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Race on the Agenda

MAKE THE INVISIBLE, VISIBLE

IN HOUSING, HEALTH & WELLBEING

RCRP 2025 REPORT

“I’VE STRUGGLED TO TRUST SERVICES… THERE’S NO POINT SEEKING SUPPORT, AS NOTHING SEEMS TO CHANGE.”

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FOREWORD

I am deeply proud of the peer researchers, participants and ROTA team in making this report possible.

It represents not only another research study but an authentic insight into the lived experiences of a broken housing and healthcare system for BGM groups. This is a system that has historically ignored, underfunded and dismissed pain.

For too long the voices and issues of BGM groups have been silenced and this report simply says: 'no more'.

The ROTA Community Research Programme (RCRP), places people who live in and among the issues that are talked about in this report, at the centre. It challenges the outsider perspective that collects data on BGM communities but then interprets it from a lens that is far removed from people's lives. This is what makes this report so powerful and so special, because it is deeply based on the principle of 'nothing about us, without us'.

While research and reports are important, I also acknowledge they are not in and of themselves enough. They support the foundations for action, movement building, narrative and policy change. This requires a collective effort as no single person or organisation can address the significant challenge of our contemporary struggles.

Finally, I also want to acknowledge the important support of Propel London and the City Bridge Foundation for funding this program. It is the collective efforts of the ROTA staff (particularly programme leads Taranjit Chana and Kulvinder Nagre), peer researchers, our members, supporters, volunteers, board members and funders that make this partnership and work possible.

Matt Johnson, CEO

INTRODUCTION

This report marks the second year of the Race on the Agenda (ROTA) Community Research Partnership (RCRP), a flagship programme committed to transforming how research is conducted with and for Black and Global Majority (BGM) communities.

Historically, research into the issues these communities face has relied on an extractive model, where at times external academics co-opt lived experiences for professional capital without ceding power or ensuring meaningful benefit to the communities themselves. The RCRP exists to fundamentally challenge this dynamic.

Enabled by funding from the City Bridge Foundation via the Propel partnership, the RCRP operates on principles of co-production and capacity building. Each year, we partner with a cohort of Peer Researchers (PRs) from BGM communities, providing intensive training and support. These PRs then design and lead innovative, community-centred research projects that amplify their expertise and drive tangible change. Over its three-year lifespan, the programme aims to develop significant community research capacity, support 30 research projects, and co-produce four impactful campaigns for systemic reform.

Following the 2024 cohort's focus on the critical areas of education and employment, the 2025 cohort has turned its attention to **housing and health & wellbeing**. These themes reflect persistent, intersecting crises disproportionately affecting BGM communities in London, from the housing emergency and its mental health impacts to entrenched inequities in healthcare access and outcomes.

Our 2025 Peer Researchers are leading a diverse and vital portfolio of projects that exemplify our commitment to intersectionality and community-defined priorities.

Their investigations include:

1. LGBTQ+ housing issues
2. The housing and wellbeing of Sudanese refugee communities
3. Wellbeing among migrant hotel residents
4. The housing and mental health impacts on families subject to No Recourse to Public Funds (NRPF)
5. Gentrification in Peckham
6. Wellbeing and mental health care for Sickle Cell patients
7. Mental health care provision at university
8. Maternal mental health care
9. Black women with hidden disabilities
10. Black women's wellbeing through art

This report presents the findings from these essential research initiatives. It underscores the power of placing research tools directly in the hands of those with lived experience, ensuring that the insights generated are not only authentic but are also owned and leveraged by the communities to advocate for a more just and equitable society.

POLICY AND PRACTICE RECOMMENDATIONS

The following integrated recommendations address the cross-cutting themes of institutional neglect, racialised inequity, and the critical need for community-led, trauma-informed solutions. They are directed at key stakeholders with the power to enact systemic change.

1

END HOSTILE ENVIRONMENT POLICIES & REDESIGN IMMIGRATION SUPPORT

FOR UK GOVERNMENT & NATIONAL POLICYMAKERS

ABOLISH NO RECOURSE TO PUBLIC FUNDS (NRPF)

Recognising its role as a primary driver of destitution, housing insecurity, and severe health harms for families (including British children). Replace with a fair support system decoupled from immigration enforcement.

ESTABLISH EQUITABLE HUMANITARIAN RESPONSE PATHWAYS

Create a dedicated, structured resettlement scheme for Sudanese arrivals, with rights and support parity to schemes like those for Ukrainians. Mandate clear, consistent guidance to all local authorities and the DWP to prevent unlawful application of residency tests.

END THE USE OF CONTINGENCY ACCOMMODATION FOR ASYLUM SEEKERS

Phase out the use of hotels and barges. Invest in dignified, safe, and stable housing with proper facilities, enforceable standards, and independent oversight.

2

MANDATE ANTI-RACISM & CULTURAL COMPETENCE ACROSS PUBLIC SERVICES

FOR UK GOVERNMENT & NATIONAL POLICYMAKERS

INTRODUCE LEGISLATIVE & FUNDING LEVERS

Require mandatory, co-produced annual training for all frontline staff in the NHS, housing, social care, and benefits agencies on anti-racism, cultural safety, and trauma-informed practice. Link service funding to demonstrated competency and improved equity outcomes for BGM communities.

ENFORCE ACCOUNTABILITY FOR RACIAL DISPARITIES

Strengthen the Public Sector Equality Duty. Require all NHS Trusts, ICBs, and local authorities to publicly report on and action plans to eliminate disparities in housing outcomes, maternal health, mental health access, and pain management (e.g., for Sickle Cell).

3

REORIENT HOUSING POLICY FROM MARKET INVESTMENT TO COMMUNITY WELLBEING

FOR UK GOVERNMENT & NATIONAL POLICYMAKERS

PRIORITISE SECURITY AND CONDITION OF SOCIAL HOUSING

Introduce a legally enforceable 'Right to a Safe Home' (building on Awaab's Law) with swift remediation timelines for damp, mould, and disrepair. Launch a national fund to retrofit social housing, starting with energy-inefficient properties in gentrifying areas.

HALT DISPLACEMENT THROUGH PLANNING REFORM

Reform planning policy to give communities democratic control over development. Mandate a minimum of 50% genuinely affordable housing (linked to local incomes) on all new developments, with robust community benefit agreements.

4

IMPLEMENT PROACTIVE, INTEGRATED HEALTH & HOUSING HUBS

FOR LOCAL AUTHORITIES & INTEGRATED CARE SYSTEMS (ICSS) IN LONDON

CO-LOCATE SERVICES

Establish one-stop community hubs in areas of high need, integrating housing advice, mental health drop-in services (with culturally matched therapists), welfare rights, and immigration support. These must be co-designed with BGM community organisations.

ADOPT A 'HOUSING AS HEALTHCARE' MODEL

Train and deploy specialist housing officers within NHS mental health and perinatal teams to prevent health crises exacerbated by poor housing. Fast-track safe housing for survivors of abuse and those with chronic health conditions, regardless of immigration status.

5

INVEST IN AND DEVOLVE POWER TO COMMUNITY-LED SOLUTIONS

FOR LOCAL AUTHORITIES & INTEGRATED CARE SYSTEMS (ICSS) IN LONDON

CREATE SUSTAINABLE FUNDING STREAMS

Allocate long-term, core funding to BGM-led community organisations (e.g., Sudanese diaspora groups, Sickle Cell peer networks, Black women's wellness initiatives) to provide culturally specific support, advocacy, and peer mentoring.

COMMISSION BY & FOR THE COMMUNITY

Change commissioning practices to favour participatory grant-making and community-owned research. Repurpose underused public assets into community wellbeing hubs run by and for BGM residents.

6

ERADICATE RACIAL BIAS IN CLINICAL PRACTICE AND PAIN MANAGEMENT

FOR THE NHS, HEALTHCARE PROVIDERS & PROFESSIONAL REGULATORS

IMPLEMENT MANDATORY SICKLE CELL & PAIN MANAGEMENT PROTOCOLS

Enforce NICE guidelines on prompt analgesia. Introduce mandatory, specialist training for all A&E and primary care staff on Sickle Cell disease, focusing on anti-racist pain management and challenging "drug-seeking" stereotypes.

EMBED CULTURALLY COMPETENT PERINATAL & MENTAL HEALTH CARE

Guarantee continuity of carer for Black and South Asian mothers. Integrate routine, culturally-attuned perinatal mental health screening. Develop and fund a national network of culturally matched therapists within IAPT and specialist perinatal services.

7

INTEGRATE HOLISTIC WELLBEING INTO CHRONIC ILLNESS CARE

INTRODUCE ROUTINE PSYCHOSOCIAL SCREENING

Make routine psychological and neurocognitive assessments standard in chronic illness clinics (e.g., for Sickle Cell, CKD). Develop flexible models of mental health support that recognise the presentation of depression and anxiety in BGM patients.

FUND AND VALIDATE COMMUNITY HEALING MODALITIES

NHS ICBs should commission and fund evidence-based, community-led wellness programmes (like Create in Mind) as complementary health interventions for BGM communities experiencing racial trauma and stress.

FOR THE NHS, HEALTHCARE PROVIDERS & PROFESSIONAL REGULATORS

8

CREATE INTERSECTIONALLY INCLUSIVE ENVIRONMENTS

DEVELOP INCLUSIVE DISABILITY & WELLBEING POLICIES

Reform workplace policies to recognise and support hidden disabilities and chronic illnesses. Mandate flexible working, proactive reasonable adjustments, and manager training on intersectional inclusion to prevent discrimination against Black women and disabled BGM staff.

GUARANTEE CULTURALLY SAFE STUDENT SUPPORT

Universities must provide mental health services with dedicated BGM and LGBTQ+ counsellors. Run proactive, anti-stigma campaigns co-created with BGM student unions and embed cultural competence training for all pastoral and academic staff.

FOR EMPLOYERS, UNIVERSITIES & EDUCATIONAL INSTITUTIONS

9

TRANSFORM FUNDING PRACTICES TO EMPOWER, NOT EXTRACT

FOR FUNDERS & COMMISSIONERS (CHARITABLE, PUBLIC & CORPORATE)

ADOPT TRUST-BASED, LONG-TERM FUNDING

Provide multi-year, unrestricted core grants to BGM-led organisations. Simplify application and reporting processes, valuing lived experience as expertise.

FUND ADVOCACY AND SYSTEMIC CHANGE

Direct significant resource towards community organising, policy advocacy, and strategic litigation led by those with lived experience (e.g., challenging NRPF, poor housing conditions). Support the infrastructure for community research and peer-led accountability.

10

CORE PRINCIPLES FOR ALL STAKEHOLDERS

CORE PRINCIPLES FOR ALL STAKEHOLDERS

NOTHING ABOUT US WITHOUT US

All policy design, service reform, and research must be co-produced with the affected BGM communities, ceding power and decision-making.

INTERSECTIONALITY IS NON-NEGOTIABLE

Solutions must address the compounded discrimination faced by people who are Black, migrant, LGBTQ+, disabled, women, or living in poverty.

HOUSING IS A HEALTHCARE INTERVENTION

Stable, safe, and affordable housing must be recognised as a foundational determinant of physical and mental health.

ACCOUNTABILITY THROUGH DATA & STORY

Combine quantitative disparity data with the qualitative lived experience evidence in this report to measure progress and hold institutions to account.

This report is a testament to the power of community-led research. The recommendations above provide a roadmap for translating that evidence into justice, equity, and wellbeing for all.

> “I CAN’T BE OPEN ABOUT AN IMPORTANT PART OF WHO I AM... I’M CONSTANTLY MONITORING MY BEHAVIOUR TO AVOID CONFLICT.”

THE MENTAL HEALTH CRISIS AMONG LONDON'S LGBTQ+ BLACK & GLOBAL MAJORITY YOUTH

Ekhlas Khadi

Young Black LGBTQ+ Londoners navigate a unique storm of racism, homophobia, transphobia, and economic inequality. For them, housing is not just about shelter; it is intrinsically linked to safety, identity, and mental wellbeing.

When home is a place of rejection or housing markets are sites of discrimination, the psychological toll is severe. This research exposes how housing precarity, intersecting with a mental health system that fails to see or serve them, creates a cycle of anxiety, depression, and isolation.

METHODOLOGY

A mixed-methods study with 17 young Black LGBTQ+ Londoners (aged 18-30), using surveys and in-depth interviews. Recruitment leveraged community networks and peer trust to safely explore this sensitive topic.

KEY FINDINGS

HOUSING PRECARITY IS WIDESPREAD AND ROOTED IN REJECTION

- Family Conflict as a Driver: **65%** (11/17) avoid expressing their LGBTQ+ identity at home for fear of losing housing. One participant shared: "I can't be open about an important part of who I am... I'm constantly monitoring my behaviour to avoid conflict."
- Unsafe and Unstable Conditions: Experiences range from hostile family environments to inadequate temporary housing plagued by mould and infestations, creating profound instability. **59%** reported facing racism or discrimination when seeking housing.
- Hindered Life Progression: This insecurity directly disrupts education, work, and future planning, with one participant stressed about life after the "safety net" of university.

A DIRECT PIPELINE FROM HOUSING INSECURITY TO MENTAL ILL-HEALTH

- Clear Correlation: **71%** (12/17) stated housing insecurity negatively impacted their mental health.
- Psychological Harm: Living in unaffirming or unsafe conditions fuels chronic anxiety, depression, and a deep sense of disconnection. Some experienced psychosomatic symptoms, like feeling bites from non-existent bedbugs.
- Redefining 'Home': For safety, "home" is often redefined—confined to a single room or relocated entirely to chosen family and friends.

SYSTEMIC FAILURE OF MENTAL HEALTH SERVICES

- Universal Lack of Understanding: **100%** of participants disagreed that London's services understand the needs of Black LGBTQ+ people.
- Inaccessible Care: Prohibitively long NHS waiting lists and the high cost of private therapy create insurmountable barriers.
- Erosion of Trust: A lack of staff diversity and cultural competence leads to disengagement: "I've struggled to trust services... there's no point seeking support, as nothing seems to change."

RESILIENCE THROUGH COMMUNITY & SELF-CARE

- Reliance on Informal Networks: **71%** depend on friends and chosen family for vital emotional and practical support, often their primary safety net.
- Personal Coping Strategies: Participants use journaling, fitness, and other methods to manage stress, highlighting resilience in the face of structural neglect.

PARTICIPANT-LED RECOMMENDATIONS

1. Safe, Identity-Affirming Housing: LGBTQ+-specific emergency housing and safer long-term options.
2. Accessible, Culturally Competent Therapy: 82% identified a need for affordable therapy from practitioners who understand their intersectional realities.
3. Investment in Community Spaces: Accessible, community-based hubs for safety, support, and belonging.

Research conducted by Ekhlas Khadi

CONCLUSION

For young Black LGBTQ+ Londoners, secure housing and mental wellbeing are inseparable.

Policy must recognise that "home" is about safety and belonging, not just shelter. Transforming their outcomes requires dismantling systemic barriers in housing and healthcare and investing in the community-led, culturally affirming solutions they have defined for themselves.

IN LIMBO: THE UNSEEN CRISIS OF SUDANESE ARRIVALS IN THE UK

Fidaa Mahmoud

Following the devastating war that began in Sudan in April 2023, many Sudanese and British-Sudanese citizens arrived in the UK after traumatic escapes. Unlike the structured resettlement offered to other groups, they were met with an ad-hoc, inconsistent, and often hostile system.

This research documents their "state of limbo" – caught between the trauma of war and a UK support system that is fragmented, culturally inaccessible, and riddled with inequity, forcing them to rely on their own resilience and community networks for survival.

METHODOLOGY

In-depth qualitative interviews with 15 Sudanese and British-Sudanese arrivals (73% British citizens) and key stakeholders (housing officers, health managers, government officials). Interviews were conducted in Sudanese Arabic across the UK.

KEY FINDINGS

UNIVERSAL MENTAL HEALTH CRISIS COMPOUNDED BY SYSTEMIC NEGLECT

- **100% of participants** reported mental health struggles – PTSD, depression, anxiety – linked to war trauma and the stress of navigating UK systems.

- Inadequate Support: A critical lack of Arabic-speaking, culturally sensitive mental health services meant needs were often unmet or only addressed with medication. "It was so difficult to get counselling in Arabic."

- Compounding Stress: Grief, family separation, and unstable immigration status intensified psychological distress.

HOUSING INSECURITY AS A FORM OF CONTINUED TRAUMA

- **93%** experienced housing insecurity. Placements in temporary accommodation (hotels, B&Bs) were often unsafe, overcrowded, poorly maintained, and isolated from support networks.

- Dangerous Conditions: Participants reported mould, damp, and being housed alongside individuals with severe substance misuse issues, exposing families to violence.

- Administrative Hostility: Chaotic booking systems led to last-minute evictions, and a lack of interpreters made communication impossible. "The system is broken, rotten!"

A HIERARCHY OF CARE: DISCRIMINATION AND UNEQUAL TREATMENT

- Participants faced discrimination based on race, nationality, and language. A stakeholder confirmed: "Sudanese evacuees received nothing close to what Ukrainians received. The system simply wasn't designed with them in mind."

- Citizenship Devalued: Even British citizens were treated as undeserving. "What's the point of being British if we can't have our private life respected?"

- Inconsistent Policy: Despite government guidance exempting them from certain residency tests, **60%** received negative homeless decisions due to inconsistent application by frontline staff.

LANGUAGE BARRIERS AND ADMINISTRATIVE LABYRINTHS

- **60%** cited language barriers as a major obstacle to accessing housing, benefits, and healthcare, often forcing children into the inappropriate role of interpreter.

- Systemic Inefficiency: Endless delays, contradictory information, and a lack of accountability in benefits and housing services caused destitution and extreme stress. "I kept calling... for over 3 months. Each time, I was told that the claim was still being processed."

COMMUNITY RESILIENCE AS THE PRIMARY SAFETY NET

- Informal networks: Sudanese community groups, volunteers, diaspora WhatsApp groups were the most relied-upon source of support for **80%** of the study participants, providing translation, advocacy, and emergency help.

- Institutional Failure: In contrast, official council and NHS support was described as limited, inconsistent, and passive, highlighting a vast gap between policy and practice.

Research conducted by Fidaa Mahmood

CORE RECOMMENDATIONS

1. Establish an Equitable Sudan Resettlement Scheme: Create a dedicated, structured resettlement pathway mirroring those for Ukrainians and Afghans, providing coordinated housing, welfare, legal, and integration support from day one.

2. Mandate Consistent Policy Application & Frontline Training Issue and enforce clear, standardised guidance to all councils and DWP on entitlements for Sudanese arrivals. Mandate trauma-informed, cultural sensitivity, and anti-discrimination training for all frontline staff.

3. Guarantee Safe Housing & Culturally Competent Healthcare: Establish rapid-response housing teams to place arrivals in safe, stable, and appropriate accommodation. Fund and provide Arabic-speaking mental health professionals and culturally sensitive therapy.

4. Invest in Community-Led Solutions: Provide core funding to Sudanese-led community organisations to deliver peer support, advocacy, and navigation services. Support community hubs.

CONCLUSION

The UK's response to Sudanese arrivals has been defined by neglect and inequity, leaving people in a painful limbo.

Their resilience, supported by community, has been their only salvation. There is both a moral imperative and a practical blueprint for change: implement a coherent, compassionate resettlement scheme that learns from past successes and centres the dignity of those it seeks to protect.

“SUDANESE EVACUEES RECEIVED NOTHING CLOSE TO WHAT UKRAINIANS RECEIVED.”

SURVIVING, NOT LIVING – THE SILENT STRUGGLES OF ASYLUM SEEKERS IN 'CONTINGENCY ACCOMMODATION'

Hannah Chaaban

This research amplifies the voices of asylum seekers housed in 'contingency accommodation' (primarily hotels) in the UK, revealing a systemic lack of institutional care and systematic dehumanisation.

The findings expose severe deficiencies in food, building maintenance, and staff treatment, which are inextricably linked to significant declines in both the physical and mental health of residents. Contrary to its name, this accommodation has become a normalised, long-term reality for many.

METHODOLOGY

6 semi-structured interviews with asylum seekers (current/former residents of asylum hotels in the past 3 years, primarily in West London). Participants were all given random pseudonyms for the purpose of this report.

KEY FINDINGS

FOOD & PHYSICAL HEALTH – A SITE OF NEGLECT AND HARM

- Total Dependency: With no kitchen access and an allowance of approx £8/week, residents have **"no choice"** but to eat the provided food.

- Dehumanising Quality: Food is described as **"awful," "smelly,"** and nutritionally poor, often served expired or unrefrigerated. Staff refusal to eat it themselves compounded feelings of worthlessness.

- Serious Health Impacts:
    - Leyla: People **"would often get sick"**
    - Frida developed a stomach ulcer and GERD, requiring costly, strict diets.
    - Adam's son: Developed celiac disease and severe reactions – "He wouldn't eat for days, we would have to force feed him".

  The food regime contributed to a **sense of incarceration**, as described by Omar: "Prison-like conditions".

MENTAL HEALTH – A UNIVERSAL STRUGGLE

Universal Impact: Every participant reported mental health struggles linked to hotel life.
Key issues:

- Isolation and Depression: Sarah felt **"deeply lonely"** Leyla was confined to her small room.

- Trauma and Self-Harm: Frida became **severely depressed**, self-harming and attempting suicide. Adam witnessed suicide attempts in his hotel.

- Instability and Stress: Relocations devastate families. Adam noted that "every time they move you, you have to start all over again", highlighting **his children's trauma**.

- Loss and Grief: Amina discussed the difficulties of being forced to leave home, compounded by issues at the hotel: "Everything I had was gone in a moment. I found myself crying and crying every day."

TREATMENT BY STAFF – INCONSISTENCY, POLICING AND ABUSE OF POWER

- Inconsistent Care: While some staff were helpful, others were hostile, racist, or exercised intrusive control.

- Policing and Dehumanisation: Staff asked invasive questions, entered rooms without permission, and policed residents' activities. Omar was referred to by his room number: "They labelled me with a number."

- Abuse and Impunity: Adam reported a manager accused of entering women's rooms while they showered. Complaints about racist behaviour were dismissed. An internal investigation into his family's treatment found "no wrongdoing," leaving him feeling helpless.

BUILDING MAINTENANCE – GRAVE HEALTH AND SAFETY FAILURES

- Institutional Neglect: Hotels were outdated and in disrepair. Complaints were ignored or met with slow, inadequate responses.

- Documented Hazards: Participants discussed broken heating and unresolved plumbing issues, alongside "really dangerous" conditions including exposed asbestos fibres and electrical wires. Adam highlighted that hotel management "can see [the issues], but don't want to do anything about it."

- Systemic Pattern: This reflects a wider institutional failure, as seen in other Home Office facilities (Legionella on the Bibby Stockholm barge, asbestos at Northeye).

CONCLUSION & ESSENTIAL RECOMMENDATIONS

The research underscores that asylum seekers in contingency accommodation are subjected to conditions that **systematically strip them of dignity, health, and agency**. Despite this, participants showed remarkable resilience, community spirit, and hope for the future.

KEY RECOMMENDATIONS:

- End Hotel Reliance: Phase out the use of contingency accommodation for long-term stays.

- Enforce Safe Standards: Mandate immediate action on health/safety hazards (asbestos, electrical faults) with independent oversight.

- Overhaul Food Provision: Ensure nutritious, culturally appropriate meals that respect dietary needs and allow for self-catering where possible.

- Mandate Comprehensive Staff Training: Training must focus on trauma-informed care, safeguarding, and anti-racism, with robust accountability for abuses.

- Guarantee Access to Resources: Provide consistent, clear information on the asylum process, legal aid, English classes, and local support services within all accommodations.

- Prioritise Mental Health Support: Provide accessible, professional mental health services tailored to the trauma experienced by asylum seekers.

ULTIMATE GOAL: Policy must recentre humanity and care, recognising asylum seekers as people who laugh, cry, hope, dream, and aspire to build better lives.

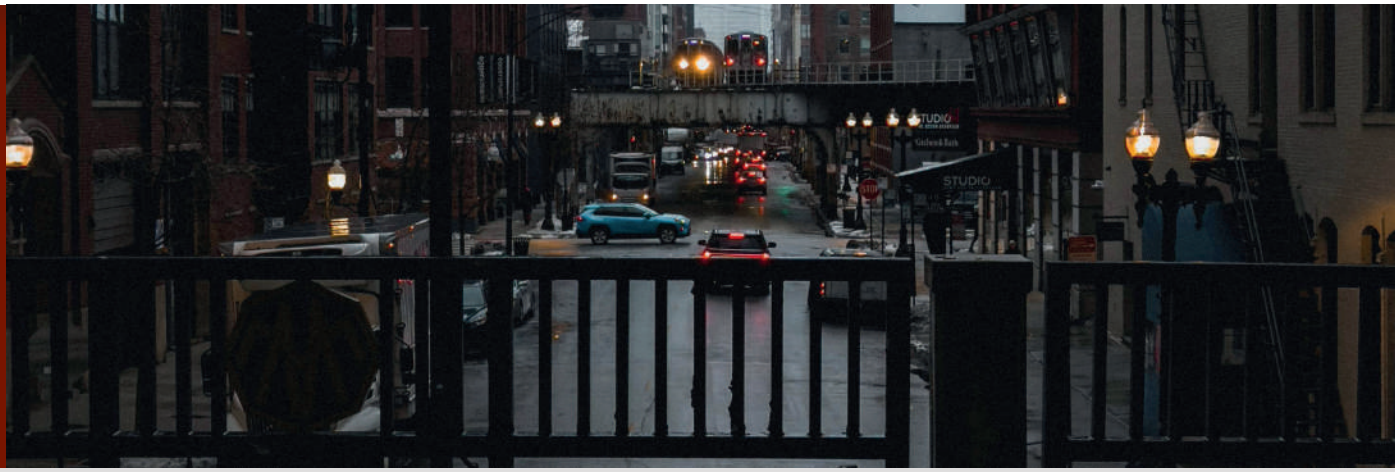
Research conducted by Hannah Chaaban

PATTERNS OF OPPRESSION: HOW NRPF MANUFACTURES HOUSING INSECURITY AND HARMS HEALTH

Yasna S. Khan

The No Recourse to Public Funds (NRPF) policy deliberately excludes migrants from the welfare safety net, forcing families into a state of perpetual crisis.

This research, grounded in the work of the grassroots group Together in Unity, reveals that housing insecurity under NRPF is not an accident but a predictable outcome of the policy's design. It systematically funnels families into overcrowded, unsafe, and unstable living conditions, with devastating consequences for their physical and mental health. For children—many of whom are British citizens—this instability becomes a foundational and harmful part of their childhood.



METHODOLOGY

Qualitative research centred on the lived experiences of families subject to NRPF, conducted in partnership with the community-led initiative Together in Unity.

KEY FINDINGS

HOUSING INSECURITY IS SYSTEMATICALLY PRODUCED

- NRPF acts as an **administrative filter**, intentionally narrowing housing options and funnelling families into temporary, overcrowded, and exploitative living situations never meant for family life.
- Policy as a Weapon: "Even when you have children... you can't have access... your status depends on your immigration." The policy deliberately manufactures precarity, **treating secure housing as a conditional privilege** rather than a right.
- Institutional Neglect: Despite working and paying taxes, families are denied safe homes. "I was working for the NHS during COVID... but **I couldn't even live in a safe house**."

DIRECT AND CUMULATIVE PHYSICAL HEALTH HARMS

- Poor housing conditions (damp, mould, poor sanitation) cause and exacerbate r**espiratory problems, skin conditions, and chronic infections**, especially in children.
- Constant instability **disrupts access to healthcare**, as frequent moves break GP registration and fear of costs delays treatment.
- The unrelenting stress manifests physically, leading to **hypertension, diabetes, and severe sleep disorders**. "The stress, the moving from one place to another, it's made my blood pressure high. I'm on medication now."

PROFOUND MENTAL DISTRESS AND SOCIAL ISOLATION

- **Constant uncertainty** creates a state of hypervigilance, anxiety, and hopelessness. "It really affected my mental condition and I was crying a lot, I felt hopeless for everything."
- Social Withdrawal: Shame, lack of privacy, and fear of eviction force families into isolation, **severing community ties** and support networks.
- **Loss of Control**: The system creates a profound sense of powerlessness. "I'm feeling unheard, and I don't have the power to make changes. I feel very vulnerable."

INTERGENERATIONAL HARM TO CHILDREN

- Instability is a Child's Reality: Inadequate space, frequent moves, and **disrupted routines define childhood.** "I don't have space for my children to play at home. Everything is in one room."
- Psychological Impact: **Children internalise the insecurity**, experiencing fear and anxiety. "After we moved... he became more scared. He didn't feel safe."
- Systemic Failure: Despite legal duties to safeguard children, the NRPF framework prioritises immigration control over child welfare, **causing avoidable harm.**

ADMINISTRATIVE GATEKEEPING INTENSIFIES THE HARM

- Designed to Exclude: Local authority processes are experienced as **deliberate barriers**—characterised by delays, opaque decisions, and impersonal communication—that extend crisis rather than provide relief.
- **Retraumatising System**s: Seeking help often compounds distress. "It's actually a depressing process... it stresses you out more than the DV you've been through."
- Justice is Priced Out: Access to vital support is contingent on expensive legal help, putting it out of reach for most. "You have to get legal backing... if you don't have the funds... probably on the streets."

Research conducted by Yasna S. Khan

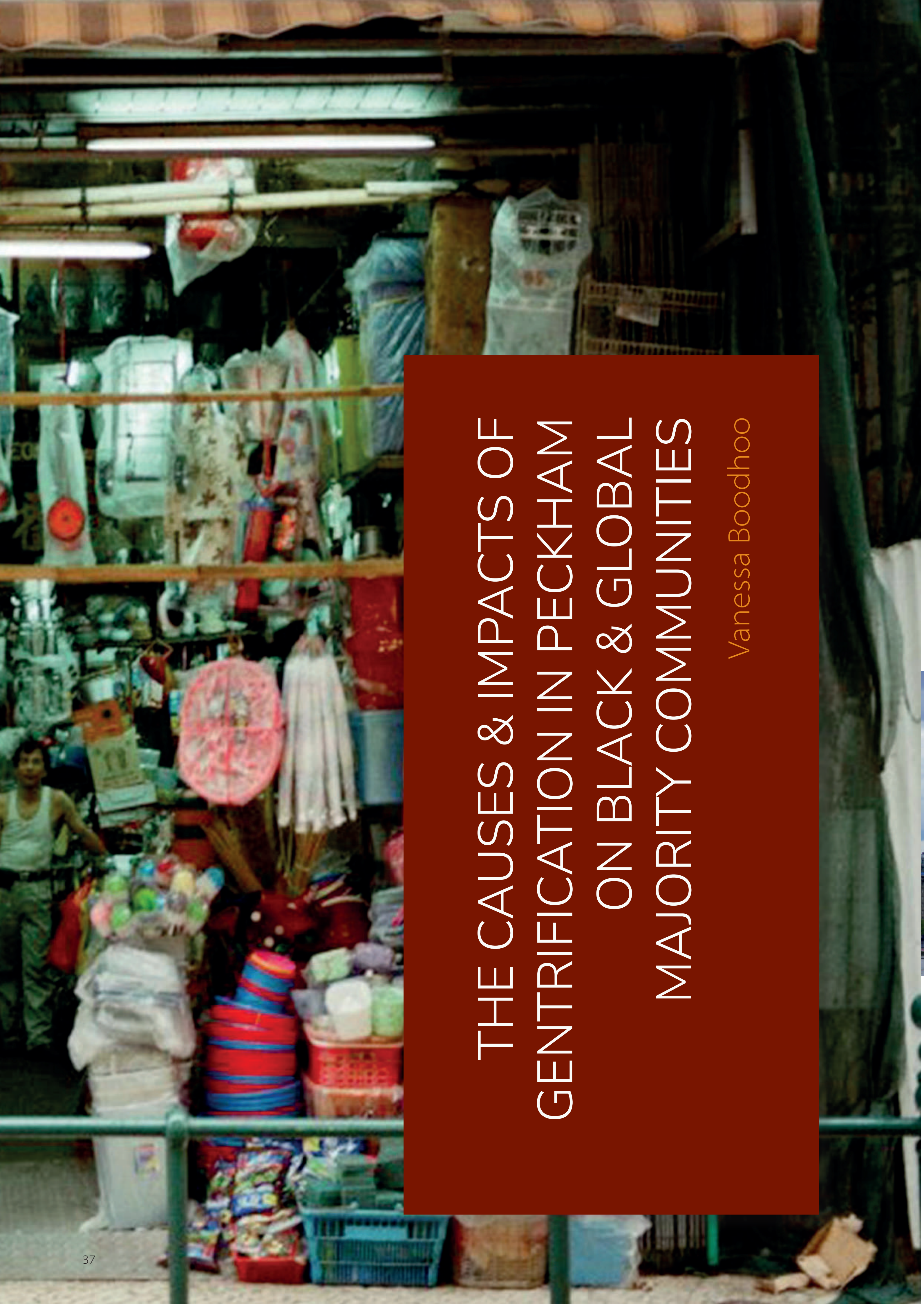
PARTICIPANT-LED RECOMMENDATIONS

Based on the lived experiences of those navigating NRPF, the report demands a fundamental shift from a system of exclusion to one of care and rights.

1. Ensure access to housing is not contingent on benefit eligibility in crisis contexts: Legislate to ensure that eligibility for emergency and safe housing is based on need, not NRPF status, particularly for families with children.
2. Ensure immediate access to safe housing for survivors of domestic abuse with NRPF: Mandate local authorities to provide immediate, stable, and secure accommodation to survivors of domestic abuse, irrespective of their NRPF condition.
3. Prioritise housing that is suitable for family life and physical wellbeing: Set and enforce mandatory standards for temporary accommodation for families, ensuring sufficient space, privacy, and safety to support physical and mental health.
4. Recognise and support the emotional labour of mothers living under NRPF: Fund accessible, peer-led emotional support services and spaces for mothers managing the immense psychological burden of NRPF and housing insecurity.
5. Introduce trauma-aware administrative practice in housing decision-making: Mandate comprehensive training for all frontline housing and social care staff in trauma awareness, cultural competence, and anti-racist practice to dismantle gatekeeping.

NRPF is a policy of engineered suffering. It systematically produces housing insecurity, which in turn generates predictable and severe physical and mental ill-health, scarring families across generations. The recommendations are not merely service adjustments but a call for a radical reorientation: to recognise housing as a cornerstone of health and justice, and to dismantle the administrative machinery that currently weaponises immigration status against wellbeing.

“AFTER WE MOVED… HE BECAME MORE SCARED. HE DIDN’T FEEL SAFE.”



THE CAUSES & IMPACTS OF GENTRIFICATION IN PECKHAM ON BLACK & GLOBAL MAJORITY COMMUNITIES

Vanessa Boodhoo

Gentrification in South London, driven by neoliberal policy and privatisation, acts as a racialised and class-based process.

The increasing loss of land to private developers, and a lack of real affordable housing disproportionately displaces Black and Global Majority (BGM) communities, a dynamic intensified by institutional neglect within social housing. This erodes housing security, belonging, and amplifies socio-economic marginalisation.

METHODOLOGY

18 qualitative interviews with BGM residents (current and former) of Lambeth and Southwark, analysed thematically.

KEY FINDINGS

HOUSING CONDITIONS AND SYSTEMIC NEGLECT

- Social Housing is Decaying: Tenants report widespread damp, mould, leaks, and outdated single-glazed windows. **46%** felt their housing was unsafe.

- Normalised Neglect: Council and Housing Association (HA) responses to repairs are chronically delayed, fostering a resigned acceptance. One HA case involved a **four-year failure to fix flood damage**.

- **Eroded Trust**: This neglect signals to residents that their safety and well-being are not a priority, deepening feelings of marginalisation.

GENTRIFICATION AS A RACIALISED EXPERIENCE

- Residents described an influx of young, White, affluent professionals.

- Black participants framed this as systemic: “they’ve revamped it, moved all the Black people out,” creating a sense of **fear and powerlessness**.

- **Loss of Cultural Space**: Areas valued as culturally familiar and safe are seen as being reshaped for new demographics.

EXCLUSION & DISPLACEMENT

- Economic Exclusion: New businesses (e.g., Gail’s, Whole Foods) and “shiny” housing developments are seen as catering to newcomers, **alienating long-standing residents**.

- **Direct Displacement**: People report being “priced out” to outer London, unable to remain in the communities that they and their communities had built.

- Generational Anxiety: Young adults (under 30) are acutely anxious, f**earing permanent rental insecurity** and an inability to stay locally. Many live with parents due to high costs.

RESILIENCE COUNCIL ROLE: DIVESTMENT & PRIORITISING AFFLUENC

- Participants see a clear pattern: investment flows to redevelopment attracting affluent newcomers, while **existing community needs are defunded.**

- Participants report chronic underfunding in youth services and housing maintenance, whilst funding is seemingly limitless of luxury developments, leading the **BGM community in Peckham to feel undervalued and unsupported.**

Research conducted by Vanessa Boodhoo

CORE RECOMMENDATIONS

1. Prioritise maintenance of existing social housing stock: Allocate budgets to replace single-glazed windows and other critical repairs, ensuring residents live in safe conditions and feel valued.

2. Funding for youth services: Provide monetary support for existing youth clubs and sports facilities to assist underfunded younger generations, and offer residents guidance or free assistance with funding applications.

3. Affordable Rent Schemes: Government schemes should cap rents at 50% of local market rates to ensure housing remains accessible for lower-income households.

4. Set minimum affordable housing quotas on new developments: Require private developers to provide at least 50% affordable housing on developments on private land, and 75% on public land, thus reducing the exclusion and displacement of lower-income households.

5. Improve communication within council housing services: Lambeth and Southwark councils should provide clearer, faster and empathetic communication on maintenance issues, ensuring adherence to Awaab’s Law (2025).

6. Council-funded training for RMOs and TRAs: Offer free training to RMOs and TRAs to support the transfer of management from the council to the residents, and co-create evaluation frameworks with residents.

7. Strengthen community development: Expand programmes that employ, train and involve residents within the council to foster local leadership and reduce alienation.

8. Fund evaluation programmes for council housing services: Allocate resources to evaluate council performance on transparency, accountability and community involvement.

9. Community Engagement and Public Comments: Community engagement throughout the planning process should be binding to a defined extent, requiring to incorporate community input into final decisions. Public comments and objections should also be proactively and extensively advertised to community members, allowing for community response.

CONCLUSION

The UK’s response to Sudanese arrivals has been defined by neglect and inequity, leaving people in a painful limbo.

Their resilience, supported by community, has been their only salvation. There is both a moral imperative and a practical blueprint for change: implement a coherent, compassionate resettlement scheme that learns from past successes and centres the dignity of those it seeks to protect.

SICKLE CELL AND THE PSYCHOLOGICAL TOLL OF MEDICAL NEGLIGENCE & IATROGENIC HARM

Xaira Olaifa-Adebayo

Sickle Cell Disease (SCD) is a serious, lifelong genetic condition primarily affecting people of African and Caribbean heritage. For patients, navigating the NHS is often as painful as the disease itself.

This research exposes how systemic racism, bias, and institutional neglect converge to produce iatrogenic harm—harm caused by medical treatment—inflicting deep and lasting psychological trauma on top of physical suffering. From dismissed pain to traumatic procedures and inaccessible mental health support, the findings reveal a healthcare system that routinely fails, retraumatises, and then abandons those it is meant to care for.

METHODOLOGY

Qualitative study using in-depth, semi-structured interviews with seven individuals (ages 24-53) living with Sickle Cell Disease, recruited via support groups and conferences.

KEY FINDINGS

SYSTEMIC NEGLIGENCE & DISMISSAL AS STANDARD PRACTICE

- **Delays as Default**: Patients face agonising waits in A&E (average 4+ hours) for pain relief, far exceeding the NICE guideline of 30 minutes. This forces many to avoid hospitals until crises are unbearable.

- GP Gatekeeping: **57%** reported negative GP experiences characterised by disbelief, coldness, and refusal to provide basic care, being told to 'go to A&E" instead.

- Failure to Escalate: Concerns about organ damage and chronic pain are routinely dismissed with a "wait and see" approach, leading to preventable, irreversible harm. "I feel like the NHS could have picked that up sooner... **the bone was dying**."

RACIALISED BIAS IN PAIN MANAGEMENT & TREATMENT

- Stereotypes Override Care: **Deep-seated racial biases** label Black patients as "drug-seeking" or exaggerating pain, leading to deliberate under-treatment and excruciating delays in analgesia.

- Scepticism & Suffering: Pain is routinely disbelieved. **One participant was left incapacitated** in a bathroom by a nurse who refused to help, doubting their distress.

- Violation of Autonomy: During traumatic procedures like difficult cannulations, patients' pleas are ignored, leading to re-hospitalisation and profound distress. "**I felt like my voice didn't matter**... It was excruciating."

OMMUNICATION BREAKDOWNS & TRAUMATIC ERRORS

- Fragmented Care: Poor coordination between specialists (e.g., haematologists, surgeons) forces patients to act as their own "middle man," leading to medication delays and **dangerous errors.**
- Dangerous Non-Compliance: Staff frequently ignore Individual Care Plans (ICPs), leading to arguments over basic treatment and **life-threatening mistakes,** such as nearly performing an unnecessary kidney transplant on the wrong patient.

- **Lack of Accountability:** Complaints via PALS are met with generic responses. "I don't have faith in the NHS that they will ever accept accountability... They will always stick together."

SEVERE & UNADDRESSED PSYCHOLOGICAL IMPACTS

- **PTSD and Trauma:** Experiences of negligence—like being forced into procedures or developing sepsis from inadequate care—lead to post-traumatic stress, flashbacks, and depressive episodes.

- Emotional Numbing: **Ongoing trauma causes alexithymia,** a difficulty in identifying or expressing feelings. "I am trying not to gaslight myself, like did this really happen?"

- Healthcare Avoidance: Anticipatory **anxiety and lost trust** cause patients to delay or avoid seeking care, worsening long-term health outcomes.

THE INVISIBLE MENTAL HEALTH CRISIS

- High Prevalence, Zero Priority: While **1 in 3** SCD patients has depression, mental health support is absent from standard care pathways. Psychological needs are only addressed if raised through another department (e.g., after a car accident).

- Gendered Stereotypes Compound Neglect: Black women face the "strong Black woman" stereotype, leading professionals to d**ismiss their mental distress**. "They have said, 'oh, you're fine... you're bubbly.'"

- Structural Barriers: Services have long waiting lists, age restrictions, and are not integrated into SCD care, leaving patients to rely on personal resilience. "**I have to be strong for my own sanity**. I don't have time to break down."

PARTICIPANT-LED RECOMMENDATIONS

1. Integrate Mandatory Mental Health Screening & Support: Implement routine psychological and neurocognitive assessments within comprehensive SCD clinics. Fund and embed culturally competent therapists within haematology teams.

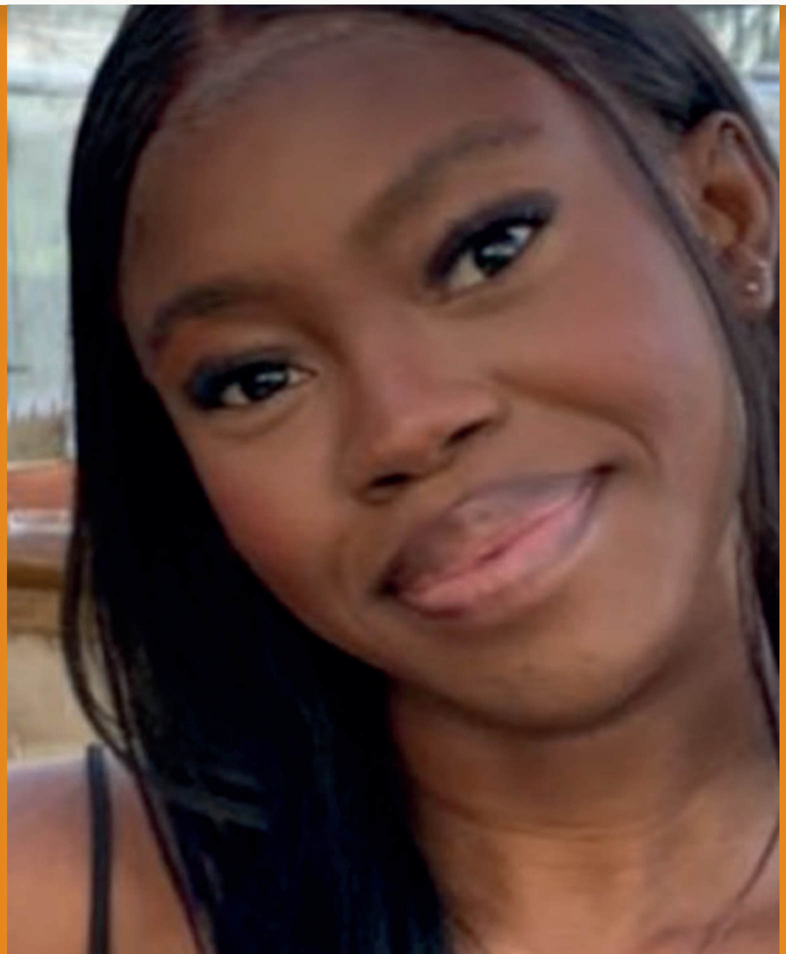
2. Enforce Anti-Racist, Bias-Aware Clinical Training: Mandate ongoing training for all staff on racial bias in pain perception, deconstructing "drug-seeking" stereotypes, and trauma-informed communication. Link training to professional revalidation.

3. Overhaul Accountability & Redress Mechanisms: Create an accessible, independent reporting and investigation system for SCD patients experiencing negligence. Ensure complaints lead to transparent, meaningful change, not generic letters.

4. Fund & Legitimise Peer-Led Community Support: Allocate NHS funding to SCD community support groups, recognising them as essential, evidence-based components of care that provide validation and belonging absent from clinical settings.

5. Mandate Proactive, Coordinated Care Pathways: Legally enforce the use of Individual Care Plans (ICPs). Establish formal, accountable multi-disciplinary teams (MDTs) that include mental health professionals. Implement strict escalation protocols for patient concerns.

Research conducted by Xaira Olaifa-Adebayo



“I FELT LIKE MY VOICE DIDN’T MATTER… IT WAS EXCRUCIATING.”

SILENCED BY STIGMA: THE MENTAL HEALTH CRISIS AMONG UNIVERSITY-AGED SOUTH ASIAN WOMEN

Aliza Mathew

University should be a time of growth, but for many South Asian women in London, it is also a period of intense, silent struggle with mental health. Shaped by cultural stigma, familial expectations, and a healthcare system that often fails to understand them, these young women are caught between internal distress and external barriers.

This research reveals that over half are unlikely to seek formal help, turning instead to friends or private coping. A critical finding is that their family's attitude towards mental health directly shapes their trust in services. To be effective, support must be culturally intelligent, ensure anonymity, and compete with the trusted informal networks they already rely on.

METHODOLOGY

Mixed-methods study with 40 South Asian women (18-24) at London universities, using a survey and in-depth interviews, including an anonymous text-based chat option to encourage open disclosure.

KEY FINDINGS

A SYSTEM OF DISMISSAL AND INACCESSIBLE CARE

- Low Confidence in Services: Participants rated available mental health services (MHS) an average of **2.88 out of 5** for meeting their needs.

- Gatekeeping & Minimisation: **35.9%** reported experiencing dismissal or minimisation in care settings. Many faced bureaucratic barriers, like receptionists refusing to book appointments unless they disclosed intimate details upfront. "How am I meant to talk to the GP if they're not letting me talk to the GP?"

- Long Waits & Low Uptake: Overwhelming NHS backlogs deter help-seeking. Consequently, **56.4%** are unlikely to seek formal support when struggling, preferring private outlets like journaling or confiding in friends (47.2%).

THE PARALYSING POWER OF CULTURAL & FAMILIAL STIGMA

- Pervasive Stigma: **87.5%** acknowledged stigma around mental health in their cultural contexts. 62.5% said their culture negatively influenced their attitude toward seeking help, and 55% felt ashamed or uncomfortable doing so.

- Internalised Invalidation: Women described feeling their problems were "**not serious enough**," a "burden," or a "waste of resources." The pressure to appear high-functioning, especially as an eldest daughter, silenced their needs. "The eldest daughter... has all those pressures... it's like tenfold."

- Family as the Key Influence: A **statistically significant correlation** was found: women from families with less supportive attitudes toward mental health also perceived services as lower quality. Family environment sets the template for trust in external help.

BUILDING TRUST: GENDER, CULTURAL COMPETENCE & ANONYMITY

- Gender Congruence Matters: **81.1%** said it was important their counsellor shared their gender, citing greater comfort in discussing gendered pressures.

- Competence Over Ethnicity: While cultural understanding was crucial (91.9% valued a counsellor experienced with their background), shared ethnicity alone did not guarantee trust. The key was a professional's ability to **understand their specific cultural and familial context**.

- **The Vital Need for Anonymity**: Fear of exposure within families and communities is a major barrier. Services that ensure confidentiality and allow discreet, anonymous access (e.g., text-based options) are essential. "Not being able to speak freely on the phone... as everyone in the house would question."

Research conducted by Aliza Mathew

POLICY & PRACTICE RECOMMENDATIONS

1. Mandate Co-Produced Cultural Competency Training: Integrated Care Boards (ICBs) must commission and mandate advanced cultural competency training for all primary care and talking therapy staff. Training must be co-designed with South Asian community organisations and include modules on familial dynamics, stigma, and intergenerational pressures.

2. Launch Community-Based Anti-Stigma Campaigns: Local authorities and employers should fund and roll out anti-stigma campaigns in South Asian-dense areas and workplaces. Use multi-language materials, social media, and community workshops to normalise help-seeking and signpost to verified resources.

3. University Proactive Outreach & Promotion: Universities must implement a formal, termly communications plan to promote mental health resources. This includes dedicated emails at key stress points, visible posters in common areas, and stalls at Freshers' Fairs and induction events.

4. Expand Anonymous & Alternative Therapy Pathways: NHS Talking Therapies should expand text-based and online chat therapy options. Government and local authorities should fund alternative, culturally-attuned therapies (e.g., art therapy) within a 5-year framework for integration into university and workplace wellbeing programs.

5. Strengthen Early Intervention via Education Staff: The Department for Education should extend mandatory mental health first-aid training to include compulsory modules on cultural sensitivity for all university lecturers, tutors, and pastoral staff.

CONCLUSION

For university-aged South Asian women, the path to mental health support is **blocked by a triad of barriers**: a dismissive system, powerful cultural stigma, and a fear of exposure.

Success requires services to be not just available, but intelligently designed – culturally competent, gender-sensitive, and discreet. By understanding that the family is the first lens through which professional help is viewed, policymakers can craft interventions that build genuine trust and **offer a lifeline to those currently suffering in silence**.

UNHEARD & UNSEEN: SYSTEMIC FAILURES IN PERINATAL MENTAL HEALTH FOR SOUTH ASIAN MOTHERS

Anita Kambo

Perinatal mental illness (PMI) is the leading cause of maternal death, and South Asian mothers face disproportionately higher risks and worse outcomes.

This research, conducted with deep cultural sensitivity and creative methods, exposes how systemic racism, cultural incompetence, and fragmented care within the NHS create a perfect storm of neglect. Mothers describe being dismissed, invisible, and isolated, with their pain invalidated and their mental health needs ignored. The findings reveal that PMI is not just a clinical issue but a profound crisis of trust and equity, where institutional harm intersects with cultural stigma to silence and endanger mothers.

METHODOLOGY

A trauma-informed, creative qualitative study with 14 South Asian mothers with lived experience of PMI. Methods included a creative focus group and in-depth interviews, using Photovoice, I-poetry, and eco-mapping to facilitate safe, open dialogue.

KEY FINDINGS

SYSTEMIC RACISM & CLINICAL DISMISSAL

- **'Mrs Begum Syndrome'**: Mothers identified a pervasive pattern of having concerns dismissed due to race. "It's institutional racism – when people look at you, we're fobbed off as whining women."

- Pain Invalidation: Agonising pain was routinely minimised, attributed to **stereotypes of Brown women's resilience**. This led to delayed interventions, severe complications, and trauma. "The trauma of being dismissed, that your pain is invalidated because you are Brown."

- Loss of Autonomy & Trust: **Fear of racist outcomes** led to defensive choices (e.g., requesting caesareans out of fear). Distrust was so acute that mothers avoided disclosing mental health struggles for fear of child removal.

CULTURAL INCOMPETENCE & THE BURDEN OF EXPLANATION

- Exhausting Emotional Labour: Constantly explaining cultural context to uninformed clinicians left **mothers feeling judged** and withdrawing from services.

- **Culturally Illiterate Support**: Guidance on infant feeding and weaning ignored South Asian practices, inducing guilt, anxiety, and isolation. "There's no guidance for weaning on a South Asian diet... how do we make daal for a six-month-old?"

- Fragmented, Impersonal Care: **Lack of continuity** (seeing a different midwife each time) and siloed services meant PMI symptoms were routinely missed, even for mothers with pre-existing mental health diagnoses.

CULTURAL STIGMA, SILENCE, & GENDERED PRESSURE

- "Get On With It" Mentality: Deep-rooted norms of stoicism, inherited from previous generations, led mothers to **internalise suffering**, seeing PMI as a personal failure or indulgence.

- The "Good Mother" Mask: Pressure to maintain appearances created isolation and self-criticism. **"You put on that face that you're this superwoman, you've got it all together.**"

- **In-Law Pressures & Martyrdom**: Expectations to prioritise extended family needs over self-care created immense strain, with mothers feeling watched and unable to set boundaries.

PROFOUND IDENTITY LOSS & ISOLATION

- "**Frozen Dreams**": Motherhood brought a painful erosion of pre-birth identity, ambition, and financial independence. "I completely lost my sense of identity becoming a mum."

- Emotional & Practical Isolation: Despite being surrounded by people, **mothers felt profoundly alone**, cut off by stigma, lack of a supportive "village," and structural barriers like unsuitable housing and broken infrastructure.

- Shrinking Worlds: **Inaccessible transport and unsafe housing** confined mothers, drastically limiting their mobility and access to support.

RESILIENCE THROUGH INFORMAL NETWORKS

- **Family as Lifeline**: Parental and sibling support was described as "lifesaving," providing practical help and the intangible feeling of being "held."

- Unexpected Solidarity: Small acts of kindness from strangers or community spaces where they were unknown provided **rare moments of safety and validation**.

- Peer Support as the Unmet Need: A unanimous desire emerged for community-based, culturally-understood peer networks that could offer **holistic support**.

Research conducted by Anita Kambo

CONCLUSION & POLICY & PRACTICE RECOMMENDATIONS

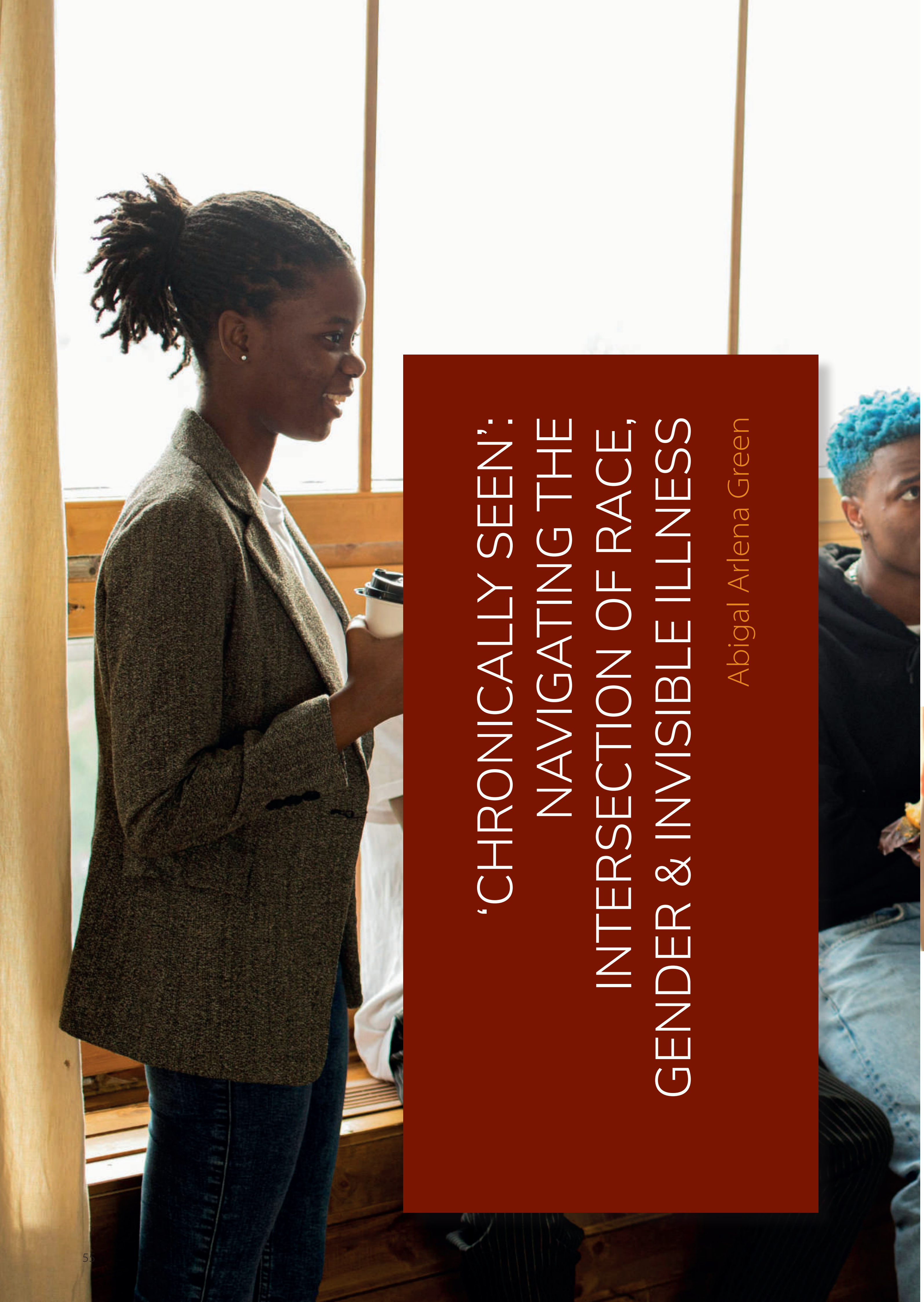
1. Mandate Anti-Racist, Co-Produced Clinical Training: NHS England, ICBs, and professional bodies must introduce mandatory annual anti-racism and cultural safety training for all maternity and PMH staff, co-designed with South Asian experts-by-experience.

2. Guarantee Continuity of Carer & Proactive PMI Screening: Prioritise South Asian mothers for continuity of carer models. Embed proactive, culturally literate PMI screening at every perinatal touchpoint using narrative-based tools co-designed with the community.

3. Invest in Culturally-Grounded Community Support Hubs: ICBs and Local Authorities must fund peer-designed and peer-led support networks in trusted community hubs. These should offer holistic support in culturally safe spaces.

4. Launch Faith-Based Anti-Stigma & Public Education Campaigns: Public Health teams must partner with faith organisations and South Asian public figures to run education campaigns normalising female health and PMI across the lifespan, targeting all genders and generations.

5. Address Structural Barriers to Access & Support: The Home Office must fast-track visas for family providing postnatal support. Local Authorities and transport operators must urgently improve housing accessibility and repair infrastructure like lifts and step-free access.



‘CHRONICALLY SEEN’: NAVIGATING THE INTERSECTION OF RACE, GENDER & INVISIBLE ILLNESS

Abigal Arlena Green

Black women living with chronic, hidden disabilities navigate a unique form of marginalisation. Their conditions are often invisible, but the racism, sexism, and ableism they face are not.

This research, led by a Peer Researcher with lived experience, exposes the intersectional invisibility Black women endure in healthcare and the workplace—simultaneously hypervisible as stereotypes (‘strong Black woman’) yet invisible in their pain and need for support. From systemic dismissal by doctors to workplace stigma, the findings chart a path of compounded barriers, profound resilience, and the urgent need for systems that finally see, believe, and support them.

METHODOLOGY

In-depth, semi-structured qualitative interviews with Black women living with chronic, hidden disabilities, conducted by a researcher with lived experience (insider positionality). Recruitment was via community networks.

KEY FINDINGS

SYSTEMIC DISMISSAL & THE CRISIS OF DISBELIEF

- Delayed & Misdiagnosis: Women reported waiting years for accurate diagnoses, with symptoms minimised or wrongly attributed to stress or anxiety, reflecting a **systemic failure** to listen and believe.

- The Burden of Proof: They are forced to become full-time self-advocates, over-explaining symptoms and 'proving' their disability to **sceptical clinicians**. "I often face challenges related to my race before my disability."

- **Hypervisibility/Invisibility Paradox**: Their identity makes them a target for stereotypes (e.g., high pain tolerance), yet their specific suffering is rendered invisible. "In medical spaces, I feel both seen and unseen at once."

THE COMPOUNDING AXES OF RACISM, SEXISM & AGEISM

- Intersectional Discrimination: Experiences are inseparable from **overlapping biases**. Racist pain stereotypes and gendered expectations of resilience lead to under-treatment and dismissal.

- **Age-Related Invalidation**: Younger Black women are told they are "too young" to be seriously ill. Older Black women face ageist assumptions that illness is inevitable, not urgent.

- The 'Strong Black Woman' Stereotype: This harmful trope is weaponised in clinical and workplace settings to deny support and **invalidate vulnerability**. "Society has branded us as strong, as resilient, as immune to struggles... I'm not surprised workplaces can't support us."

WORKPLACE AS A SITE OF HARM OR INCLUSION

- **Scrutiny & Stigma**: Disclosure carries high risk. Black women report being under a "microscope," with health needs viewed as personal failings or threats to reliability.

- Lack of Accommodation: Despite equal or greater need, they are **less likely to receive workplace adjustments** due to racialised perceptions and rigid policies.

- Potential for Transformation: Conversely, workplaces with culturally aware, flexible leadership become vital spaces of belonging and productivity, proving **inclusive practice is possible**.

AFFIRMING SPACES AS ESSENTIAL SURVIVAL TOOLS

- Community as Counter-Narrative: Online forums and peer networks created **by and for Black women** are lifelines. They provide validation, practical advice, and the profound relief of being "finally believed."

- Institutional Exclusion: In contrast, healthcare settings and often family environments are experienced as exclusionary, marked by **misunderstanding and microaggressions**.

- **Agency Through Advocacy**: Many participants channel their frustration into advocacy, using social media and community organising to create the visibility and support systems institutions deny them.

POLICY & PRACTICE RECOMMENDATIONS

1. Mandate Intersectional, Anti-Racist Clinical Training: Implement mandatory, ongoing CPD training for all healthcare staff on implicit bias, cultural competency, and the specific intersectional realities of Black women with chronic illness. Co-produce training with experts-by-experience.

2. Establish Dedicated Intersectional Patient Advocate Roles: Fund and embed dedicated patient advocate roles within NHS trusts, specifically for marginalised groups. Advocates should have cultural competency training and/or lived experience to support Black women in navigating consultations and ensuring their voices are heard.

3. Reform Workplace Policies with an Intersectional Lens: Develop and enforce inclusive workplace policies that explicitly address the intersectional needs of Black women with hidden disabilities. Mandate flexible working as a standard option, provide manager training, and conduct regular equity audits.

4. Redefine Disability Frameworks to Centre Hidden Conditions: Update the Social Model of Disability and related legislation/policies to explicitly recognise and validate hidden disabilities. Promote intersectional health assessments that consider race, gender, and social context alongside medical history.
5. 5. Fund & Legitimise Peer-Led Online Community Spaces: Provide funding and institutional partnerships to support and amplify existing online peer communities created by Black women with chronic illness. Recognise these as vital components of health and wellbeing.

Research conducted by Abigail Arlena Green

CREATE IN MIND: THE TRANSFORMATIVE POWER OF MINDFUL ART & SISTERHOOD FOR BLACK WOMEN

Birungi Kawooya

In a world that demands constant resilience from Black women, the *Create in Mind* programme offered something radical: spaciousness, creativity, and cultural belonging.

This research documents an eight-week journey of mindful art and liberation work, exploring how creative practice serves as a vital tool for healing from the compounded trauma of racism, sexism, and ableism. Despite structural flaws, the programme revealed a profound truth: when Black women are given a safe, culturally-grounded space to create, they experience deep emotional healing, reclaim their identities, and build the sisterhood necessary for collective liberation.

METHODOLOGY

Participatory action research and peer observation with 8 Black women (ages 46-66) participating in the Create in Mind programme. The researcher served as both a participant-facilitator and observer, using surveys, interviews, and reflection.

KEY FINDINGS - A JOURNEY OF TRANSFORMATION

PROFOUND EMOTIONAL HEALING & GROUNDING

- Women arrived carrying anxiety, shame, and hypervigilance. Through creative practice, they found **calm, rest,** and **emotional release.**

- One participant with ADHD shared: “**I healed more in these sessions than in talking therapy... I feel much more peace.**”

- The programme became **a counter-practice to survival mode**, reducing stress and restoring a sense of inner spaciousness and hope.

RECLAIMING EMBODIMENT & CREATIVE IDENTITY

- Many participants had disconnected from their bodies due to trauma. Sensory art and floristry helped them **re-inhabit their senses** and reconnect with ancestral ways of knowing.

- Creative identity was unlocked: from “I'm not good at art” to “**I am an artist**.” This reclamation was framed as an act of **justice**—reclaiming imagination and authorship over one's life.

SURGING CONFIDENCE & BOUNDARY-SETTING

- The experience **fostered tangible confidence**: “I'm choosing myself more,” “I speak up now,” “I know what I deserve.”

- Participants learned to recognise harm and **prioritise self-preservation**, a radical shift from being raised to endure attack. One woman declared she would now protect her weekly wellbeing day from work demands.

THE VITAL, UNMATCHED POWER OF SISTERHOOD

- The deepest outcome was the **cultivation of sisterhood**—a space of deep trust, shared humour, and cultural understanding without explanation.

- Women created their own “**Black women's space**,” offering mutual kindness and solidarity in a hostile world. This kinship proved to be a healing force in itself.

A REFUGE FOR NEURODIVERGENT BLACK WOMEN

- For a participant with ADHD, the culturally safe, non-pathologising space was transformative where mainstream therapy had failed, highlighting the urgent need for **culturally competent wellbeing approaches.**

CRITICAL STRUCTURAL BARRIERS IDENTIFIED

The research also honestly documented failures that hindered the programme's potential:

1. Broken Promise on Safe Space: The programme was not held as Black-women-only as advertised, causing feelings of betrayal, reduced safety, and reinforcing the message that Black women's boundaries are not prioritised.

2. Exclusionary Timing: Tuesday mornings structurally excluded working Black women, privileging those who could attend daytime sessions.

3. Harmful Facilitation: One facilitator's unprepared, culturally misaligned approach caused distress, underscoring the non-negotiable need for trauma-informed, culturally competent leadership.

RECOMMENDATIONS FOR LIBERATION-FOCUSED WELLBEING

1. Honour Black-Women-Only Spaces with Integrity: Funders and organisers must uphold advertised boundaries without exception. Safe, exclusive space is not exclusionary but essential for the deep healing of a systematically targeted group.

2. Invest in Black Women's Leadership & Design: Provide long-term, stable funding for programmes conceived, designed, and led by Black women artists, therapists, healers, and facilitators.

3. Prioritise Accessible, Community-Centred Scheduling: Schedule sessions during evenings and weekends to include working Black women and those with caring responsibilities.

4. Mandate Trauma-Informed, Culturally Aligned Facilitation: All facilitators must undergo rigorous training in trauma-informed practice and deep cultural competency specific to Black women's lives, including spiritual and political contexts.

5. Centre Sensory, Creative & Embodied Practice: Recognise and fund sensory, creative art, and embodied work as core, evidence-based wellbeing modalities, not peripheral activities.

Research conducted by Birungi Kawooya

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Race on the Agenda

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