A novel UK, peer-led, non-clinical, community-based intervention for racialised communities affected by racism and racial trauma.

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Abstract

Purpose

This paper details the conceptualisation of the HeaRRT approach and subsequent development, delivery and learning from the piloting of a novel 12-week, semi structured, community-based, peer-led HeaRRT group. The group is non-clinical in nature and adheres to the principles of strengths-based and trauma-informed practice and was developed by a third sector organisation to address the harms of racism and racial trauma for racialised communities.

Design/methodology/approach

This paper describes the HeaRRT approach and the development and delivery of a 12 week semi structured HeaRRT group, from conception to the end of the first pilot group cohort, including outcome data.

Findings

Outcome data and feedback from the first group cohort shows positive change in addressing racial trauma across two externally validated outcome measures.

Limitations/Implications

Given the small sample size, we are unable to generalise the findings to the wider population, therefore testing the effectiveness and acceptability of the HeaRRT group with a larger sample is necessary.

Practical Implications

HeaRRT represents a unique approach to addressing the impact of racism and racial trauma, by offering a peer-led, non-clinical solution to bridge the current gap that exists in service provision; typically comprising clinical, cognitive-behavioural therapy-focused approaches.

Social Implications

HeaRRT has the potential to encourage shared learning, promote strength and empowerment in individuals affected by racism and racial trauma by providing a safe, supportive space.

Originality

Relevant interventions developed to date have been clinical and US-focused. The HeaRRT approach and group represents, to our knowledge, the first UK-based, non-clinical, peer-led initiative of this type.

Introduction

There has been an undeniable rise in societal awareness and recognition of racism and inequality post pandemic, particularly following the murder of George Floyd in 2020, the growth of the Black Lives Matter movement internationally and the online awareness raising that followed (Warmington, 2024). However, the past five years has also seen the rise of mainstream right-wing politics in Europe and the UK, alongside a rise in race, sexuality and gender related hate crime, anti-immigration fuelled rioting and online abuse (Galpin & Vernon, 2024; Mondon, 2025; Newey, 2024). Prior to, and in response to, these events, many health and social care organisations embarked on journeys towards becoming antiracist; achieving good progress in areas of staff training, however there is recognition that more needs to be done, especially at a time when potential exposure to retraumatising events is almost an everyday occurrence (Cane & Tedam, 2023; Griffin, Clayton & Adamson, 2025).

The term *'racial trauma' can be* defined as the emotional and psychological impact of stress related to racism, racial discrimination, and race-related stressors, though definitional clarity remains inconsistent (Mudzongo, Robinson & Alhassan, 2025). Racial trauma can refer to a specific incident of racial discrimination or the ongoing, harmful emotional impact of racial discrimination that builds up over time. This can be experienced directly or from seeing others mistreated because of their race (National Centre for PTSD, 2025). In terms of its links to PTSD, current routine diagnostic criteria used in the identification of PTSD, such as the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 2013) fails to adequately consider racially traumatic experiences, overt or otherwise, and recommendations have been made for this to be addressed (Holmes, Facemire & DaFonseca, 2016). That said, it is important not to conflate racial trauma with PTSD. Most notably, the aspect of 'post' outlined in PTSD cannot be applied to racial trauma because racialised communities continue to experience societal oppression. Racial trauma therefore should be seen as a distinct category of traumatic experience as it is something that is ongoing and prolonged (Cénat, 2023). In line with this, measures have been developed to

‘diagnose’ racial trauma as a distinct presentation, for example, the Racial Trauma Scale (Williams et al., 2022)

In terms of its relationship to complex trauma, racial trauma itself should be considered a type of complex trauma given its widespread impact on all aspects of those from racialised communities, including physical, psychological, and social (Bird et al., 2024; Macintyre, Zare & Williams, 2023).

Racial trauma is also intergenerational and collective, perpetuated through structural violence and institutional racism (Kirkinis et al., 2021; Lee et al., 2023). Studies have shown that racial trauma is linked to higher rates of Post Traumatic Stress Disorder (PTSD) and other disorders such as major depressive disorder, social anxiety disorder, substance use disorders, and psychosis (Holmes et al., 2024; Williams et al., 2021). Further, racial trauma is posited as having similar debilitating outcomes to those documented in individuals that have experienced assaultive violence (Pascoe & Smart Richman, 2009).

The targeted identification and assessment of racial trauma in services is an area that has historically received little attention, however, there have been positive developments to accommodate for this in clinical settings in recent years. For example, the UConn Racial/Ethnic Stress & Trauma Survey (UnRESTS) – a tool that assists clinicians with detecting racial trauma, developing a culturally informed case conceptualisation, and including racial trauma experiences in the diagnosis of PTSD, when justified (Williams et al., 2018). This is just one example taken from a fast-developing field; however, this area of work is very much US-centred, and to our knowledge, no significant non-clinical racial trauma approach has been developed in the UK, particularly from the ‘ground up’ – that is peer-led.

In the UK, discussion and focus have been centred on considering racial trauma within mainstream clinical services, as opposed to the development of specific, targeted, stand-alone interventions (Majors, 2020; Prajapati & Liebling, 2021; Samuel & Simonds, 2025). While this is important and acknowledged, non-clinical services such as the approach and group intervention that is the subject of this study, are required because they provide choice and control to those that experience racism and racial trauma; the importance of which is being increasingly appreciated in both clinical

and non-clinical care (Sundet, 2021). Research over the last decade has shown that choice and flexibility is particularly important in the context of treating trauma, in line with a move to patient-centred care and strengths-based approaches, stepping away from the 'one size fits all' western medical model and the potentially retraumatising power dynamics that this brings (Cloitre, 2015; Isobel et al., 2021; Sweeney et al., 2018).

The need for alternative, non-clinical support in this area is further heightened by the fact that, in direct service provision, racial trauma and conversations about race are often avoided by clinicians, and when these issues are raised by those accessing services, they are typically misunderstood or invalidated, often causing re-traumatisation and adding to racialised communities mistrust in clinical services (Hassan et al, 2026; King, 2021; Samuel & Simonds, 2025). This is at least in part due to the dominance of Western, Cognitive-Behavioural Therapy (CBT) based approaches which stem from a Eurocentric, clinical approach of individualistic healing which lacks cultural transferability (Benjamin et al, 2025; Lawton et al, 2021). Research shows that the effectiveness of the main interventions used in clinical approaches in the UK, including trauma-informed CBT as well as prolonged exposure therapy, eye movement desensitisation and reprocessing therapy (EMDR), and narrative exposure therapy cannot be generalised to racialised communities due to low uptake of these demographics participating in clinical trials and research (Benjamin et al, 2025).

This starkly highlights the need for alternative, collectivist approaches which recognise the cultural, historical and structural conditions that play a role in racial trauma, moving towards communal healing and in keeping with the principles of liberation psychology (Bryant, 2024 Grzeda, 2025; Hassan et al., 2026). Studies have shown that alternatives such as community groups, cultural practices, faith networks and grassroots organisations that exist across the UK bring a level of cultural understanding that statutory services often lack, evidencing that the current one-size-fits-all approach is not working, and more needs to be done to develop a more appropriate range of approaches in treating racial trauma (Hassan et al., 2026). Furthermore, peer support interventions (PSIs) are scarce in this field. A systematic review and meta-analysis focused on the effectiveness of such interventions for individuals with mental illness concluded that there is potential efficacy for PSI across a wide range of mental disorders and intervention types (Smit et al., 2023).

Taken together, there is clearly a need for peer-led approaches and interventions that offer a safe, non-clinical space where people from afflicted communities can come together and discuss their experiences of racism and racial trauma.

This paper describes a feasibility study for the formation of a non-clinical, peer-led, community-based approach and intervention – the HeaRRT approach – and the ensuing initial 12-week semi structured group, along with outcome data for the first HeaRRT group cohort.

Methods

Organisational Values

The organisation concerned delivers a diverse range of services. Each is unique, but all are connected by an approach to delivery that ensures all services offer first-class, whole person support. Underpinning this are four intersecting approaches, detailed below:

1. Operating in a trauma-informed manner, meaning services are designed and delivered to recognise how past and ongoing trauma can shape a person's behaviour and emotions. People are responded to with compassion, safety, and support rather than judgment.
2. Striving towards being an anti-oppression organisation, meaning the impact of oppression on the organisation is recognised in all its forms including in its systems and people, with a commitment to purposefully identifying, discussing and challenging oppression.
3. Adopting the principles of the Power Threat Meaning Framework (PTMF) (Johnstone & Boyle, 2018), where the organisation goes beyond the exclusive use of traditional, medically based diagnoses to understand mental distress and difficult emotions, offering a compassionate, non-pathologising alternative. This shifts the focus away from blaming individuals, towards exploring social, relational, and cultural contexts.
4. Being research-informed, meaning that all services are informed by research and evaluation, with the impact of the organisation’s work measured, with a focus on continual improvement and testing new services such as HeaRRT.

Developing the HeaRRT approach

As part of the organisation's programme of antiracist activities, the HeaRRT approach was conceptualised and led by its Transformation Manager to support individuals in the community affected by racism and racial trauma, based on the approach's foundational principles which are depicted below in Figure 1 and detailed in Table I.

Figure I: Foundational principles of the HeaRRT approach (Source: Author's own work)

Table I: Foundational Principles of the HeaRRT approach in detail

Safety	Power lies in spaces; safety is the overarching factor for this group. The safety is not only physical but psychological and emotional. This is how we enter as well as maintain the space.
Non-clinical and community-based	This is a non-clinical approach; the facilitator does not necessarily have to have a clinical background. The decision to be non-clinical was made to support the existence of services that already exist; by offering an additional, community-based and intentionally race-focused approach that is often missing when supporting people with racial trauma.
Collective healing	The principle of collective healing refers to a shared process, through which a community or group addresses trauma, grief, injustice, or harm together. Collective healing validates the experiences of individuals by recognising that trauma and harm is not just personal but often communal. It reinforces the idea that suffering isn't isolated, and others have felt it too, creating space for empathy, understanding, and solidarity but equally recognising the importance of collectively healing, learning, growing and effecting change for all.
Lived experience	The lived experience, peer-led element of the approach is critical as it provides firsthand insight into how individuals have been affected. Unlike theoretical knowledge, it reflects the reality of people's day-to-day lives, making it essential for authenticity. It offers solutions rooted in real needs, empowering these voices and offering autonomy and agency over lives and experiences. It also builds empathy and connection by bringing depth, relevance, and humanity to discussions that might otherwise remain disconnected or unheard.
Trauma-informed	Taking a trauma-informed approach shifts the question from "What's wrong with you?" to "What happened to you?", encouraging healing, restoring dignity, and offering relevant support. This is very much in line with the central tenant of the PTMF.

Strengths Based	Being strength-based recognises and focuses on helping people see themselves as capable agents of their own growth and success, because it focuses on individuals' and communities' capabilities, talents and resources, rather than their problems or deficits. This provides individuals with agency over their own healing and emphasises that's it's not just about the individual but that there is power in collective activism.

Following conceptualisation of the HeaRRT approach, a small project steering group was formed, comprising key external stakeholders from research and public health, who provided strategic direction on the development and deployment of the HeaRRT approach. Input was also commissioned from an external NHS Trust with expertise in trauma management, who trained HeaRRT group facilitators in generic trauma self-management approaches which were then adapted to make culturally appropriate.

The HeaRRT 12-week, semi-structured, closed group was then designed by the organisation's Transformation Manager, to provide a psychologically safe, supportive, validating and non-judgemental space for individuals affected by racism and racial trauma to share experiences, embrace healing, reclaim strength and develop coping strategies to navigate the ongoing impact of racism.

The group's objectives are:

- To build resilience among group participants to navigate racial trauma
- To build individual (racial) self-esteem amongst group participants
- To build collective racial identity, racial self-worth and cultural pride
- To equip group participants with self-management strategies to better cope with racial trauma
- To reduce isolation in group participants by fostering collective self-esteem.

The initial HeaRRT group was designed for people who self-defined as being from Black African or Caribbean descent, with lived experienced of racism or racial trauma, seeking support and an

opportunity to develop and learn self-help and self-management strategies to cope with racial trauma.

Recruitment

Participants were recruited via a poster distributed in the local community and among relevant networks including community groups and centres, youth services, barber shops and African Caribbean services in the community. Interested participants were invited to attend a telephone appointment during which their suitability for the HeaRRT group was collaboratively assessed. Inclusion criteria included: participants must be aged 18 and over, of black African or Caribbean descent, with lived experienced of racism or racial trauma and in a place of psychological readiness to enable commitment to attending a group of this nature. Exclusion criteria included: individuals who, following the telephone appointment, collaboratively determined that existing comorbidities or issues may prevent them from attending the full course of the group. This criterion was continuously monitored throughout the group by facilitators and participants.

Delivery

The semi-structured group was delivered in a community venue over 12 weeks in person. Each session was two hours long , facilitated by two individuals of black African or Caribbean heritage with experience of running group interventions and having lived experience of racism and racial trauma.

All participants completed and signed a participant consent form which served to obtain their permission to use their anonymised data for research and evaluation purposes.

Participants attended the group on a weekly basis, with sessions covering the topics detailed in Figure II below.

Figure II: Overview of key areas covered in the HeaRRT 12-week semi structured group (Source: Author's own work)

Both facilitators engaged in post-group debriefs and had access to external supervision if required. During the last session (session 12), participants were asked to complete an evaluation form that asked what aspects of the group they found most challenging and useful, as well as whether they had learned any skills, and how the group could be improved in future.

Measures

Before and after the intervention, participants completed two outcome measures: the Cross Ethnic-Racial Identity Scale – Adult, abbreviated to CERIS-A, (Worrell, Mendoza-Denton & Wang, 2019) and the Africultural Coping Systems Inventory, abbreviated to ACSI, (Utsey, Adams & Bolden, 2000). These measures were selected following a review of available measures in the field being undertaken and chosen based on their alignment with the HeaRRT approach, group objectives and desired outcomes.

Specifically, CERIS-A (Worrell et al., 2019) was selected as it is a comprehensive measure that quantifies seven dimensions of adult ethnic-racial identity, validated across a variety of ethnic groups. The seven dimensions of the scale include: assimilation, miseducation, self-hatred, anti-dominant group, ethnocentricity, multiculturalist inclusive and ethnic racial salience (see Table II).

This measure was designed to be used in the US and was therefore appropriately adapted to better fit with the UK sample in this study, as recommended and with oversight and approval from the original author. For example, many questions refer to 'being American', or to 'life in the US'. These were changed to 'being British', and 'life in the UK' respectively. Furthermore, question seven: 'I am not so much a member of a racial group, as I am American' saw 'American' replaced with 'British'.

The ACSI (Utsey et al., 2000) measure was chosen because of its ability to track differences in culture-specific, spiritually based coping behaviours and strategies used by people of African Caribbean heritage in everyday, stressful situations.

In addition to completing the above referred to pre- and post-intervention outcome measures, participants also undertook a group reflection exercise at the end of each group session which involved sharing perspectives and identifying what was learnt from the session or needed to be expanded on or strengthened. A self-management support tool was also used collaboratively with participants to end each group session in a psychologically safe manner.

Results

Eight individuals signed up to attend the group, with three dropping out in the first two weeks due to work and family constraints, and sessions being held in the evening. Of those that completed the full HeaRRT group (n=5), positive changes across all scores were detected at cohort level via the CERIS-A (Worrell et al., 2019) as depicted below in Table II, and average improvements were also seen at cohort level, in three out of the four domains on the ASCI (Utsey et al., 2000) (see Table III) This evidences participants' greater use of culturally grounded coping mechanisms, linked to resilience and positive mental health outcomes.

Table II: CERIS-A (Worrell et al., 2019) results

CERIS-A dimension	Definition of dimension	Average cohort change pre-post intervention	Interpretation of change
Assimilation	Assimilation items assess the degree to which respondents place greater	Reduced by 2.8	Participants were less likely to identify with or prioritise the dominant culture over

	emphasis on their national identity than their ethnic or racial identity.		their own ethnic or racial identity.
Miseducation	Miseducation items assess the degree to which respondents endorse stereotypes about their ethnic/racial group	Reduced by 3.1	Participants were less likely to accept or endorse negative stereotypes about their own ethnic or racial group.
Self-hatred	Self-hatred items assess the degree to which respondents dislike being members of the ethnic/racial group they belong to.	Reduced by 3.5	Participants had fewer negative feelings or attitudes towards their own ethnic or racial group.
Anti-dominant group	Anti-dominant group items assess the degree to which respondents dislike the dominant or majority group in their cultural context.	Increased by 2.5	Participants placed greater importance on the values, principles and heritage of their own ethnic or racial group in guiding their lives.
Ethnocentricity	Ethnocentricity items assess the degree to which respondents feel that values from their ethnic/racial group should inform	Increased by 1.8	Participants placed greater emphasis on the values and principles of their own ethnic or racial group as a guide for their lives.

	their thinking and daily living.		
Multiculturalist inclusive	Multiculturalist Inclusive items assess the degree to which respondents have a strong connection to their own racial/ethnic group alongside a willingness to engage with other cultural groups and value those other groups' perspectives.	This increased by 3	Participants expressed greater respect and appreciation for both their own ethnic or racial group and other cultural groups in society. They are more likely to value diversity and to seek out cross-cultural interactions.
Ethnic-racial salience	Race salience items assess the degree to which respondents indicate that racial issues are salient in their daily lives.	Increased by 3	Participants' racial or ethnic identity is more prominent in their thoughts, feelings and decision-making. This does not indicate whether their attitude toward their identity is positive or negative, only that their race or ethnicity is more salient or more noticeable to them in everyday life.

Table III: ACSI (Utsey et al., 2000) results

ACSI dimension	Definition of dimension	Average cohort change	Interpretation of change

		pre-post intervention	
Cognitive/emotional debriefing	Defined as one's adaptive reactions to environmentally based and racially charged stressors	+1.4	The group score increased, showing that various proactive coping mechanisms were used such as socialising or changing routine. This shows a level of adaptive stress processing, where barriers to emotional expression have been reduced.
Spiritual centred coping	One's resilience due to harmony with the universe and/or one's higher power	+0.8	The group score increased, showing increased use of spirituality as a coping strategy. This is an important aspect of African-centred healing traditions where spirituality can play a protective role against stressors.
Collective-Centred coping	One's comfort derived from social connections with others or groups	+3.2	This dimension showed the biggest rise, meaning participants increased in their connections with others, including family, their community and their shared histories. This is particularly important as it shows the African-centred values of collectivism, shared resilience, and group problem solving.
Ritual Centred coping	Described as one's use of rituals to preserve balance	-0.2	This measure slightly decreased for the group, suggesting that rituals and symbolic behaviours were not as important as other dimensions.

Discussion

Third sector organisations are often at the forefront of innovation when it comes to identifying and filling gaps in health and social care and responding to community need (Tuurnas, Paananen & Kork, 2025). Services developed to address racial trauma to date have been largely clinical and US-centered, therefore HeaRRT was created to offer a unique, community-based, peer-led, non-clinical approach. This is needed not just because racial trauma fails to be identified in clinical settings in the UK, but the nature of clinical care can mean it is not seriously or sensitively addressed (Samuel and Simonds 2025).

Findings from the CERIS-A (Worrell et al., 2019) indicated that participants moved away from internalising negative views about their own group and instead developed a stronger, more central, and more inclusive sense of ethnic-racial identity. This shift was reflected in reduced internalised stigma and greater appreciation for their own group as well as for wider cultural diversity, with ethnic-racial identity becoming a more meaningful part of their daily lives. Results from the ACSI (Utsey et al., 2020) demonstrated that participants experienced a slight overall increase in coping resources across cognitive, emotional, spiritual-centred and collective-centred strategies. The strongest gains were seen in coping through connection with others, including talking things through, drawing on faith, and especially leaning on community support, while reliance on ritual-based coping was less important.

Taken together, these findings suggest that participants not only strengthened their sense of ethnic-racial self but also enhanced their ability to cope through relational and community-based strategies.

The HeaRRT group intervention and foundational approach, therefore, appears to facilitate a step back from the individualistic, Eurocentric lens that clinical care is founded on, allowing a community and strengths-based, peer-led approach to promoting individual and collective healing.

Reflections and learning

As a result of delivering the HeaRRT 12-week semi structured group, several key learnings were derived which are highlighted here:

Forming a safe space

The creation, and maintenance of a safe space was imperative throughout the group, for both participants and facilitators. Key to this was the physical space in which the group was held, as was group size. In person sessions made creating a safe space easier, as did having a smaller group. In this initial pilot group, all participants were female, which may have had the effect of making the space feel psychologically safer for participant; this area will be investigated in more detail through the delivering of future groups.

Safety and wellbeing of staff

Facilitators with lived experience bring valuable insight, but this also necessitates a heightened awareness of personal triggers and the potential for emotional reactivity. Managing one's own responses to often highly emotive content is critical to maintaining a supportive and professional environment. In practice this meant that the facilitators had to engage in a range of personal work and organisational support prior to, and throughout facilitation of the group session, through regular debriefing and reflective supervisions which included:

- Checking in on oneself and one's co facilitator to ensure emotional boundaries are recognised and set to manage both oneself and the group.
- Establishing clear communication and role expectations with co-facilitators through regular planning sessions. The need to build a trusting and communicative relationship with co-facilitators is key as it provides a foundation for shared responsibility, mutual support, and dynamic responsiveness to group needs.
- Developing coping strategies by utilising and engaging with self-management tools and techniques for emotional regulation at the end of each session.
- Accessing peer support networks that are on offer within the group.
- Sharing key aspects of own experiences that may be activated in group settings and actively processing past experiences.

The above helps ensure facilitators can build emotional resilience and remain grounded, present and effective without allowing personal matters to interfere with the groups' needs.

Participant and facilitator readiness

Participant readiness was a necessity; group members had to be psychologically ready to share experiences and explore topics fully. Whether they were able to do this was established in a conversation with group facilitators before joining the group. A high level of readiness and support for each other was also important for the facilitators. This was key in terms of navigating and mitigating against their own re-traumatisation but also the challenge of seeing the widespread experiences of racial trauma in the community and the normalisation of this. In this sense, deciding on the ethnicity of the group and whether the appropriate staff for delivery of the group were available was also important.

Outcome measure accessibility and acceptability

Accessibility issues meant that feedback and outcome measures were moved from paper copy to electronic, which improved accessibility and acceptability. This was important as some participants felt the measures, in particular the ACSI, (Utsey et al., 2000), were quite lengthy to complete. We wanted to address this issue as were aware that questionnaire completion can lead to participant apathy and take away from the benefits of the group (Mes et al. 2019).

Group size and generalisability

We aimed to recruit 12 participants, knowing that attrition and dropouts are always likely, and that participants often prefer smaller groups, as was the case in our first cohort of five people. We were mindful that there will always be a tension between the advantages of a larger group or sample size and creating a safe psychological space where people feel comfortable sharing. Hence, we recommend an upper limit of 12 people per group, which does mean that generalisations to the wider target population cannot be made.

Transferability

The HeaRRT group intervention in its current format, as outlined in this paper cannot necessarily be utilised for all ethnic groups, as different groups may require an alternative model, and potentially different outcome measures, depending on the racial background of the target group. There is, to our knowledge, no standardised scale that can be used to measure recovery in relation to racial trauma and other salient outcomes or improvement across different ethnic groups, however there are plans for future adapted versions of the HeaRTT group to make it suitable for different racialised communities.

Racial trauma awareness

Racialised communities often do not realise that they have experienced racial trauma, and even when individuals are aware, racial trauma can have associations with stigma and shame, which likely acted as a barrier to recruitment (Cénat, 2023). To combat this, we changed the name of the approach from initially being Healing from Racial Trauma (HeaRT) to Healing from Racism and Racial Trauma (HeaRRT), to specifically address this issue, which we hoped made the group more accessible and relevant.

More generally, racial trauma is not widely recognised in the UK, both in professional and public environments, which has implications not just for this group but also in terms of scaling up racial trauma support interventions across the health and social care sector (Bakare, 2024).

Measuring recovery

Sadly, as referred to earlier, there is no 'end point' or point of full recovery from racial trauma, therefore the outcome measures that we chose to use tracked only to what extent participants learned to process past experiences and develop coping mechanisms for managing their experiences. It is also worth highlighting that there are likely to be important and relevant aspects of learning or improvement that are we could not track or estimate here, such as the impact in terms of collective healing of the community, which research shows is a key aspect of healing from racial trauma (Grills et al, 2025).

Implications

The HeaRRT semi structured group and the HeaRRT approach itself from which the group was born, provide an opportunity for individuals that have been experienced racism or racial trauma in the UK to explore these experiences in a psychologically safe environment, through offering a novel, community-based, peer-led, non-clinical group intervention; thereby widening accessibility to support in this area.

Despite a small sample size, this study found positive early feedback, and it is hoped that these initial findings can be built on to bridge the current gap in health and social care provision that currently exists for those that have experienced racial trauma.

Next steps

The authors intend to deliver further 12-week semi structured groups for a range of racialised communities as well as developing other interventions as part of the HeaRRT approach, with the goal of expanding the range of support interventions available to those that have experienced racial trauma.

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