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

THE QUESTION WE ARE ASKED MOST

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

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 one London trust, 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 public health learned first in the HIV epidemic: 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 EACH OF US CAN DO

PUBLIC HEALTH

DIRECTORS OF PUBLIC HEALTH · OHID · ICBS · COMMISSIONERS

- **Convene across the gap.** It exists because no single party owns it — exactly the problem convening power solves and nothing else does. A room with analysts, ICBs and both sectors in it, with the intersection on the agenda.
- **Name it in a document.** Citable is what makes a population commissionable, and nobody can cite this one outside HIV.
- **Commission at city-region scale.** Borough-level populations of 1,500–2,500 are too small for specialised provision; a mental health trust footprint is the minimum viable unit.
- **Require the disaggregation.** Copy HIV's design — record probable route of exposure as a clinical variable rather than sexual identity as a tick-box.

PRIMARY CARE AND PRACTITIONERS

GPS · PRACTICE NURSES · SEXUAL HEALTH · TALKING THERAPIES

- **Raise PrEP first.** Black gay and bisexual men's PrEP need is identified at 77.9% against 87.7% for white men — but once identified they start at 89.9% against 90.5%. The gap is in the offer, not the answer.
- **Prostate risk starts at 45.** One in four Black men will be diagnosed, against one in eight white men. Survival after diagnosis does not differ by ethnicity, so everything is won before it.
- **Check blood pressure before 40.** Health Checks begin too late for a group presenting with stroke earlier and more often unwarned.
- **Follow up non-attendance.** The talking-therapies loss happens at referral and assessment, before treatment — a discharge letter closes the only door.

COMMUNITY AND VOLUNTARY SECTOR

BLACK-LED ORGANISATIONS · LGBT+ ORGANISATIONS · FUNDERS

- **Say the other word.** Black-led organisations that never say gay, and LGBT+ organisations that never say Black, together produce “I cannot go home like this”. Neither is failing. That is the point.
- **Refer sideways, not only up.** The intersection is reached by two sectors knowing each other's provision, not by either building a new service.
- **Share what you see.** Journey data from the front door is the evidence no dataset holds. Pool it rather than each holding a fragment.
- **Funders: fund the join.** Single-characteristic funding streams are what created the gap; a cross-stream award is the correction.

BLACK QUEER MEN

US — WHERE OUR OWN ACTION HAS MOST LEVERAGE

- **Ask for PrEP by name.** The data is unambiguous: when it is raised, we take it at the same rate as everyone else. Raising it ourselves closes the gap the consulting room leaves open.
- **If the therapy didn't fit, that is information about the therapy.** Ask for a different modality rather than concluding it isn't for us.
- **From 45, ask about your prostate. Before 40, ask about your blood pressure.** Earlier than the guidance assumes, because the guidance was not built with us in mind.
- **Be counted, and own it.** The dataset that does not exist is one we can build ourselves — and the platform that holds it is a community benefit society with an asset lock, member-owned.

WHAT THE PROGRAMME NEEDS

£0

Convening, naming the gap, and requiring the disaggregation. The highest-leverage moves on this page cost nothing and outlive any grant.

£1.8M

A three-year proving ground at mental health trust scale — around 10,000 Black queer men, crossing two ICBs by design, six to nine months to start.

£60 per man / year · start here

£10.5M

The full five-year programme: 35,000 Black queer men, 60% into the specialist cohort and its support, 40% into the infrastructure that sustains it.

£60 per man / year · £5 a month

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

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