

**COMMUNITY ENGAGEMENT PROJECT
NIMHE MENTAL HEALTH PROGRAMME**

ASTON CHRISTIAN CENTRE

**REPORT OF THE COMMUNITY LED RESEARCH PROJECT
FOCUSSING ON**

**THE NEEDS OF AFRICAN CARIBBEAN PEOPLE BETWEEN THE AGES OF
18-65 THAT LIVE IN THE ASTON AND SURROUNDING AREAS OF
BIRMINGHAM WITH REGARD TO THEIR MENTAL HEALTH
AND
TALKING THERAPY**

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REPORT

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Birmingham and Solihull 
Mental Health NHS Trust



*National Institute for Mental
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The Steering Group Committee as follows:

Novelette Aldred – Counsellor, Psychotherapist

Nasreen Akhtar – Support worker, University of Central Lancashire

Sharon Annakie – Director of Servol Mental Health

Lakhvir Rellon - Director of Diversity, Birmingham & Solihull Mental Health Trust. NHS

Ranjit Senghera – Race Equality Lead, West Midlands National Institute of Mental health England

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Ester Watson – Recovered Service User

Pastor Calvin Young – Chair, Aston Christian Centre

Victoria Road Evangelical Church for facilitating one focus group

This report would not be complete without the valuable participation of the local community members and mental health service users who agreed to be interviewed and contributed to the research programme.

Profile of Researchers

Clifford Allen – a family man, was involved in planning and consultations in the building industry for a number of years in the Caribbean prior to coming to the UK. He has been living in the UK since 1998. Presently involved in mental health research project as a researcher. Clifford's interest in the project was as a result of his role as a carer.

Winifred Caesar – recently moved to Birmingham but has been involved in community work in Northampton for over 25 years with the African and Caribbean community. She has been involved in developing questionnaires, conducting interviews, collating and analysing the statistical data and assisting with the production of this report.

Stephanie Glasford – has been seconded from the Birmingham & Solihull Mental Health Trust. She has worked in mental health for over 14 years. Her background is in vocational training for service users in mental health. She has been involved in the research around counselling and psychotherapy for this project. She has helped with the piloting of the questionnaire, conducted interviews, facilitated the mental health service users focus group and assisted in collating and summarising data for analysis.

Viola Roberts – worked as a Community Development Officer in the Caribbean island of Montserrat before moving to Birmingham in 1998. She has since worked as an assistant Learning mentor in a local school. She has been the lead research/ coordinator of this project and has brought extensive knowledge and experience in community and youth work to the project.

CONTENTS

Acknowledgements

Profile of Researchers

Executive summary	5
Background to Project	
Findings	
Key recommendations	
1. Introduction	9
Centre for Ethnicity and Health, University of Central Lancashire	
2. Talking Therapy Research Project	
3. Methodology	15
a) Set up of steering group	
b) Accessing the local community	
c) Analysis of data	
d) Ethics	
4. Findings	18
5. Church based focus group	36
6. Service users focus group findings	40
7. Discussion	45
a) Findings	
b) Reflections	
8. Conclusion	49
Bibliography	52
Appendices:	
i) Demographics of Aston	
ii) Questionnaire	
iii) Church focus group questions	
iv) Service users focus group questions	
v) Contact details of community organisation	
vi) Ethics proforma	

EXECUTIVE SUMMARY

As part of the wider strategy for caring for the local community, the **Aston Christian Centre** has identified several gaps within health, training, and education. As a result of this it has set up useful partnerships with the National Institute of Mental Health England (NIHME) and Birmingham and Solihull Mental Health Trust (BSMHT) to specially address the mental health needs of the African Caribbean community. Initial consultation took place with these organisations which resulted in ACC being identified as the managing organisation for this project.

Background to the Project

Delivering race equality in mental health care is an action plan to improve mental health services to BME communities. Its vision is that by 2010 that there will be a service characterised by

“less fear of mental health services among BME communities and service users”

“increased satisfaction with the services”

“a more balanced range of effective therapies, such as ... psychotherapeutic and counselling treatments....that are culturally appropriate and responsive.”

“ a more active role for BME communities and BME service users ...in the development of mental health policy, and in the planning and provision of services”

“ a workforce and organisation capable of delivering appropriate and responsive mental health services to BME communities” (**page 4 DRE 2005**)

This community led research was undertaken to complement the work of the national and local strategies in relation to developing psychological therapies for the African Caribbean community. The mental health of the Black African Caribbean population and mental health issues in the BME community give great cause for concern. There is widely documented evidence that suggests that the treatment given to this group of people is inadequate and ineffective and the proposition is that “talking therapies” would be a more effective treatment for people of African Caribbean origin.

The aim of this project is to develop community engagement and awareness within the African Caribbean community of Aston and surrounding areas of Birmingham, to ascertain knowledge and access of counselling/talking therapies within the community.

In order to achieve the above objectives, this project recruited 4 community researchers. All the researchers are of African Caribbean origin. The researchers were recruited because they knew the culture and the community under research.

The sample group consisted of 70 individuals aged 18 –65, of which 50 were from the community, 11 were from a church based focus group and 9 were from a service users focus group

Findings

It is important to note that the findings of this report is subjected to the sample groups selected, and is not representative of the general population.

The largest age group that took part in the research project was between the ages of 40-49 years (37%); the gender balance was fairly even with 49% male and 51% female

The targeted sample group was Black Caribbean (83%). Other respondents reported themselves as Black British, Black African, and Black European

Ninety seven percent (97%) of the respondents were British citizens, of these 50% were born outside the UK and the other 50% were born in the UK.

English was identified as the language that 92% of respondents felt most comfortable speaking, Patois and Somalian were the only other languages identified.

With regard to religion 65% stated that they were Christians, covering such groups as Pentecostals, Church of England, Methodists, Catholics and Baptists. 16% said that they were Rastafarians. Other religions mentioned includes, Muslims and Spiritualists, Believer in God, Ethiopian Orthodox, and Jewish.

Ninety one percent (91%) stated that they were heterosexual while 9% gave no response.

Twenty three percent (23%) of respondents declared that they had a disability that ranged from mobility problems to schizophrenia.

Of the 70 participants contacted, there seemed to be varied degrees of awareness of mental health and mental health issues. There was a very small percentage that showed no awareness and felt that they could not contribute to the project. However there were 37 respondents who showed a high degree of awareness by virtue of the fact 9 were service users and the others had a family, spouse and or close friend using the mental health services.

Fifty six percent (56%) of respondents were aware of the issues surrounding the care and treatment of mental illness in the BME community.

Of those participants who had experience of mental health distress and received treatment from the NHS (30%) were given medication only, compared to 8% who were offered counselling. The follow up services showed that a majority of people (12%) had CPN and consultant GP services, 5 % had a social worker and 2% had no support after being discharged.

A high percentage of respondents (80%) were not aware of any counselling services for the African Caribbean community in the locality. Some 54% stated that they would prefer to be counselled at home, " *more comfortable*" 28% in day centres, "*when you leave...you tend to forget your problems,*" churches and community centres.

Of the respondents that were interviewed, the majority (66%) did not know of any member of the black community who is a talking therapist.

When asked about their knowledge of voluntary support services in the area only 27% of the respondents answered in the affirmative citing Omnicare (formerly Handsworth Community Care) and COPE. Two statutory agencies Ladywood Day Centre and the NHS Crisis Line were also mentioned.

Of the respondents who stated that the ethnicity of the therapist would be important to them (76%) stated that understanding and empathy were the key factors. For those who said that ethnicity was not an issue (39%) stated that choice and professionalism was most important. "*this is where choice comes in because whether black or white you may not understand.*"

The percentage of people in employment and those who were unemployed was even. (49%) Those who were unemployed stated that they have registered with Jobcentre plus, being referred to the Pertemps Employment Alliance, and have constantly looked in Newspapers, in an effort at finding employment but have been unsuccessful.

The participants identified the support systems in place to help them succeed as “*personal coaches*”, “*complaints procedures*”, and “*occupational therapy*.” However with regard to the question as to what support system they would like to see put in place to help them succeed responses included:

- “*more equal opportunity exercised in the workplace,*”
- “*more one to one support for employees,*”
- “*more Black people in upper management,*”
- “*a fast track procedure for dealing with complaints*” and
- “*counsellors made available during the process.*”

Of the respondents interviewed 48% said that they can see themselves developing a career in one of the talking therapies, and 39% showed no interest.

A high percentage of respondents (80%) had never undergone a training course in counselling. However those who had undergone a course rated it as “*good*”.

If there were a course in counselling identified for the African Caribbean community, 63% of respondents said that they would be willing to pursue it provided that it was “*culturally appropriate*” and offered qualification levels up to professional status.

The project has also identified a number of people from the African Caribbean community who are considering careers in counselling and other ‘talking therapy’ disciplines in an effort at addressing the imbalance in the system. As reflected in the research “*it’s about choices*”.

Conclusion

These findings suggest that there is a need for early intervention as a way of preventing a mental health crisis in the BME community. Concerns raised during the focus group held at the church include concerns over “*bullying in schools and peer pressure*”, “*look at children’s behaviour generally*” and “*the number of children in child mental institutions*” “*Focus on youths, and*” “*the Government has taken away the responsibility of children away from parents.*”

Service users find it very difficult to make informed decisions in respect of their mental health treatment because in most cases “*the effects and side effects of medication*” are not explained to them and further more they do not realise and it is not explained to them that they have choices. Service users want the emphasis shifted from the old adage that ‘doctors know best’ to ‘*only who feels it knows it*’.

None of the respondents interviewed indicated any established institutional setting as a preferred place for counselling sessions. The most common places were churches, home and day centres. The service users interviewed indicated that more “*peer group settings managed and run by service users themselves, and café style walk in services*” would be more beneficial to their recovery. User forums that are real and purposeful (not tokenistic) need to be considered as complementary treatment.

The people interviewed also highlighted the need for more African Caribbean ‘talking therapists’ to be trained and recruited to the National Health Service.” “*Love to see more black professionals in the system.*” “*The NHS should take a strong look at the staff that they employ*”. “*They need to find ways to integrate black people into the work force*”

The research highlights the need for more joint work between different agencies, particularly colleges and higher education providers that deliver counselling courses. They should ensure that. “*elements of culture, behaviour, and religious components taught alongside*”.

It is imperative that the stakeholders make use of this report and take into consideration the findings and address the needs of the community. As expressed in the focus group held at the church,” *Hope that this is not just another dead end research.* ”

As a result of this research the following recommendations are made for service providers, key stakeholders and commissioners

Key recommendations

1. The Primary Care Trusts should “contract out” the care and treatment of the mentally ill to voluntary and charity sector organisations such as Aston Christian Centre and Omnicare Ltd who have proved that they have access to BME community and that culturally sensitive services be delivered from non-stigmatised settings like churches, community centres, walk in cafes .
2. Birmingham and Solihull Mental Health Trust need to invest in colleges and universities to ensure that the courses and programmes offered recognise the personal, racial, social and cultural experiences of the African Caribbean community.
3. The Department of Health needs to commission research in particular into the mental health needs of African Caribbean young men as concerns were expressed over the high suicide rate among this group as early intervention could prove to be a beneficial strategy.
4. All agencies offering health care should appoint a Public Relations Officer who will become the link between the community and the health services and whose remit will include the dissemination of good quality information to the African Caribbean community.

Introduction

The Centre for Ethnicity and Health, University of Central Lancashire's Model of Community Engagement.

Background

We often hear the following words or phrases:

- Community Consultation
- Community Representation
- Community Involvement/Participation
- Community Empowerment
- Community Development
- Community Engagement

Sometimes they are used inter-changeably to mean the same thing. Sometimes different people in the same meeting to mean different things use the same word or phrase. The Centre for Ethnicity and Health has a very specific notion of Community Engagement, and this paper is an attempt to describe it. The Centre's Model of Community Engagement evolved over a number of years as a result of its involvement in a number of projects. Perhaps the most important milestone however came in November 2000, when the Department of Health awarded a contract to what was then the Ethnicity and Health Unit at the University of Central Lancashire to administer and support a new grants initiative. The initiative aimed to get local Black and minority ethnic community groups across England to conduct their own needs assessments, in relation to drugs education, prevention, and treatment services.

The Department of Health had two key things in mind when it commissioned the work; first, the Department of Health wanted a number of reports to be produced that would highlight the drug-related needs of a range of Black and minority ethnic communities. Second, and to an extent even more important, was the process by which this was to be done. If all the Department of Health had wanted was a needs assessment and a 'glossy report', they could have directly commissioned a number of researchers who could have gone into local Black and minority ethnic communities, talked to them about their needs, written up a report, and produced yet another set of reports that potentially do not have any long term impact. This scheme was different however. The Department of Health was clear that it did not want researchers to go into the community, to do the work, and then to go away. It wanted local Black and minority ethnic communities to undertake the work themselves. These groups may not have known anything about drugs, or anything about undertaking a needs assessment at the start of the project; what they would have is proven access to the communities they were working with, the potential to be supported and trained and the infrastructure to conduct such a piece of work. They would be able to use the six-month process to learn about drug related issues and about how to undertake a needs assessment. They would be able to benefit and learn from the training and support that the Ethnicity & Health Unit would provide, and they would learn from actually managing and undertaking the work. In this way, at the end of the process, there would be a number of individuals left behind in the community who would have gained from undertaking this work. They would have learned about drugs, and learned about the needs of their communities, and they would be able to continue to articulate those needs to their local service providers, and their local Drug Action Teams. It was out of this project that the Centre for Ethnicity and Health's model of community engagement was born.

The model has since been developed and refined, and has been applied to a number of areas or domains of work. These include:

- Substance Misuse
- The Criminal Justice System
- Sexual Health
- Mental Health
- Regeneration
- Higher Education
- Asylum

New communities have also been brought into the programme: although Black and minority ethnic communities remain a focus to the work, the Centre has also worked with:

- Young people
- People with disabilities
- Service user groups
- Victims of domestic violence
- Gay, lesbian and bi-sexual people
- Women
- White deprived communities
- Rural communities

In addition to the Department of Health, key partners have included the Home Office, the National Treatment Agency for Substance Misuse, the Healthcare Commission, and The National Institute for Mental Health in England, the Greater London Authority and Aim Higher

The Key Ingredients

According to the Centre for Ethnicity and Health model, a Community Engagement project must have the community at its very heart. In order to achieve this, it is essential to work through a **host community organisation**. This may be an existing community group, but it might also be necessary to set a real or virtual group up where one does not exist already. The key thing is that this host community organisation should have good links to the target community¹ (whoever this is) such that it is able to recruit a number of people from the target community take part in the project and to do the work (see section on task below). It is important that the host community organisation is able to provide a co-ordination and infrastructure (e.g. somewhere to meet; access to phones and computers; financial systems) for the day-to-day activities that will be undertaken once the project is underway. One of the first tasks that this host community organisation undertakes will be to recruit a number of people from the target community to work on the project.

¹ The target community may be defined in a number of ways – in many of the Community Engagement Projects that we have run we have defined it by ethnicity. We have also worked with projects where it has been defined by some other criteria however, such as age (e.g. young people); gender (e.g. women); sexuality (e.g. gay men); service users (e.g. drug users or mental health service users); geography (e.g. within a particular ward or estate) or by some other label that people can identify with or rally around (e.g. victims of domestic violence, sex workers).

A Host Community Organisation	With Good Links To The Target Community	To Provide Basic Infrastructure For The Project (Recruit And Co-ordinate Project Team; Provide Office Space, Phones And Computers; Look After The Finances)	To Recruit A Number Of People From The Target Community To Do The Work
A Task	Time Limited Meaningful Manageable	A Piece Of Research Into Key Needs/Gaps/Issues For The Community	Learning And Development Of Key Individuals; Access Hard To Reach Groups; Raise Awareness and Debate; Community Ownership
Support	Financial (Typically Up To £20,000)	Training And Workshops; On-Going Support And Guidance; Personal Tutor	Statutory Partnerships; Steering Groups; Sustainability

The second key ingredient is the **task** that the community is to be engaged in. According to the Centre for Ethnicity and Health model, this must be something that is meaningful, time limited and manageable. Nearly all of the community engagement projects that we have run have involved communities in undertaking a piece of research or a consultation exercise within their own communities. Sometimes we have been met with an initial resistance to doing ‘yet another piece of research’, but this misses the point. As in the initial programme that we ran on behalf of the Department of Health, *the process (i.e. of getting ordinary people involved in doing the work) is as important*, if not more important, than the report that they produce at the end of the day. The task or activity is something around which lots of other things will happen over the lifetime of the project. Individuals will learn and new partnerships will be formed.

The final ingredient, according to the Centre for Ethnicity and Health’s model, is the provision of appropriate **support** and guidance. We do not expect community groups to become involved for nothing. Typically we would make in the region of £15-20,000 available to the host organisation. We would expect that the bulk of this money would be used to pay people from the target community as community researchers². We then allocate a named member of staff from our Community Engagement Team as a project support worker. This person will visit the project at for at least half a day once a fortnight. It is their role to support and guide the host organisation and the researchers through the project. We also provide a package of training – typically in the form of a series of accredited workshops. The accredited workshops give participants in the project a chance to gain a University qualification whilst they undertake the work. The support workers will also assist the group to pull together a steering group for the project³. The steering group is an essential element of the project: without one, it is difficult to see who the community are engaging with and it is unlikely that anything out of the project will be sustained in the longer term. The group will be doing a needs assessment or a consultation exercise, but for what purpose? It is the role of the steering group to ensure that the work that the group undertakes sits with local priorities and strategies, and that there is a mechanism for picking up the findings and recommendations that the group may make. It is also their role to help to pick up the key individuals who are developed through the project process to help them to take their ‘next steps’.

² This is not always possible, for example, where potential participants are in receipt of state benefits and where to receive payment would leave the participant worse off.

³ Very often we will have helped groups to do this very early on in the process at the point at which they are applying to take part in the project.

The Community Engagement Team

The Community Engagement Team comprises of 25 members of staff. They work across a range of Community Engagement areas of specialism, within a tight regional framework.

National Programme Directors			
Northern Team	Midlands Team	Southern Team	Senior Programme Advisors
Senior Support Worker	Senior Support Worker	Senior Support Worker	
Support Workers X 3	Support Workers X 3	Support Workers X 6	Drug Interventions Programme
			Regeneration
			Mental Health
Teaching And Learning Team			
Administration Team			
Communications Officer			

Programme Outcomes

Each group involved in any of our Community Engagement Programmes is required to submit a report detailing the needs, issues or concerns of the community that it consulted with. The qualitative themes that emerge from the reports are often very powerful, particularly when taken together with other reports produced by groups involved in the same programme. Such information is key to commissioning and planning services for diverse and 'hard to reach' communities. Often new partnerships between statutory sector and hard to reach communities are formed as a direct result of community engagement projects.

The capacity building of the individuals and groups involved in the programme is often one of the key outcomes. Over 20% of those who are formally trained go on to find work in a related field.

The Focus Of This Report

Since 2000 over 200 community groups have taken part in one or other of the Centre for Ethnicity and Health's Community Engagement Work Programmes.

National Institute for Mental Health in England Community Engagement Programme:

Aston Christian Centre's Vine Project was one of the 11 community groups who took part in the National Institute for Mental Health in England's Community Engagement Programme in 2005. The objectives of the programme were to deliver and improve equality of access, experience and outcomes for Black and minority ethnic mental health service users by:

- Building capacity in the non-statutory sector.
- Encouraging the engagement of Black and minority ethnic (BME) communities in the commissioning process.

- Ensuring a better understanding by the statutory sector of the innovative approaches that are used in the non-statutory sector.
- Involving Black and minority ethnic communities in identifying needs and in the design and delivery of more appropriate, effective and responsive services.
- Ensuring greater community participation in, and ownership of, mental health services.
- Allowing local populations to influence the way services are planned and delivered.
- Contributing to workforce development, and specifically the recruitment of 500 Community Development Workers.

The focus of our work was to conduct a local needs analysis in relation to 'talking therapies' within the African and Caribbean community targeting males and females aged 18-65.

Aims and Objectives

The Diversity Strategy 2004-2007 gives recognition to the fact that people from Black and minority ethnic communities have been subject to discriminatory practice in the NHS. This has been evident in the nature of treatments received and made available to BME communities as well as the employment of BME communities in the structure of the NHS. **(Promoting diversity in Mental Health Services/Birmingham and Solihull Mental Health Trust Diversity Strategy 2004-2007)**

Many of our African Caribbean users of the mental health service have expressed a growing concern that very little has changed. Their opinions were echoed in the Inside Outside report, which carried out extensive consultation in the community.

A partnership approach was identified as a positive way forward in tackling some of these issues within the African Caribbean community. The Diversity Directorate, Trust Psychological Services, and the Franz Fanon Centre for African Caribbean and Asian Services are currently pioneering some of this work. A draft report produced to support this partnership approach has documented some of the issues for people of African Caribbean descent. Information in this document concurs with the Diversity Strategy around the under representation of African Caribbean professionals within the clinical psychology. **(Roberts, G., et al, 2004)**

The key recommendations made in the above report arising from the death of David 'Rocky' Bennett, places an obligation on service providers to identify and meet the cultural, psychological, social, spiritual and other needs of the minority ethnic service users.

To compliment the work of the national and local strategies in relation to developing psychological therapies for the African Caribbean community, the aim of this project is to develop community engagement and awareness within the African Caribbean community of Birmingham, to improve knowledge and access to counselling/talking therapies within the community.

The objectives of the project are to:

- Establish a local needs analysis in relation to 'talking therapies' within the community targeting individuals, community groups, and service users.
- Establish a local needs assessment of current issues around talking therapies for the African Caribbean community.
- Identify key partners and agencies to ensure a joint up approach to developing the agenda i.e. educational institutions, Mental Health Trust, Primary Care Trust, who are responsible commissioning services and committed black professionals.
- Establish a comprehensive community engagement programme aimed at:

- i) Raising awareness within the community around mental health, stigma, and racism.
- ii) Creating opportunities to engage partner agencies to promote counselling courses as a positive career option.

The **long-term goal** of the project, however, was to ensure that we support the government's policies and initiative:

- Tackle the under representation of African Caribbean's taking up counselling courses
- Support the Inside Outside Report and Breaking the Circles of Fear recommendations in developing a culturally appropriate workforce. (**Inside Outside 2002**)
- Support the community in recruiting and retaining jobs in these careers
- Working in partnership with colleges creating cultural relevance to their approach to teaching
- To begin to tackle the under representation of African Caribbean's in the NHS
- Carrying out local needs analysis and support an exit strategy for the project.
- Implement a project, which will complement mainstream strategy.

Methodology

Training of Researchers

The former Community Development manager for Aston Christian Centre recruited the researchers for the project. One got the post from an advert with Jobcentre plus. Two, as a result of networking within the church, and the final researcher was seconded from the Birmingham and Solihull Mental Health trust following negotiations with stakeholders.

All four researchers attended the 6-day workshop provided by the Centre for Ethnicity and Health, the workshops were arranged as follows:

- Two days workshop on mental health covering basic mental health information, mental health and stigma, public perception, discrimination, legislation, labels, the user movement and the national strategy.
- Two days workshop on different research methods, different stages of research and designing tools for the research.
- Two days workshop on data analysis and guideline on report writing and the process of disseminating the findings to the wider community and local stakeholders.

The researchers were also given the opportunity to enrol for the University Certificate in Mental Health and Community Research. In addition to the workshops, the community researchers were allocated a support worker from the centre for Ethnicity and Health, University of Central Lancashire. The support worker visited the project on a fortnightly basis to ensure tasks allocated were met in order to complete the project.

The actual project was conducted between June 2005 and March 2006. The task allocated to the community researchers varied from individual to individual depending on their ability to undertake the work. Key roles of the community researchers were as follows:

- Design a research focus
- Develop the research instrument
- Identify the sample group
- Pilot the draft questionnaires
- Attend steering group meetings on a monthly basis
- Arrange interviews with members of the community
- Arrange interviews with service users
- Arrange 2 focus group interviews
- Data collection
- Assist with the input of data
- Assist with the analysis of data
- Assist with the report writing
- Set up a disseminating event for the findings to local stakeholders and local community members

Set up of the steering group

The former Community Development manager of ACC used her skills at networking and capacity building to set up the steering group. She also assisted the project with contact details of other stakeholders and mental health services.

Due to the nature of the topic for this project a sensitive approach was needed. Aston Christian Centre offered to host the project and steering group meetings by providing a venue to meet, arranging refreshments, facilitating the meetings and providing administrative support.

The steering group brought their expertise and knowledge and this was used for guiding the project, for signposting, and also to provide advice and assistance on the development of the questionnaires and on seeking recommendations.

About the community

As one of the most disadvantaged areas of the country, Aston is at the top of deprived wards requiring renewal and regeneration. Levels of long term unemployment, low incomes resulting from low paid work, and high levels of long term sickness, mean that a majority of households rely on state benefits.

While there is much variation within different ethnic groups, people from minority ethnic communities are more likely to live in deprived neighbourhoods, and in unpopular and overcrowded housing. They are more likely to be unemployed, and have below national wage, irrespective of age, qualification, and place of residence. Minority ethnic communities are more likely to report suffering from mental health problems than European people. Generally they have less access to medical provisions, leisure and education facilities, and meaningful job opportunities.

Nearly 28,000 people live in Aston. A balance almost 50:50 between men and women with a significant number of young people, and over a third of households with more than one child under 5 years of age.

The DETR's Indices of Deprivation for England ranks the Aston Ward as the most deprived in Birmingham out of the City's 39 wards. Many of Aston's problems may lie in its residents low participation in the labour market. The employment rate in Aston is 20 percent lower than the City average and economic inactivity rates are significantly higher; 28.3% in Aston are inactive compared to 10.25 in Birmingham; 10.3% of working age women in Aston are inactive compared to 3.9% in Birmingham.

Aston is a culturally diverse community with nearly 60% of its residents belonging to the black and ethnic minority communities. Over recent years, Aston has seen increases in the emerging communities of Kosovan and Somalian refugees and asylum seekers. Aston has a strong sense of community and local identity. However, there is a feeling that, in recent years, the community has become more divided into various ethnic groups living in Aston, which has in part become a barrier to creating wealth and jobs through social enterprise.

Accessing the local community

Once the samples were identified, the interviews were conducted with consent using a structured questionnaire (see **appendix i& ii**). This method was chosen because it offered topics and questions to the interviewees that were carefully designed to elicit the interviewee's ideas and opinions on the topic of interest. There were some questions with predetermined choices, but the interviewer followed up with probes to get in depth information. During the interviews, which were conducted at a local establishment situated in a shopping centre, the interviewer strove to create a relaxed, comfortable conversation while at the same time tried to avoid influencing the interviewee's response.

A focus group was convened at the Victoria Road Evangelical Church (see **appendix iii**) in September 2005 to identify their level of awareness of mental health problems in the community. Permission was given for the facilitators to tape and take notes at this session.

The other focus group was convened at Omnicare Limited during the months of October and November 2005 (see **appendix iv**) with service users to identify their level of satisfaction with the present services, and suggestions on how it could be improved. It took more time, effort and patience to gather the information from the service users but the effort was well worth it.

Information gathered from these interviews was noted on the questionnaires and the discussion from the focus group interviews were transcribed and notes made.

Analysis of Data

A total of 70 interviews were completed, of which 50 were from members of the public in Aston and surrounding areas, 11 from the focus group at the Church and 9 were from service users.

Quantitative data from the interviews were recorded using Microsoft Excel Spreadsheets and subsequently analysed. However, the qualitative data from the questionnaires and the transcribed notes from the focus groups were analysed by identifying the main themes.

Ethics

Great care was taken to ensure that the research was ethically sound. Issues of informed consent, confidentiality and anonymity, health and safety, were discussed and approved by the ethics committee of UCLan (see **appendix vi**). No financial incentive was offered to the respondents and none was solicited.

Findings

The Core Data for all participants in this research project.

A total of 70 participants were contacted:

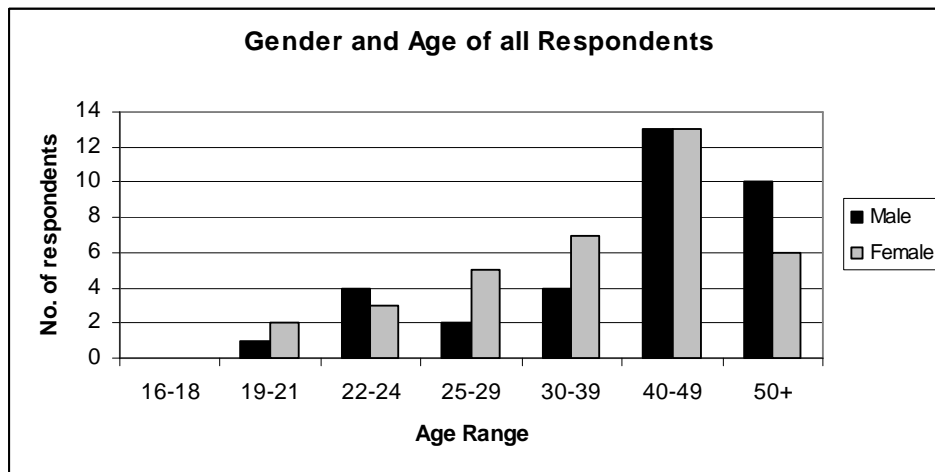
- Structured interviews with service users and community members 50 participants
- Church based focus group interviews 11 participants
- Service users focus group 9 participants

1. Age and Gender of participants

Table 1

Age range	16-18	19-21	22-24	25-29	30-39	40-49	50+	Total	%
Male	0	1	4	2	4	13	10	34	49%
Female	0	2	3	5	7	13	6	36	51%
Total	0	3	7	7	11	26	16	70	
%	0%	4%	10%	10%	16%	37%	23%		100%

Figure 1

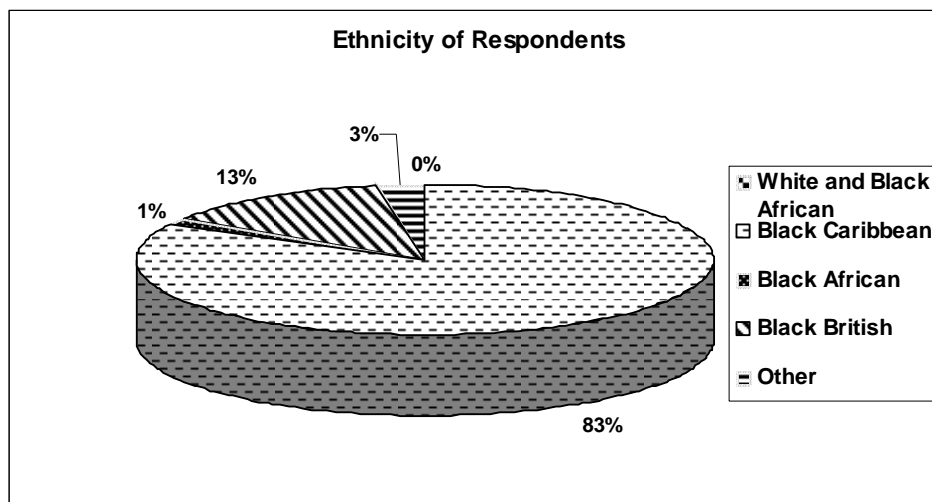


2. Ethnicity of participants

Table 2

Ethnicity	Number	Percentage
White and Black Caribbean	0	0%
White and Black African	0	0%
Black Caribbean	58	83%
Black African	1	1%
Black British	9	13%
Black European	1	1%
No response	1	1%

Figure 2



3 Participants' Residency in UK

Figure 3

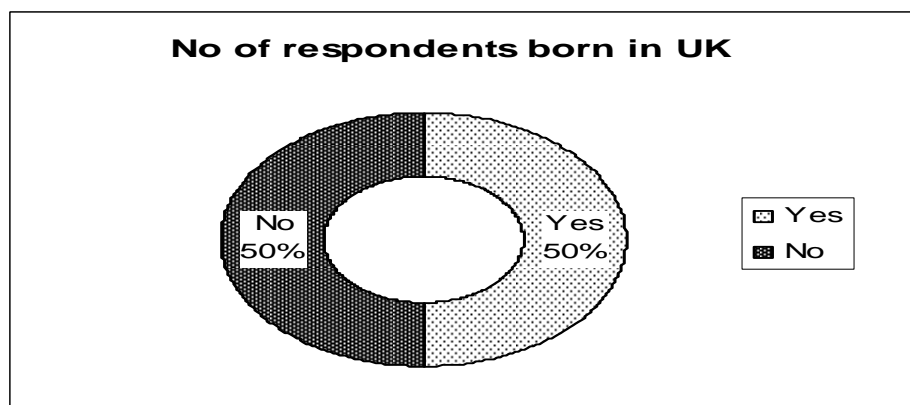


Table 3

Residence in UK	Number	Percentage
Less than 1 year	3	4%
1 – 5 years	3	4%
6 – 10 years	13	19%
11 years or more	50	71%
No response	1	2%
Total	70	

4. Citizenship of participants**Table 4**

Citizenship	Number	Percentage
British citizen	68	97%
Refugee	0	0%
Asylum seeker	0	0%
Jamaican citizen	1	1%
Egyptian citizen	1	1%
Total	70	

5. Languages spoken by participants**Table 5**

Language	Number	Percentage
English	68	92%
Somalian	1	1%
Patois	5	7%

The number here adds to 74 because some participants were fluent in more than one language.

6. Religion of participants**Table 6(a)**

Religion	Number	Percentage
Muslim	2	3%
Rastafarianism	11	17%
Christian	45	65%
Jewish	1	1%
Ethiopian Orthodox	1	1%
None	1	1%
No response	7	10%
Spiritualist	1	1%
Believer in God	1	1%
Total	70	

The participants who reported they were Christians stated the following denominations:

Table 6(b)

Denomination	Number	Percentage
Pentecostal/Evangelical	18	40%
Church of England	6	14%
Methodist	2	4%
Catholic	2	4%
Baptist	1	2%
No response	16	36%

7. Sexuality of participants

Table 7

Sexuality	Number	Percentage
Lesbian or gay woman	0	0
Homosexual or gay man	0	0
Bisexual	0	0
Heterosexual or straight	64	91%
No response	6	9%
Total	70	

8. Disability of participants

Table 8

Disability	Number	Percentage
No disability	54	77%
Declaration of disability	16	23%
Total	70	

Those who reported a disability mentioned as follows:

- “*Mobility problems*”
- “*Diabetes*”
- “*Dyslexia*”
- “*Being black*”
- “*Mental health problem*” including “*schizophrenia*” was mentioned on 6 occasions

11. What do you understand by mental health?

Of the responses received most expressed that they had some knowledge and understanding of mental health.

The most common quotes were as followed: -

- *“People’s state of mind”*
- *“Depression”*
- *“Stress/coping with everyday life”*
- *“Psychological issues”*
- *“people unable to cope with the stress and strain of daily life”*

12. Are you aware of the issues surrounding the care and treatment of mental illness in the Black and minority ethnic community?

	Number	Percentage
Yes	33	56%
No	23	39%
No response	3	5%

Of the 70 respondents who took part in the project, only 59 were fully completed questionnaires. The 11 from the focus group held at the church only completed the core questions.

Of the 56% who answered yes the following responses were recorded

- *“Inadequate care”*
- *“Ineffective treatment”*
- *“Medication”*
- *“Care in the community (no good)”*
- *“Police at fault”*
- *“Perception of black people”*
- *“Sectioning (The Mental Health Act)”*
- *“Racism”*
- *“Segregation”*
- *“David Bennett”*
- *“Drugs related”*

13 Have you or any one in your family ever experienced mental health distress?

Figure 13a

	Number	Percentage
Yes	37	63%
No	19	32%
Other	1	2%
No response	2	3%

Those with experience of mental health distress reported that either they themselves had been affected or a high proportion of them had family members who had been affected.

Figure 13b

	Number	Percentage
Myself	11	30%
Parent	8	22%
Brother/Sister	11	30%
Friends	5	13%
Other	2	5%

14 If yes, what services have you/they received from the NHS?

	Number	Percentage
Counselling	3	8%
Medication	11	30%
In Patient care	1	3%
Counselling, Medication, In Patient care	5	13%
Counselling, Medication	4	11%
Counselling, In Patient care	1	3%
Medication, In Patient care	8	22%
Other	2	5%
No response	2	5%

15 If you received counselling what was your experience of this?

Of the 13 that received counselling 10 stated that they found it appropriate or useful and the others did not find it useful or appropriate for the following reasons:

- “Not enough time”
- “Not focussed on problem”
- “Not specific enough”
- “Did not solve problem”

16 How did you access this service?

One person stated “*self referral*” and the others were “*referred by their GP*”.

17 How can these services be improved to meet the needs of the Black and Minority Ethnic Community (BME)?

The following themes emerged:

Workforce

- “More black mental health care”
- “More black people involved in counselling”

- *“Black people must be represented in the care profession”*
- *“Having more black people running them”*
- *“More services run by our own people”*
- *“Get people of our own kind to deal with situations”*
- *“Our own people should run them”*
- *“By getting more black professionals”*
- *“More trained black nurses and doctors”*

Training

- *“We need more training for people especially black and ethnic minority workers that work within the mental health field”*
- *“Professionals should learn more about the persons’ background and needs”*
- *“Problems begin at the doctors’ surgery”*
- *“Professionals need to listen more”*

Public awareness

- *“Need to advertise all services that are offered to mental health. Tell people of their options”*
- *“Raising awareness in the community”*
- *“By extending more media and publicity for those in need”*
- *“More information and awareness. Community awareness programmes*
- *“More information needed”*

Services

- *“More time allocated for individual counselling”* *“Proper diagnosis”*. *“Early diagnosis”*
- *“Suggest alternate treatment”*
- *“Good and appropriate counselling. Medication should be the last resort”*
- *“Problems begin at the doctors’ surgery, they pawn people off”*
- *“People should be taken to the ‘right’ place for treatment when the police pick them up.”* *“ One to one consultation”*. *“ Group therapy”*
- *“More variety of treatment”*
- *“Counselling or alternate treatment”*

Family/Friends involvement

- *“Should have more family support”*
- *“First, family support. Tap into family”*
- *“Families should take responsibility”*
- *“Incorporate family and friends”*

Service user involvement

- *“Speak to service users more. ‘Only those who feels it knows it’”*
- *“Involve people with experience of mental health”*
- *“Listen to people on medication”*

Legislation

- *“Stop racism and discrimination”*
- *“Less discrimination “*

18 If you have been an in-patient how long were you hospitalised?

	Number	Percentage
Less than 3 months	1	7%
4 – 6 months	2	13%
7 – 12 months	9	60%
No response	3	20%

19 What follow up services have you received since being discharged?

	Number	Percentage
CPN	7	12%
Advocacy	0	0%
Consultant/GP	7	12%
Review meeting	1	2%
Social Worker	3	5%
Social support	1	2%
Voluntary support	0	0%
None	2	3%
No response	14	24%
Not applicable	24	40%

20 Did you receive any help/support from any source other than the NHS?

Of those questioned 29 stated that they received help/support as follows:

	Number	Percentage
Family	22	76%
Friend	3	10%
Church	1	4%
Community worker/Voluntary	3	10%

There were a high percentage of respondents who could not respond to this question because although they knew people who access the system they were not in a position to answer the question.

Of the voluntary organisations offering support “Handsworth Community Care” was reported on two occasions and “COPE “on one occasion.

21 **How useful was this help?**

	Number	Percentage
Very useful	16	55%
Useful	4	14%
Moderate	3	10%
Not useful	2	7%
No response	4	14%

Those who found the help very useful or useful gave the following comments:

“Family support unit helped me get through it”

“Voluntary organisation gives space with people who understands and can help”

“Without the centre. ... Would be lonely and depressed.”

“They guided me back on track.... it’s a bad thing when (illness) happens”

“Without support from mom and sisters ...we would not be safe. Police need to know who is mentally ill...they should be more gentle to them...(sick people) should carry ID to indicate that they are mentally ill.”

“Helped me to cope and follow through to a resolution”

“Church gave a spiritual perspective that helped me to cope with all other aspects of life.”

“Trust”. “They listened”

Those who did not find it useful commented:

“At the time I was on a lot of medication and just wanted to be left alone”

“Nothing wrong in the first place.”

Section 4 - Support

22 **Are you aware of any counselling services for the African Caribbean and other communities in the locality?**

	Number	Percentage
Yes	9	15%
No	47	80%
No response	3	5%

Most participants were not aware of the above services but of the 9 that were aware they mentioned the following organisations:

COPE is a black mental health foundation... committed to providing quality services for mental health service users, carers, survivors, lone parents and their families

Aston Christian Centre is a faith-based local charity that is the host organisation for this project.

Birmingham Mencap is a local charity which works and campaigns for accessible and inclusive services for a better quality of life for everyone with experience of Learning Disability.

Franz Fanon is part of Birmingham and Solihull Mental Health NHS Trust and provides accessible mental health care for BME communities.

Ladywood Day Centre is a day centre for service users of Ladywood and Handsworth community mental health teams only. It is not a drop in centre.

Handsworth Community Care (OMNICARE) exists to deliver services to people from the African Caribbean and South Asian community (although not exclusively), who have or are experiencing mental health problems.

23 If you made the decision to be counselled where would you prefer it to be?

	Number	Percentage
At Home	32	54%
Community centre	5	8%
Church	4	8%
Day Centre	7	12%
Other	5	8%
No response	6	10%

When asked about the reasons for their preference the reasons include:

Home

*“More comfortable”; “private”; “more relaxing”; “convenient”;
“Institutions come with a stigma...need understanding not shunned”
“When you leave (own environment) you tend to forget your problems”*

Day Centre:

*“To get out the house and mix with other people”
“Meet more like minded people”*

The Church

“Spiritual perspective” “private” and “non judgemental.”

Others felt at ease being counselled “in a hospital”; “office”; and one stated that “another country” would be fine.

The researchers are however aware that there are health and safety implications to be considered.

24 Have you ever offered help and support to someone with mental distress?

	Number	Percentage
Yes	44	75%
No	10	17%
No response	5	8%

Of the 44 respondents who said yes the following responses were recorded

	Number	Percentage
Family	4	9%
Friend	15	34%
Family, friend, co-worker	7	16%
Friend, co-worker	2	5%
Family, friend, prisoners	1	2%
Family, friend	11	25%
Service users	1	2%
Anyone	1	2%
No response	2	5%

25 Do you know of any member of the Black community who does any of the following as a profession?

	Number	Percentage
Yes	15	25%
No	39	66%
No response	5	9%

Of the 15 who responded 'yes' the following results were recorded:

	Number	Percentage
Counsellor	9	60%
Psychologist	1	6%
Psychotherapist	1	6%
Counsellor, psychiatrist	1	6%
Counsellor, psychotherapist	1	6%
Priest – Ethiopian Orthodox	1	6%
Did not specify	1	6%

26. Would the ethnicity of a talking therapist you were referred to matter to you?

	Number	Percentage
Yes	27	46%
No	23	39%
Not sure	2	3%
No response	7	12%

Of those who said yes, understanding and empathy were deemed to be necessary qualities, and those who answered no felt that choice and professionalism were more important than the ethnicity of the therapist.

Section 5 -Career/Employment/Training

27 What is your current employment status?

	Number	Percentage
Employed	29	49%
Unemployed	29	49%
No response	1	2%

28 If you are looking for employment what avenues have you explored so far?

	Number	Percentage
Job centre plus	14	48
Pertemps	7	24
Newspapers	1	4
No response	7	24

29 What support systems were/are in place to help you succeed?

Only 21 participants responded giving a range of systems:

- *“Personal coach”*
- *“Complaints procedure”*
- *“Office procedures”*
- *“Occupational therapy”*
- *“Informal talks with boss or line manager”*
- *“Day centre”*
- *“Counsellors”*
- *“Parents and friends”*

30 What support system would you like to see put in place to help you?

Only 18 participants responded giving the following:

- *“Equal opportunity in the workplace”*
- *“More funding for small business”*
- *“More one to one support”*
- *“More money”*
- *“More black people in upper management”*
- *“Counsellors based at work place”*

- “Black people support groups”
- “Black helpers who really care and not just shuffling people”
- “Home help, advocacy, volunteer in the home”
- “More facilities for disabled black people”
- “Understanding people with young children”
- “A fair one”
- “Black people helping other black people”

31 Are you aware of any volunteer service in the community that people with mental distress can access?

	Number	Percentage
Yes	16	27%
No	37	63%
No response	6	10%

Of the 16 that answered yes, the following organisations were mentioned

- Ladywood Day centre was mentioned twice
- Omnicare (formerly Handsworth Community Care) was mentioned six times
- COPE (Caring, Opportunity, Partnership, Equality) was mentioned twice
- Church, Crisis Line, Home treatment were each mentioned once.

Home treatment can be accessed through the GP.

32 Can you see yourself developing a career in one of the talking therapies?

	Number	Percentage
Yes	28	48%
No	23	39%
Unsure	3	5%
No response	5	8%

Of those who answered no the following reasons were mentioned:

- “Doing my music”
- “Doing what I want to do”
- “Not what I want to do”
- “Producing employment is less stress”
- “Prefer the profession, but may consider on a part time basis”
- “Does not pay enough”
- “Have not got the time”
- “Not sure if I could do it”

33 Have you ever done a course or training in counselling?

	Number	Percentage
Yes	8	14%
No	47	80%
No response	4	6%

34 What did you think of it?

Only 9 responded: 7 thought it was **Very good** and 2 thought it was **Good**

35 Have you ever picked up any information about taking up counselling as a career?

	Number	Percentage
Yes	14	24%
No	37	63%
No response	8	13%

Of the 14 participants who answered yes, 7 obtained the information from the following places:

Seminars, Internet, the post, Citizens Advice Bureau, College and the Ladywood Day Centre.

36 What did you think of it?

The following comments were recorded:

- “Very good”
- “Good”
- “Did not deal with issues of culture and heritage”
- “Interesting”

One respondent said, “I would like to do voluntary work with mentally ill.”

37 If there were a course in counselling (talking therapy) identified for the African Caribbean communities would you attend?

	Number	Percentage
Yes	37	63%
No	16	27%
No response	5	8%
Don't know	1	2%

Of the No responses:

- 3- “not interested in becoming counsellors”
- 1- “did not feel he could help anybody”
- 1- “too busy”
- 1- “not sure how I would feel about it”
- 1- “not enough time”
- 1- “not interested in formal counselling course”
- 8- did not give a reason

38 What specific elements would you like to see included in any course designed for the African Caribbean community?

Only (8%) participants did not respond. The other 92% all stated that they would like all the elements listed included in a course and specified the inclusion of other elements i.e. religion, history/heritage and drug issues.

39 What level of qualification would you be interested in?

	Number	Percentage
Foundation	8	21%
Intermediate	4	11%
Advanced	1	3%
Professional	23	62%
Already qualified	1	3%

The researchers were aware of the fact that respondents might have other important information on mental health issues that was not covered in the questionnaire, and also that there may be other burning issues unrelated to mental health others would want highlighted. We have highlighted these below under different themes.

Personal and family

- *“Family and friends should help/support more”*
- *“People should stop living in denial of mental health issues”*
- *“People should take personal responsibility for their mental health”*
- *“People should be proactive about their treatment.... put away pride”*
- *“People should seek counselling before a crisis”*
- *“Black people should have more access to counsellors.... especially black men.... they are at risk”*

Youth focus

- *“Look at children’s behaviour generally”*
- *“Look at under 20’s in respect to their mental health in view of the recent suicides in the area.”*
- *“Address drug issues”*
- *“Address problems in school like bullying and peer pressure.”*
- *“Focus on youths. Government has taken away the responsibility for the child away from parents”*

Support in the workplace

- *“It is hard to prove discrimination in the workplace. Sometimes it is not worth it to pursue a case. The pathways to resolving issues in the workplace should be looked at to make it shorter and less stressful. There should be a fast track to deal with cases in the workplace. Also, counselling should be made available to anyone going through this experience. “*

Information /Education

- *“Publicise services available to black people in respect of careers and education.”*
- *“Need regular information on issues. Black people need to know their rights and need to be encouraged to be assertive especially in the GP’s surgery.”*
- *“The system is making depressed people into mentally ill people by giving them medication. Some people just need help prioritising and focussing.”*
- *“More advertisement around counselling.”*
- *“Need to reassure ethnic minority that there are opportunities available without racism involved. Be given every chance to set up more business and have professional help to succeed “*

Staffing

- *“The NHS should take a strong look at the staff that they employ. They need to find ways to integrate black people into the work force.”*
- *“Need more black professionals”*
- *“Black people to be offered quality jobs and better care in mental health”*

Church based focus group findings

We ran a focus group with 20 individuals of Caribbean origin who have lived in the UK, for periods of 6 years and more. This was held at the Victoria Road Evangelical Church in Aston, Birmingham.

1. What is your understanding of Mental Health?

Most of these when asked as to their understanding of mental health gave responses;

- *“The Mental state of a person.”*
- *“State of mind, being good or bad.”*
- *“Coping mechanism of a person.”*
- *“Not to say the person is actually crazy.”*
- *“The ability to cope with everyday life.”*

Other responses included:

- *“Deranged mind.”*
- *“Malfunction of the nervous system.”*

2. Are you aware of the issues surrounding the care and treatment of mental illness in the Black and Minority Ethnic community?

The group showed varied degrees of awareness of the issues surrounding the care and treatment of mental illness in the black communities.

The ones that were very aware cited issues like:

- *“Cultural aspects they tend to ignore”*
- *“They lived in deprived environment”*
- *“Black project not supported/funded”*
- *“Lack of proper housing allocated to the mentally ill”*
- *“Racism in the health system”*
- *“They go to the GP...not feeling well../maybe depression and are given medication, not ‘talking therapy’”*

Another expressed that:

“She was not aware that the problems were that bad, but upon reflection – expressed that “ this is not a new problem.... and that the relatives who returned to the Caribbean from England showing signs of mental ill health was always a topic of conversation and great cause for concern.”

Most in the group through their body language gave affirmation to the visible *“effects of medication on individuals that includes side effects”*

Their main concern that because of *“ addiction” –there is” ultimately a group within society that cannot make any valuable/ worthwhile contribution to society they live in.”*

“Racism- the lack of participation in respect of one’s treatment and also in respect of the professionals involved in that treatment were also raised as important issues.”

Concerns were raised in respect of the –“*Incarceration of young people as young as 11 in the mental institutions* “and “*They put a lot of blacks who have mental problems in prison and prison is not the place for them.*”

3. **How can the present services be improved to meet the needs of the African Caribbean community?**

Education and training:

There needs to be more training about culture because of the stereotyping of black people.

“Once you are black everybody believes that you are Jamaican.”

“Culture awareness”

“Proper diagnosis by GP’s.”

“Appropriate and culturally sensitive treatment.”

Services

Professionals to be targeted are

The police. *“The police need to take a different approach when dealing with black people.... in England once you are black everybody believe that you are from Jamaicaits there everything starts”*

The GP. *“If a black man is suffering with stress or mentally ill and is being taken to the doctor he needs to be diagnosed properly...If not they are given wrong medication and that person is mad for the rest of their lives”.*

“ The stigma...that person is stigmatised. As soon as a black person goes to the doctor with stress they are given antidepressants and it leads from there...You can’t even ask no questions or nothing.”

Employment

“Create opportunities for people to get jobs... Caribbean people coming here with all there A- levels... it is difficult for them to get jobs and they are out there. They need to remove some of the stressful agents and make it easier for people to get national insurance numbers; remove barriers, make things simpler to get jobs etc.... it’s hard, really hard.”

Employer’s need to *“Acknowledge overseas qualification.”*

Legislation

“The mental health act need to be revisited...it is not mutual because if a black person is convicted and they believe that the person is a danger to society that person can be locked up in a secure mental institution”

“Legislation must not only seem to be fair but must also be seen to be executed fairly.”

Community Engagement

“There should be more programmes like this so that we as black people can be educated to help ourselves.”

“Hope that this is not just another dead-end research. I have heard and been part of researches before that that have gone no where”

4a **Are you aware of any counselling services for the African Caribbean community in the area?**

Some 95% did not know members of the African Caribbean community who does any form of counselling as a career.

4b **What do you do when you feel stressed?**

(This probed question was asked because of the response to the former question)

Faith is an important aspect of the black family. Most respondent’s tap into

“ Belief in the love and goodness of God to find relief when they are mentally distressed.”

Many openly admitted that

“They find relief in prayer and encourage each other to do the same.”

Others find help from family and friends near and far.

“take the telephone up and talk to my family “

Still others feel that a “good cry “ is therapeutic.

5. **Do you know any member of the African Caribbean community who does any form of counselling?**

Only one respondent out of 20 knew anyone.

6. **Would the ethnicity of a talking therapist you were referred to matter to you?**

Most respondents were more interested in the issue of choice rather than that of ethnicity.

They agreed that they would

” Love to see more black professionals in the system “they would prefer “understanding rather than theory... Empathy rather than sympathy” “training is the key.”

“If you go to one (counsellor) and you are not satisfied you should be given a choice.”

“This is where choice comes in, because no matter who you are whether black or white you may not understand.”

“Choices - not only of counsellors but of environment identified in treatment.”

7. Can you see yourself developing a career in one of the talking therapies?

There were 11 people who expressed an interest in getting information/pursuing training in counselling.

8. What elements would you like to see included in any course identified for the African Caribbean community?

“ Elements of culture, behaviour, and religious components taught alongside”

SERVICE USERS FOCUS GROUP FINDINGS

The service user focus group met over a period of 3 days during the months of October and November 2005. Accessing this information from the user group needed a measure of sensitivity and patience but the information gathered was crucial to the research.

1. Are you happy with the services you receive from the NHS system?

The majority of the service users said that they were not happy with the services that they receive from the NHS. Their responses include:

- *“They have double standards and treat white people different from us.”*
- *“If you complain to staff, they do not listen; they just try to fob you off.”*
- *“When you complain or talk to them they never have anything positive to say, they are always negative.”*
- *“They don’t catch you in time, they wait till your at your worst.”*
- *“I think when you cry for help, you should be seen straight away, not six months down the line.”*
- *“It’s good that we have day centres like this, because when you attend the staff can notice the warning signs and changing patterns.”*
- *“Sometimes you phone the teams, and you just want to talk, and they admit you into hospital.”*
- *“Sometimes when family members are in hospital or get sectioned, the staff don’t tell you when they move them, not even a phone call, or tell us when they change their medication.”*
- *“A lot of the time, the family are the last to know what is happening to those in hospital.”*
- *“Even when, black people look after black people, there’s need to be more empathy.”*
- *“The first port of call should be your G.P. and the G.P. needs to listen and do more for you, instead of sending you into hospital.”*

2. Do you understand the medication you take and its effects?

The responses below, indicates that the service users did not understand the effects/side effects of the medication that they were taking.

- *“When I ask my doctor to reduce my medication, he always tells me that I’m not ready yet, but it’s my body.”*
- *“They help me when I’m down, but I have looked at other medication.”*
- *“I don’t understand about my medication, I just take them.”*
- *“I hate the medication I take; it’s a breach of human rights.”*
- *“They never explain what the medication does, or what the side affects will do.”*
- *“They never give you just one set of pills.”*
- *“I just want to come off them. I took them when I was really ill, but I feel it’s time to stop.”*

3 If you have been in hospital, what services/support were you offered after being discharged from hospital?

The respondents identified the following:

Care in the Community

- *“After being discharged from hospital, a community psychiatric nurse came to see me; she explained she was coming to help me with my medication”.*
- *“I went to my community centre, because I wanted to be around Black people”.*
- *“My key worker visited me every fortnight, it helped me with my mental health”.*
- *“My social worker helped me with my housing and my benefits”.*

4 What improvements would you like to see in the mental health system for Black people?

Service User Involvement

- *“They need to listen to the people; find out what their problems are, not just give you needles”*
- *“We need to form a conference, and we do down there and sit down with these people, like Tony Blair, the Politicians and even the Queen, and talk to them about how black people feel with mental health problems. When they hear about black people with mental health, all they believe is that we are going to kill somebody with a gun or knife. Then they say, “there’s another black person with mental health, let’s lock him up.” “All they do is write us off, because we have mental health and we’re black.”*
- *“I would like to see black organisations running their own mental health place. Some black people have a better understanding of their own black people and some don’t”.*
- *“I would like to see more black people helping and supporting other black people with mental health problems and not being judgemental”.*
- *“Why don’t they give us jobs to help black people move on”?*
- *“They need to listen to us first, before they give us medication or put us in hospital, not everybody needs to go into hospital”.*
- *“The NHS has got worse; they take advantage of people, especially black people, always drugging you up and putting us in hospital for a very long time”.*
- *“The police need to change their attitude towards black people with mental health, they’re just as bad as the nurses in the hospital”.*

5. What are your views on Counselling?

Most people cited the element of **Trust**

- *“Don’t trust them, I went to see a counsellor once and before I left the building, I heard her telling someone else about what we had talked about.”*
- *“I personally would not go down that road because I’ve had some bad experiences with counsellors in the past, I don’t trust them either.”*
- *“The counsellor only wants to give you a short piece of time, and then take you off their book.”*
- *“They don’t offer counselling, because it’s too expensive; and black people like to express themselves and it would take too long.”*
- *“I would rather talk to my cat, than talk to a counsellor; it’s about trust, at least my cat isn’t going to talk.”*

6. Would the ethnicity of the counsellor make a difference?

The responses include:

- *“If their black, they may know your family and friends and tell them your business and it’s supposed to be confidential and private.”*
- *“It would be ok to have a white counsellor, because they wouldn’t know your family.”*
- *“Some black people would be better, as they would understand where I’m coming from.”*
- *“They would have an understanding about oppression and racism.”*
- *“They would know what it’s like being black and having problems.”*
- *“Black people are told not to chat their business, so we tend to keep a lot inside, especially the fear of someone else knowing our business.”*
- *“In spite of what we are saying about black counsellors, doctors and nurses, we still want black people to help us with our mental health.”*

7. **When you are feeling down, how do you relax?**

General

“Phone advice line”
“I go out and socialise”
“You have to know who to ask for help”
“Phone a friend that you can trust”
“I phone my mom”
“I have a cup of tea and a fag”
“Keep fit”
“Yoga”
“Play music”
“Listen to music”

Faith/Religion

“Pray a lot”
“I read my bible”
“I always pray, and read my bible to give me comfort”
“I read the bible; it tells you how to manage your life”
“Religion does help”
“Prayer is important”
“You can only trust in God”

8. **What are the barriers you face when looking for work or training because of your mental health?**

The barriers identified are:

Prison record

“I had a prison record, no-one wants to give me a chance”.

Learning Difficulties

“People need to recognise that everyone’s illness is different and learning difficulties is a part of mental health.”

Stress/Environment

“Going to work can be stressful!”
“Your work environment can make you have breakdowns, depending what work you do.”

Intolerance

“Employers should have a scheme to allow you back to work after a relapse.”

Stereotypes

“People need to look outside of the person’s appearance and see the talents inside.”

“If your black and you have mental health, and there’s a white person with mental health, chances are they will get the job instead of the black person.”

“If you have the qualification, it does not mean you will get the job.”

“It’s like the advert says, look at the person, not the disability.”

Lack of Confidence/Motivation

“Sometimes, we need the encouragement and support to just get out of bed, and when we do people should praise us.”

“We have the motivation, but they don’t want to give us the job.”

“We need encouragement to help us find work, mental health is hard, thats why we need more education and training.”

Discussion

This discussion section covers the findings from the report including demographics and statistics, a reflection of the research process and reflections from the perspectives of the researchers.

Sample group

The sample group consisted of 70 individuals aged 18-65, of which 50 were from the community, 11 were from a church based focus group and 9 were from a service user focus group. It is important to note that the findings of this report are subjected to the sample groups selected, and are not representative to the general population.

The age span under research is 18-65 years. The project by design chose not to use children or elderly people. It is hoped however that some work would be done on these group to determine their level of mental health awareness with a view of influencing policies and practices.

The largest age group that took part in the research project were between the ages of 40-49 years (37%) the gender balance was fairly even with (49%) males and (51%) females.

The largest ethnic group consulted was black Caribbean (83%). 13% of the participants reported themselves as Black British, 1% Black African, 1% as Black European and another 1% gave no response.

Ninety seven (97%) of the respondents were British citizens, of these 50% were born outside the UK and the other 50% were born in the UK. The majority of the respondents (71%) has been living in the UK for 11 years and more, 19% for between 6-10 years, 4% between 1-5 years and another 4% for less than 1 year. 2% did not respond.

English was identified as the language that 92% of respondents felt most comfortable speaking, 7% were more comfortable with Patois and 1% said that they spoke Somalian.

With regard to religion 65% stated that they were Christians, covering such groups as Pentecostals, Church of England, Methodists, Catholics and Baptists. 16% said that they were Rastafarians, 3% Muslims, and Spiritualists, Believer in God, Ethiopian Orthodox, and Jewish 1% each and 1% did not state a religion. Of those who stated that they were Christians 36% did not indicate any particular denomination.

Ninety one percent of respondents 91% stated that they were heterosexual while 9% gave no response. This relatively high percentage of non-response seems to underscore the relevance and the sensitivity of this question in data collection. 23% of respondents declared that they had a disability that ranged from mobility problems to schizophrenia.

Mental health

Of the 70 participants contacted, there seemed to be varied degrees of awareness of mental health and mental health issues. There was a very small percentage that showed no awareness and felt that they could not contribute to the project. However there were 37 respondents who showed a high degree of awareness by virtue of the fact 9 were service users and the others had a family, spouse and or close friend using the mental health services.

Fifty six percent (56%) of respondents were aware of the issues surrounding the care and treatment of mental illness in the BME community, 39% were not aware of the issues and 5% gave no response.

Of those participants who had experience of mental health distress and received treatment from the NHS a high proportion (30%) was given medication only while only 8% were offered counselling. A further 22% received in-patient coupled with medication with another 3 % had inpatient coupled with counselling. The in-patient periods varied between less than 3 months and 7-12 months.

The follow up services showed that a majority of people (12%) received Community psychiatric Nurse(CPN) and consultant GP services 5 % had a social worker and 2% had no support after being discharged.

Furthermore, of those questioned (76%), stated that they received help/support from family, 10% received support from friends and a further 4% from the church. The other 10% support was received from community worker and voluntary support. There was no response from a further 10%. The Handsworth community care and COPE were the voluntary organisations most mentioned.

Support

A high percentage of people (80%) were not aware of any counselling services for the African Caribbean community in the locality. Some 54% stated that they would prefer to be counselled in their home, 28% in a day centres, churches and community centres. Another 18% did not specify. An institutional setting was never mentioned. The researchers are however aware that there are health and safety issues to be considered with these preferences.

Seventy five (75%) said that they have offered help/support to family, friends, co-workers and service users with mental distress.

Of the respondents that were interviewed, the majority (66%) did not know of any member of the black community who is a talking therapist.

When asked about their knowledge of voluntary support services in the area only 27% of the respondents answered in the affirmative citing, Omnicare, (formerly Handsworth community care) and COPE . Two statutory agencies, the Ladywood Day Centre and the NHS Crisis Line were also mentioned.

Of the respondents who stated that the ethnicity of the therapist would be important to them (76%) stated that understanding and empathy were the key factors. For those who said that ethnicity was not an issue (39%). choice and professionalism as more important.

Careers, employment, training

The percentage of people in employment and those who were unemployed was even (49%). The other 2% (1 individual) did not give a response. Those who were unemployed stated that they had tried Jobcentre plus (48%), Pertemps alliance (24%), newspapers (4%), and 24% gave no response.

The participants identified the support systems in place to help them succeed as personal coaches, complaints procedures, and occupational therapy. However, with regard to the question as to what other support system they would like to see put in place to help them succeed responses included.

- *“more equal opportunity exercised in the workplace”*
- *“more one to one support for employees”*

- “more black people in upper management”
- “more facilities for the disabled”
- “counsellors based in the workplace”
- “fast track procedure for dealing with complaints and counsellors made available during this process”

Of the respondents interviewed 48% said that they can see themselves developing a career in one of the talking therapies. 39% showed no interest citing various reasons, 9% were unsure and another 8% gave no explanation.

A high percentage of respondents (80%) had never undergone a training course in counselling. However of the 14% who said that they had done a course 75% thought that it was very good, and the other 25% thought that it was good.

In respect of the availability of information about taking up counselling as a career 24% admitted to have picked information from places like seminars, the internet, the post, Citizens advice bureau and the Ladywood day centre. This information was rated as good, did not deal with issues of culture and heritage, and interesting.

If there were a course in counselling identified for the African Caribbean community, 63% of respondents said that they would be willing to pursue it provided that it was culturally appropriate and offered qualification levels up to professional status.

The project has also identified a number of people from the African Caribbean community who are considering careers in counselling and other talking therapy disciplines in an effort at addressing the imbalance in the National health Service and the private sector, thereby offering the community, and specifically the service users.

The findings seem to indicate that for the service users the experience is that of being on an ever-revolving door.” *I just want to come off them, I took them when I was really ill, but I feel its time to stop.*” For the families/carers the experience is that of facing a closed door “*should have more family support*” “*Tap into family*” “*Incorporate family and friends*” “*A lot of the time, the family are the last to know what is happening to those in hospital*” “and the community is asking an open door.” *There should be more programmes like this so that we as black people can be educated to help ourselves.*”

Reflections of the process

The research project began in June 2005 in office space provided by the Aston Christian Centre. The four researchers, all from African Caribbean heritage (1 male and 3 females) came together as a team to complete this research project. All researchers attended the workshops on Mental Health policies and practices and community research and two went on to complete the certificate in community based research offered by the Centre for Ethnicity and health, University of Central Lancashire.

From the onset the researchers took the project to heart. The first task was to identify the strengths of each researcher and capitalising on that. Although the team had never worked together it was evident that each researcher came to the table with special abilities and skills that would ensure the success of the project.

The workshops, and the support of the worker assigned to the project from UCLAN ensured that the project was ethically sound, that the researchers and those interviewed were not placed at risk and that everything was on schedule. There were some issues that arose that would have compromised on the confidentiality and anonymity promised to respondents but these were

resolved. The researchers were able also to get the cooperation of the respondents without monetary incentive. Money was never offered and it was never solicited.

The researchers took the opportunity to raise awareness of the project and to pilot the questionnaire at the Aston Pride festival held on September 4th 2005. As a result of this some valuable lessons were learnt and changes made to the formatting and delivery of the questionnaire.

It was a privilege for the team to have attended the 'Turning the tide' conference in Manchester on October 3rd and 4th. Although we found the presentations very inspiring, the experience that was most relevant and offered insight to our project was sitting in on the carers' workshop and hearing them talk about their experiences.

The research facilitated their first workshop at the 'Dementia plus' conference held in Birmingham on November 2, 2005. Although we were confident about the content of the presentation our unfamiliarity with the power point technology was evident.

During the interviews some 30 people expressed an interest in getting more information and /or pursuing a course in counselling during the interviews. On November 24 Novelette Aldred of Tranquility counselling facilitated a taster session in counselling on behalf of the project at the Pertempts Alliance facilities in the Newtown Shopping Centre in Birmingham. From the evaluations received this session was a success.

This project was successful in reaching a community labelled 'hard to reach.' and extract valuable information that should be used to influence policies and practices in the care and treatment of mental ill health. This success was to a large extent due to the fact that all the researchers are of African Caribbean origin and therefore had a common reference point with the community under research. The African Caribbean community is an accessible and vibrant community willing and ready to participate in any project programme that will ensure and encourage positive changes for individuals and the community on a whole.

CONCLUSION

Delivering race equality in mental health care is an action plan to improve mental health services in the BME communities. The three main points:

- More appropriate and responsive service
- Community engagement
- Better information

In keeping with this agenda this ‘talking therapies’ community engagement project has succeeded in interviewing 70 people of the African Caribbean community in respect of their awareness of mental health issues, and to hear from them how this service can be improved/changed to meet the needs of the African Caribbean community. Of these 50 were interviewed from an office establishment situated in the Newtown shopping centre, 10 from a focus group held at the Victoria Evangelical church and 9 were service users who regularly attend the Handsworth Community centre. The data were collected and analysed to produce the findings.

For those contacted, mental health and mental health issues with people of African Caribbean community gives great cause for concern. This is in keeping with other reports, which indicate that there are issues of racism and discrimination in the system and therefore the treatment meted out to the community under research is inadequate and ineffective. It seems to be the popular opinion that “talking therapies’ would be a viable option and something that should be seriously considered as treatment in place of, or alongside medication.

However, although most would be happy to see ‘**friendly**’ face, the issue for most is not the ethnicity of the talking therapist, *“but whether the therapist has undergone adequate training, has cultural awareness, is gender sensitive, and treats the client with respect.”* The majority would like to know that *“they have a choice in respect of the therapist and also an input into decision in respect of the treatment they receive,”* and *“the families/carers of people with mental health problems wants to participate actively in the treatment of their loved ones.”*

These findings also suggest that there is a need *“for early intervention”* as a way of preventing a mental health crisis in the BME community. Concerns raised during the focus group held at the church include concerns over *“bullying in schools and peer pressure”, “look at children’s behaviour generally” and “the number of children in child mental institutions” “Focus on youths, and” the Government has taken away the responsibility of children away from parents.”*

There were concerns raised over the number of young men who have committed suicide in the area around the time that the research was been undertaken. *“Look at under 20’s in respect to their mental health in view of the recent suicides in the area, and “address drug issues”*

In our targeted sample there are a high number of African Caribbean people using the mental health services. Nevertheless, of the large number of the public interviewed showed a lack of awareness of mental health issues. As a result of this there is a need of the targeted community for more forums around mental health. *“There should be more programmes like this so that we as black people can be educated to help ourselves.”*

Service users of the sample group claims that they cannot make informed decisions in respect of their mental health treatment because they *“do not understand about the medication”* In most cases the effects and side effects of medication are not explained to them and further more they do not realise and it is not explained to them that they have choices. They want the emphasis shifted from the old adage that **‘doctors know best’** to **‘only who feels it knows it’**.

None of the respondents interviewed indicated any established institutional setting as a preferred place for counselling sessions. The most common sites were churches, at home, and day centres. We however, recognise that this has health and safety implications for the counsellor.

Service users indicated that “*more peer group settings managed and run by service users themselves, and café’ style walk in services*” would be more beneficial to their recovery. “*User forums that are real and purposeful (not tokenistic) have to be considered*” as alternate treatment.

“We need to form a conference, and we go down there and sit down with people, like Tony Blair, the Politicians and even the Queen, and talk to them about how black people feel with mental health problems. When they hear about black people with mental health, all they believe is that we are going to kill somebody with a gun or knife. Then they say that there’s another black person with mental health, lets lock him up! “All they do is write us off, because we have mental health and we’re black.” (quote from a service user).

The people interviewed also highlighted the need for more African Caribbean ‘talking therapists’ to be trained and recruited in the system and a refresher course in cultural, racial gender and other related issues for those who are already practising.

“More black mental health care”

“More black people involved in counselling”

“Trained black professional nurses and doctors”

“Professional should learn more about the person’s background and needs”

“More information and, community awareness programmes”

(quotes from the participants)

The research highlights the need for more joint work between different agencies, particularly colleges and higher education providers that deliver counselling courses. They should ensure that the courses delivered are culturally applicable, racially sound, with elements of religion, gender and history.

“Elements of culture, Behaviour, and religious components taught alongside” (quote from the church focus group)

It is vitally important that the stakeholders make use of this report and take into consideration the findings that have emerged from this report and address the needs of the community. As a result of this research the following recommendations are made for service providers, key stakeholders and commissioners.

Key recommendations

1. The Primary Care Trusts should “contract out” the care and treatment of the mentally ill to voluntary and charity sector organisations such as Aston Christian Centre and Omnicare Ltd who have proved that they have access to BME community and that culturally sensitive services be delivered from non-stigmatised settings like churches, community centres, walk in cafes .
2. Birmingham and Solihull Mental Health Trust need to invest in colleges and universities to ensure that the courses and programmes offered recognise the personal, racial, social and cultural experiences of the African Caribbean community.
3. The Department of Health needs to commission research in particular into the mental health needs of African Caribbean young men as concerns were expressed over the high suicide rate among this group as early intervention could prove to be a beneficial strategy.
4. All agencies offering health care should appoint a Public Relations Officer who will become the link between the community and the health services and whose remit will include the dissemination of good quality information to the African Caribbean community.

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Demographics of Aston – Birmingham City Council

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APPENDICES

i) Demographics of Aston

Aston Ward is situated to the north of Birmingham city centre and covers parts of the old Aston and Handsworth wards. It has a younger age profile than the City average. The percentage of ethnic minority residents is above the city average. Unemployment is above the city average.



The figures shown below are for the new ward boundaries, which came into effect in June 2004. Please note that only limited official data is currently available for the new wards and that the Census data is based on estimates produced by Birmingham City Council, which may vary slightly from data produced by ONS.

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DEMOGRAPHIC

Aston Ward Population by Age

Years of Age	Number of People	Percentage of Ward Population
0-4	2,871	11.2
5-15	5,574	21.7
16-17	1,023	4.0
18-19	1,111	3.9
20-24	2,637	10.3
25-44	7,655	29.9
45-49	2,932	11.4
60-74	2,596	10.1
75-85	823	3.2
85+	230	0.9
Total	27,452	-

Source: 2001 Census, Crown Copyright/BCC

Aston Ward Population by Ethnic Group

Ethnic Group	Number of People	Percentage of Ward Population
Asian	13,701	50.1
Asian - Bangladeshi	4,185	15.3
Asian – Indian	3,063	11.2
Asian – Pakistani	6,082	22.2
Black	5,535	20.2
Black – Caribbean	4,489	16.4
Chinese, other	578	2.1
White	6,388	23.4
White – British	5,499	20.1
White – Irish	624	2.3
Mixed Background	1,128	4.1

Source: 2001 Census, Crown Copyright/BCC

Aston Ward People with a Limiting Long-Term Illness

	Number of People	Percentage of Ward Population
People with a Limiting Long-Term Illness	5,311	20.7

Source: 2001 Census, Crown Copyright/BCC

Aston Ward Household Type

Household Type (excludes communal households)	Number of Households	Percentage of Households
Private households	9,670	-
Lone parent households*	1,428	35.0
Average persons per household	2.80	-

Source: 2001 Census, Crown Copyright/BCC

* percentage of households with dependent children that are lone parent households

Aston Ward Household Tenure

Household Tenure	Number of Households	Percentage of Households
Owner Occupier	3,662	34.6
Rented: local authority	3,283	31.0
Rented: housing association	1,315	12.4
Rented: privately	861	8.1

Source: 2001 Census, Crown Copyright/BCC

Aston Ward Car Ownership

Car Ownership	Number of Households	Percentage of Households
Households with no car	5,524	52.2
Households with 2 or more cars	778	7.4

Source: 2001 Census, Crown Copyright/BCC

EMPLOYMENT AND UNEMPLOYMENT STATISTICS

Aston Ward Economic Activity

Economic Activity (men aged 16-64 / women aged 16-59)	Number of People	Percentage of Ward Population
Economically Active	8,239	52.4
Economically Inactive	7,479	47.6
Employed	5,840	37.2
With No Qualifications	7,731	49.2

Source: 2001 Census, Crown Copyright/BCC

Aston Ward Unemployment by Gender

	Male	Female	Total
Number of Unemployed	1,477	377	1,854
Unemployment Rate	28.9%	12.1%	22.5%

Note: Birmingham Average Unemployment Rate is 8.4%
Source: Office for National Statistics / BEIC (August 2005)

Aston Ward Largest Employer Organisations

Organisation Name		Number of Employees (rounded to nearest 10)	Nature of Business
1.	Royal Mail	1,500	Postal activities
2.	Floors 2 Go plc	600	Wood & laminate flooring
3.	Timet (UK) Ltd	600	Non ferrous metal production
4.	McNicholas Construction	500	Construction Engineers
5.	Gass	500	Utility contractors for Transco
6.	Legrand	400	Electrical Accessories
7.	Centro	340	Passenger Transport Executive
8.	Aston Villa Catering	320	Catering
9.	West Midlands Police	300	Police
10.	West Midlands Passenger Transport Executive	300	Local government transport
11.	Goliath International (Tools) Ltd	240	Manufacturers of Taps & Dies
12.	Widney UK Ltd	220	Off road vehicle windows
13.	Aston & Fincher Ltd	210	Hairdressing supplies wholesalers
14.	Birmingham City Council (Transportation Dept)	200	Transport Policy, road maintenance
15.	Bailey Peerless	200	Hot metal forgings/stampings

Source: Birmingham Chamber of Commerce & Industry