"You've set out the problem. What do solutions look like — and what do you need?"

ANSWERED, IN THREE PAGES

DON'T BUILD ANOTHER SERVICE. BUILD THE COUNTING.

The system runs on data. The data does not see Black queer men — so the system does not serve them. **Critical Frequency builds the evidence the system will not gather, puts our own people inside the institutions that use it, and funds the care that reaches men who will never present.**

WHO WE ARE TALKING ABOUT

50-65K

Black queer men in the UK

Census 2021 synthesis · conservative floor 35-40k

25-32K

In Greater London — about half the national total, in your region

48% of the UK Black population · higher LGB rates

88,500

Black residents in Croydon — the largest absolute number of any London borough

Absolute numbers, not percentages, should drive allocation

THE PROBLEM, IN THREE NUMBERS

262 VS 66

Detentions under the Mental Health Act per 100,000, Black or Black British against White, England 2024–25. Nearly four times the rate. Community Treatment Orders run at 8.5 times.

ETHNICITY IS RECORDED

NHS England, MHA Statistics 2024-25

5 ×

Black gay and bisexual men are five times more likely to attempt suicide than white gay and bisexual men. The study is ten years old, and no national dataset has been built since that could refresh it.

ORIENTATION IS RECORDED

LSHTM / Stonewall, 2016 · n=5,799

0

Published statistics outside HIV surveillance that report both. So the two columns to the left can never be joined, no disparity at the intersection can be measured, and no commissioner is accountable for it.

THE INTERSECTION IS NOT

Some specifications carry the field. None publish it.

NOBODY IS FAILING. THAT IS EXACTLY WHY NOTHING CORRECTS IT.

Commissioning by single protected characteristic produces a gap that no commissioner owns. **The Black voluntary sector is doing its job. The LGBT+ sector is doing its job.** There is no accountable party for the intersection, so there is no route to funding it, and the infrastructure that does exist is volunteer-run and precarious.

"I cannot go home like this." When you cannot go home, community infrastructure **is** the home — and it sits between two funded sectors, funded by neither.

WHAT SOLUTIONS LOOK LIKE

01 PEOPLE INSIDE – AND PEOPLE AT THE DOOR

Ten Black queer specialists on 18–24 month reform posts across NHS mental health, housing, social care, legal advocacy, arts and employment — championed by a consultancy team, not managed by one. Alongside them a **referral and advice team — not a service**: it maps how men actually move through the systems that already exist, refers better because it can see those journeys, and from year two feeds that documentation back to the organisations as learning. Action research, not a five-year evaluation — so **nobody is told to come back in five years, when we will understand your needs**.

10 specialists · 6 sectors · £4.3M

02 CARE THAT REACHES MEN WHO DON'T PRESENT

365 men a year into culturally competent talking therapy — 1,825 over five years — allocated by position in the network rather than place in a queue. A London hub with spokes in Manchester, Birmingham and Bristol, because 60% of this population lives outside London. 200 men a year trained in mental health first aid adapted for Black queer men's experience, and a bridging fund so specialists can act on the crises they can see coming rather than waiting for a referral.

1,825 men · 4 cities · £800k

03 CULTURAL PRODUCTION, NOT INTERVENTION

The BLKOUT magazine: four guest editors a year, each commissioning six writers and bringing their own audience — twenty-eight Black queer people through the masthead annually, writing, and making the audio and film that carries each edition. Writers deliberately paired across lines that don't usually cross. Built on Sanity, claimed and locked at **£0 platform cost, permanently**, so every funded pound pays Black queer editors and writers rather than infrastructure.

4 editions/yr · 28 contributors · £400k

04 EVIDENCE THAT CHANGES PRACTICE

Consented data building the comparator that does not exist — ethnicity by sexual orientation — plus **the two variables nobody records: which modality a man was offered, and why he stopped**. Recovery rates are computed among those who complete treatment, after drop-out has removed the men it did not suit; across 85,800 referrals in this catchment, Black service users were less likely to self-refer, be assessed, or start at all. Until both are recorded, “therapy does not work for us” cannot be separated from “this form of it does not” — and only the second is fixable.

£200k · annual · Harwood et al., SLaM, 2021

ALLOCATE BY NETWORK POSITION, NOT BY NEED QUEUE

The lesson your own field learned first: you do not reach a dispersed, stigmatised population by opening a door and waiting. Therapy here is the delivery mechanism for a change in what the community believes about seeking help — 1,825 men, each with some twenty-five close ties, put most of the population within one step of someone who has been through it, provided they are distributed across the network rather than clustered. That is what hub-and-spoke exists to ensure.

NOT A STANDING START

88
members of BLKOUTHUB over six years — 79% joined for connection, not services or information

36
Black queer men through Ivor's Compass at Stanley Arts, April 2026 — delivered and evaluated

1ST
published UK synthesis of ethnicity × sexual orientation population estimates, open to correction

£0
of this programme funded to date — the platform, research and governance already exist and run

HOW IT PHASES

YR 1
Specialists placed · referral team live · journey mapping begins · bridging fund open · governance established

YR 2
Documented journeys offered back to partner organisations as learning · first governance decisions on the fund

YR 3
Mid-programme evaluation · community decides what infrastructure years six to ten should build

YR 4
Evidence synthesis · years six to ten planned and costed with the community that will own them

YR 5
Community-led evaluation · model documented for replication · diversified funding in place

WHAT WE NEED

£0

Within your own gift
Highest leverage here

WHAT ONLY YOU CAN GIVE

- **Convene it — and name it afterwards.** The gap exists because no single party owns it: exactly the problem convening power solves and nothing else does. A room with the London analysts, the ICBs and both sectors in it is something you can call and we cannot. A sentence in a London public health document afterwards makes it citable, which is what makes a population commissionable.
- **Extend the counting that already works.** HIV surveillance is the one place this population is visible at the intersection — and it manages that by recording probable route of exposure, a clinical variable, rather than sexual identity as a tick-box. That design is worth copying, and it answers the disclosure objection before it is raised.
- **Put the question to your analysts.** Can population health methods serve a sub-population this small and this cross-cut? We will bring Critical Frequency as the worked example and take the answer either way.

£1.8M

over three years
£60 per man / year
6-9 months to start

★ START HERE

THE PROVING GROUND — SOUTH EAST LONDON

The South London and Maudsley footprint — Croydon, Lambeth, Lewisham and Southwark — holds the four largest Black populations in London and an estimated 7,500–10,500 Black queer men. That is above the minimum viable scale for specialised provision, and it sits in your region. It also crosses two Integrated Care Boards, which is not a complication but **the actual test**: whether resources can follow a population that organises relationally rather than by postcode. Same unit cost as the national programme, at a scale commissionable this financial year and evaluated before the next spending round.

£10.5M

over five years
£60 per man / year
£5 a month

THE FULL PROGRAMME — NATIONAL

35,000 Black queer men. Sixty per cent into the specialist cohort and its protection; forty per cent into the relational infrastructure and democratic governance that sustain it. Phased from London outward, where half this population lives and where the model can be proved before it is exported.

WHAT £10.5M BUYS

£2.5M	Specialist cohort fellowship — 10 posts, 5 years
£1.8M	Referral and advice team — journey mapping and system learning
£1.6M	Consultancy team championing specialists — 5–6 FTE
£800k	Cultural strategy — therapy normalisation, hub and spoke
£400k	BLKOUT magazine — 4 editions a year, with audio and film
£1.0M	Democratic governance and deliberation
£800k	Platform and digital infrastructure
£600k	Training and professional development
£400k	Development lab coordination
£300k	Community governance
£200k	Community-led evaluation and evidence
£100k	Emergency response fund
£10.5M	**35,000 MEN · 5 YEARS · £60 EACH PER YEAR**

THE ECONOMICS

£50,000

Cost per suicide prevented through peer support, against **£3.12M** total cost per suicide including lost productivity. Knapp et al., 2011

£12-16M

Indicative annual cost of detaining an estimated 150–200 Black queer men under the Mental Health Act in England.

That last figure is triangulated, not measured. No official dataset links detention to sexual orientation, so it cannot be verified — by us or by you. We publish it as an indicative estimate and say so plainly. The absence is not a footnote to the argument; it is the argument.

THE LAYERS BENEATH THIS PAGE

critical.blkoutuk.com — the interactive research narrative
mental-health.blkoutuk.com/research-briefing.html — the evidence base
mental-health.blkoutuk.com/outcomes-paper.html — network model, predictions
mental-health.blkoutuk.com/policy-briefing.html — the policy case
mental-health.blkoutuk.com/cost-model.html — the full cost model

DR ROB BERKELEY MBE
Founder & Director, BLKOUT Creative Ltd
Community Benefit Society RS009639
research@blkoutuk.com