

## Research paper

# Inpatients from black and minority ethnic backgrounds in mental health services in Wales: a secondary analysis of the *Count Me In* census, 2005–2010

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### What is known on this subject

- Studies suggest that people from minority ethnic backgrounds fare less well in the mental health systems in the UK, the rest of Europe and America.
- The way in which services are used and experienced by individuals from different minority ethnic and migrant groups is just as much a product of their own beliefs, needs, social experiences and expectations as it is a product of the attitudes and perceptions of service providers.
- There is limited empirical research and evidence on the care pathways of people from racialised population groups and their experiences of mental healthcare provision in Wales.

### What this paper adds

- The paper provides baseline information on key protected characteristics (race, as well as gender, sexuality and religion) of inpatients in mental health hospitals and facilities in Wales over a 6-year period.
- The paper contributes to the evidence base on the mental health pathways of people from racialised backgrounds.
- Within the context of devolution and the development of nation-specific mental health systems, the paper provides evidence to underpin future research priorities for regional and national policy initiatives in Wales.

## ABSTRACT

*Count Me In* was an annual census of mental health inpatients that was undertaken in England and Wales from 2005 to 2010. Apart from brief, unpublished commentaries by the Welsh government, the data generated in Wales have received little attention and limited analysis. This paper presents a secondary analysis of the census data, with a focus on mental health inpatients from Black and minority ethnic (BME) backgrounds in Wales.

Analyses focused on the number and characteristics of patients (age, gender, ethnicity, language and religion), the distribution of patients across Wales, sources of referral, detention status under the Mental Health Act 1983 on admission, and length of stay from admission to census day. The results revealed that the numbers of BME patients from different ethnic groups fluctuated over the 6 years; it was difficult to identify any distinct pattern.

The number and proportion of BME patients admitted to, or being supervised by, inpatient facilities increased year on year from 57 (2.7% of all patients) in 2005 to 76 (3.2%) in 2010. The three highest ethnic-group categories were 'Other', 'Black African' and 'Mixed Caribbean.' Racialised minorities in Wales were over-represented in inpatient mental healthcare, including compulsory detention. A consistently higher proportion of BME people than White people in Wales were referred from the criminal justice system, while a consistently higher proportion of White people than BME people were referred by GPs.

Although the results cannot reveal the care pathways followed by particular groups or indicate emerging trends for the BME inpatient population, there are differences between the majority and minority ethnic population groups. Action is required to address this imbalance, and future data collection is necessary to determine whether this action has any impact. In-depth exploration of care pathways remains another clear priority for research and policy.

**Keywords:** inpatients, mental health, minority ethnic groups

## Introduction

Inequities in mental healthcare delivery and access for people from minority ethnic groups have been reported in several European countries (Hjern *et al*, 2004; Lay *et al*, 2006; Norredam *et al*, 2010) and also in America (US Department of Health, 2001; Boyd *et al*, 2011). Explorations of the global transnational context of mental health, the impact of diagnostic tools, and the pathways to care, support and recovery have attempted to explain or address these inequities from diverse perspectives (e.g. Secker and Harding, 2002; Cantor-Graae and Selten, 2005; Morgan *et al*, 2005a; Singh and Burns, 2006; Moffat *et al*, 2009; Sass *et al*, 2009; Morgan and Hutchinson, 2010; Bennewith *et al*, 2010; Bhui *et al*, 2003). Inherent in these explorations is a preoccupation with understanding the process of racialisation, that is, how ideas about race are mapped on to particular groups or populations and how the consequent forms of racism affect people's mental health and well-being.

Current evidence suggests that socially ascribed differences such as race, ethnicity, socio-economic status and geographical location may lead to poorer mental health and mental health outcomes. Social differences may also have a negative impact on access to mental health information, treatment and recovery pathways (e.g. Pinto-Foltz and Logsdon, 2008). Social isolation and exclusion are cited as being of particular importance (Tew *et al*, 2012). Finally, social differences may also affect utilisation, experience and knowledge of mental health and social care services, and compliance with or acceptance of treatment and care pathways (e.g. Sashidharan, 1993; O'Connor and Nazroo, 2000; Arai and Harding, 2002; Kirkbride *et al*, 2008).

In the UK, the impact of some of these social differences has been well documented. Black Caribbean and Black African patients are more likely than their

White counterparts to experience coercion and compulsory admissions (Bhui *et al*, 2003; Morgan *et al*, 2005a,b). Large-scale mental health surveys (Nazroo, 1997; Weich *et al*, 2004) and national censuses (Erens *et al*, 2001; Singleton *et al*, 2001; O'Brien *et al*, 2002; Meltzer *et al*, 2002; Sproston and Nazroo, 2002; Singleton and Lewis, 2003; Sproston and Mindell, 2006; Neighbors *et al*, 2007; McManus *et al*, 2009) have mapped in detail the experiences of, and pathways through, mental health services of people from racialised backgrounds. Such evidence has also demonstrated that the way in which individuals from minority ethnic backgrounds use and experience mental health services is as much a product of their own beliefs, needs, social experiences and expectations as it is of the attitudes and perceptions of service providers (e.g. Owens *et al*, 1991; Nazroo, 1997; Williams and Williams-Morris, 2000; Keating and Robertson, 2004; Saltus and Kaur-Mann, 2005; Bowl, 2007; Pieterse *et al*, 2012).

## Mental health and Wales

Wales has a long established history of migration from diverse societies. There is consequently considerable variety with regard to histories, settlement patterns, residential status and occupational profiles within the population, which makes Wales markedly different from other countries in the UK, particularly as there is an absence of politicised collectivities providing a strong voice as to the needs of minority ethnic groups (Williams *et al*, 2007).

As in other parts of the UK, mental health is a Welsh Government priority, with policies in place to raise the standard of mental health service provision, reduce hospital (re)admissions, enhance the inpatient environment, and address and reform specialist services (Welsh Assembly Government, 2005, 2006, 2009).

However, there is very limited empirical research and evidence, in Wales, on the health and social care of minority ethnic groups in general, not least the mental health of people from racialised population groups and their experiences of mental healthcare provision (Saltus, 2005; Saltus and Kaur-Mann, 2005). A study by Papadopoulos and Lay (2008), which included focus group interviews with participants from BME backgrounds ( $n = 96$ ), found that many participants felt that mental health problems related to the impact of migration and difficulties adjusting to this transition, the oppression of women, and accompanying social isolation and negative health behaviours. There was also a perception that mental illness was misdiagnosed in some cases. Smith (2007) interviewed people with disabilities from Black African and Caribbean backgrounds in Cardiff and the Vale who had a psychotic condition. The findings showed a lack of support from mainstream mental health services. None of those interviewed were employed, and all felt that their mental health condition was a major impediment; many were not aware of specialised employment support available to them. Aspinall (2006) identified that barriers to accessing mental health services experienced by some BME people with mental health problems related to perceptions of symptoms as somatic rather than psychiatric in origin, lack of knowledge about statutory services, lack of access to bilingual health professionals, and lack of social support. A study by Thomas *et al* (2010) of service users' and carers' perspectives on their involvement in mental healthcare planning and delivery found that participation in decision making was largely absent. Thomas *et al* (2010) concluded that more needed to be done to effectively engage hard-to-reach BME groups.

## Study design

*Count Me In* was an annual census of mental health inpatients under the Mental Health Act (1983), and from 2008, those receiving supervised treatment in the community under the Mental Health Act (2007). The census was undertaken in England and Wales on a specific day in March, every year, between 2005 and 2010 (see Box 1). This paper reports on the secondary analysis of data from this 6-year census, with a focus on mental health inpatients from BME backgrounds based in Wales. There is no published evidence on the disaggregated data for Wales.

Secondary analysis of survey data is a well-established research method that allows for the timely collation, interpretation and re-interpretation of data that can inform research agendas and aid in the formulation of policy and practice initiatives. A detailed

### Box 1 Count Me In

The census was part of the Department of Health (England) programme of work to:

- improve mental health services for minority ethnic groups
- develop service provision via community engagement and support
- encourage providers to collect ethnicity data
- take practical steps in combating racial discrimination in the provision of services (Department of Health, 2005).

explanation of the development and testing of the original census tool was provided by the Mental Health Act Commission (replaced in 2008 by the Care Quality Commission), which coordinated *Count Me In*. The yearly findings were presented in a series of Microsoft Excel spreadsheets that were made fully accessible to the public; moreover, these were disaggregated by country and also by region, allowing for this analysis of data relating to Wales. Information was captured in three main areas, namely demographic information, administrative details (i.e. whether the service was a mental health or learning disability service), and details of individual patients' treatment. This paper presents the results relating to the distribution of patients across Wales, their characteristics (age, gender, ethnicity, language and religion), source of referral, detention status under the Mental Health Act 1983 on admission, and length of stay from admission to census day.

## Data analysis and interpretation

In our analysis, the term 'patient' refers both to inpatients in mental health facilities in Wales and to outpatients subject to supervised treatment in the community under the Mental Health Act (2007). Where data have been analysed by minority ethnic group, the term 'BME' refers to all ethnic minority subcategories listed in the UK 2001 national population census (Office for National Statistics, 2001); in this context the term 'White' is used to refer to patients from the subcategories of 'White British', 'White Irish' and 'Other White.' With our primary focus on patients from visible minority ethnic backgrounds, we are aware that this excluded White minorities; the 'White Irish group' is considered to be a minority ethnic group. Although the *Count Me In* census used ethnic categories derived from the UK national population census, the use of ethnic categories in research will always be open to criticism (see Box 2).

### Box 2 Challenges in ethnicity and health research

These challenges include:

- the transformatory and socially constructed nature of ethnicity and of social identity, and the varying extents to which and contexts in which racialisation affects individuals across the life course
- conceptual and methodological imprecision
- the ways in which concepts such as 'minority' and 'ethnicity' are used in research.

(Ahmad and Bradby, 2007; Aspinall, 2007; Nazroo, 2006; Burton *et al*, 2010; Salway *et al*, 2011)

Our data analysis involved looking at the key characteristics of patients in mental healthcare and of the provision of this healthcare in Wales. In some instances, data were compared with those for England; for example, we compared the BME patient population with the White patient population in both countries in terms of key healthcare indicators captured in the census. This was achieved by comparing the numbers and proportions of each sample population across the census years. In most analyses, the valid response rate was used. This excludes any responses that were categorised in the raw data as being invalid and, where appropriate, responses of 'unknown.' Where there were a significant number of invalid or 'unknown' responses for any question, this is highlighted and discussed. The data as presented did not discriminate between potential types of invalid response or indicate what these might constitute. Ethnicity was not recorded for 0.9–1.5% of all subjects in England for all years, and for 0.5–1.1% of all subjects in Wales for all years except for 2010, which had a large unexplained increase to 7.8% missing ethnicity data. The amount of invalid or unknown data in other categories varied. Among the variables discussed in this paper, the variable with the largest amount of invalid or unknown answers was religion, with median proportions of missing data of 22.2% and 17.1% for Wales and England, respectively, across the time period of the study. Other variables had smaller proportions of missing data, for example, 'length of stay' with median proportions of missing data of 0.4% and 1.1% for Wales and England, respectively. Although there may be some categories that are more likely to produce 'unknown' answers, as this is a secondary analysis of previously collected data it was not possible to revisit the source and explore whether there are patterns in the distribution of missing answers, or to identify other characteristics related to a particular piece of missing data. As such, no imputations have been made. The data have been treated as

if they were missing completely at random, which Howell (2012) has noted will mean that estimated parameters are not biased by their absence ([www.uvm.edu/~dhowell/StatPages/More\\_Stuff/Missing\\_Data/Missing.html](http://www.uvm.edu/~dhowell/StatPages/More_Stuff/Missing_Data/Missing.html))

## Results

### Patient distribution across Wales

The annual censuses recorded the number and type of mental health service providers and the number of patients cared for by each service provider; this included, for 2009 and 2010 only, those subject to supervised treatment in the community under the Mental Health Act (2007). Over the period of the census, the total number of patients in mental health services in Wales increased by 11.4% (from 2117 to 2359), although some of this increase was accounted for by outpatients. The number of independent providers, together with the number and proportion of patients in the independent sector, more than doubled over the 6-year period in Wales. The most recent census indicated that the number of independent service providers was beginning to decline slightly or perhaps to stabilise. Provision of inpatient care by the independent sector in England had also grown, although at a slower pace. In the baseline year (2005), the proportion of mental healthcare provided by the independent sector was higher in England than in Wales, but that situation has changed in more recent years, with Wales overtaking England in 2008.

The number of patients from White and BME backgrounds based in hospitals or centres in the most ethnically diverse areas of Wales, namely Cardiff, the Vale of Glamorgan, Swansea and Newport, and other places was examined for the years 2008 and 2009 (see Table 1). In both years, there were no patients based in the Vale of Glamorgan, while 10% of the total patient population was based in Newport. Around one-third of BME patients could be classed as based in mental health facilities outside the above areas. The proportion of BME mental healthcare patients in each location was very similar to the proportion of people from BME backgrounds resident in these places in the 2001 UK census.

### Patient characteristics

#### *Ethnicity*

Ethnic origin was recorded for approximately 99% of patients in each of the census years until 2009; during this period, the number of people for whom ethnic origin was unknown ranged from 11% to 23%. How-

**Table 1** Distribution of mental healthcare patients across Wales

Ethnic group, year*	Cardiff (%)	Swansea (%)	Newport (%)	Vale of Glamorgan (%)	Other (%)	Total (n)
BME, 2008	42.53	9.20	12.64	0	35.63	87
White, 2008	15.78	24.80	10.86	0	48.56	2117
BME, 2009	38.04	10.87	9.78	0	41.30	92
White, 2009	16.08	24.74	10.48	0	48.71	2090

\* Data are not accessible in the same format for 2005, 2006 and 2007. Data for 2010 could not be obtained.

**Table 2** Number of patients from ethnic groups in Wales (2005–2010)

Census group	Census category	2005	2006	2007	2008	2009	2010
White	British	1962	1954	1962	2055	2021	2042
	Irish	45	32	26	16	18	15
	Other White	41	63	62	51	97	43
Mixed	White and Black Caribbean	6	8	15	9	10	8
	White and Black African	3	0	1	3	0	2
	White and Asian	5	2	3	4	4	6
	Other Mixed	2	4	8	6	8	6
Asian or Asian British	Indian	3	3	7	8	5	3
	Pakistani	2	4	3	3	7	5
	Bangladeshi	4	2	1	4	4	4
	Other Asian	1	5	1	3	4	7
Black or Black British	Caribbean	6	2	11	9	17	9
	African	9	6	10	8	17	9
	Other Black	4	5	1	4	5	8
Other ethnic groups	Chinese	2	3	1	5	3	5
	Other ethnic groups	10	13	4	19	8	4
Not stated	Not stated	12	11	21	16	23	183
Invalid	Invalid	0	0	0	0	0	0
Total number of BME patients		57	57	66	85	92	76
	Total	2117	2117	2137	2223	2251	2359

ever, ethnic origin was not recorded for approximately 8% of the total sample in 2010 ( $n = 183$ ). The numbers of BME patients from different ethnic groups fluctuated over the course of the 6-year period, and it is difficult to identify any distinct pattern, especially

given the high number of invalid or 'unknown' responses for ethnic origin in 2010, some of which may belong to BME groups (see Table 2). However, the number and proportion of BME patients who had been admitted to, or were being supervised by, in-

patient facilities saw a year-on-year increase from 57 (2.7% of all patients) in 2005 to 76 (3.2% of all patients) in 2010. Aside from the 'other' ethnic group category, Black African and Mixed Caribbean ethnic groups predominated in each census year; the same can be said of the Black Caribbean group for every year except 2006. It is also interesting to note the increasing number of people classed as 'Other White' until 2009, after which this figure declined to approximately the same value as was recorded in the baseline year. Although the number of patients from White backgrounds increased until 2010, the actual proportion gradually decreased each year.

### **Age**

Patients in Welsh mental healthcare facilities over the census period were much older than those in England. The majority of patients in Wales (approximately 56–64%) were consistently aged 50 years or over, compared with approximately 43–49% of patients in England. A small proportion of patients in both Wales (4–7%) and England (7–9%) were aged 18–24 years. There appeared to be a slight trend emerging in terms of the age profile of mental healthcare patients in both Wales and England from 2006, with modest increases in the proportions of those aged 25–49 years and a corresponding decrease in those aged 50 years or over. Based on the 2001 UK national population census, approximately 8%, 32% and 36% of the Welsh population were aged 18–24, 25–49, and 50 years or over, respectively. Thus it appears that those aged 18–24 years were slightly under-represented in the patient population, while those aged 50 years or over were greatly over-represented. Those aged 25–49 years were slightly over-represented in some census years, although changes in the demographic profile of the population since 2001 may account for this. Those aged 17 years or under were usually treated within child mental health services. Looking at the BME patient population in Wales, the majority were aged 25–49 years in each of the census years, with this majority increasing annually from 55% in 2005 to 68% in 2010. Unlike the general population, older people accounted for less of the total number of BME patients; this is probably due to the younger age structure of many of the BME population groups.

### **Gender and sexual orientation**

In terms of gender, over half (approximately 56%) of the patient population in 2010 was male, representing a continuing increase in the proportion over previous years. Likewise, figures from England showed an increasing proportion of male patients in each of the census years, and this majority was slightly larger than in Wales in all years. Among the BME patient population in Wales, men represented an even greater proportion in all census years (64–76%).

Sexual orientation was recorded as 'not known' for at least 10% or more of the sample between 2006 and 2010, while the number of those selecting 'prefer not to say' ranged from none of the patient population (in both 2009 and 2010) to approximately 11% (in 2006). More people identified themselves as heterosexual in 2010 (approximately 87%) than in 2006 (approximately 78%). This does not indicate changing proportions of patients who identified themselves as gay/lesbian, bisexual or 'other'; these categories remained stable at approximately 1% in each year except for 2006, when the proportion in the 'other' category was approximately 10%. This inconsistency in the figures does not necessarily reflect real variation in the sexual orientation of the patient population. Instead, it could be due to the absence of the 'not known' category in 2006 that was available in subsequent years, and also to what appears to be the non-use of the 'prefer not to say' category in 2009 and 2010.

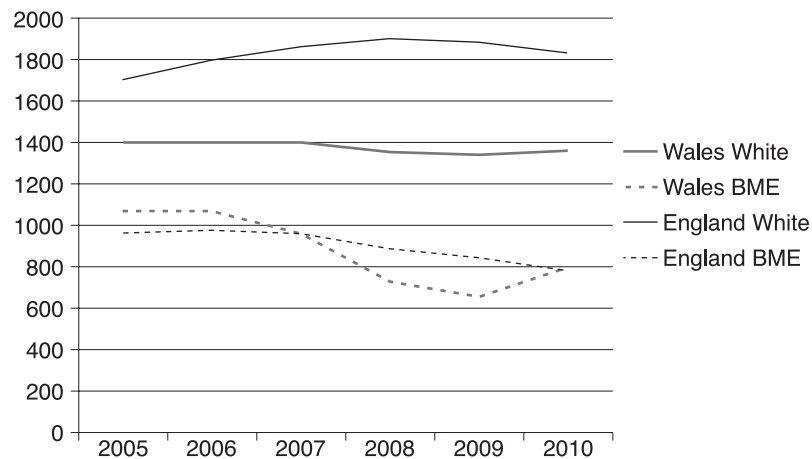
### **Language and religion**

For over 90% of the White population in each year their first or preferred language was English, for approximately 4–6% it was Welsh, and for approximately 1% it was another language. Of all patients in mental healthcare facilities during this period, 1% or less of the population required an interpreter. However, a higher proportion of BME patients than White patients in both Wales and England required an interpreter. In 2006 and 2010 it was found that for 16% and 37%, respectively, of the BME patients their first or preferred language was not English.

The largest proportion of patients in the census years 2006 to 2010 were of Christian faith. In these same years, from 14% of patients in 2006 to around 30% in 2010 did not state their religion. The proportion who stated that they had no religion ranged from around 13% to approximately 18% over the 5 years. Very small proportions (approximately 1% or less) of the patient population in each year identified themselves as being Buddhist, Hindu, Jewish, Muslim or Sikh.

### **Admissions and detention**

Admission refers to the number of inpatients who were in detained in hospital on each of the six census days. For the years 2009 and 2010, the figure also includes all mental health patients who were outpatients subject to a community treatment order on census day. Using the 2001 UK national population census, we can see that people from BME backgrounds were over-represented in the patient population in each of the census years in comparison with people from White backgrounds, with the difference in representation between the ethnic groups increasing (see Figure 1).



**Figure 1** Number of individuals in the general population for every 1 inpatient in Wales and England.

In Wales, the ratio for the White ethnic population groups remained much the same throughout the census period, while the ratio decreased overall for BME patients, meaning that there was greater over-representation of BME patients in 2010 than in the baseline year. In Wales, for every patient from a BME background, there were approximately 1081 BME people in the general population in 2005, with an increased ratio of 1 to 810 by 2010. Among people from White backgrounds, the ratios remained relatively stable, at 1 to 1387 in 2005, compared with 1 to 1353 in 2010. In England, too, there was a higher representation of BME than White patients, together with a similar trend to that seen in Wales of growing over-representation of the BME patient population.

A higher proportion of White than BME patients in both countries were detained informally. The proportion of both BME and White people detained informally in both Wales and England declined during the census period, although there was greater fluctuation for the BME group. This means that an increasing proportion of mental healthcare patients were being detained formally; it appears that most of these were detained under Section 3 of the Mental Health Act (2007). This section provides for the compulsory admission of patients to hospital for treatment and for their subsequent detention, which can last for an initial period of up to 6 months and is renewable after this (Care Quality Commission, 2010). A consistent pattern across all census years was that the BME patient population in both Wales and England had a higher proportion detained formally (under Sections 3, 37/41, 47, 48 and 47/49) as opposed to informally, compared with the White patient population.

### *Source of referral*

The data relating to sources of referral to inpatient care allowed us to look at referral routes in order to

ascertain whether there were any distinct patterns for mental health patients in Wales. However, the figures for referrals from community mental health teams may include referrals from other original sources, such as general practitioners (GPs) and Accident and Emergency (A&E) departments, as do the figures for referrals from tertiary care (Care Quality Commission, 2010). Therefore full mapping of referrals and pathways to care is impossible. Moreover, data from 2005 were excluded from the analysis, as they were captured differently from data in subsequent years.

Excluding those patients for whom source-of-referral information was not available, over 50% of all patients in Wales were referred from either community teams or 'other inpatient services', while the majority of patients in England were also referred from these sources. The proportion of patients referred from the criminal justice system was approximately 6–9% (median 8.2%) for Wales, and 9–11% (median 10.2%) for England during the years 2006 to 2010. Meanwhile, the proportion of patients referred from medium- or high-security facilities was approximately 3–5% (median 3.7%) for Wales, and 5–7% (median 5.6%) for England (see Tables 3 and 4). Referrals from the criminal justice system and from medium- or high-security facilities were generally higher in England, and tended to increase slightly every year, but to decline overall in Wales. A similar decline in the proportion of patients referred by GPs was observed in both England and Wales from 2006 to 2010. However, there was fluctuation in the intervening years in Wales, while the decline in England was steady. The proportion referred from 'other' sources increased substantially in the years 2009 and 2010 in Wales, mainly as a result of increases in referrals from both A&E and local authority social services. Overall, the patterns of referrals from all sources in England varied little, with steady annual increases or decreases. The pattern of referral

**Table 3** Sources of referral for all patients in Wales, 2006-2010

Source of referral*	GP (%)	Community team (%)	Other inpatient service (%)†	Criminal justice system (%)‡	Medium-/high-security facility (%)	Other clinical specialty (%)	All other sources (%)§	Valid total (n)	Missing (invalid or unknown)
2006	15.8	24.8	27.2	8.0	3.6	13	7.6	1764	353
2007	9.7	34.5	30.4	8.6	4.6	7.2	5.0	1865	272
2008	7.3	40.1	26.5	8.2	5.1	4.3	8.5	1981	242
2009	12.0	34.2	22.5	6.0	3.7	5.4	16.3	2194	57
2010	7.3	27.8	26.0	5.8	2.4	14.4	16.6	2062	297

Percentages are based upon valid responses, excluding missing data.

\* Those with unknown sources of referral are excluded from the figures.

† 'Other inpatient service' includes referrals by both NHS and independent providers.

‡ 'Criminal justice system' includes referrals by the police, courts, probation services, prisons, and court liaison and diversion services.

§ 'All other sources' includes referrals by education services, employers, carers, local authority social services, A&E and asylum services, plus self-referrals.

**Table 4** Sources of referral for all patients in England, 2006-2010

Source of referral*	GP (%)	Community team (%)	Other inpatient service (%)†	Criminal justice system (%)‡	Medium-/high-security facility (%)	Other clinical specialty (%)	All other sources (%)§	Valid total (n)	Missing (invalid or unknown)
2006	15.7	24.1	20.7	9.8	5.1	13.5	11.0	28 580	1326
2007	14.6	26.0	22.4	9.6	5.6	10.6	11.1	27 249	1701
2008	11.7	28.3	21.9	10.2	5.5	11.4	11.0	27 095	1702
2009	10.7	28.8	22.9	10.7	6.0	11.3	9.7	27 350	2185
2010	8.1	29.8	24.0	10.7	6.5	10.3	10.6	26 493	3947

Percentages are based upon valid responses, excluding missing data.

\* Those with unknown sources of referral are excluded from the figures.

† 'Other inpatient service' includes referrals by both NHS and independent providers.

‡ 'Criminal justice system' includes referrals by the police, courts, probation services, prisons, and court liaison and diversion services.

§ 'All other sources' includes referrals by education services, employers, carers, local authority social services, A&E and asylum services, plus self-referrals.

from sources in Wales was characterised by much more fluctuation.

Thus it appears that the routes of referral for both BME and White patients in England and Wales were broadly similar, with a consistently high proportion of patients from both groups in each census year referred by community teams, inpatient services or the criminal justice system. Differences were apparent between

the two groups in terms of the consistently higher proportion of BME than White patients referred from the criminal justice system compared with White inpatients, and the consistently higher proportion of White inpatients referred from the GP compared with BME inpatients.



### Length of stay

Length-of-stay data indicate the duration of each patient's stay in hospital from admission until census day (not their release date). In nearly all cases, this figure is shorter than the patient's full length of stay (Care Quality Commission, 2010). Patients' length of stay in Wales was generally 1 to 3 months. Approximately 66–69% of the patient population had been in hospital for less than 1 year between 2006 and 2010, and so around one-third had been there for more than 1 year. Examination of the median duration of hospital stay in relation to ethnicity for Wales revealed that there was no trend or pattern that suggested that the BME population's experience differed from that of White patients.

## Discussion

### Study limitations

The survey results should be understood within the context of some limitations. First, many analyses were not conducted by ethnic group, and where they were, the small numbers of patients involved meant that the analyses were descriptive in character. For example, the small sample size of the BME inpatient population in Wales precluded the standardisation of results by age and gender. Much more analysis is needed to explore the richness of the data set while at the same time being mindful of its restrictions.

A second limitation of the data is the large number of individuals for whom ethnicity was unrecorded in 2010, compared with other years. This makes it difficult to establish some trends with certainty, so caution is needed when interpreting the results. Linked to this limitation is the fact that the use of ethnic categories and ethnicity-linked variables remains problematic because of the multidimensional nature of the concept and the host of other factors known to have an impact on and to shape one's sense of identity, access to and experiences of care, and pathways through mental health systems towards recovery. Moreover, there are known ethnic variations in the age and gender profile of the Welsh population, with those from White ethnic backgrounds tending to have an older age structure than those from the minority ethnic groups, while Black and Asian populations have the highest proportion of men of all ethnic groups (Statistical Directorate, 2004). Therefore differences observed in the results may be attributable to ethnic differences in these characteristics, or indeed to a range of other factors that the census data did not measure, such as the diagnosis and severity of the mental health illness.

The *Count Me In* questionnaire altered slightly over time. Several items were not covered in 2005 (which meant that we had to omit this census from some results), while the categories for some questions changed slightly from year to year (limiting the analysis to selected years for some questions). In addition, the 2001 UK national population census data were used to compare the representation of BME and White people in the population of mental healthcare patients. There have been changes in the demographic population since 2001, so caution must be exercised when interpreting results based upon this approach.

### The study's contribution

Despite these limitations, the study does add to the evidence base of empirical research. The study revealed that, over the census period, the majority of the patient population in Wales was male, aged 50 years or over, predominantly English speaking, and of Christian faith. Compared with other patients, the BME population tended to be younger, an even higher proportion was male, and a higher proportion did not have English as their first or preferred language. The findings reveal that the numbers of BME patients from different ethnic groups fluctuated over the course of the 6 years, and it is difficult to identify any distinct pattern. However, the number and proportion of BME patients admitted to inpatient facilities increased annually until 2010. Aside from the 'other' ethnic group category, Black African and Mixed Caribbean ethnic groups were among the three highest for numbers of BME patients in each census year. The same can be said of the Black Caribbean group in every year except 2006. It is also interesting to note the increasing number of people categorised as 'Other White' until 2009, after which this number declined to approximately that recorded in the baseline year.

Although the total number of patients was very small, BME people in Wales, as in England, were over-represented in inpatient mental healthcare, and a higher proportion was compulsorily detained as compared with their White counterparts. This is consistent with findings in the empirical research literature (e.g. Bhui *et al*, 2003; Coid *et al*, 2000; Aspinall, 2006) and in all *Count Me In* reports published by the Care Quality Commission (2010). Much more work is needed to address the disproportionate rates of inpatient admission and detention among BME service users.

In terms of referrals, this secondary analysis of the census data found that a consistently higher proportion of BME than White people in Wales were referred from the criminal justice system, whereas a consistently higher proportion of White than BME people were referred by GPs. Entry via the criminal justice system for certain BME groups may be explained by a

number of factors. Several studies have shown that some minority ethnic patient groups experience more complex and coercive pathways to specialist services, greater contact with helping agencies or carers prior to admission, and more involvement with police and emergency services (e.g. Bhui *et al*, 2003; Morgan *et al*, 2004; Leese *et al*, 2006; Pereira *et al*, 2006; Bowers *et al*, 2008). A study by Morgan *et al* (2005b) found that, after controlling for other contributing factors, the odds of GP referral for both African Caribbean and Black African patients were less than half of those for White patients. Possible reasons for this include variations in primary care assessments, delayed help-seeking behaviour, and lack of family involvement in help seeking (Bhui *et al*, 2003; Morgan *et al*, 2005b). Thus, compared with other groups, some BME groups experience pathways to care more often as crisis interventions. It is important to note that the findings could not reveal the care pathways followed by particular groups or even indicate trends emerging from the BME inpatient population.

## Summary

This paper has provided a descriptive secondary analysis of the mental health data covering the 6 years during which the *Count Me In* census was conducted in Wales. Although they do not reflect people's experiences of the quality of services, the census data provided, for the first time, valuable baseline information about the ethnicity of patients in mental health hospitals and facilities in Wales. Moreover, although providing only a one-day snapshot of patients in Welsh establishments, the *Count Me In* census provides a baseline in terms of numbers and key points along the care pathway.

With the discontinuation of the *Count Me In* census in England and Wales, there is a substantial gap in ethnic monitoring in Wales. None of the operational sources for mental health data in Wales collect data relating to ethnicity (Statistical Directorate, 2011). Although there are a number of limitations to utilising and analysing survey and administrative data as reliable sources of ethnicity data, the dearth of research on the mental health of BME people in Wales and on their experiences of mental healthcare provision needs to be addressed urgently.

Moreover, it is evident that much more work is needed to address mental health inequalities and inequities at a global level, not least in countries in Europe and in the USA where there are increasingly large and ethnically diverse populations. Of importance is the collation of statistical as well as experiential empirical evidence, and the development of policy that seeks to explore the social determinants of health

and the structural inequalities that underpin people's health and well-being as manifested in the delivery and organisation of care, as well as in the individual and collective responses. In-depth exploration of care pathways remains another clear priority for research and policy, as do the recovery pathways taken or forged by people from racialised backgrounds.

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#### CONFLICTS OF INTEREST

None.

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