialised in working with Black women, trans and non-binary people with ADHD including those without diagnosis. The majority of members had late diagnoses of ADHD as adults, after diagnoses of mental health conditions, such as depression, anxiety, personality disorder and bipolar. Many women missed ADHD symptoms when younger due to masking and expectations from family and society. Black women experience added layers of prejudice regarding how they should behave, such as notions of being strong and persevering alone rather than seeking help. The pressure of having to conform to these expectations can push women to mental distress.*

*The organisation started from being a Facebook group at a time when existing support groups had few Black members and the founder was often the only Black person in the group. Over the last 5 years ADHD Babes has grown to become a Community Interest Company with over 300 members across and beyond the UK. The organisation operates on a sliding scale membership scheme, the fee can be negotiated. Their membership fees are used for internal individual grants, for purposes including transport, emergency funds, childcare and equipment to enable members to participate in the activities. The organisation runs social activities and trips, peer support groups and workshops on specific topics for wellbeing and personal development, alongside collective advocacy for systemic change.*

<https://www.adhdbabes.com/>



## 1.6 Embedding awareness

In addition to embedding inclusive practice day to day through building, communication and online, raising awareness and celebrating diversity through disability related dates is a good practice. Many of such dates are listed on various websites including the AbilityNet<sup>16</sup> which is a UK-wide charity offering technology support for disabled and older people.

Examples include;

15 March: International Long Covid Awareness Day

Mid-March: Neurodiversity Celebration Week

April: Irritable Bowel Syndrome (IBS) Awareness Month

12 May: World Fibromyalgia Awareness Day

Mid-June: Learning Disability Week

July: Disability Pride Month

Mid-September: National Inclusion Week

October: ADHD Awareness Month

From 20 November for a month: Disability History Month

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<sup>16</sup> <https://abilitynet.org.uk/disability-and-accessibility-related-events-calendar>

## 1.7 Language

The social model of disability offers useful guidance on language. It rejects terminology with negative connotations and intentionally uses disabled person rather than person with a disability. This is a political stance that highlights how social, physical, and institutional barriers, are what disable people by denying equal access, rather than individual impairments.

No	Yes
Handicapped or cripple	Disabled person (Some disabled people may use “cripple” or “crip” in their self-expression)
Wheelchair bound	Wheelchair user
Retarded or special	Person with learning difficulties or disability
Suffering from	Person with an impairment
The blind or the visually impaired	Blind people, partially sighted people
The deaf or the hearing impaired	Deaf person, people with hearing loss, people with a hearing impairment

From Inclusion London and Scope<sup>17</sup>

The umbrella term neurodiversity refers to a range of neurological differences and is used to emphasise variations in how people think and experience the world, rather than disorders or deficits. The opposite term is neurotypical. Many autistic people prefer this identity-first language, over people with autism. Services should use clear, accessible language and be prepared to provide information in plain English, considering the needs of people with a learning disability and those with limited understanding of English.

No	Yes
Person with autism	Autistic person or ask what is preferred

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<sup>17</sup> <https://www.scope.org.uk/about-us/accessibility-at-scope/accessibility-guidelines/how-we-speak-about-disability>  
[https://www.inclusionlondon.org.uk/wp-content/uploads/2015/05/FactSheets\\_TheSocialModel.pdf](https://www.inclusionlondon.org.uk/wp-content/uploads/2015/05/FactSheets_TheSocialModel.pdf)

ASD or Autism Spectrum Disorder	ASC Autism Spectrum Condition or Autism – recognising that Autism is not a “disorder” or illness
Symptoms of autism	Characteristics or traits of autism

From consultation with the Autism Hub<sup>18</sup> and resource from NHS Dorset Neurodiversity Hub<sup>19</sup>

In mental health, person-centred and recovery-oriented language offers a useful perspective to align with this toolkit. Although some people describe their own mental health conditions as “mad” to reclaim words once used in derogatory way, in a professional setting, those words and any other slurs and disrespectful language must be avoided. It is important to respect people’s choices and self-identification, including those who do not agree with diagnosis. Language continuously changes and we must always educate ourselves and ask our service users for input.

No / Do not say	Yes / Do say
Don’t equate identity with a person’s diagnosis. Very often there is no need to mention a diagnosis. “X is bipolar / schizophrenic / anorexic.”	Do say “a person who has been diagnosed with”, leaving the individual the freedom to accept it or not
Don’t presume that a person wants to be called by a particular term (e.g. customer or client)	Do enquire as to how the person would like to be described, maybe use first name and ask
Don’t argue with a person’s perception of events, or minimise their experience	Do validate a person’s experience
Don’t tell someone that certain information is irrelevant	Do allow people the time to find the words and express what they need to say
Don’t assume that you know what is best for a person	Do ask what has been helpful and unhelpful in the past

<sup>18</sup> <https://theautismhub.org.uk/>

<sup>19</sup> <https://nhsdorset.nhs.uk/neurodiversity/about/language/>

Don't tell someone to "get a grip" or "pull your socks up"	Do listen with kindness and empathy
Don't say unsuccessful / successful suicide – implying suicide as a desired outcome	Do say suicide attempt / suicide
Don't say commit suicide – implying "crime" or "sin"	Do say die by suicide, take one's life, end their own life
Don't appear shocked or change the subject when a disclosure has been made	Do remain calm

From Oxfordshire Safeguarding Adults Board<sup>20</sup> and Islington Mind Coproduction Group

### Case study – a mental health service user who identifies as a Black woman and wishes to remain anonymous

*During her early contact with mental health services in the early 2000s, she was described as and spoken to using stigmatising language that reduced her identity to an illness. At times, she was directly referred to as "mad" or "crazy" by professionals, terms she experienced as demeaning and harmful. She wondered if racism was part of the mistreatment. Communication was often one-sided, with information about her shared without explanation, reinforcing a sense of being talked about rather than spoken with.*

*In contrast, a later experience with a psychiatrist demonstrated how respectful language and practice can transform care. She was given sufficient time to speak and felt listened to. Following the appointment, she received a written summary of the discussion, which was also shared with her GP. This approach felt more collaborative, transparent and dignified, contributing to a more positive and empowering experience.*

<sup>20</sup> <https://www.osab.co.uk/wp-content/uploads/2025/01/Trauma-Informed-Recovery-Orientated-Language-Guide.pdf>

## 2. How we support – examining practice, systems and gaps

### 2.1 Peer support, value-based approach

Within NHS mental health services, peer support roles are a growing part of the workforce, as recognised in the NHS Long Term Workforce Plan<sup>21</sup>. Peer workers draw on their own lived experience of mental health challenges and of using services, offering understanding, empathy and hope to people currently accessing care. This perspective can complement traditional clinical roles and help to reduce power imbalances that have historically existed within mental health services.

Throughout the history of psychiatry, there have also been important debates and critiques about certain practices and approaches to care. More recently, organisations such as the National Survivor User Network (NSUN) have led research and campaigning focused on improving mental health care and reducing harm. NSUN have also developed a Peer Support Charter<sup>22</sup>, helping to shape good practice in peer roles prior to the introduction of national NHS Peer Work Competence Frameworks<sup>23</sup>.

Central to this is relational work, building consistent, respectful relationships where people are met with empathy, curiosity and care. By valuing lived experience and shared understanding, peer roles help create environments where people feel heard, respected and able to connect at their own pace.

Mental health needs are complex and individual. A recovery-focused, holistic approach recognises that people's goals extend beyond symptom reduction alone. Alongside clinical treatment, peer support can help individuals identify what matters to them, build on strengths, and move towards outcomes that feel meaningful in their own lives.

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<sup>21</sup> <https://www.england.nhs.uk/long-read/nhs-long-term-workforce-plan-2/>

<sup>22</sup> <https://www.nsun.org.uk/resource/peer-support-charter/>

<sup>23</sup> <https://www.hee.nhs.uk/our-work/mental-health/new-roles-mental-health/peer-support-workers>

Within North Central London Foundation Trust, Peer Coaches and Peer Support Workers support people across the boroughs. Their Recovery College<sup>24</sup> runs courses on self-care tools and wellbeing, as well as introduction to peer work, all facilitated by experts by experience. In addition, local charities also utilise peer workers in the community.

### Case study from an anonymous contributor – value of non-clinical staff in multi-disciplinary meetings

*Non-clinical support workers play a crucial role in advocating for clients within multi-disciplinary meetings, ensuring that lived experience and personal preferences are considered alongside clinical perspectives. Clinical treatment pathways do not always reflect clients' individual needs, particularly when concerns such as medication side effects are dismissed. The support worker helped clients prepare for appointments by writing down concerns and, where possible, attending meetings with them to support clear communication. This client-centred approach enabled a more holistic understanding of clients, beyond symptoms and treatment plans, particularly for those who had lost confidence following hospitalisation or crisis and required reassurance and step-by-step support.*

*Clear and sensitive communication was also essential. Clinical assessments sometimes felt judgemental to clients, especially when noting appearance or self-care. The support worker helped manage expectations and explained processes. They also used clients' preferred language, recognising that some disagreed with diagnoses or lacked understanding due to limited discussion with clinicians.*

*Overall, non-clinical staff strengthened trust, improved communication and ensured care remained person-centred and responsive within multi-disciplinary settings.*

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<sup>24</sup> <https://www.northlondonmentalhealth.nhs.uk/our-services-page/service/recovery-college-224/>

## 2.2 How we pitch our services – all-encompassing or targeted

Help on Your Doorstep, Islington Hubs and the Stuart Low Trust all offer services which are not mental health specific. Help on Your Doorstep and Islington Hubs offer no-wrong door for all issues. Many of their users are disabled and have mental health conditions, which they may or may not be aware of. Often mental health difficulties arise from practical and material unmet needs, such as poverty or homelessness, or from isolation. Due to stigma, it often takes time to come to terms with mental health needs and problems. To address the underlying issues that cause mental health distress, it can be very effective to support the person, without directly addressing mental health, if appropriate. All listed organisations above are equipped to support people with mental health needs by appropriately trained frontline staff.

### Case study –Stuart Low Trust

*Stuart Low Trust runs social activities for everyone who wants to access them free of charge. The origin of the organisation was to foster connection for those feeling isolated, with an aim to complement statutory-run mental health services by providing out-of-hours activities for holistic wellbeing. Although not specifically for people with mental health needs or disability, the organisation attracts a high percentage of those people. The organisation offers activities across the week, evening and weekends in accessible and inclusive formats. Their activities are risk assessed and planned so they are inclusive. For physical activities, such as yoga, qigong and walks, indication of physical level is given.*

<https://www.slt.org.uk/>

In contrast, for some marginalised communities, targeted services and clearly defined safe spaces are essential. Experiences of discrimination, trauma, or exclusion may make it difficult for individuals to access universal services or feel understood within them. Targeted services can build trust with historically underserved communities, reducing barriers related to stigma, language, or cultural misunderstanding, and creating

environments where people feel safe to share experiences and seek help.

### Case study – misery

*misery is a mental health community and sober rave based in London and led by and for queer, trans, intersex, Black people and people of colour with lived experience of madness, mental health challenges, time in hospital, addiction, public service use, disability, trauma, medication and neurodivergence. It is based on peer-to-peer support and is facilitated by a collective of practitioners bringing in wealth of knowledge in ecology, mycology, herbalism, music, art etc to create a safer space which fosters a sense of belonging and collective healing. The targeted support is essential to ensuring creation of a safe and nurturing space.*

@miseryparty on Instagram / email hello@miseryparty.org

## 2.3 Welfare benefits as a basic right to equity

In the current climate of austerity, accessing state welfare benefits has become increasingly difficult from initial application to renewal.

For people living with mental health conditions, the system can feel particularly unsupportive. Application forms often prioritise physical health, with little guidance on where or how to describe mental health difficulties. “Invisible disabilities” and persistent stigma create further barriers. Many people struggle to articulate their needs or provide sufficient evidence without clear prompts or specialist support. Guidance documents from Mental Health and Money Advice offer comprehensive information.<sup>25</sup>

The process itself is frequently distressing. We regularly hear from service users who experience heightened anxiety or mental health crises triggered by form-filling or benefit assessments. Claimants are often required to repeatedly describe deeply personal and painful experiences

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<sup>25</sup> <https://mentalhealthandmoneyadvice.org/welfare-benefits/>



in order to prove their eligibility for financial support, making the process feel stigmatising and shaming rather than supportive.

In Islington, there is a wide range of local organisations that provide help with disability benefit claims and appeals.

These include:

- Access Islington Hubs
- Age UK Islington
- Islington People's Rights
- Income Maximisation Team
- Disability Action in Islington
- Citizens Advice Islington
- City Community Legal Advice Centre
- Islington BAMER Advice Alliance (IBAA)
- Help on Your Doorstep
- Islington Law Centre
- Manor Gardens Centre
- Islington Mind

### Case study – Islington Mind Welfare Benefits Clinic

*A specialist clinic supporting people with mental health needs plays a vital role in addressing gaps left by mainstream services. Recognising how difficult it can be to explain mental health challenges within benefit applications, the clinic offers a series of short appointments. This approach allows time to build trust, reflect between sessions, and complete applications at a manageable pace. Staff deliver the service with empathy, patience, and understanding.*

*The clinic has successfully challenged DWP decisions in a high proportion of cases. Many clients would otherwise abandon appeals due to exhaustion or distress caused by the process. Where specific criteria are met, appeal deadlines can be extended to up to 13 months, a provision that many claimants are unaware of without specialist advice.*

<https://www.islingtonmind.org.uk/>

Some service users also report difficulties when meeting job coaches at Jobcentres. They describe feeling misunderstood about their mental health conditions or disabilities and pressured to meet Universal Credit requirements they are unable to fulfil as well as experiencing anxiety about the risk of sanctions. There appears to be limited awareness of, or access to, specialist support from Disability Employment Advisors (DEAs), which could otherwise help ensure reasonable adjustments are made.

Disabled people also have a legal right to access care and support at home. Funded through adult social care this support enables them to live independently. While contributions may be required depending on income, the support is a fundamental part of enabling disabled people to participate fully in society.

### Case study – free social care in Hammersmith and Fulham

*Since 2015, disabled residents in Hammersmith and Fulham have not been charged for their local authority-provided home care packages in the same way that NHS services are free at the point of use. This makes Hammersmith and Fulham the only London borough where disabled residents successfully challenged social care charges.*

*The campaign demonstrated the social model of disability in practice, recognising that barriers arise from systems and structures rather than individuals' impairments. A documentary film "£12.40 an hour for a Shower: The Story of Disabled People's Struggle to Abolish Home Care Charging in Hammersmith & Fulham" has been made about the campaigners who fought for this change, highlighting the power of collective action in advancing equity and rights for disabled people.*

<https://vimeo.com/1124827034> (link to the film with audio description)

<https://vimeo.com/1124826592> (link without audio description, but with BSL)

## 2.4 Carers of disabled people

A carer is defined as someone who provides unpaid care or support to another person. This may include a family member, partner, friend or neighbour, and the level and type of support provided can vary significantly. Under the Care Act 2014, carers have a legal right to a Carer's Assessment, which is separate from the assessment of the person they support and may lead to the provision of support for the carer. Carer assessments are the responsibility of the local authority. In Islington, further information and support for carers is available via the Carers' Hub<sup>26</sup>.

Carers may play an important role in care planning and ongoing support for the person they care for. In mental health settings, and across all services, professionals must ensure that the person receiving care has given informed consent for the carer to be involved in assessment, care planning and information sharing. Carers can share any necessary information to the professionals who should hear their concerns. It is also important to recognise that caring relationships can be complex, particularly where one person is dependent on the other, as this may create power imbalances. Professionals should remain alert to safeguarding concerns and consider both the needs of the carer and the autonomy, wishes and safety of the person receiving care.

In addition, carers themselves are at a higher risk of mental health conditions. 64% of carers registered at the Carer's Hub who were classed as a complex case also had a health condition. The most common health condition in these carers was a mental health condition.<sup>27</sup>

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<sup>26</sup> <https://islingtoncarershub.org/>

<sup>27</sup> <https://stats.islington.gov.uk/wp-content/uploads/2025/07/Islington-Mental-Health-Joint-Strategic-Needs-Assessment-March-2025.pdf>

## 2.5 Hate crimes, mate crimes

In recent safeguarding practice and discourse concerning victims and perpetrators, the concept of “vulnerability” is increasingly questioned and debated. It is now widely recognised that certain groups are not inherently vulnerable; rather, they are made vulnerable through perpetrators’ aggression, discrimination, and exploitation as well as discriminatory system and systemic biases<sup>28</sup>. Nevertheless, evidence consistently shows that disabled people and individuals with mental health needs are more likely to experience abuse than the non-disabled population. Furthermore, experiencing violence or abuse can significantly exacerbate existing mental health difficulties or contribute to the development of new ones.

Mate crime is a form of abuse where someone is harmed, exploited, or manipulated by a person they consider to be a friend, partner, or trusted acquaintance. Common examples include financial and material abuse and exploitation. In addition, “cuckooing” is a relatively newly recognised form of abuse where perpetrators take over a residential property of the victim and refuse to move out, often for the purpose of criminal activity. Hate crimes and mate crimes are frequently underreported due to fear of retaliation, lack of trust in systems, and feelings of shame or self-blame. These acts constitute criminal offences and should be reported to the police. Islington Council<sup>29</sup> provides guidance on reporting hate crime and signposts to third-sector organisations, including Stay Safe East<sup>30</sup>, a specialist in disability hate crimes, who offers advocacy, specialist support and advice to victims.

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<sup>28</sup> <https://migrantsrights.org.uk/projects/wordsmatter/vulnerability/>

<sup>29</sup> <https://www.islington.gov.uk/community-safety/tackling-hate-crime>

<sup>30</sup> <https://www.staysafe-east.org.uk/>

### 3. Data collection and analysis

To support disabled people and offer necessary reasonable adjustments, it is important professionals ask about individuals' conditions and needs and especially how they would like to be supported. A good starting point is a set of questions found in the Disability toolkit published by Birmingham City Council<sup>31</sup>. Following a question on whether a respondent has a disability, with a definition of what disability is, here is a list of appropriate questions.

If you have answered yes to having a disability, Now we are going to ask you some questions about your ability to do different activities on a regular basis, (think about days which are more difficult for you as well as good days):

- Do you have difficulty seeing, even if wearing glasses?
- Do you have difficulty hearing, even if using a hearing aid?
- Do you have difficulty walking or climbing steps?
- Do you have difficulty remembering or concentrating?
- Do you have difficulty with self-care such as washing all over or dressing?
- Do you experience fits or seizures?
- Using your usual language, do you have difficulty communicating for example understanding or being understood by others?
- Do any of your conditions or illnesses reduce your ability to carry out day to day activities?
  - ☐ Yes, a lot
  - ☐ Yes, a little
  - ☐ Not at all
  - ☐ Do not wish to answer

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<sup>31</sup> [https://www.birmingham.gov.uk/downloads/file/28619/disability\\_webinar\\_presentation](https://www.birmingham.gov.uk/downloads/file/28619/disability_webinar_presentation)

Do you have a diagnosis which sits under the umbrella term “neurodiversity”? Examples include Autism, Attention Deficit Hyperactivity Disorder (ADHD) and learning difficulties:

- ☐ Yes
- ☐ No
- ☐ Do not wish to answer

If you have answered “Yes” to the above question, then please tick all that apply to you:

- ☐ Autism
- ☐ Attention Deficit Hyperactivity Disorder (ADHD)
- ☐ Dyspraxia
- ☐ Dyslexia
- ☐ Dyscalculia
- ☐ Dysgraphia
- ☐ Other
- ☐ Do not wish to answer

In addition, services should routinely ask follow-up questions where a disability or additional need is identified, ensuring that support is provided in a way that genuinely meets the individual’s circumstances. In mental health services, particular attention should be paid to reducing anxiety within the service environment, as outlined in section 1.4 to enhance engagement.

When analysing service user data, it is important to take an intersectional approach, recognising how different aspects of identity and experience can overlap. UK government data<sup>32</sup> shows that 28% of working-age people are disabled, with higher rates reported among some ethnic groups, including 36% of Bangladeshi people, 32% of Pakistani people, 30% of people from mixed ethnic backgrounds, and 28% of White people.

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<sup>32</sup> <https://researchbriefings.files.parliament.uk/documents/CBP-9602/CBP-9602.pdf>

## 4. Organisation governance

### 4.1 Disabled staff and volunteer inclusion

Almost half of working-age disabled people report a mental health condition as their primary disability, and the number of people identifying mental health as a disability has increased over the past decade<sup>33</sup>. This rise may reflect greater social awareness and acceptance of mental health conditions, improved diagnosis by medical professionals and expanded access to mental health services.

Under the Equality Act 2010, an individual does not need a formal diagnosis to be considered disabled. On the other hand, having a diagnosed mental health condition does not automatically mean that a person meets the legal definition of disability. While not a statutory requirement, it is considered best practice for employers to have a workplace policy supporting the inclusion of disabled employees, provided the organisation complies with its obligations under the Equality Act 2010.

Major HR organisations publish guidelines;

<https://www.acas.org.uk/disability-at-work>

<https://www.acas.org.uk/reasonable-adjustments/mental-health-adjustments>

<https://businessdisabilityforum.org.uk/resource/toolkits/>

Employers should work with the disabled employee to discuss adjustments, as the needs are completely different from one individual to another.

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<sup>33</sup> <https://researchbriefings.files.parliament.uk/documents/CBP-9602/CBP-9602.pdf>

Some typical examples of workplace adjustments for mental health disability include:

- Flexible working hours; to avoid travelling during rush hour; to reduce unnecessary pressure and stress; later start and sufficient breaks for those on psychiatric medication which makes them slow starter in the morning
- Flexible work pattern and location; hybrid working, part-time work
- Regular and more frequent check-ins and supervision from a manager
- Adjustments to the role if certain tasks cannot be completed due to disability, and the employer to reallocate the tasks to another worker
- Consider whether a suitable alternative role is available if a worker becomes disabled or their condition worsens and they can no longer do their current job
- Adjustments to the environment; access to quiet space, low stimulation
- Adjusted workloads; modified duties, phased returns to work after absence, or extended deadlines where possible
- Arrangements for social interactions at work; organisation stating socialising being not mandatory; creating a quieter staff rest area

It can be helpful for organisations to engage an occupational health service provider to support fair and informed decision-making. Further guidance is available on the ACAS website<sup>34</sup>. Some employees may also use a “health adjustment passport” or “workplace adjustments passport” to clearly communicate their needs at work. The Department for Work and Pensions (DWP) provides a template to support this process<sup>35</sup>.

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<sup>34</sup> <https://www.acas.org.uk/using-occupational-health-at-work#:~:text=Occupational%20health%20is%20a%20type,service%20or%20an%20outside%20agency>

<sup>35</sup> <https://assets.publishing.service.gov.uk/media/62e13326d3bf7f2d73f8a2f4/health-adjustment-passport.pdf>



## Access to Work scheme

Access to Work is a government-run scheme that helps fund the additional costs disabled people may face in order to start, stay in or return to employment. It is available to people who are already in work, self-employed, or seeking employment. Support may include equipment such as noise-cancelling headphones, specialist software (for example, screen-reading or speech-to-text software), funding for support workers, and assistance with travel costs where public transport is not accessible.

Despite the absence of any formally announced policy changes, there is growing evidence that unofficial cuts and restrictions are already taking place ahead of anticipated reforms. Reports from mid to late 2025 indicate increasing delays in reimbursing essential travel costs, reductions in approved support-worker hours, and longer processing times for claims<sup>36</sup>. These changes are already having a significant impact, with some disabled employees reporting that they are unable to continue working due to the withdrawal or delay of vital support.

### Case study – Hillside Clubhouse, part 1

*Hillside Clubhouse is a local charity supporting people with mental health needs to find and sustain employment, and around 70% of its workforce has a diagnosed mental health condition, alongside others with physical health needs. For Hillside Clubhouse, Access to Work has enabled staff to benefit from a wide range of specialist equipment and software that would not be covered through standard workplace reasonable adjustments. Employees work closely with managers and an occupational health provider to identify and meet their support needs. By using Access to Work alongside fair and supportive management practices, Hillside Clubhouse ensures employees are treated equitably and have the tools they need to thrive at work.*

<https://www.hillsideclubhouse.org.uk/>

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<sup>36</sup> <https://www.disabilitynewsservice.com/government-figures-show-first-signs-of-perverse-cuts-to-access-to-work/>  
<https://disabilityarts.online/resources/guides-and-toolkits/access-to-work/access-to-work-changes-and-actions-2025/>

## 4.2 Inclusive recruitment

To attract and engage disabled candidates, employers should ensure that the recruitment and selection processes are inclusive, accessible and flexible.

- Do you provide information on accessibility of your workplace in the recruitment information?
- Do you clearly state your commitment to inclusive recruitment and disability equality in job adverts?
- Is your application form compatible with screen readers?
- Do you offer an alternative format to an application form? For example, video statement application instead of written form.
- Do you ask if any adjustments are required for interview to all the candidates? Examples are having interview questions printed out and sharing questions in advance. These help with the candidate's confidence, reduce anxiety and are particularly suitable for roles that require specific examples of experience spoken during the interview.
- Do you offer an alternative assessment, instead of interview? Examples include work trial and skills-based assessment. Recognise that traditional interviews may disadvantage some disabled candidates, especially for those who experience anxiety.

## 4.3 Employment support

Disabled people in the UK experience significantly higher unemployment rates, at around twice that of non-disabled people<sup>37</sup>. While overall disabled unemployment has gradually fallen over the past decade, the number of disabled people whose main impairment is a mental health condition has doubled during the same period. The same data shows people with mental health conditions are more likely to be unemployed than those with physical impairments, highlighting persistent barriers to employment.

To address employment barriers, support services are available. Typical support offered includes;

- Discussing when to disclose mental health disability to a new employer
- Discussing reasonable adjustments and communicating with the employer
- Helping to apply for Access to Work
- CV, application form and interview support

### Case study – Disability Employment Advisors service at Jobcentre

*At Jobcentre Plus, Disability Employment Advisers (DEAs) are available to support disabled people and others who face barriers to work. During the initial Universal Credit meeting, work coaches are expected to ask every claimant whether they have any health conditions or other barriers that affect job-seeking or employment. Disabled claimants have the right to request reasonable adjustments to their claimant commitment, such as reducing the number of required job applications or adapting tasks, if these are unmanageable because of their condition. Claimants can also ask to speak with a DEA for specialist support, including guidance on finding and sustaining suitable employment, understanding reasonable adjustments, accessing programmes like Access to Work, and getting help when applying for long-term sickness-related assessments.*

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<sup>37</sup> <https://www.gov.uk/government/statistics/the-employment-of-disabled-people-2024/the-employment-of-disabled-people-2024>

## Case study – Hillside Clubhouse, part 2

*In Islington, specialist employment support for people with mental health conditions is delivered by a charity, Hillside Clubhouse, through Individual Placement and Support (IPS) and Talking Therapies services within the NHS. The IPS service supports people to move directly into paid employment, offering personalised, practical help to find and sustain work. For those who are not yet ready for employment, Hillside Clubhouse provides a recovery-focused clubhouse model, offering structured activities, skills development, and peer support to build confidence and readiness for work. In addition, Talking Therapies offers one-to-one support to help individuals address mental health barriers that may affect their ability to seek or maintain employment. Together, these services provide a flexible, person-centred pathway into work and recovery.*

<https://www.hillsideclubhouse.org.uk/>



## 4.4 Types of audits to ensure accessibility and inclusion

A range of audits and assessments can help organisations ensure accessibility and inclusion in the workplace and demonstrate compliance with the Equality Act 2010. Accessibility audits identify physical, digital, and organisational barriers that may disadvantage disabled people, while Equality Impact Assessments help organisations understand how policies and practices affect different groups and prevent unintended discrimination. Meaningful involvement of an organisation's own service users or employees with lived experience of disability is essential to ensure audits reflect real-world barriers rather than theoretical compliance. Some employers also seek Disability Confident Employer accreditation; however, this has been criticised for being a one-time application with limited follow-up. To be effective, accessibility and inclusion audits should be supported by ongoing monitoring, review, and clear accountability, rather than relying on one-off accreditation.

## 4.5 Staff training

To make changes to services, organisations and the system at large, training, especially from trainers with lived experience, should be provided to frontline staff, in addition to creating mechanisms that foster the coproduction of services by service users.

- Social model of disability and different ways of making reasonable adjustments in your workplace and service (Disability Action in Islington, Shape Arts)  
<https://www.daii.org/>  
<https://www.shapearts.org.uk/news/training>
- Learning disability and neurodiversity awareness (Elfrida Society, ADHD Babes, Autism Hub, Mencap)  
<https://www.elfrida.com/>  
<https://www.adhdbabes.com/>  
<https://theautismhub.org.uk/>
- Disability disclosure during recruitment process, Access to Work, disability confidence for employers (Hillside Clubhouse, Disability Rights UK)  
<https://www.hillsideclubhouse.org.uk/>  
<https://www.disabilityrightsuk.org/disability-confidence-training>
- Trauma-informed practice (Islington Council via MyLearning, With-You)  
<https://with-you.co.uk/services/training-consultancy>

## 5. Partnership work

From within this toolkit document and previous ones, it is evident that Islington offers a wealth of local support for people with mental health needs. Each organisation has its strengths and partnership work is especially effective in holistic support. Working in partnership and collaboratively strengthen our networks and maximises benefits to our service users.

### Case study – Arsenal

*Our local football team Arsenal has been successfully running a diverse range of community programmes with local partners for a long time. By combining their expertise in football coaching with local partners' expertise in enhancing wellbeing and education, their approach is to develop and deliver long-term partnership projects that benefit local residents. All projects are referral-only and accessed through collaborating organisations. One example is their work with North Central London NHS Foundation Trust's secondary care team, which has been running for over 17 years. All participants are assessed by the NHS and are invited to play football twice weekly; once at Arsenal and once in the community. Participants benefit from professional football coaching and the social connections built within the team, while also having regular opportunities to speak with their care coordinator outside of a medical setting.*

<https://www.arsenal.com/community>

# Contributions

ADHD Babes [www.adhdbabes.com](http://www.adhdbabes.com)

Arsenal [www.arsenal.com/community](http://www.arsenal.com/community)

Autism Hub [theautismhub.org.uk](http://theautismhub.org.uk)

Choice and Control (former NHS service, mental health peer coaching)

DWP, Barnsbury Jobcentre

Healthwatch Islington [www.healthwatchislington.co.uk](http://www.healthwatchislington.co.uk)

Help on Your Doorstep [www.helponyourdoorstep.com](http://www.helponyourdoorstep.com)

Hillside Clubhouse [www.hillsideclubhouse.org.uk](http://www.hillsideclubhouse.org.uk)

Islington Mind [www.islingtonmind.org.uk](http://www.islingtonmind.org.uk)

Islington Mind Coproduction Group

Islington Mind Hand in Hand volunteers

Mencap Islington

Stroke Association, Islington branch [www.stroke.org.uk](http://www.stroke.org.uk)

Stuart Low [www.slt.org.uk](http://www.slt.org.uk)