Continuing professional development

Making the *Count Me In* census (2005–2010) count in Wales

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The concept of 'race' (Miles, 1989; Winant, 2000; Fredrickson, 2003) in mental healthcare continues to be a pressing concern for academics, practitioners and mental health advocates. Inequities in mental health-care 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). There is a growing body of research that explores access routes, diagnosis, rates of detention, and care pathways of a range of migrant groups, with attention given not only to racialisation, but also to a host of social and environmental factors that have an impact on a person's mental health and well-being (e.g. Secker and Harding, 2002; Bhui *et al*, 2003; Cantor-Graae and Selten, 2005; Morgan *et al*, 2005; Singh and Burns, 2006; Moffat *et al*, 2009; Sass *et al*, 2009; Morgan and Hutchinson, 2010, Bennewith *et al*, 2010). What is evident from these studies is that 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.

The *Count Me In* census, which took place annually from 2005 to 2010, represented an attempt to address some inequities by requiring service providers to actively engage with ethnic monitoring and tackle racial discrimination. The census counted and recorded the ethnicity of every inpatient in mental health and learning disability hospitals in England and Wales on 31 March each year (Care Quality Commission, http://archive.cqc.org.uk). The census reports reflected and sharpened our understanding of what had already been revealed by the research evidence. In contrast to people from many of the White majority population groups, those from visible minority ethnic groups, and from Black groups in particular, faced higher detention rates under the Mental Health Act, were more likely to be admitted to intensive care and secure services, more likely to be forcibly restrained, more likely to be given higher doses of antipsychotic medication and more likely to be placed in seclusion (supervised confinement in a room, which may be locked to protect others from significant harm).

The last census took place in 2010, and it seems that little has changed. Admission rates remain higher than average among some minority ethnic groups, especially Black and White/Black Mixed groups. In contrast, admission rates remain average or lower than average among the South Asian (Indian, Pakistani and Bangladeshi) and Chinese groups. Rates of detention under the Mental Health Act are higher than average among the Black, White/Black Caribbean Mixed and Other White groups (but not in other ethnic groups). The rates for detained patients placed on a Community Treatment Order (CTO) are higher among the South Asian and Black groups. Although there have been fluctuations in seclusion rates, they have generally been higher than average for the Black, White/Black Mixed and Other White groups (Care Quality Commission, 2011). 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 people from minority ethnic backgrounds in Wales and on their experiences of mental healthcare provision needs to be addressed urgently.

What is needed in research?

Addressing the seemingly intractable problem of mental health inequities requires acknowledgement that there is more to 'race' than racism, and that mental health and care must be examined in the global context and from a range of positions (Singh and Burns, 2006). Such examination must include:

- exploration of the role of social factors that impede as well as enhance recovery, and also exploration of

notions of 'resilience' in capturing individual and collective ways to recovery and maintenance of mental well-being (see, for example, Tew *et al*, 2012; Kalathil, 2011)

- ending the conceptual and methodological imprecision that underpins the use of concepts such as 'minority' and 'ethnicity' (Nazroo, 1997; Ahmad and Bradby, 2007; Aspinall, 2007; Burton *et al*, 2010; Salway *et al*, 2011)
- continued exploration of the varying extents to which and contexts in which racialisation affects individuals with mental health problems across the life course
- giving attention to intersectionality approaches in research, where the focus is on perceptions and experiences that are rooted in the interdependent and mutually constitutive nature of individual identities and social categories such as 'race', gender, socio-economic status and sexual orientation
- greater insistence on the routine collection of meaningful and usable equality data that facilitate the monitoring of population groups and their care pathways through the health and care system, and the development of policies and practices that address health inequities (for a recent analysis see, for example, Psoinos *et al*, 2011; Johnson, 2012).

What is needed in Wales?

The annual *Count Me In* census (2005–2010) recorded valuable data across all of the equality strands. It is recommended that underpinning the new Mental Health Strategy for Wales, *Together for Mental Health* (Welsh Government, 2012), there must be a framework that will allow for the capture and recording of all equality data annually in order to address the impact of mental health services on the specific marginalised communities.

Given that people from minority ethnic backgrounds in Wales remain over-represented in inpatient mental healthcare, it is recommended that their needs and issues are kept high on the agenda and linked to the annual monitoring recommended. Real action should be taken to address this over-representation.

It is essential to recognise the needs of individuals from a diverse range of backgrounds. It is recommended that a comprehensive training and awareness plan, both for mental health practitioners (including those working in general practice, and in all other health and social care sectors) and for the community itself, is put in place and fully resourced.

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