Care Services Improvement Partnership CSIP

National Institute for Mental Health in England

Healthcare Commission

Count me in 2008

Results of the 2008 national census of inpatients in mental health and learning disability services in England and Wales

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Summary

This is the fourth national census of the ethnicity of all inpatients in NHS and independent mental health and learning disability hospitals and facilities in England and Wales. It was conducted on 31 March 2008, and follows a similar census carried out in 2006 and 2007, and a census of inpatients in mental health services only, which was carried out in 2005.

The census is a joint initiative between the Healthcare Commission, the Mental Health Act Commission (MHAC), the Care Services Improvement Partnership and the National Institute for Mental Health in England (NIMHE).

All patients are entitled to receive the same high level of healthcare, regardless of factors such as race, religion, age, gender, sexual orientation, and whether they have a disability. But people with varying patterns of mental illness use mental health and learning disability services in different ways. Therefore, in order to understand and focus on the differences in the way these services are used, Government agencies, commissioners and providers of services need to engage effectively with voluntary agencies, minority ethnic communities and the people who use services themselves.

This census aims to support this process by:

1. Obtaining accurate figures relating to inpatients in mental health and learning disability services in England and Wales.
2. Encouraging providers of health services to implement procedures for the comprehensive recording and monitoring of data on the ethnic group of patients.
3. Providing information to help health services move towards achieving the Government's five-year plan *Delivering Race Equality in Mental Health Care* (DRE), which aims to improve mental health services for black and minority ethnic communities. *The Race Equality Action Plan for Adult Mental Health Services in Wales* provides similar information.

The first section in this report provides information on inpatients receiving mental health services and the second section deals with inpatients receiving learning disability services. We make comparisons with results from the previous censuses in order to see any emerging trends.

Key findings*

Mental health

We obtained information about 31,020 inpatients who were on the mental health wards of 255 NHS and independent healthcare organisations in England and Wales. The overall patterns emerging from this census are broadly similar to those observed in previous years. This is perhaps not surprising, as 30% of the inpatients in 2008 were also inpatients in 2007, and 19% of them had also been in hospital at the time of the 2006 census.

The key findings are:

- The number of inpatients in each census has declined from 33,785 in 2005, to 32,023 in 2006, to 31,187 in 2007, and to 31,020 in 2008.
- The proportion of inpatients in independent hospitals has increased steadily from 10% of the total in 2005 to 14% in 2008, with a corresponding decline in the proportion of inpatients in NHS services.
- Information about ethnicity was available for 99% of inpatients, of whom:
  - 77% were White British
  - 10% were from Black or White/Black Mixed groups
  - 5% were from Other White groups
  - 3% were from South Asian (Indian, Pakistani and Bangladeshi) groups
  - 2% were White Irish
  - 3% were from other ethnic groups (including Chinese).

  Overall, 23% of inpatients were from minority ethnic groups, compared with 20% in the 2005 census. The increase was largely due to the increased proportion of the Other White group.
- 70% of inpatients from black and minority ethnic groups were inpatients at 27 of the 255 organisations involved in the census.
- 6% of inpatients reported that English was not their first language.
- Rates of admission were lower than the national average among the White British, Indian and Chinese groups, and were average for the Pakistani and Bangladeshi groups. They were higher than average among other minority ethnic groups – particularly in the Black Caribbean, Black African, Other Black, White/Black Caribbean Mixed and White/Black African Mixed groups – with rates three to five times higher than average, and almost 10 times higher in the Other Black group. These patterns are similar to those observed in previous censuses.
- One of the 12 goals of *Delivering Race Equality in Mental Health Care* (DRE) is to reduce admission rates among black and minority ethnic groups. In terms of the changes in admission rates between 2008 and the DRE baseline of 2005, we found that admission rates fell for the Other Black group, but they increased for all other Black and White/Black groups (Black Caribbean, Black African, White/Black Caribbean Mixed, White/Black African Mixed). The admission rate for the Other White group also increased between 2005 and 2008.

* All comparisons for ethnic groups are with the national average.

- Rates of referral from GPs and community mental health teams were lower than average among some Black and White/Black groups, and rates of referral from the criminal justice system were higher. Patterns were less consistent for other minority ethnic groups. Overall, 36% of patients were referred from tertiary services. However, the information on sources of referral does not capture the original source of referral.
- 45% of inpatients were detained under the Mental Health Act on admission, an increase on previous censuses (39% in 2005, 40% in 2006 and 43% in 2007). Overall rates of detention were higher than average among the Black Caribbean, Black African, Other Black and White/Black Caribbean Mixed groups (by 20% to 36%). Detention rates under section 37/41 (imposed by courts) were also higher in these groups (except Black African). Detention rates were also higher than average among the Other White and Pakistani groups.
- Another of the 12 goals of DRE is to reduce detention rates among black and minority ethnic groups. However, the patterns described above are broadly similar to those reported in previous censuses, with no evidence of a decline. Detention rates have been higher than average among:
  - Black Caribbean, Black African and Other Black groups in all four annual censuses (2005, 2006, 2007 and 2008).
  - The White/Black Caribbean Mixed group in three censuses (2006, 2007 and 2008).
  - The other White group in three censuses (2005, 2007 and 2008).
- A consistent pattern across all four annual censuses was the higher than average detention rate under section 37/41 for Black Caribbean and Other Black groups.
- Another of DRE's 12 goals is to reduce seclusion among black and minority ethnic groups. Rates of seclusion were higher than average among the Black Caribbean, Black African and Other Black groups, and among the Other White group. Some emerging patterns about seclusion rates over the four censuses to date are:
  - The proportion of all inpatients who had an episode of seclusion stayed fairly constant over the four censuses at about 4%.
  - The seclusion rate was higher than average for the Other Black group in all four censuses, with no evidence of a decline from the baseline of 2005.
  - The rate was higher for the Black Caribbean group in 2005, 2007 and 2008.
  - The rate was higher for the Black African group in 2005 and 2008.
  - The rate was higher for the Other White group in 2007 and 2008.
- Rates of hands-on restraint were higher than average among the Other White and White/Black Caribbean Mixed groups.
- Overall rates of self-harm and accidents stayed fairly constant across the censuses (at about 7% and 13% respectively). In 2008, as in previous years, rates of self-harm and accidents were generally low in the Black Caribbean, Black African and Other Black groups of patients, as were rates of self-harm in Indian, Pakistani and Bangladeshi groups, whereas the White British group had a higher than average rate of self-harm across all four censuses.

- The proportion of patients experiencing a physical assault (although the identity of the assailant is not specified) stayed constant between 2007 and 2008 at 12%, with a higher than average rate among the White/Black Caribbean Mixed and Other Black groups in 2008 (no ethnic differences were observed in 2007).
- As in previous years, 30% of patients had been in hospital for one year or more, and 19% for over two years. The median duration of stay from the day of admission to the day of census was two and a half months for women and five months for men. Overall, median lengths of stay were among the longest for patients from the Black Caribbean and White/Black Caribbean Mixed groups, with Chinese, South Asian and White British groups having shorter durations of stay.
- As in previous years, patients from the Black Caribbean, White/Black Caribbean Mixed and Other Black groups were more likely than average to be on a medium or high secure ward.
- 68% (the same as in 2007) of patients were not in a single sex ward. The proportion was lower among most minority ethnic groups than among the White British group (see definition of mixed ward accommodation on page 41).

Learning disabilities

We obtained information about 4,107 inpatients in 129 organisations providing services for people with learning disabilities in England and Wales. Again, the overall patterns are very similar to those observed in the 2006 and 2007 censuses, as 71% of the inpatients in 2008 were also inpatients in 2007, and 58% were also inpatients in 2006.

The key findings are:

- The total number of providers was 129 compared with 124 in 2006, and the number of patients fell from 4,609 in 2006 to 4,107 in 2008. The proportion of inpatients in independent healthcare organisations increased from 20% of the total in 2006 to 27% in 2008. The proportion of patients in NHS services fell correspondingly.
- Information about ethnicity was available for 99% of inpatients, of whom:
  - 88% were White British
  - 4% were from Black or White/Black mixed groups
  - 3% were from Other White groups
  - 2% were from South Asian groups
  - 1% were White Irish
  - 1% were from other ethnic groups (including Chinese).

  Overall, 12% of inpatients were from black and minority ethnic groups. Numbers of inpatients were low for several minority ethnic groups. These patterns are similar to those reported previously, except for the increase in the number and proportion of patients from the Other White group.
- Approximately 70% of inpatients from black and minority ethnic groups were inpatients at 27 of the 129 organisations involved in the census.

- 9% of inpatients reported that English was not their first language. Non-verbal languages were recorded for 7% of inpatients.
- Rates of admission were lower than the national average among the South Asian, Other Asian and Chinese groups, and were between two and three times higher than average in the White/Black Caribbean Mixed, Black Caribbean and Other Black groups. These results are similar to those reported in 2006, and those for inpatients in mental health establishments. It is likely that some of the patients from the Black groups are mental health patients.
- 42% of inpatients were detained under the Mental Health Act on admission, compared with 35% in 2006. Almost no ethnic differences were apparent, as in previous years.
- As in 2007, the rate of seclusion among the White Irish and Other White group was higher than average, although this was based on a small number of patients
- No ethnic differences were apparent for the rates of physical assault, hands-on restraint, self-harm and accidents.
- 71% of patients had been in hospital for one year or more, and 36% for over five years. The median duration of stay from the day of admission to the day of census was 37 months for women and 33 months for men.
- 57% (slightly lower than the 60% in 2007) of patients were not in a single sex ward (see definition of mixed ward accommodation on page 54).

Conclusions

The census was designed to support the goals of the Government's five-year action plan *Delivering Race Equality in Mental Health Care* (DRE) by providing an annual profile of inpatients in mental health services. It was not designed to provide explanations for the patterns observed, or examine whether mental health services are meeting the needs of individual ethnic minority groups.

Again, the findings of this fourth census show differences **between** mental health patients from black and minority ethnic groups and white groups, and also differences **within** these groups. The census also shows that patterns have remained relatively unchanged since 2005, and there has been no reduction in admission, detention and seclusion rates – key goals of DRE – among black and minority ethnic groups. However, the findings do not of themselves indicate that services are failing to meet the needs of black and minority ethnic service users.

The factors that contribute to these findings are complex and may differ between ethnic groups and areas. The findings need to be interpreted in the context of available evidence on ethnic variations in the rates of mental illness and the different pathways to care experienced by different black and minority ethnic groups and the possible contributory factors. However, these patterns reinforce the need for early intervention, with statutory services working together to reduce the risk of admission and detention where possible, and without compromising the care given to patients.

The findings about the Other White group are noteworthy, and could reflect the effects of recent demographic changes in the UK. It is important that mental healthcare services are responsive to psychiatric morbidity in these groups and are sensitive to their needs.

Delivering race equality in mental health care is complex, and requires the cooperation of various organisations to understand the problems and deliver the solutions. Mental health services have a key role to play, but partnership with statutory organisations outside the healthcare sector, black and minority ethnic communities and service users themselves will be needed to help achieve this. Services need in particular to focus around prevention and early intervention.

Overall, there is considerable room for improvement in the provision of single sex wards in both mental health and learning disability services. Commissioners and providers of mental health and learning disability services need to address this as a matter of high priority.

Recommendations

A number of recommendations can be drawn from the key findings of this report, some of which were also set out in the 2007 census report, and which we reiterate here.

1. DRE outlines an action plan for improving mental health services for black and minority ethnic communities. Healthcare organisations must work towards achieving the goals set out in the plan.
2. We recommend that statutory agencies, working in partnership with others, make every effort to understand the local demographic and clinical needs of the population, and to commission and deliver services that are personalised, effective, fair and which improve the pathways to mental healthcare taken by black and minority ethnic groups. Commissioners and providers of services also need to take into consideration the changing demographic profile of local populations.
3. We urge all providers of learning disability services to review the findings of the Healthcare Commission's reports into learning disability services, learn any lessons from them and act on the recommendations, to avoid the risk of serious failures of care recurring and to ensure services meet required standards.
4. We recommend that commissioners and providers of mental health and learning disability services make renewed and strenuous efforts to improve the provision of designated single sex wards for inpatients.
5. We expect commissioners and providers of mental healthcare, in both the NHS and the independent sector, to have fully comprehensive systems to record and monitor ethnicity. In the same way, it is also vital that learning disability services have accurate and sustainable ethnic monitoring arrangements in place.

We strongly recommend to the Department of Health and the Information Centre for Health and Social Care that:

6. Some changes and extensions should be made to the Mental Health Minimum Data Set (MHMDS) (the Healthcare Commission and MHAC have responded to the review of mental health information undertaken recently by the Information Centre, with proposals for changes to the MHMDS). In particular, changes and enhancements to current data collections (MHMDS and Hospital Episode Statistics (HES)) need to be suitable for supporting effective monitoring of the Mental Health Act 2007.
7. Submission of the MHMDS and HES should be made mandatory for all independent providers of inpatient mental health services, especially in view of the growing number and proportion of all mental health inpatients cared for in these establishments. Submission of these data sets should be a requirement in the mental health standard contract under development by the Department of Health.

8. The Information Centre should routinely monitor and publish reports on the quality of MHMDS data submitted by all providers of mental health services, including those in the independent sector.
9. Collection of ethnicity data about patients should be extended to primary care.
10. We recommend that the Information Centre regularly publishes data on all detentions and supervised community treatment orders under the Mental Health Act in England (in both NHS and independent healthcare providers) by the ethnicity of patients, to supplement its current publication on all detentions,[1] and with the longer term aim of the MHMDS being the definitive source of information about mental health patients, including on detentions.

High quality, appropriate data is essential for monitoring the way that patients gain access to healthcare, the quality of care they receive and the outcomes of that care. This applies to all patients with mental health problems and learning disabilities, including those from black and minority ethnic groups. Information that is fit for purpose is also vital for the effective regulation of mental healthcare services.

Changes to the regulation of health and social care

During 2005, the Department of Health undertook a 'wider regulatory review', which led to the publication of the consultation document *The Future Regulation of Health and Adult Social Care in England*. The consultation announced the Government's intention to create a new health and social care regulator bringing together the Commission for Social Care Inspection, the Healthcare Commission and the Mental Health Act Commission via the Health and Social Care Bill. Following this consultation, in November 2007 the Government announced that the Care Quality Commission will be established from 1 April 2009, and that a new regulatory framework will be implemented with effect from April 2010.

It is expected that the 2009 census will be undertaken by the existing organisations in March 2009, and the results will be published by the Care Quality Commission later in 2009.

Introduction

The Government aims to promote equality in healthcare – to ensure that the same high levels of healthcare are provided to all patients, irrespective of their age, gender, race, religion and sexual orientation, and regardless of whether or not they have a disability. It works to achieve this through policies and legislation with which healthcare organisations must comply.

Patterns of mental illness and the ways in which mental health services are used vary considerably between different ethnic groups. Addressing this requires the active participation of a range of groups and individuals including politicians, policymakers, providers of services from all sectors, commissioners of services, those who use services, carers, voluntary agencies and minority ethnic groups themselves.

On 31 March 2008, the Healthcare Commission, the Mental Health Act Commission (MHAC) and the National Institute for Mental Health in England (NIMHE) carried out a national census to record the ethnicity of inpatients in NHS and independent mental health and learning disability hospitals and facilities in England and Wales. The census also captured selected details concerning a patient's stay in hospital, such as how they were referred, how long they had been an inpatient, and whether they had been detained under the Mental Health Act. We collected information from 31,020 inpatients in mental health hospitals and 4,107 inpatients in learning disability hospitals.

This is the fourth Count me in census. Similar censuses were conducted in 2005, 2006 and 2007, although in 2005, only inpatients in mental health hospitals and facilities were included.[2,3,4] The censuses are undertaken in support of the Department of Health's five-year action plan for improving mental health services for black and minority ethnic communities, *Delivering Race Equality in Mental Health Care* (DRE).[5] The Department of Health requires healthcare organisations to work towards achieving the goals set out in this action plan, and to ensure compliance with its standards for improving healthcare set out in its framework document of 2004, *National Standards, Local Action.*[6]

The NHS Next Stage Review sets out a new foundation for a health service that empowers staff and gives patients choice.[7] It ensures that healthcare will be personalised and fair, that it includes the most effective treatments within a safe system, and that it helps patients to stay healthy. The World Class Commissioning programme aims to help the NHS to meet the changing needs of the population and deliver a service that is clinically-driven, patient-centred and responsive to local needs. It aims to do this by developing a more strategic, long-term and community-focused approach to commissioning services, where commissioners and health and care professionals work together to deliver improved local health outcomes.[8]

The Delivering Race Equality action plan requires commissioners and providers to take responsibility for implementing changes to services that are generally consistent with the requirements of these policy initiatives.

There are three building blocks in the DRE action plan:

- More appropriate and responsive services
- More community engagement
- Higher quality information, more intelligently used.

The Count me in census helps healthcare organisations with the third building block, by providing information that can be used to plan and deliver services that are relevant to, and informed by, the concerns and values of all groups within the community.

The action plan states that services should have 12 desirable characteristics in place by 2010. A 'dashboard', which enables healthcare organisations to measure outcomes for achieving the characteristics, helps to monitor six headline priorities:

- Access to early intervention services.
- Access to crisis resolution/home treatment services.
- Use of assertive outreach services.
- Access to psychological therapies.
- Impact of supervised community treatment orders.
- Recruitment and use of community development workers (CDWs).

Further details are available at: www.actiondre.org.uk

The census also supports the Welsh Assembly Government's *Raising the Standard: Race Equality Action Plan for Adult Mental Health Services in Wales*, published in October 2006.[9] This action plan aims to improve equality of access, treatment and outcomes in the provision of adult mental health services for minority ethnic groups in Wales. The headline actions of this plan are:

- Developing the evidence base – inpatient and community-based patient monitoring.
- Designing appropriate and responsive services, including conducting race impact assessments on all new major policies and procedures, where relevant.
- Training and recruitment.
- Delivery of services.
- Performance management, monitoring and audit.

Learning disabilities

The Department of Health's White Paper, *Valuing People*, set out the Government's vision for people with a learning disability across a range of services, based on four key principles of rights, independence, choice and inclusion, and detailed the problems and challenges that needed to be overcome.[10] The Department of Health has just finished a consultation *Valuing People Now: From Progress to Transformation* to examine the progress made by *Valuing People*. This sets out the Department's priorities for the provision of services for people with learning disabilities for 2008-2011, aimed at giving people with learning disabilities more choice and control over the services and support they need, and ensuring that mainstream public services become more inclusive of people with learning disabilities.[11] The main priorities identified for 2008-2011 are:

- Personalisation, so that people have real choice and control over their lives and services.
- What people do during the day.
- Helping people to be properly included in their communities, with a particular focus on paid work.
- Better health, ensuring that the NHS provides full and equal access to good quality healthcare.
- Access to housing.
- Making sure that the policy is delivered, including making partnership boards more effective.

A report by the Disability Rights Commission provides evidence that people with learning disabilities or mental health problems are more likely to experience major illness, to develop serious health conditions at an earlier age and to die of them sooner than other people. But at the same time, they are also less likely to receive some treatments than people with the same medical condition, but without a mental health condition or learning disability.[12]

People from minority ethnic communities who have learning disabilities have still greater problems. *Learning Difficulties and Ethnicity* noted that the disadvantage experienced by people from minority ethnic communities because of their ethnicity (in education and employment, for example) is compounded by the disadvantage they experience because of their impairment.[13]

The number of inpatients with learning disabilities is expected to decrease gradually over the next few years as patients are moved from NHS campuses to more appropriate community settings, therefore increasing their life experience, independence and everyday choice.

Aims of the census

The goals of the 2008 census are the same as those in previous years:

- To obtain robust figures for all inpatients (those detained under the Mental Health Act* and those admitted 'informally', that is, voluntarily) in mental health and learning disability hospitals and facilities in England and Wales.
- To encourage providers of such healthcare to put in place procedures for keeping accurate and comprehensive records of patients' ethnicity, and for using this information for ethnic monitoring.
- To provide information that will help providers of healthcare to take practical steps to achieve the Government's five-year plan, *Delivering Race Equality in Mental Health Care*.

As in previous years, there are two separate sections in this report – the first covers inpatients using mental health services and the second looks at those using learning disability services. Where possible, comparisons are made with results for previous years.

Although the census included some children and young people, we use the terms "men" and "women" throughout this report to refer to people of all ages – including children, young people and older people.

It should be noted that the census does not include children and young people in residential settings such as paediatric wards and services looked after by social services.

More information about the census and how it was carried out, including the full set of results, is available at: www.healthcarecommission.org.uk/countmein.cfm

* Revisions were made to the Mental Health Act 1983 in the Mental Health Act 2007. The census date of 31 March 2008 preceded the date (3 November 2008) when most of the revisions came into effect. Changes to the Mental Health Act will therefore be reflected in the 2009 census. In particular, the 2009 data collection will include new provisions establishing Supervised Community Treatment (s.17A) and exclude Supervised Discharge (s.25A), which is to be abolished.

National organisations coordinating the census

The Healthcare Commission

The Healthcare Commission is the health watchdog in England and promotes improvements in the quality of healthcare and public health in England and Wales. Concerns about the quality of services for patients are brought to the attention of the Commission, of which a significant number each year relate to services for people with mental health problems or learning disabilities.

In 2005, the Commission undertook an audit of violence in mental health settings, and in 2006 it published an action plan based on the findings.[14] The results of wave two of the audit were published in 2007.[15]

The Healthcare Commission's work covers both community and inpatient mental health services. In 2006, it conducted a joint review of specialist community mental health services in England.[16] The results provided a mixed picture of performance, with many services showing progress on staff training in diversity issues, but less progress on some of the strategic changes required to implement disability rights equality effectively.

In 2008, the Healthcare Commission published its findings from a review of the acute inpatient mental health services provided by all NHS trusts in England for adults aged 18 to 65.[17] The review identified that more needed to be done to ensure that acute inpatient services are personalised as a basis for promoting recovery, that they are provided in an environment where everyone feels safe, that they provide the most appropriate range of interventions and that the service is delivered within an effective care pathway. Overall, there were some encouraging findings in relation to acute inpatient service provision for people from black and minority ethnic groups:

- There were no differences in relation to the overall scores awarded for NHS provider trusts by the proportion of inpatients from black and minority ethnic groups.
- There were no differences between White British patients and those from black and minority ethnic groups in relation to medication prescribed above British National Formulary (BNF) limits during their first week in hospital.
- There were improvements in the proportion of staff trained in diversity issues, although further work is needed.
- There were improvements in ethnicity coding in hospital care records.

However, the findings also pointed to areas where there was scope for improvement in meeting the needs of people from black and minority ethnic groups:

- The views of people from black and minority ethnic groups were recorded less often on their care plans, although practice in this area was generally poor for all service users.
- Inpatients from black and minority ethnic groups were less likely to have a one-to-one session with ward staff during their first week of admission.

The Healthcare Commission is committed to ensuring that services for people with learning disabilities improve. Referrals relating to learning disability services have included concerns about adult protection, inappropriate use of restraint and the standard of care. The Commission's formal investigations into serious failures in learning disability services have shown that patients were receiving poor standards of care, unsafe services and abuse.

Following these investigations, the Commission implemented a national audit of learning disability services that involved peer groups of people with learning disabilities, family carers and clinicians, to assess the quality of services in England. The national findings were published in 2007[18], and identified the following key issues:

- General health services and choices are poorer for people with learning disabilities.
- Care planning, active treatment and meaningful occupation are poorer for people with learning disabilities.
- Abusive practices, poor environment and poor attitudes among staff appear to be an accepted part of the culture in some areas.

The audit recommended joint work between the Healthcare Commission, CSCI and MHAC to review commissioning for people with learning disabilities and complex needs. The work is now well underway.

The Commission coordinates a large, national programme of surveys about the experiences of patients. In 2008, it conducted its fourth survey of the experiences of people using NHS community mental health services in England. The Commission is also undertaking development work to conduct a survey of inpatients in NHS mental health services in 2009, and is exploring the feasibility of carrying out a survey of people with learning disabilities.

The Mental Health Act Commission

The Mental Health Act Commission (MHAC) is a special health authority established under the Mental Health Act 1983. It has two main statutory functions:

- To keep under review the operation of the Mental Health Act in relation to detained patients, and to visit and interview these patients in private.
- To manage arrangements for second opinions concerning the consent provisions of the Act (notably at section 58).

In 2007/08, MHAC met with over 6,000 detained patients to discuss their care and treatment, and its panel of consultant psychiatrists conducted nearly 12,000 independent statutory reviews of treatment plans proposed for patients.

Since 2005, MHAC has hosted a service user reference panel of between 20 and 30 people who are either detained under the Act or have recently experienced such detention. This panel advises MHAC on its priorities in visiting, development and publication of findings, and members of the panel have taken part in visits. The panel complements further representation by service users among appointed Commissioners and at board level.

MHAC works in partnership with the Healthcare Commission and the Commission for Social Care Inspection (CSCI) on various projects and in sharing information. In 2008/09, it is taking part in a joint review of the assessment of commissioning services for people with learning disability and complex needs.

From its first biennial report in 1985, MHAC has consistently drawn attention to the disproportionate admission and detention of patients from black and minority ethnic groups. Its 11th report *In Place of Fear* drew attention to the difficulties faced by patients from black and minority ethnic groups and the importance of tackling discrimination, developing culturally relevant and appropriate services, and using the Delivering Race Equality action plan as the basis for achieving real and lasting change.[19] Its 12th report *Risk, Rights, Recovery* again highlights the need for improvements in the quality of services for people from BME groups.[20]

Care Services Improvement Partnership (CSIP)

CSIP was established in 2005 by the integration of a number of initiatives supporting the development of health and social care services. CSIP is a partnership of four national programmes, delivered through nine regional development centres (RDCs). The RDCs and national programmes are jointly commissioned by the Department of Health and strategic health authorities.

The RDCs and national programmes work to:

- Develop capacity and capability locally to achieve improvements in delivery
- Support policy implementation
- Support the development of policy.

The RDCs' activity is focused on four core programmes – social care, NIMHE (mental health), children and young people, and health and social care criminal justice. Social care programmes include work on older people, learning disabilities and the CSIP networks.

National Institute for Mental Health in England (NIMHE)

NIMHE was formed in 2002 to help the mental health system implement the National Service Framework for Mental Health and the NHS Plan.

NIMHE's strategic objectives are to:

- Improve health and wellbeing
- Support services and improving performance
- Promote equality, access, choice and independence
- Support system change.

The NIMHE work programme seeks to implement national policies for local benefit, taking a whole systems approach across health and social care. The work takes place:

- Nationally, through NIMHE's programmes contributing to and supporting the implementation of national priorities and programmes.
- Regionally, through the RDCs, and in partnership with the strategic health authorities and Government Offices, to share information and good practice and facilitate collaborative work.
- With sectors to broker agreements setting out the focus of programmes, plus additional work required locally.

Changes to the regulation of health and social care

During 2005, the Department of Health undertook a 'wider regulatory review', which led to the publication of a consultation document entitled *The Future Regulation of Health and Adult Social Care in England*. The consultation announced the Government's intention to create a new health and social care regulator bringing together the Commission for Social Care Inspection, the Healthcare Commission and the Mental Health Act Commission via the Health and Social Care Bill. Following this consultation, in November 2007 the Government announced that the Care Quality Commission will be established from 1 April 2009, and that a new regulatory framework will be implemented with effect from April 2010.

It is expected that the 2009 census will be undertaken by the existing organisations in March 2009, and the results will then be published by the Care Quality Commission later in 2009.

Data, methods of analysis and interpretation

Ethnic groups

The ethnic categories referred to in this report are those used by the Office for National Statistics (ONS) in its 2001 census of the general population of England and Wales (see box 1). The term 'black and minority ethnic groups' defines all groups other than 'White British'.

Box 1: Ethnic categories used in this report

White British	Other Mixed	Black African
White Irish	Indian	Other Black
Other White	Pakistani	Chinese
White/Black Caribbean Mixed	Bangladeshi	Other
White/Black African Mixed	Other Asian	
White/Asian	Black Caribbean	

Coverage of learning disability establishments

The 2008 census included all independent providers in England registered with the Healthcare Commission and all independent providers in Wales registered with the Healthcare Inspectorate Wales, under section 2 of the Care Standards Act 2000 to provide inpatient learning disability services. It did not include care homes registered only with social services.

In the NHS, there is a continuum from inpatient services through to registered and supported homes. All of these can have some links to the NHS, either directly or through seconded staff. Where such NHS facilities were both registered as care homes under the Care Standards Act 2000 and regulated by the Healthcare Commission, they were included. Those regulated by CSCI were not eligible for inclusion in the census.

Distinguishing between mental health inpatients and learning disability inpatients

Distinguishing the patients using mental health services from those using learning disability services was not straightforward. Some healthcare providers offer both services and there is considerable overlap between them. The census asked providers to distinguish between the services by describing wards as either "mainly providing mental health services" or "mainly providing learning disability services". The 2005 census only included wards that provided mainly mental health services. This separation of results by type of ward gives us a means of comparing the results across years, and also ensures that no patient was counted twice.

It is important to note, however, that not all patients on the "mainly mental health wards" are there because of a mental health problem and not all patients in "mainly learning disability wards" are there because of a learning disability. Some patients on mental health wards have a learning disability or Autistic Spectrum Disorder, including Asperger's syndrome, and some patients on learning disability wards have a mental health problem.

Methods of statistical analysis

The statistical methods used for data analysis in this report are given in Appendix A.

For the admission rates, the ONS estimates of the general population were used as denominators. For all other analyses (for example, rates of detention, seclusion etc), the census inpatient numbers were used as denominators.

Some results in this report are standardised for age and gender, including those relating to admission, detention, source of referral, care programme approach, seclusion, restraint, accidents, assault, self-harm, consent and presence on a secure ward. This is because there are underlying differences in the age and gender profiles of different ethnic populations, and comparisons based on crude rates would be misleading. Standardisation allows comparisons between the results for different ethnic groups to be made reliably, by taking account of variations in age and gender. The report uses the conventionally accepted statistical methods for taking account of age and gender differences between ethnic groups when calculating these rates.

The terms "higher" and "lower" than average, used in the text for ethnic comparisons, relate to differences from the national average that are statistically significant at the 5% level.

Interpreting the results

In this report, for convenience, we refer to "admission rates" for mental health and learning disability patients. However, these are in fact rates of population-based hospital stays for inpatients on one day – that is, they are population-based rates of patients who are already in hospital on the census day, and not for admissions made on the census day. The number of admissions made on the census day will differ from the number of patients in hospital on that day, and both of these will differ from the number of admissions throughout the year.

As with any study, our results have some caveats and should be interpreted in the following context:

1. As in previous years, we used the 2001 census population estimates from ONS to derive the rates of admission. ONS advises that these estimates are approximate and that they tend to underestimate the number of people from black and minority ethnic groups.[21,22] Furthermore, the 2001 estimates are now seven years out of date, during which time there have been significant increases in the size of black and minority ethnic populations. This means that the admission rates presented for them in this report are higher than would be expected. ONS has published population estimates by ethnic group for 2005 for England, and we have used these also for analysing rates of admission by ethnic group for England.[23] However, these estimates are described by ONS as "experimental" and are subject to margins of error. Furthermore, they are not available for Wales, so we cannot derive rates of admission for England and Wales using updated population denominators. These issues are considered further in the results section.
2. The results are not adjusted for diagnosis and other clinical information, so any differences between ethnic groups in the levels, nature or severity of mental illness or disability may be reflected in the results.
3. The data collected for the census does not allow adjustment for socioeconomic factors such as poverty, unemployment and inner city residence. These occur more commonly in black and minority ethnic communities. Equally it was not possible to take account of social factors, such as marital status, living alone, separation from one or both parents, or lack of social networks. Both socioeconomic and social factors are known to be associated with the risk of mental illness, and can affect pathways into care and the nature of patients' interaction with services.
4. In some instances, the numbers for some ethnic groups are so small that we cannot statistically demonstrate differences from the general population.
5. The census is a one-day count designed to give the number and ethnic composition of inpatients. Its value is in providing a year-by-year snapshot profile of the whole inpatient population. However, by its very nature, it cannot give the picture for the whole year.
6. Some changes in patterns from one census to the next (for example in rates of seclusion) may be due to changes in the small numbers of affected patients in the individual minority ethnic groups on the census day, leading to a statistical phenomenon known as 'regression to the mean'. This means that rates based on small and fluctuating numbers of patients can change in either direction (high to low or vice versa), from one year to the next, as a result of random rather than real variation.
7. The census does not assess the quality of services, the experience of patients or the reasons for any differences found between ethnic groups.

Results: mental health

We collected information on 31,020 patients from the mental health wards of 255 NHS and independent healthcare organisations in England and Wales. All establishments identified as eligible took part in the census, covering 98 NHS organisations and 157 independent healthcare organisations. The number of inpatients was approximately 0.6% lower than in 2007 (31,187 inpatients) and 8% lower than in 2005 (33,785 inpatients) (see table 1).

The number of providers in 2008 (255) was higher than in 2005 (207) and 2006 (238), and similar to 2007 (257). The number of NHS providers in England in 2008 (87) was lower than in the baseline year 2005 (92), but did not change much in Wales. The number of independent healthcare providers increased significantly over the baseline year in both England (from 98 to 141) and Wales (from 7 to 16). The proportion of all mental health inpatients cared for by such providers has risen from 10% of the total in 2005 to 14% in 2008.

Table 1: Number of providers of mental health services and inpatients

	NHS (England)	Independent (England)	NHS (Wales)	Independent (Wales)	Total
2008 census					
Number of providers	87	141	11	16	**255**
Number of inpatients	24,842	3,931	1,892	355	**31,020**
% of inpatients	80.1	12.7	6.1	1.1	**100**
2007 census					
Number of providers	82	153	11	11	**257**
Number of inpatients	25,020	4,030	1,875	262	**31,187**
% of inpatients	80.2	12.9	6.0	0.8	**100**
2006 census					
Number of providers	97	125	11	5	**238**
Number of inpatients	26,565	3,341	1,962	155	**32,023**
% of inpatients	83.0	10.4	6.1	0.5	**100**
2005 census					
Number of providers	92	98	10	7	**207**
Number of inpatients	28,590	3,078	1,939	178	**33,785**
% of inpatients	84.6	9.1	5.7	0.5	**100**

Ethnicity

Information about ethnicity was available for 99% of inpatients, similar to levels in previous censuses. Of these, 77% were White British, 10% were from Black or White/Black Mixed groups, 3% were from South Asian groups (Indian, Pakistani and Bangladeshi), 2% were White Irish, 5% were from Other White groups, and 3% were from other ethnic groups (including Chinese). This showed that 23% of all inpatients belonged to black and minority ethnic groups, defined as all groups that are not White British (White Irish and Other White groups are counted among the black and minority ethnic groups). This compares with 22% in 2007, 21% in 2006 and 20% in 2005.

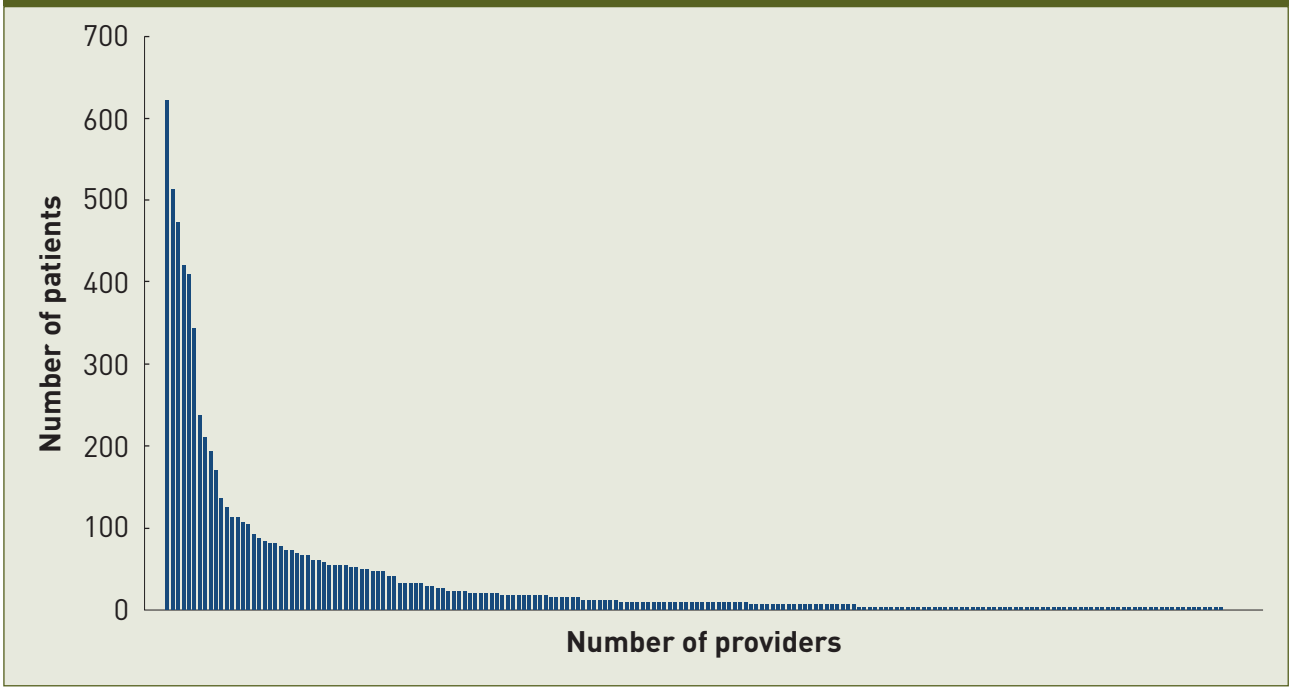
Compared with the baseline year of 2005, the 2008 census recorded a lower proportion of inpatients from the White British and White Irish groups, and a greater proportion from the Other White group. There were increases in the proportions of inpatients from the White/Black Caribbean, White/Black African, Black Caribbean and Black African groups, and a fall in the proportion from the Other Black group. Table 2 shows the ethnic group of inpatients in each of the censuses.

Table 2: Mental health inpatients by ethnic group

	2008 census		2007 census		2006 census		2005 census	
Ethnic group	%	Number	%	Number	%	Number	%	Number
White British	76.5	23,738	77.6	24,198	78.6	25,170	79.2	26,762
White Irish	1.8	567	1.7	538	1.8	582	2.2	727
Other White	4.5	1,399	4.6	1,449	3.8	1,210	3.1	1,055
White and Black Caribbean	1.1	336	0.9	288	0.9	287	0.8	255
White and Black African	0.4	110	0.3	91	0.3	102	0.2	71
White and Asian	0.4	117	0.3	91	0.3	109	0.3	104
Other Mixed	0.5	148	0.6	180	0.5	173	0.5	167
Indian	1.4	426	1.3	393	1.3	411	1.3	434
Pakistani	1.3	396	1.0	315	1.1	349	1.0	325
Bangladeshi	0.5	144	0.4	130	0.5	158	0.5	153
Other Asian	1.0	300	0.8	261	0.8	262	0.8	264
Black Caribbean	4.7	1,468	4.3	1,330	3.9	1,264	4.1	1,369
Black African	2.3	715	2.1	648	2.0	652	1.9	645
Other Black	1.2	376	1.7	545	1.7	535	1.7	569
Chinese	0.3	91	0.3	82	0.2	78	0.2	81
Other	1.2	362	1.1	356	1.1	338	1.1	357
Not stated	1.1	327	0.9	292	1.1	342	1.2	416
Invalid						1	0.1	31
Total	**100**	**31,020**	**100**	**31,187**	**100**	**32,023**	**100**	**33,785**

As in the previous censuses, inpatients from black and minority ethnic groups were concentrated in a relatively small number of organisations: 70% were inpatients in 27 of the 255 organisations that took part in the census. Of all organisations, 187 had between one and 50 inpatients from black and minority ethnic groups each, and another 22 organisations had no inpatients at all from these groups. Figure 1 shows the distribution of black and ethnic minority patients across providers.

Figure 1: Number of mental health inpatients from black and minority ethnic groups by provider



Reporting of ethnicity

Seventy-five per cent of inpatients reported their own ethnic group, and 25% did not. Where patients did not report their own ethnic group, staff or relatives did so on their behalf (17% and 7% respectively). These proportions are similar to those in previous censuses. We cannot be certain that ethnicity was recorded accurately for these patients.

The proportion of inpatients who reported their own ethnicity ranged from about 74% in the White British and White Other groups to about 80% among the Black groups.

Age and gender

Of all inpatients, 2% (583) were under 18 years of age. The numbers of children and young people among minority ethnic groups were generally very low, ranging from none in the Chinese group to 12 in the Pakistani and Black African groups, with the maximum being 33 among the Other White group.

About 68% (21,192) of all inpatients were adults of working age (18 to 64). This proportion was lowest in the White British, White Irish and Other White groups (ranging between 55% and 66%), and higher among the remaining ethnic groups (80 to 97%).

Overall, 30% (9,212) of inpatients were 65 or older. The proportion of older patients was highest in the three White groups (ranging between 33% and 44%). In other ethnic groups, the proportion ranged between 1% and 17%.

Table 3: Age and gender of inpatients

	Age (%)					Gender (%)		Total (n)
Ethnic group	0-17	18-24	25-49	50-64	65+	Men	Women	
White British	1.8	7.2	39.1	18.3	33.6	54.9	45.0	100 (23,738)
White Irish	1.4	4.2	31.4	19.4	43.6	54.7	45.3	100 (567)
Other White	2.4	7.2	43.5	15.5	31.6	56.7	43.3	100 (1,399)
White and Black Caribbean	2.4	17.6	70.2	5.7	4.2	68.8	31.3	100 (336)
White and Black African	5.5	13.8	64.2	11.0	5.5	62.7	37.3	100 (110)
White and Asian	3.4	13.7	62.4	16.2	4.3	62.4	37.6	100 (117)
Other Mixed	2.7	18.2	64.9	13.5	0.7	70.7	29.3	100 (148)
Indian	2.1	6.6	54.5	22.8	14.1	63.8	36.2	100 (426)
Pakistani	3.0	11.6	66.6	10.4	8.4	69.4	30.6	100 (396)
Bangladeshi	2.8	17.4	64.6	6.3	9.0	64.6	35.4	100 (144)
Other Asian	2.3	9.7	69.0	11.7	7.3	74.3	25.7	100 (300)
Black Caribbean	0.5	7.0	64.5	13.5	14.5	67.1	32.8	100 (1,468)
Black African	1.7	14.1	74.8	6.7	2.7	70.9	29.1	100 (715)
Other Black	1.9	11.2	73.7	8.8	4.5	75.8	24.2	100 (376)
Chinese	0.0	9.9	52.7	26.4	11.0	53.8	46.2	100 (91)
Other	2.5	11.3	56.4	12.7	17.1	75.4	24.6	100 (362)
Total	**1.9**	**7.8**	**43.5**	**17.1**	**29.7**	**57.2**	**42.6**	**100**
	(n= 583)	**(n= 2,406)**	**(n= 13,479)**	**(n= 5,307)**	**(n= 9,212)**	**(n= 17,748)**	**(n= 13,227)**	**(n= 31,020)**

These ethnic differences in the age profiles of the patients largely reflect the age profiles of the minority ethnic populations, which differ significantly from those of the White groups. Minority ethnic populations generally have a much younger age structure than the White populations.

Overall, 57% of inpatients were men, compared to 56% in 2007 and 55% in both 2006 and 2005. Men outnumbered women in all ethnic groups. In the White British, White Irish, Other White and Chinese groups, there were similar proportions of men and women. In other ethnic groups, higher proportions were men, reaching 76% in the Other Black group. Table 3 shows the age and gender composition of inpatients.

Language and religion

As in previous censuses, 6% of inpatients reported that their first language was not English. Table 4 shows the proportions of patients with a first language other than English. The groups with the highest proportions of people whose first language was not English were Bangladeshi (54%), Chinese (51%), Other (45%) and Pakistani (43%). Among the White Other group, 22% had a first language other than English. About 2% of patients said they needed an interpreter, and of these, 22% were from the White British group. A small proportion (0.4%) of patients reported using non-verbal language.

Table 4: Percentage of inpatients with a first language other than English

Ethnic group	% with first language other than English (n)
White British	2.0 (480)
White Irish	6.2 (35)
Other White	22.0 (308)
White and Black Caribbean	1.8 (6)
White and Black African	5.5 (6)
White and Asian	12.8 (15)
Other Mixed	8.8 (13)
Indian	35.0 (149)
Pakistani	43.4 (172)
Bangladeshi	54.2 (78)
Other Asian	24.3 (73)
Black Caribbean	6.1 (90)
Black African	24.6 (176)
Other Black	17.6 (66)
Chinese	50.5 (46)
Other	45.3 (164)
Total	**6.2 (1,926)**

Religion was not recorded for 18% of inpatients, and 13% of inpatients said they had no religion. The proportions stating they did not have a religion were highest among the Mixed groups, and lowest among the South Asian groups. Table 5 shows the religion of inpatients.

Table 5: Religion of inpatients by ethnic group

	Religion and faith groups (%)								
Ethnic group	None	Christian	Buddhist	Hindu	Jewish	Muslim	Sikh	Any other religion	Not stated
White British	13.9%	63.3%	0.5%		0.7%	0.3%		2.8%	18.4%
White Irish	6.7%	74.1%	0.4%		0.7%	0.4%		6.7%	11.1%
Other White	14.3%	59.0%	0.6%	0.3%	2.4%	3.4%	0.1%	5.2%	14.6%
White and Black Caribbean	19.6%	52.7%			0.9%	3.3%		4.8%	18.8%
White and Black African	17.3%	40.9%	0.9%		0.9%	11.8%		6.4%	21.8%
White and Asian	12.8%	36.8%	1.7%	2.6%		18.8%	4.3%		23.1%
Other Mixed	19.6%	37.8%	1.4%		0.7%	12.2%		6.8%	21.6%
Indian	3.8%	12.0%	0.2%	30.0%	0.2%	15.3%	28.2%	1.2%	8.9%
Pakistani	1.3%	2.3%		2.0%		82.6%	1.5%	1.3%	8.8%
Bangladeshi	2.8%	4.9%		3.5%		80.6%	1.4%	3.5%	3.5%
Other Asian	7.0%	28.7%	3.0%	8.3%	0.7%	30.3%	3.0%	4.3%	14.3%
Black Caribbean	11.9%	61.6%	0.3%	0.2%	0.3%	3.5%	0.1%	8.0%	13.9%
Black African	8.8%	47.4%	0.3%		0.1%	21.8%	0.1%	4.2%	16.9%
Other Black	12.5%	48.9%	0.5%	0.3%		14.4%	0.8%	5.9%	16.8%
Chinese	14.3%	24.2%	16.5%			1.1%		3.3%	40.7%
Other	9.9%	27.6%	3.9%	1.1%	2.8%	29.3%		6.6%	18.8%
Total	**13.2%**	**59.3%**	**0.6%**	**0.6%**	**0.8%**	**3.7%**	**0.5%**	**3.4%**	**17.9%**

Sexual orientation

We asked inpatients about their sexual orientation. The results were not valid for 2% of inpatients. Seven per cent of patients preferred not to answer the question, and for 14% the response was recorded as "not known" by the provider. Seventy-four per cent of patients said they were heterosexual, 1% said gay/lesbian, 1% said bisexual, less than 1% said "other".

The overall figure of 2% who said they were gay/lesbian or bisexual is lower than the estimated proportions of gay/lesbian or bisexual people in the general population (these estimates range from 5% to 7%).[24,25] The number of non-heterosexuals in minority ethnic groups was very low, so it was not possible to compare the results between groups.

Disability

Approximately 30% (9,179) of inpatients said that they had one or more disability. (Comparisons with previous censuses are not possible because the 2008 census included additional fields for the type of disability.) Of these, 7% were blind or had a sight impairment, 2% were deaf or had a hearing impairment, 2% had a learning disability, 1% had Autistic Spectrum Disorder, 5% had a mobility impairment and 2% used a wheelchair. The remaining 11% had more than one disability. The proportion of inpatients with a disability was highest among the White Irish (36%), White Other (34%) and White British (31%) groups, which could reflect the high age profiles of these populations compared with other ethnic groups.

Rates of admission

The rates of admission are given in Appendix B, in tables B1a (all ages) and B1b (ages 65 and over). The ONS estimates of the general population were used as denominators in deriving the admission rates.

All ages

Men from the White British, Indian and Chinese ethnic groups had lower admission rates than average, by 16%, 18% and 32% respectively. Admission rates were higher than average for men among all other ethnic groups. As in previous censuses, they were particularly high for men from the Black and White/Black Mixed groups, with rates three or more times higher than average. Also, as in previous years, the rate was highest among men from the Other Black group – 13 times higher than average.

Admission rates for women showed a broadly similar pattern: rates for the White British and Indian groups were lower than average by 9% and 25% respectively. Women from most other ethnic groups had rates higher than average. As in previous censuses, rates were particularly high for women from the Black and White/Black Mixed groups – three or more times higher than average – with the highest being among women from the Other Black group (six times higher than average).

When we combined the admission rates for both genders, those from the White British, Indian and Chinese groups were lower than the average, and those for other ethnic groups were higher than the average. Once again, they were particularly high for the Black and White/Black Mixed groups, with rates three or more times higher than the average, and highest – 10 times higher than average – among the Other Black group.

These admission patterns are similar to those we reported in previous censuses.

In terms of changes between 2008 and the baseline of 2005, there were some statistically significant differences, as shown by non-overlapping confidence intervals in the two periods:

- The admission rate for the Other Black group was lower in 2008 than in 2005, being 10 times higher than the average in 2008 compared with 14 times higher in 2005.
- However, the rates for the remaining Black and White/Black groups were higher in 2008 than in 2005: the rates for the White/Black Caribbean Mixed group increased from 369 to 528, White/Black African Mixed from 235 to 388, Black Caribbean from 418 to 482, and Black African from 277 to 327.
- The rate for the Other White group also showed a relative increase, from 122 to 174.
- Admission rates for other minority ethnic groups did not change between 2005 and 2008.

Ages 65 and over

Age-standardised admission rates for minority ethnic groups at older ages show broadly similar patterns to those reported for all ages, although results for some minority groups failed to reach significance because of the small numbers involved. Rates were higher than average among the following groups: White Irish, Other White, White/Black Caribbean Mixed, White/Black African Mixed, Other Asian, Black Caribbean, Black African, Other Black, and Other.

Older black and minority ethnic patients in the census are too few in most ethnic groups to support analyses of subgroups within them, for example those detained.

Changes in population estimates

We calculated the admission rates reported above using the 2001 census population estimates from the Office for National Statistics (ONS). However, those estimates do not take account of the substantial increase in the number of people from black and minority ethnic groups in England and Wales since 2001.

ONS has produced updated population estimates by ethnic group for 2005, which aim to reflect some of these changes. ONS describes these estimates as "experimental", and they are subject to margins of error. These updated population estimates are available for England but not for Wales. Furthermore, they do not reflect the demographic changes between 2005 and 2008.

With these caveats, we have used the 2005 population estimates to re-calculate the admission rates for England. To enable comparisons over time, we have also recalculated the admission rates for England for the 2005 census, using the 2005 ONS population estimates. Both sets of admission rates are given in Appendix B, table B2.

The results show that:

- Using the 2005 ONS population estimates instead of the 2001 estimates results in a slight increase in the admission rates for the White British and White Irish groups, and significantly reduces the admission rates for minority ethnic groups, although the overall patterns largely remain the same.
- Admission rates between 2005 and 2008 remained fairly stable and consistent for most ethnic groups, as shown by the overlapping confidence intervals for each ethnic group across both years. The exceptions to this are:
  - The rates for the Other Black group were lower in 2008 than in 2005.
  - However, the rates for the remaining Black and the White/Black groups were higher in 2008 than in 2005.
- Admission rates in the Other White group have risen consistently since 2005, as noted also in the 2007 census report.
- It is important to note that admission rates for the Pakistani and Bangladeshi groups are about average when the updated ONS populations are used (see Appendix B, table B2). This contrasts with, and is more reliable than, the pattern when the 2001 ONS populations are used, which shows the Pakistani and Bangladeshi groups to have higher than average admission rates.

Source of referral

People can be referred to healthcare services in a number of ways. The detailed results for sources of referral are available at: www.healthcarecommission.org.uk/countmein.cfm.

Referrals for inpatient care often come from community mental health teams rather than the original source, so the results for referrals from community mental health teams may include referrals from other sources, such as GPs and accident and emergency (A&E) departments. Furthermore, about 36% of inpatients were referred from tertiary care, and in these cases, information as to the original referral source was not available. In the case of 6% of all patients (1,944), information about referral source was not known.

Because of the changes in the classification of referral source, we can make comparisons with the 2007 census, but not with censuses prior to that. The referral patterns described below are broadly similar to those reported for 2007.

Referrals by self, carer or employer

Of the 2% (672) of inpatients who were referred to hospital by their carer, employer or themselves, nearly all were self-referred or referred by a carer. Very occasionally, they were referred by an employer. Almost no ethnic differences were apparent, with the exception of a higher rate of such referrals among women from the Indian group; however, this finding was based on a small number of cases only. These rates of referral are given in Appendix B, table B3.

GP referrals

Eleven per cent (3,317) of inpatients were referred by a GP. Rates among the White British group were 5% higher than average. Rates among the White/Black Caribbean Mixed, Black Caribbean and Pakistani groups were below average by 63%, 30% and 58% respectively. The rates of referral by GPs are given in Appendix B, table B4.

Referrals from A&E departments

Five per cent (1,477) of inpatients were referred by A&E departments. The White British group had an 11% lower than average rate of such referrals. The Bangladeshi, Other Asian, Black African and Chinese groups, and women from the Black Caribbean group, were more likely than average to be referred in this way.

Referrals from social services

Three per cent (987) of inpatients were referred from social services. Rates of such referrals were lower than average among inpatients from the Other White group, but higher among those from the White/Black Caribbean Mixed group.

Referrals from community teams

A quarter (27%) (8,473) of inpatients were referred by community teams. The White British group had a 4% higher than average rate of such referrals, and in the Pakistani group it was 24% higher. Among the White/Black Caribbean Mixed, Black Caribbean and Black African groups, and the Other White groups, the rate of such referrals was lower than average by about 20% to 30%. The rates of referral are given in Appendix B, table B5.

Referrals from the criminal justice system

Nine per cent of inpatients (2,925) were referred through the criminal justice system (defined as the police, courts, probation service, prison, and court liaison and diversion service).

People from the White British group were 10% less likely than average to be referred in this way, whereas the White/Asian Mixed, Black Caribbean, Black African and Pakistani groups had rates that were higher than average (by 70%, 52% 38% and 31% respectively).

No differences from the average rate were observed for other ethnic groups. Rates of referral via the criminal justice system are given in Appendix B, table B6.

Tertiary care: referrals from medium or high secure units

A significant proportion (36%) of all referrals were from tertiary care. Five per cent of inpatients (1,584) were referred from medium or high secure units in the NHS or independent sectors. The rate for such referrals was lower than average among the Other White group by 36%. It was higher than average among the White/Black Caribbean Mixed, Black Caribbean and Other Black groups – by 50%, 55% and 100% respectively – and among the Other Mixed group by 88%. No other ethnic differences were observed.

Tertiary care: referrals from other inpatient services

Twenty-one per cent (6,447) of inpatients were referred from other inpatient services, 91% of which were NHS services. The rate for such referrals was 58% higher than average among the Other White group. The rate was lower than average in the Indian, Bangladeshi, Other Asian and Black African groups.

Tertiary care: referrals from other clinical specialties

Ten per cent (3,181) of inpatients were referred by other clinical specialties. Rates of such referrals were higher than average among the Indian and Other Asian groups, and lower than average among the Other Black and Other groups.

Detention under the Mental Health Act 1983 (on day of admission)

All detentions

Forty-five per cent (14,108) of inpatients were detained under the Mental Health Act on the day of admission to hospital. This was a higher proportion than recorded in the previous censuses: 43% in 2007, and 40% in 2005 and 2006. Of all detained patients, 30% (4,179) were from a minority ethnic group.

Detention rates (using the mental health inpatient numbers as denominators) were 6% lower than average among White British patients. Those from the Black Caribbean, Black African, Other Black and White/Black Caribbean Mixed groups were between 20% and 36% more likely than average to be detained. Detention rates were also higher in the Other White (by 11%), Other Asian (by 17%) and Pakistani (by 19%) groups. No other ethnic differences were observed. The rates of detention are given in Appendix B, table B7.

With the exception of the Pakistani group, these patterns are broadly similar to those reported in previous censuses. Detention rates have been higher than average among:

- The Black Caribbean, Black African and Other Black groups in all four annual censuses conducted from 2005 to 2008 (between 25% to 38% higher than average), with no evidence of a decline from the baseline of 2005.
- The White/Black Caribbean Mixed group in three annual censuses conducted in 2006 to 2008 (about 20% higher than average), with no evidence of a decline since 2006.
- The Other White group in two annual censuses conducted in 2007 and 2008 (about 10% higher than average in both years).

We also analysed detention rates under individual sections of the Mental Health Act.

Detention under section 2

Section 2 of the Mental Health Act gives authority for a person to be detained in hospital for assessment for a period not exceeding 28 days. It is mainly applied where the patient is unknown to the service or where there has been a significant interval between periods of inpatient treatment.

Of all the patients detained under the Mental Health Act, 19% (2,734) were detained under section 2. Rates of detention under this section were higher than average among the Pakistani group by 79%, the Bangladeshi group by 111%, the Other Asian group by 59%, the Black African group by 61%, the Other Black group by 46%, and the Other group by 70% (see Appendix B, table B8).

The rates over time by ethnic group are not consistent, with some groups having a high rate in some censuses and not in others. This could, as noted in the Methods section, be due to random year-on-year changes in underlying small numbers of inpatients under this section in some ethnic groups.

Detention under section 3

Section 3 of the Mental Health Act provides for the compulsory admission of a patient to hospital for 'treatment' and for his or her subsequent detention, which can last for an initial period of up to six months, and is renewable thereafter.

Of all the patients detained under the Mental Health Act, 48% (6,717) were detained under this section. Rates were higher than average among the Black Caribbean group by 24%, the White/Black Caribbean Mixed group by 26% and the Other Black group by 33%. No other ethnic differences were observed.

No ethnic differences were observed for detentions under section 3 in 2005 and 2006, although in 2007 detention rates were higher than average among the Black Caribbean and Other Black groups, as in 2008. The rates of detention under section 3 are given in Appendix B, table B9.

Detention under section 37/41

Section 37 of the Mental Health Act allows a court to send a person to hospital for treatment when they might otherwise have been given a prison sentence, and section 41 allows a court to place restrictions on a person's discharge from hospital. Admission to hospital rather than prison is generally regarded as a more positive outcome for the person concerned.

Of the patients detained under the Mental Health Act, 13% (1,863) were detained under section 37 with a section 41 restriction order applied. The rates of detention are given in Appendix B, table B10. The rate of detention for the White British group was 13% lower than average. The rate was higher than average in the White/Black Caribbean Mixed group by 49%, the Other Black by 78%, and the Black Caribbean group by 89%. It was higher also in the Other Asian and Other Mixed groups by 79% and 93% respectively. In all ethnic groups, very few women were detained under section 37/41.

A consistent pattern across all four annual censuses was the higher than average detention rate under section 37/41 for the Black Caribbean and Other Black groups.

Detention under sections 47, 48 and 47/49

These sections of the Mental Health Act allow the Home Office to issue a direction to transfer a person detained in prison to a hospital for treatment.

Of the patients detained under the Mental Health Act, 6% (857) were detained under these sections. No ethnic differences were observed, probably because the numbers of detentions under these sections were low in most minority ethnic groups, especially in women. These rates of detention are given in Appendix B, table B11.

The previous four censuses also showed virtually no ethnic differences for rates of detention under sections 47, 48 and 47/49.

Detention under the Mental Health Act 1983 (on day of census)

Detention rates for the different ethnic groups on the day of the census, compared with detention rates on the day of a patient's admission to hospital, were almost identical. On both admission and census day, rates were higher than average among the Black Caribbean, Black African, Other Black and White/Black Caribbean Mixed groups. The same pattern was also observed for the Other White, Pakistani and Other Asian groups.

Consent

About 28% (4,632) of informally admitted inpatients were deemed incapable of consenting to treatment. No ethnic differences were observed.

About 22% (3,059) of detained patients were deemed incapable of consenting to treatment. These rates were lower than average by 7% in the White British group. They were higher than average among the White/Black Caribbean Mixed, Black Caribbean and Chinese groups.

In addition, 14% (2,002) of detained inpatients were deemed capable of consenting to treatment but refused to do so. The White British group had a rate of refusals that was 10% lower than average. Rates were higher than average among the three Black groups – Black Caribbean, Black African, Other Black – and the Other White and Other Mixed groups.

Care programme approach

The care programme approach (CPA) provides support for people with long-term mental health needs. Patients with complex needs are on an enhanced CPA, while others are on a standard CPA. We found that 74% (22,868) of all inpatients were on an enhanced CPA. As in the 2005 and 2007 censuses, the only ethnic difference observed was that the rate of patients on enhanced CPA was higher than average for the Black Caribbean group (by 12% in 2008). The way that trusts classify the standard and enhanced CPA can vary widely.

The proportion of patients on enhanced CPA has increased steadily over the four censuses, from 58% in 2005, to 66% in 2006, to 72% in 2007, and to 74% in 2008.

Eighteen per cent (5,573) of patients were on standard CPA, and another 2% (569) were on a single assessment process. Six per cent of inpatients (2,008) were not on either CPA or a single assessment process.

Following the recent review of CPA by the Department of Health, there are changes to the way in which CPA will be implemented from October 2008. These changes will be reflected in the data collection for the 2009 census.*

Recorded incidents

The 2008 census asked about the number of times that patients experienced seclusion, hands-on restraint, self-harm, accident and physical assault. In all cases of recorded incidents, the results relate to the number of incidents in a patient's current hospital spell, or, if the patient's hospital spell was longer than three months, to the number that took place within the last three months.

Seclusion

Four per cent (1,167) of inpatients had experienced one or more episodes of seclusion. The White British group had a seclusion rate that was 16% lower than average. Rates were higher than average in the three Black groups – Black Caribbean, Black African, and Other Black – by 51%, 67% and 65% respectively. The Other White group also had a higher than average rate (by 84%). The number of incidents of seclusion was low in several minority ethnic groups, particularly among women.

Some emerging patterns about seclusion rates over the four censuses to date are:

- The proportion of all inpatients who had an episode of seclusion stayed fairly constant over the four censuses (4% in 2008 and 3% in previous years).
- The seclusion rate was higher than average for the Other Black group in all four censuses.
- It was higher for the Black Caribbean group in 2005, 2007 and 2008.
- It was higher for the Black African group in 2005 and 2008.
- It was higher for the Other White group in 2007 and 2008.

No other ethnic differences were observed in all four censuses.

* From October 2008, the term CPA will no longer be used to describe the usual system of provision of mental health services to those with more straightforward needs in secondary mental health services (formerly standard). In general, the individuals needing the support of (new) CPA should not be significantly different from those currently needing the support of enhanced CPA. The current characteristics of those needing enhanced CPA are described as individuals who need: multi-agency support; active engagement; intense intervention; support with dual diagnoses; and who are at higher risk. Dataset descriptors of 'standard' and 'enhanced' CPA will be amended to non-CPA and CPA in due course.

Hands-on restraint

Hands-on restraint was defined as the physical restraint of an inpatient by one or more members of staff in response to aggressive behaviour or resistance to treatment. About 12% (3,594) of inpatients had experienced one or more episodes of hands-on restraint. The only ethnic differences observed were a higher than average rate among the Other White and White/Black Caribbean Mixed groups, of 29% and 34% respectively.

The definition of restraint used in the 2005 census differed from the definition used subsequently, therefore comparisons cannot be made with 2005 (when the definition of "control and restraint" was not limited to physical restraint). In terms of comparisons with the censuses of 2006 to 2008:

- The proportion of all inpatients who had an episode of hands-on-restraint increased from 8% in 2006 to 11% in 2007 to 12% in 2008.
- No ethnic differences were observed in 2006 or 2007, with the exception of a higher rate in the White/Black Caribbean Mixed group in 2006.
- The White/Black Caribbean Mixed group had a higher than average rate in 2006 and 2008, but not in 2007.
- The rate was higher than average for the Other White group for the first time in 2008.

Self-harm

Seven per cent (2,319) of inpatients had harmed themselves on one or more occasions. Only the White British group had a rate that was higher than average (by 11%). Rates among the three Black groups (Black Caribbean, Black African and Other Black) were between 51% and 61% lower than average. Rates were also lower among the South Asian groups: by 60% for Indians, 75% for Pakistanis and 61% for Bangladeshis.

Self-harm was not included in the 2005 census. In terms of comparisons with the censuses of 2006 to 2008:

- The proportion of all inpatients who had harmed themselves on one or more occasions stayed fairly constant (6% in 2006, 7% in 2007 and 7% in 2008).
- In all three censuses, the White British group had a higher than average rate of self-harm.
- In all three censuses, the Black and South Asian groups had a lower than average rate of self-harm.

Accidents

Approximately 13% (3,937) of inpatients had experienced one or more accidents. Inpatients from the Other White group experienced a rate of accidents that was 19% higher than average. Rates were lower than average in the Black Caribbean, Other Black, Indian and Other Asian groups by 43%, 45%, 53% and 64% respectively. Again, these patterns are broadly similar to those observed in 2006 and 2007.

Accidents were not included in the 2005 census. In terms of comparisons with the censuses of 2006 to 2008:

- The proportion of all inpatients who had had one or more accidents stayed fairly constant (12% in 2006, 12% in 2007 and 13% in 2008).
- The Black Caribbean group had a lower than average rate of accidents in all three censuses.
- The Black African group had a lower than average rate of accidents in 2006 and 2007.
- The Other Black group had a lower than average rate of accidents in 2006 and 2008.
- The Other White group had a higher than average rate of accidents in 2007 and 2008.

Physical assault on the patient

The definition of assault includes incidents of physical assault on the patient, irrespective of who committed the assault. We do not have information on who committed the assault, for example, whether it was another patient or a member of staff. Eleven per cent (3,522) of inpatients were involved in one or more episodes of physical assault. The rate was higher than average among the White/Black Caribbean Mixed and Other Black groups, by 49% and 54% respectively.

As this information was collected to a different definition in 2006, and not collected at all for the 2005 census, comparisons with these years are not possible. However, using the same definition for 2008 as we did in 2007, no ethnic differences had been observed in the 2007 census. The proportion of all inpatients experiencing a physical assault stayed fairly constant (12% in 2007 and 11% in 2008).

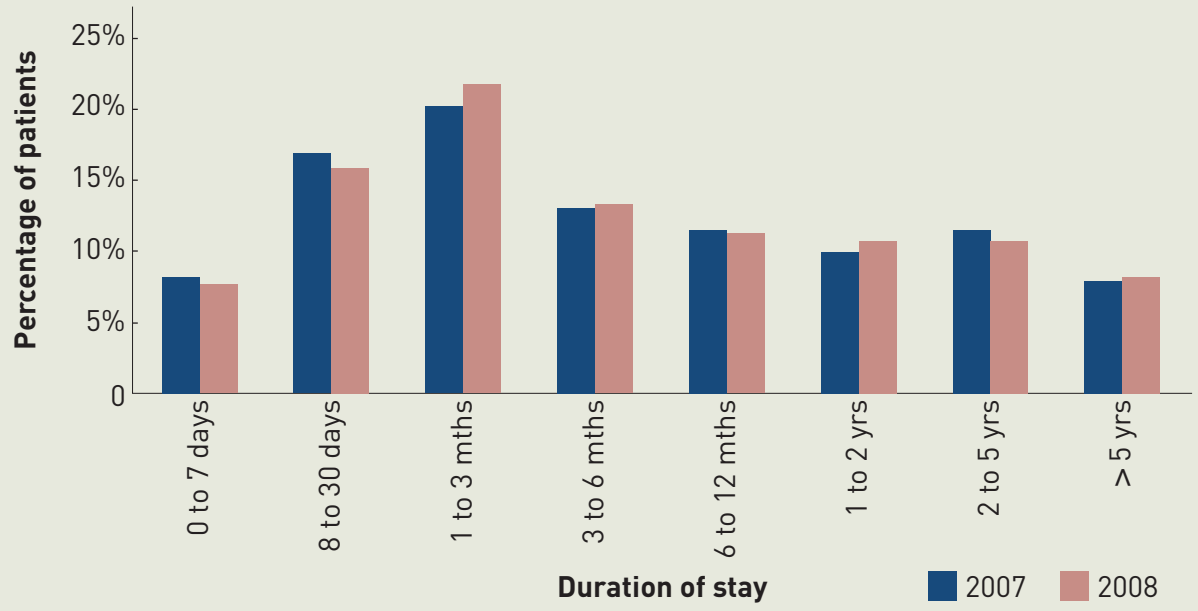
Duration of stay in hospital

We analysed the length of the period between each patient's admission to hospital and the census day. This period is, of course, shorter than a patient's full length of stay in hospital, which runs from admission to the date when they are discharged. The results on the day of the 2008 census found that:

- 24% of inpatients had been in hospital for one month or less
- 22% had been in hospital between one and three months
- 13% had been in hospital between three and six months
- 11% had been in hospital between six months and one year
- 11% had been in hospital between one and two years
- 11% had been in hospital between two and five years
- 8% had been in hospital for more than five years.

Figure 2 shows the duration from the day of admission to the day of census for all patients in 2008, and a comparison with 2007. The patterns for 2007 and 2008 are very similar, as were those for 2006. As these figures show, 30% of patients had been in hospital for more than a year. Therefore, almost one-third of the patients covered by the 2008 census were also covered by the 2007 census. In addition, almost 20% of patients had been in hospital for more than two years, and will have been included in the 2006 census.

Figure 2: Duration of patients' stay in hospital from the day of admission to the day of census in 2007 and 2008



We calculated the median length of stay for different ethnic groups. The median is the midpoint of the range of values, so the median length of stay for a given ethnic group is the one at which half the patients of that ethnic group had a length of stay less than the median, and half had a stay longer than the median. Table 6 shows the median number of days from the day of admission to the day of the census. Overall, and as in 2007, the median amount of time that women had spent in hospital was about two and a half months, and the median for men was about five months. In most ethnic groups, men had been in hospital for about twice as long as women. The exceptions were the White/Black Caribbean Mixed, Other Mixed and Other Black groups, among whom the median stay was three to five times longer among men than women.

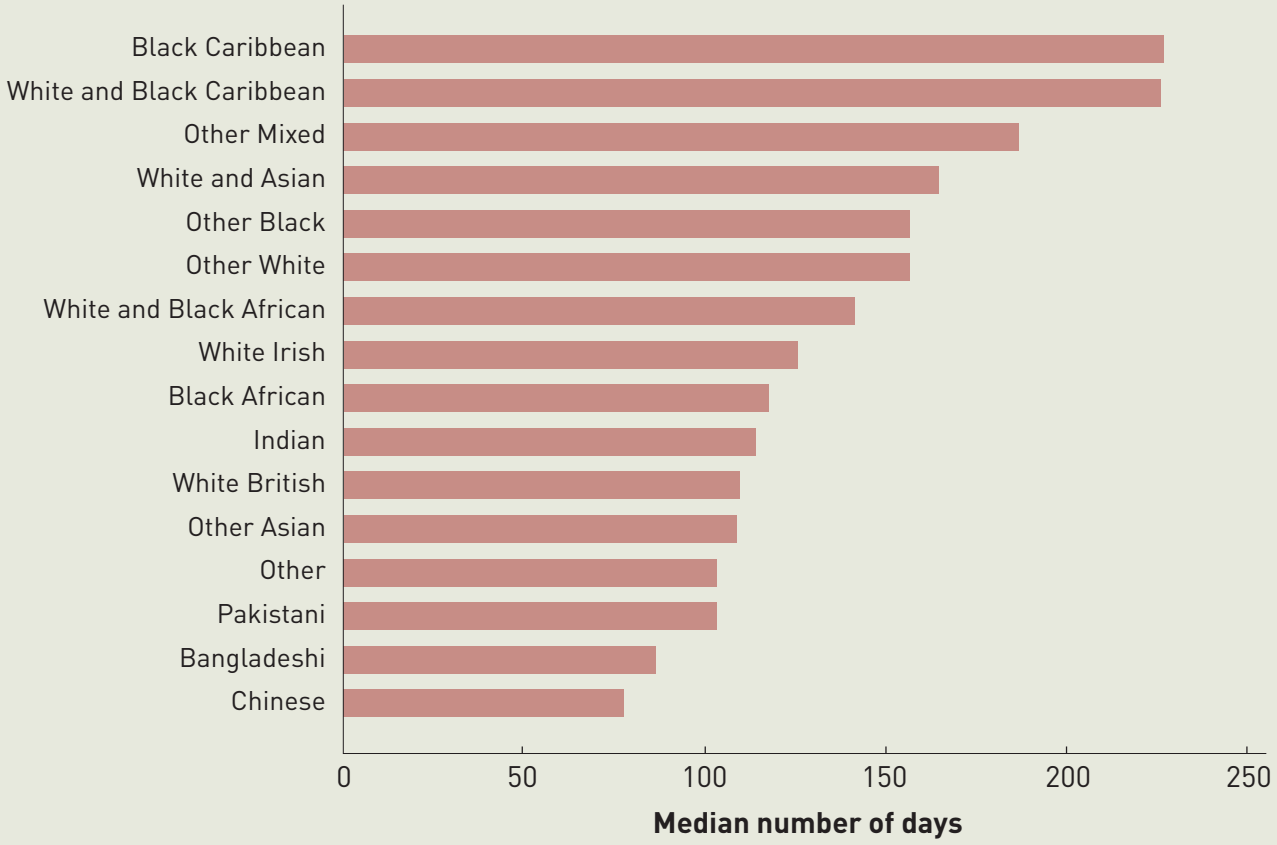
Table 6: Median number of days from the day of admission to the day of census

Ethnic group	Persons	Men	Women
White British	109	151	75
White Irish	125	165	83
Other White	156	227	110
White and Black Caribbean	226	321	58
White and Black African	141	173	82
White and Asian	164	208	104
Other Mixed	187	262	62
Indian	114	143	85
Pakistani	103	127	69
Bangladeshi	86	108	66
Other Asian	108	117	74
Black Caribbean	227	294	143
Black African	117	144	60
Other Black	156	187	60
Chinese	77	115	38
Other	103	104	93
Total	**116**	**158**	**76**

For both men and women, the median lengths of stay were among the longest for patients from the Black Caribbean group, and among the shortest for patients from the Chinese group. Overall, patients from the Chinese, South Asian and White British groups had shorter durations of stay, and patients from the Black Caribbean and White/Black Caribbean had the longest durations of stay. These patterns are similar to those observed for 2006 and 2007. Figure 3 shows the median lengths of stay by ethnic group for men and women combined.

It is important to note that a number of factors influence a patient's length of stay in hospital, including age, gender, whether or not they are detained (and the section under which they are detained and whether there is an additional Home Office restriction order), the type and severity of their illness, the nature of their treatment and the availability of support in the community. The data in the census does not allow for analysis of these factors.

Figure 3: Median number of days from the day of admission to the census day (persons)



Ward security

As in 2007, 13% (3,951) of all inpatients were on a medium or high secure ward, as opposed to a general (74%) or low secure (14%) ward.

Patients from the White British and Indian groups were less likely than average to be on a medium or high secure ward, by 9% and 34% respectively. Patients from the Other Black, Black Caribbean and White/Black Caribbean Mixed groups were more likely than average to be on a medium or high secure ward, by 26%, 49% and 74% respectively, reflecting similar patterns to those observed in 2006 and 2007. Rates were also higher for the White Irish, Other White, Other Mixed and Other Asian groups, by 23% to 46%. The number of women on medium or high secure wards was very low in minority ethnic groups.

Age range on wards

There were 48 inpatients under 18 years of age being cared for on wards for working-age adults and none were on wards for older people. This is a significant improvement on 2005, when 128 children were on adult wards and seven were on wards for older people.

Almost 7% (1,569) of inpatients on wards for working-age adults were 65 or over, and 5% (436) of those on wards for older people were adults of working age. These figures are similar to those for 2007. There were very few 'out of age' placements among minority ethnic groups.

Patients in wards designated as single sex or mixed*

The 2008 census asked providers to supply the following information about patients: "Is this patient in a ward designated as mixed gender/men only/women only?" The report provides the results for this question, but comparisons with previous censuses are not possible because of changes to the wording of the question. In 2008, we piloted three questions that examined further the single sex facilities available to patients. However, some of the data returned for these pilot questions showed inconsistencies and was unreliable, therefore we did not analyse the results in this report.

* A ward can be described as single sex (ie the intended sex of the ward is either male or female and not mixed) when the accommodation complies with the following definition from the Department of Health of single sex accommodation: "Sleeping areas must be segregated, and members of one sex must not have to walk through an area occupied by the other sex to reach toilets or bathrooms. Separate male and female only toilets and bathrooms must be provided. There should be separate day rooms to which only women have access." However, there is a discrepancy for providers because accommodation designated as a 'ward' for administrative purposes may incorporate single sex accommodation for both sexes that meets the guidelines – but in this case the ward would still be 'mixed' (based on guidance from *Safety, Privacy and Dignity*, Department of Health, 2000).

As long as men and women are cared for in separate bays or rooms, and have their own toilet facilities, then it may well be appropriate for them to be on the same ward, being cared for by the same team of doctors and nurses. In practice, good segregation can be achieved if men and women have separate sleeping areas (for example single sex bays) and have separate toilets and bathrooms that they can reach without having to pass through (or close to) areas for the opposite sex. The layout of wards should minimise any risk of overlooking or overhearing by members of the opposite gender (from *Privacy and Dignity – A report by the Chief Nursing Officer into mixed sex accommodation in hospitals*, Department of Health, 2007).

Providers were asked whether the patient was on a ward designated as men or women only, or mixed gender. Overall, 68% of patients (21,185) were not in a single sex ward, the same proportion as in 2007. The proportions among men and women were 61% and 78% respectively. The proportion of patients not in a single sex ward was lower among all minority ethnic groups than among the White British group. In all ethnic groups, the proportion of men who were not in a single sex ward was lower than among women (see table 7 for details).

Table 7: Percentage of patients not in a single sex ward by ethnic group

	Sex of patients intended to use a ward					
	Male		Female		Persons	
Ethnic group	Male ward	Female or mixed ward*	Female ward	Male or mixed ward*	Appropriate ward	Inappropriate or mixed ward*
White British	35.0	64.9	19.8	80.1	28.3	71.6
White Irish	33.9	66.1	23.0	76.7	29.3	70.5
Other White	43.3	56.7	23.9	76.1	35.1	64.9
White and Black Caribbean	61.5	38.1	39.0	61.0	54.8	44.9
White and Black African	50.7	49.3	41.5	58.5	47.3	52.7
White and Asian	52.1	47.9	27.3	72.7	42.7	57.3
Other Mixed	61.5	38.5	39.5	60.5	56.1	43.9
Indian	41.5	58.5	28.6	71.4	37.6	62.4
Pakistani	54.2	45.5	27.3	72.7	46.2	53.5
Bangladeshi	41.9	58.1	13.7	86.3	31.9	68.1
Other Asian	52.5	47.5	24.7	75.3	45.7	54.3
Black Caribbean	54.1	45.9	35.3	64.7	48.2	51.8
Black African	51.5	48.5	38.9	61.1	48.3	51.7
Other Black	56.5	43.5	27.5	72.5	49.7	50.3
Chinese	46.9	53.1	26.2	73.8	37.4	62.6
Other	39.6	60.4	23.6	76.4	35.6	64.4
Total	**38.8**	**61.1**	**21.6**	**78.4**	**31.6**	**68.3**

* The vast majority of patients in this category were in mixed wards; very few (0.2%) male patients were on female-only wards, or vice versa.

Results: learning disabilities

We obtained information about 4,107 inpatients in 129 organisations providing services for people with learning disabilities in England and Wales. These organisations comprised all 67 NHS trusts that were eligible to take part in the census (of whom 57 also returned information for their mental health inpatients), and 62 independent healthcare organisations.

Table 8 shows the number of providers and inpatients in the 2008 census and comparisons with 2006 and 2007. The total number of providers increased from 124 in 2006 and 120 in 2007 to 129 in 2008. However, the number of patients fell from 4,609 in 2006 to 4,107 in 2008. The proportion of inpatients in independent healthcare organisations increased from 20% in 2006 to 27% in 2008. The proportion and numbers of patients in NHS providers declined, whereas those in independent providers increased.

Table 8: The number of providers of learning disability services and inpatients

	NHS (England)	Independent (England)	NHS (Wales)	Independent (Wales)	Total
2008 census					
Number of providers	62	57	5	5	**129**
Number of inpatients	2,873	1,050	143	41	**4,107**
% of inpatients	70.0	25.6	3.5	1.0	**100**
2007 census					
Number of providers	64	47	5	4	**120**
Number of inpatients	3,063	900	154	36	**4,153**
% of inpatients	73.8	21.7	3.7	0.9	**100**
2006 census					
Number of providers	70	48	5	1	**124**
Number of inpatients	3,505	930	164	10	**4,609**
% of inpatients	76.0	20.2	3.6	0.2	**100**

As stated in previous censuses, the results reported in the section for mental health services almost certainly include some inpatients with a learning disability or Autistic Spectrum Disorder. This was unavoidable due to the considerable overlap between the services for patients with mental health problems and those for patients with learning disabilities. People with a mental health problem who also have a learning disability may be treated in either type of service. However, people with learning disabilities may experience difficulties in accessing mental health services. To address this issue, the Government is encouraging healthcare providers to treat people with learning disabilities, who also have a diagnosed mental health problem, in mainstream mental health services.

The pattern of results for learning disability patients in 2008 is broadly similar to that reported in the 2006 and 2007 censuses. This is not surprising, since many of the patients had been in hospital for a considerable period of time on the day of each census, and they therefore appear in successive censuses.

Ethnicity

Information on ethnicity was available for 99% of inpatients. Of these, 12% were from black and minority ethnic groups, defined as all groups that are not White British (i.e. White Irish and Other White groups are counted among the black and minority ethnic groups). This figure is the same as the 12% reported for 2007 and similar to the 11% for 2006, and is significantly lower than the 23% of inpatients using mental health services who were from minority ethnic groups, as reported in the mental health section of this report.

Table 9: Learning disability inpatients by ethnic group

	2008 census		2007 census		2006 census	
Ethnic group	%	Number	%	Number	%	Number
White British	88.9	3,616	88.3	3,642	88.7	4,037
White Irish	1.3	53	1.0	40	1.4	66
Other White	2.6	104	2.6	109	1.7	77
White and Black Caribbean	0.7	29	0.8	34	0.7	32
White and Black African	0.0	2	0.2	10	0.1	3
White and Asian	0.3	12	0.3	13	0.2	9
Other Mixed	0.3	14	0.4	16	0.3	14
Indian	0.7	28	0.8	32	1.1	49
Pakistani	0.7	30	0.8	32	0.7	34
Bangladeshi	0.3	11	0.3	11	0.2	9
Other Asian	0.3	12	0.2	8	0.3	12
Black Caribbean	2.3	94	2.6	108	2.8	129
Black African	0.7	29	0.8	33	0.7	33
Other Black	0.4	15	0.4	18	0.4	17
Chinese	0.1	5	0.2	8	0.2	7
Other	0.4	15	0.2	10	0.5	24
Total	**100**	**4,069**	**100**	**4,124**	**100**	**4,552**

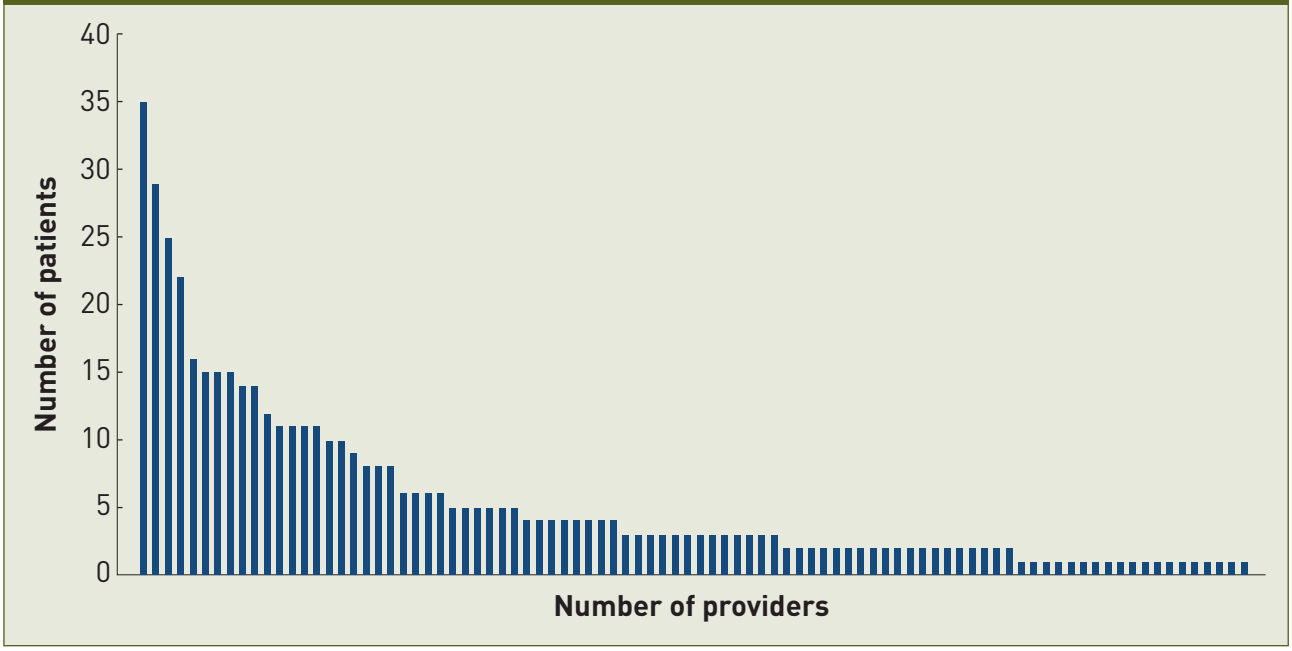
The White British ethnic group accounted for 88% of inpatients, 4% were from Black or White/Black Mixed groups, 3% were from Other White groups, 2% were from South Asian groups (Indian, Pakistani, Bangladeshi) 1% were White Irish, and 1% were from other ethnic groups (including Chinese). After the White British group, the largest groups of inpatients were Other White and Black Caribbean. These patterns are broadly similar to 2006 and 2007 for most ethnic groups. However, there was an increase between 2006 and 2008 in the number and proportion of Other White inpatients, and a fall in those from the Indian and Black Caribbean groups.

Table 9 shows the ethnic group of inpatients. Some ethnic groups had very few inpatients, which limits the observations that we were able to make.

As in the previous censuses, inpatients from black and minority ethnic groups were concentrated in a relatively small number of organisations: 70% were inpatients in 27 of the 129 organisations that took part in the census. Ninety organisations had between one and 35 inpatients from black and minority ethnic groups each, and another 39 organisations had no inpatients at all from these groups. Figure 4 shows the distribution of black and ethnic minority patients across providers.

However, it is important to note that the number of people with severe and profound learning disabilities in some areas is affected by past funding and placement practices, especially the presence of old long stay hospitals and of people placed outside their original area of residence by funding authorities.

Figure 4: Number of learning disability inpatients from black and minority ethnic groups by provider



Reporting of ethnicity

Less than half (44%) of inpatients reported their own ethnic group, compared with 75% of inpatients in mental health services who did so. Staff reported the ethnic group for 29% of inpatients, and relatives for 21%. It is therefore possible that ethnicity could have been misreported for some patients. Ethnicity was not recorded for 6% of inpatients.

Age and gender

Table 10 gives the age and gender composition of inpatients. Two per cent (104) of inpatients were under 18 years old. The number of young inpatients from minority ethnic groups was very low, ranging between one and seven, and there were no young inpatients in several ethnic minority groups.

Table 10: Age and gender of inpatients in learning disability services

	Age (%)		Gender (%)	
Ethnic group	Under 50	50 and over	Men	Women
White British	70.5	29.3	66.8	32.8
White Irish	75.5	24.5	60.4	39.6
Other White	86.5	12.5	81.7	18.3
White and Black Caribbean	100.0	0.0	79.3	20.7
White and Black African	100.0	0.0	50.0	50.0
White and Asian	91.7	8.3	91.7	8.3
Other Mixed	85.7	14.3	71.4	28.6
Indian	89.3	10.7	82.1	17.9
Pakistani	90.0	10.0	93.3	6.7
Bangladeshi	90.9	9.1	81.8	18.2
Other Asian	91.7	8.3	66.7	33.3
Black Caribbean	85.1	14.9	71.3	28.7
Black African	93.1	3.4	75.9	24.1
Other Black	80.0	20.0	73.3	26.7
Chinese	80.0	20.0	60.0	40.0
Other	100.0	0.0	86.7	13.3
Total	**72.5**	**27.3**	**68.0**	**31.7**

Overall, 73% (2,978) of inpatients were under 50 years old, and 28% (1,143) were aged 50 or over. As with mental health inpatients, the proportion of people under 50 was higher among inpatients from black and minority ethnic groups than among the White British group. This is not surprising, given that minority ethnic populations are generally younger than the White population. About two-thirds (68%) of inpatients in learning disability services were men, whereas in mental health services 57% of inpatients were men.

Language and religion

Nine per cent (386) of inpatients reported that their first language was not English. Non-verbal communication was the most often selected language after English, accounting for 7% of inpatients (277).

Religion was not recorded for 19% of inpatients, and 13% of inpatients said they had none. South Asians (Indians, Bangladeshis and Pakistanis) were mostly Muslim, Hindu or Sikh, and those from the White, Black and White/Black Mixed groups were mostly Christian.

Sexual orientation

Overall, 11% of inpatients declined to answer the question, and for another 45% of inpatients, the results were not known. Therefore we do not know the sexual orientation of about 56% of inpatients.

Of those who answered the question about sexual orientation, 37% said they were heterosexual, 2% said gay/lesbian, 2% said bisexual, and 1% said 'other'. The proportion of non-heterosexuals in each minority ethnic group was very low (zero or in single figures), so further analysis of ethnic group by sexual orientation was not possible.

Disability

Of all inpatients in learning disability services:

- 47% had a learning disability only
- 1% had Autistic Spectrum Disorder including Asperger's Syndrome
- 49% had multiple disabilities.

The patterns among minority ethnic groups were similar, in that most patients had either a learning disability or multiple disabilities. Comparisons with previous censuses are not possible because the 2008 census included additional fields for the type of disability.

Rates of admission

The rates of admission are given in Appendix C, table C1.

Admission rates were lower than average among the Chinese, Indian, Pakistani and Other Asian groups by 75%, 68%, 41% and 44% respectively. They were two to three times higher than average among the White/Black Caribbean Mixed, Black Caribbean and Other Black groups.

These results are similar to those for inpatients in mental health establishments, particularly the lower rates among Indian and Chinese groups and the higher rates among some Black groups.

These patterns of admission are very similar to those we reported in 2006 and 2007.

Changes in population estimates

We calculated the admission rates reported above using the 2001 census population estimates from the Office for National Statistics (ONS). However, those estimates do not take account of the substantial increase in the number of people from black and minority ethnic groups in England and Wales since 2001.

ONS has produced updated population estimates by ethnic group for 2005, which aim to reflect some of these changes. ONS describes these estimates as "experimental", and they are subject to margins of error. These updated population estimates are only available for England. Furthermore, they do not reflect the demographic changes between 2005 and 2008.

With these caveats, we have used the 2005 population estimates to re-calculate the admission rates for England. To enable comparisons over time, we have also recalculated the admission rates for England for the 2006 census, using the 2005 ONS population estimates. Both sets of admission rates are given in Appendix C, table C2.

The results show that:

- As with mental health, using the ONS population estimates from 2005 instead of 2001 results in a slight increase in the admission ratios for the White British and White Irish groups in 2008, and significantly reduces the admission ratios for minority ethnic groups. Rates for some groups (Other White, Bangladeshi, Other Asian, Black African and Other) go from average to lower than average, along with the low rates for the Chinese, Indian, Pakistani and Other Asian groups. Rates for the White/Black Caribbean Mixed, Black Caribbean and Other Black groups remain higher than average.
- Admission ratios across 2006 and 2008 remain fairly stable and consistent for almost all ethnic groups, as shown by the overlapping confidence intervals for each ethnic group across the two years.

Source of referral

As we reported in the section on mental health inpatients, we must be careful when interpreting data about sources of referral, since the original referral source is not always known. Furthermore, in the case of inpatients with learning disabilities, this information was invalid, missing or unknown for 14% (576) of them. The detailed results are available at: www.healthcarecommission.org.uk/countmein.cfm

Referrals by self, carer or employer

Of the 5% (196) of inpatients who were referred to hospital through these routes, nearly all (93%) were referred by carers. The only ethnic difference observed was the higher than average rate of referral via these routes among inpatients from the Indian group, however, this finding was based on only seven patients.

Referrals from medium or high secure units (NHS or independent sector)

Seven per cent (274) of inpatients were referred from medium or high secure units in the NHS or independent sector. The numbers of patients referred through these routes were very low in most minority ethnic groups, and no ethnic differences were observed in referral rates.

Other sources of referral

Other sources of referral include GPs, community mental health and learning disability teams, tertiary services, social services, and criminal justice agencies. We could make few observations about differences between ethnic groups with regard to these sources, given the small number of cases.

Detention under the Mental Health Act (on day of admission and on day of census)

All detentions

Of all the inpatients in learning disability services, 42% (1,718) were detained under the Mental Health Act on admission. Of these, 15% (254) were from minority ethnic groups – a lower proportion than the 30% found among inpatients in mental health services, and same as the figure reported for learning disability patients in 2006.

Rates of detention on the day of admission by ethnic group are in Appendix C, table C3. As in 2006 and 2007, no ethnic differences were observed. The only exception was a higher than average rate among the Other White group in 2007, but this was not apparent in 2006 or 2008.

However, the rate of detention was higher than average for the Other White group on the 2008 census day.

As the number of detained patients from each minority ethnic group was low, we did not undertake further analysis for individual sections of the Act.

Consent

About 72% (1,644) of informally admitted inpatients were deemed incapable of consenting to treatment, a similar proportion to that reported for 2007. The only ethnic difference observed was the lower than average rate for the Other White group, based on just 19 patients. However, this pattern was also apparent in 2007.

Among detained patients, 38% (633) were deemed incapable of consenting to treatment. The only ethnic differences observed were the higher than average rates for the White Irish and Black Caribbean groups. Again, these were based on small numbers of patients.

In addition, 8% (135) of detained patients were deemed capable of consenting to treatment but refused. There were few or no ethnic minority patients, and no ethnic differences were observed.

Care programme approach

The care programme approach (CPA) provides support for people with long-term mental health needs. Patients with complex needs are on an enhanced CPA, while others are on a standard CPA. We found that 54% (2,234) of all inpatients were on an enhanced CPA. The only ethnic differences observed were the higher than average rate for being on enhanced CPA among the Other White and Black Caribbean groups (35% higher for both). The Other White group had a higher than average rate also in 2007. The way that trusts classify the standard and enhanced CPA can vary widely.

Nine per cent (365) of patients were on standard CPA, and another 2% (91) were on a single assessment process. Thirty-five per cent of inpatients (1,417) were not on either CPA or a single assessment process.

Following the recent review of CPA by the Department of Health, there are changes to the way in which CPA will be implemented from October 2008. These changes will be reflected in the data collection for the 2009 census.*

* From October 2008 the term CPA will no longer be used to describe the usual system of provision of mental health services to those with more straightforward needs in secondary mental health services (formerly standard). In general, the individuals needing the support of (new) CPA should not be significantly different from those currently needing the support of enhanced CPA. The current characteristics of those needing enhanced CPA are described as individuals who need: multi-agency support; active engagement; intense intervention; support with dual diagnoses; and who are at higher risk. Dataset descriptors of "standard" and "enhanced" CPA will be amended to non-CPA and CPA in due course.

Recorded incidents

The 2008 census asked about the number of times that patients experienced seclusion, hands-on restraint, self-harm, accident and physical assault. In all cases of recorded incidents, the results relate to the number of incidents in a patient's current hospital spell, or, if the patient's hospital spell was longer than three months, to the number that took place within the last three months. The patterns are similar to those observed for 2007.

Seclusion

Five per cent (201) of inpatients had experienced one or more episodes of seclusion. The rate of seclusion among the White Irish and Other White group was higher than average, although this was based on small numbers of patients. This pattern was also apparent in 2007, though not in 2006.

Physical assault on the patient

The definition of assault includes incidents of physical assault on the patient, irrespective of who committed the assault, but we do not have information on who committed the assault. About 28% (1,137) of inpatients had been involved in one or more episodes of physical assault, similar to the proportion in 2007 (30%). The only ethnic difference observed was a higher than average rate among the Other Asian group, however, this was based on only nine patients.

Hands-on restraint, self-harm, accidents

Twenty-five per cent (1,015) of inpatients had experienced one or more episodes of hands-on restraint, 22% (895) had attempted to harm themselves and 24% (984) had suffered an accident. As in 2007, we observed no differences in the results for various ethnic groups, with the exception of a higher than average rate for the White/Black Caribbean Mixed group for hands-on restraint, but this was based on just 15 patients.

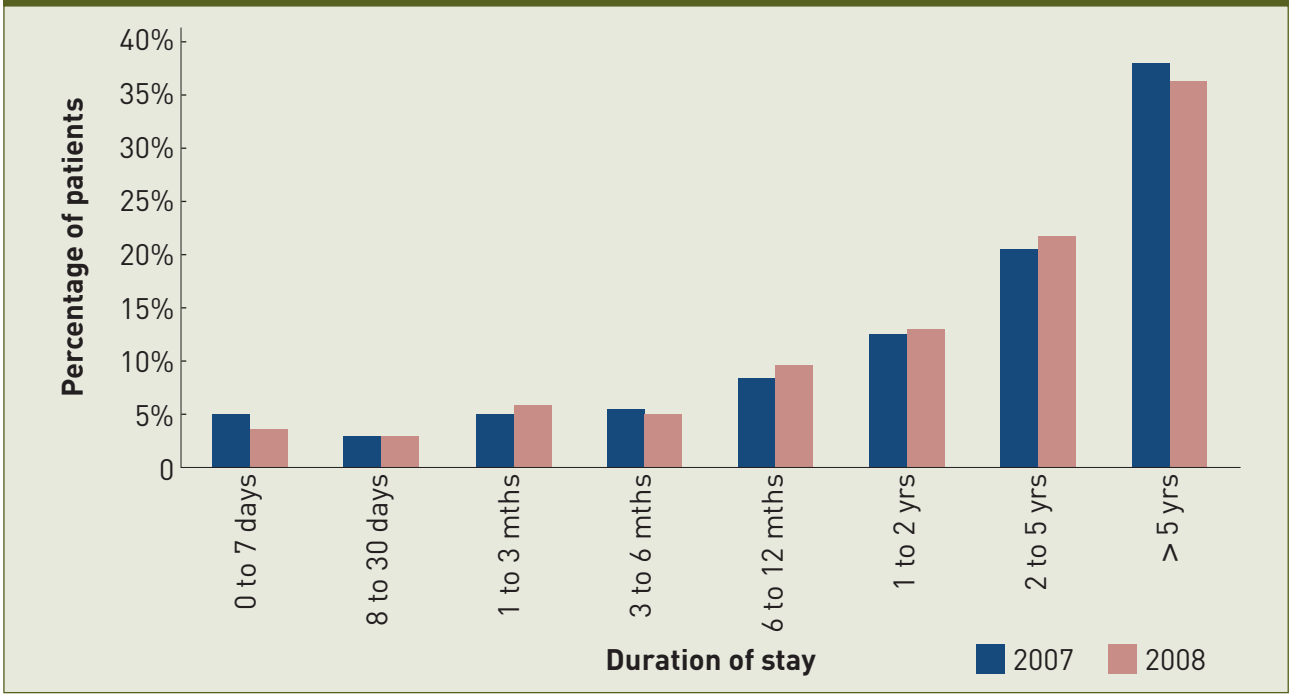
Duration of stay in hospital

We analysed the length of the period between each patient's admission to hospital and the census day. This period is, of course, shorter than a patient's full length of stay in hospital, which runs from admission to the date when they are discharged. The results on the day of the 2008 census found that:

- 7% of inpatients had been in hospital for one month or less
- 6% had been in hospital between one and three months
- 5% had been in hospital between three and six months
- 10% had been in hospital between six months and one year
- 13% had been in hospital between one and two years
- 22% had been in hospital between two and five years
- 36% had been in hospital for over five years.

As these figures show, 71% of patients had been in hospital for more than a year. Therefore, almost three-quarters of the patients covered by the 2008 census were also covered by the 2007 census. In addition, over half (58%) of patients had been in hospital for more than two years, and will also have been included in the 2006 census. Figure 5 shows the duration

Figure 5: Duration of patients' stay in hospital from the day of admission to the day of census in 2007 and 2008



from the day of admission to the day of census for all patients in 2008, and a comparison with 2007. The patterns for 2007 and 2008 are very similar, as were those for 2006.

We also calculated the median length of stay. The median is the mid-point of the range of values, so the median length of stay is the one at which half the patients had a length of stay less than the median, and half had a stay longer than the median. Overall, the median amount of time that women had spent in hospital was about 37 months, and the median for men was about 33 months. This compares with a median for mental health patients of two and a half months for women and five months for men. It is difficult to compare length of stay by ethnic group because of the small numbers of patients among several of the groups.

Ward security

As in 2007, 11% (497) of all inpatients were on a medium or high secure ward, as opposed to a general (58%) or low secure (30%) ward. The proportion of patients on a medium or high secure ward was higher in the 2006 census (18%).

As in 2007, rates of inpatients on medium or high secure wards were about double the average among the White Irish and Other White groups, although some of these results are based on low numbers. Most minority ethnic groups had very few inpatients on medium or high secure wards, and we could see no differences in the results for other ethnic groups.

Age range on wards

There were 13 inpatients aged under 18 being cared for on wards for working-age adults and none were on wards for older people. This is a significant improvement on 2005, when 26 children were on adult wards.

Almost 6% (231) of inpatients on wards for working-age adults were aged 65 or over, and there were very few patients (24) on wards for older people. These figures are similar to those for 2006 and 2007. There were very few 'out of age' placements among minority ethnic groups, so we could make no significant observations about differences between ethnic groups.

Patients in wards designated as single sex or mixed*

The 2008 census asked providers to supply the following information about patients: "Is this patient in a ward designated as mixed gender/men only/women only?" The report provides the results for this question, but comparisons with previous censuses are not possible because of changes to the wording of the question. In 2008, we piloted three questions that examined further the single sex facilities available to patients. However, some of the data returned for these pilot questions showed inconsistencies and was unreliable, therefore we did not analyse the results in this report.

* A ward can be described as single sex (ie the intended sex of the ward is either male or female and not mixed) when the accommodation complies with the following definition from the Department of Health of single sex accommodation: "Sleeping areas must be segregated, and members of one sex must not have to walk through an area occupied by the other sex to reach toilets or bathrooms. Separate male and female only toilets and bathrooms must be provided. There should be separate day rooms to which only women have access." However, there is a discrepancy for providers because accommodation designated as a 'ward' for administrative purposes may incorporate single sex accommodation for both sexes that meets the guidelines – but in this case the ward would still be 'mixed' (based on guidance from *Safety, Privacy and Dignity*, Department of Health, 2000).

As long as men and women are cared for in separate bays or rooms, and have their own toilet facilities, then it may well be appropriate for them to be on the same ward, being cared for by the same team of doctors and nurses. In practice, good segregation can be achieved if men and women have separate sleeping areas (for example single sex bays) and have separate toilets and bathrooms that they can reach without having to pass through (or close to) areas for the opposite sex. The layout of wards should minimise any risk of overlooking or overhearing by members of the opposite gender (from *Privacy and Dignity – A report by the Chief Nursing Officer into mixed sex accommodation in hospitals*, Department of Health, 2007).

Conclusions

Mental health

Observations on the census data

Overall, the findings relating to ethnic groups from the 2008 census of mental health inpatients are similar to the findings of previous annual censuses conducted since 2005. This is perhaps not surprising, as 30% of patients had been in hospital for over a year and 20% had been in hospital for over two years, so were included in the three censuses of 2006, 2007 and 2008. However, there are some patterns that emerge from the four censuses to date:

- The overall number of mental health inpatients in England and Wales fell by 8% between the 2005 and 2008 censuses (the 2005 census did not include patients with learning disabilities).
- The proportion of inpatients receiving care from independent providers is rising (an increase of 32% since 2005) and the proportion of NHS providers is falling (a decrease of 13% since 2005). The proportion of inpatients receiving care from independent providers increased from 10% of all patients in 2005 to 14% in 2008.
- While the numbers and proportions of patients in most minority ethnic groups have been relatively stable, the numbers and proportions of patients from the Other White group increased markedly between 2005 and 2008.
- Rates of admission showed similar patterns to previous censuses, being lower than the national average among the White British, Indian and Chinese groups, average for the Pakistani and Bangladeshi groups, and higher than average among other minority ethnic groups – particularly in the Black and White/Black Mixed groups.
- One of the goals of the *Delivering Race Equality in Mental Health Care* (DRE) plan is to reduce admission rates among black and minority ethnic groups, but there is little evidence of this having occurred since the launch of DRE in 2005. Between the DRE baseline of 2005 and 2008, we found that admission rates fell for the Other Black group*, although they were still 10 times higher than the national average in 2008. In contrast, admission rates increased for all other Black and White/Black groups (Black Caribbean, Black African, White/Black Caribbean Mixed, White/Black African Mixed). The admission rate for the Other White group also increased between 2005 and 2008. Admission rates for other minority ethnic groups did not change between 2005 and 2008.
- Overall, the proportion of inpatients detained under the Mental Health Act on admission has risen since 2005. DRE aims to reduce detention rates among black and minority ethnic groups, but detention rates have remained higher than average among some minority ethnic groups (Black Caribbean, Black African, Other Black, White/Black Caribbean Mixed and Other White), with no evidence of a decline from the baseline of 2005. However, we have not seen high detention rates in other minority ethnic groups over the four censuses.

* This is an unexpected result as (a) the numbers of Other Black patients remained fairly stable between 2005 and 2007, as in most minority ethnic groups, but fell sharply in 2008, (b) in contrast, the numbers of Black Caribbean, Black African and White/Black Mixed patients increased in 2008, and (c) a significant proportion of patients are long-stay. This difference in patterns between the Other Black group and all other Black and White/Black groups could be real, or possibly the result of coding of patients' ethnicity – since ethnicity was not self-reported for 25% of patients.

- Furthermore, a consistent pattern across the four annual censuses was the higher than average detention rate under section 37/41 for Black Caribbean and Other Black groups, indicating that patients are being routed to hospital for treatment rather than being sent to prison.
- Another of DRE's goals is to reduce seclusion among black and minority ethnic groups, but again, there has been little change in patterns. Rates of seclusion have been fairly consistently high for the Black groups (Black Caribbean, Black African and Other Black) groups since 2005. Furthermore, rates of seclusion for patients in the Other White group increased from being average in 2005-2006 to being higher than average in 2007-2008.
- Some changes in patterns from one census to the next may be due to changes in the small numbers of affected patients in the individual minority ethnic groups on census day, leading to a statistical phenomenon known as 'regression to the mean'. This means that rates based on small and fluctuating numbers of patients for some minority ethnic groups can change in either direction (high to low or vice versa), from one year to the next, as a result of random rather than real variation – as, for example, with numbers for hands-on restraint, self-harm, accidents, physical assault and seclusion.
- Lengths of stay were shorter among the White British, South Asian and Chinese groups, and longer among the Black Caribbean and White/Black Caribbean groups.

In summary, the 2008 census shows similar patterns to previous censuses. Overall, in terms of the key DRE goals: since 2005, ethnic differences in admission rates have not changed in many minority ethnic groups, and have increased in most groups with the highest rates in 2005 (Black and White/Black groups), and there has been no reduction in ethnic differences in rates of detention and seclusion among high-risk groups (Black and White/Black groups).

There are changing patterns for patients from the Other White group, whose numbers, proportions and admission rates are increasing (which could reflect recent demographic changes), with indications also of increasing rates of detention, seclusion and accidents.

Implications for the way forward

The census was designed to support the goals of the Government's five-year DRE plan by providing an annual profile of inpatients in mental health services. It was designed to assist in understanding the way that black and minority ethnic communities are affected by service policies and priorities, although it cannot in itself provide explanations for the patterns observed, or examine whether mental health services are meeting the needs of individual ethnic minority groups. The results contain caveats that must be considered when interpreting the results (see section on data, methods of analysis and interpretation).

The findings of this fourth census show continuing statistically significant differences between black and minority ethnic groups and white groups, and also differences within these groups. The census also shows that patterns have remained relatively unchanged

since 2005, and there has been no reduction in admission, detention and seclusion rates – key DRE goals – among black and minority ethnic groups.

The findings do not themselves reflect the performance of services in meeting the needs of black and minority ethnic service users. The factors that contribute to these findings are complex and may differ between ethnic groups and areas. The findings need to be interpreted in the context of available evidence on ethnic variations in the rates of mental illness and the varying pathways to care taken by different black and minority ethnic groups and the possible contributory factors. Some publications provide further information on these issues.[26-40]

When interpreting the results, it should be noted that several factors may affect levels of mental illness and the likelihood of admission and detention for different black and minority ethnic groups. Studies of first episodes of psychosis show ethnic variations in incidence – with high rates in migrant groups, especially in African-Caribbean groups – and that socioeconomic and family-related factors influence pathways into admission for some ethnic groups.[26-28, 37] The ethnic differences observed in the census could reflect the effects of these determinants, with patterns of service use reflecting ethnic variations in need and precipitating factors. However, these patterns reinforce the need for early intervention, with statutory services working together to reduce the risk of admission and detention where possible and without compromising the care of patients.

Healthcare organisations are required to work towards achieving the goals set out in the DRE action plan to improve mental health services for black and minority ethnic communities. However, delivering race equality in mental health is complex, and requires the cooperation of various organisations to understand the problems and deliver the solutions. Mental health services have a key role to play, but partnership with statutory organisations outside the healthcare sector, black and minority ethnic communities and service users themselves will be needed to help achieve this. Services need in particular to focus around prevention and early intervention. Early intervention services in England and Wales aim to reach, diagnose and treat patients with psychosis earlier in the course of their illness, with the aim of reducing the risk of acute outcomes such as admission and detention.

The findings about the Other White group are noteworthy, and could reflect the effects of recent demographic changes in the UK, in particular the in-migration following the expansion of the EU. There is strong evidence that migration is associated with higher rates of psychosis, among both white and non-white groups.[41, 42] Others have noted that current UK immigration patterns may present substantial challenges for mental healthcare services in forthcoming decades, and the importance of ensuring that services are prepared for the prospect of psychiatric morbidity in these groups and sensitive to their needs.[40] Commissioners and providers should take note of the census findings, and ensure that the specific needs of and access to services of the Other White group (as with other ethnic groups) are addressed appropriately and monitored on an ongoing basis, including with the use of data sets such as Hospital Episode Statistics (HES) and Mental Health Minimum Data Set (MHMDS).

Overall, the level of provision of single sex wards continues to show considerable room for improvement, with 68% of patients in mixed wards. This issue was highlighted in both the national audit of violence in inpatient settings and the Healthcare Commission's review of acute inpatient mental health services as one of a number of mechanisms for promoting the safety and dignity of patients.[15, 17] However, there was no evidence that minority ethnic patients were disadvantaged in these respects.

Health service commissioners and providers must take responsibility for implementing changes to services that are commensurate with the vision set out in the NHS Next Stage Review and World Class Commissioning. In this context, the DRE action plan sets out a strategy for improving mental health outcomes for people from black and ethnic groups and we expect commissioners and providers to take responsibility for delivering this.

The importance of better information

The availability of comprehensive patient-level data sets with ethnicity and other key variables fully coded is vitally important for a range of reasons.[43] It enables the care provided to patients of all ethnic backgrounds to be monitored on an ongoing basis, irrespective of the place of treatment. It also supports the monitoring of compliance with the Race Relations Amendment Act and the Department of Health's standards. The HES and MHMDS are mandated data sets for NHS trusts, in which the recording of ethnicity for patients is mandatory. However, the quality, coverage and completeness of ethnicity data in mental health services is not comprehensive, and improved recording and data quality must be a priority for the NHS.[44]

The Healthcare Commission, MHAC and NIMHE expect commissioners and providers of mental healthcare in the NHS and independent sector to have systems for fully comprehensive recording and monitoring of ethnicity on an ongoing basis, in accordance with guidance provided by the Department of Health.[45] The Healthcare Commission uses these data sets in a range of assessments of the performance of NHS organisations, and those with poor quality data will be penalised in the annual review of performance.

We also take this opportunity to remind NHS trusts that ethnicity coding in the MHMDS is mandatory for **all** patients, not just inpatients, and including those receiving community services.[46]

There has been a lack of clarity about this among some providers, which probably explains why ethnicity coding in the MHMDS is very much better (94% complete) for inpatients than for those receiving services in the community (about 79%). The Data Set Change Notices make clear that ethnicity coding has **always** been a requirement for **all** patients in the MHMDS.[46]

Improvements in the information that is currently available for NHS providers and, in particular, for providers in the independent sector, are imperative for effective monitoring of the quality of care provided to all those who use mental health services, including those from black and minority ethnic groups. Having information that is fit for purpose is also vital for the effective regulation of mental healthcare services. In the recommendations that follow, we make proposals that relate to improving information about patients. We have made some of these recommendations in previous census reports, and now reiterate the need for their urgent implementation.

In previous census reports, we have consistently recommended that recording the ethnicity of patients should be made mandatory for all patients, regardless of whether they are treated in the community or a hospital. We are pleased to report that, following formal sponsorship by the Healthcare Commission, ethnicity coding in the commissioning data sets for outpatients, A&E attendees and births has been mandated by the Information Centre from April 2009.[47]

The Healthcare Commission is also promoting these developments by participating in the Department of Health's Equality Monitoring group, chaired by the Permanent Secretary. This initiative is aimed at improving the coverage of information on equality dimensions (age, gender, ethnicity, disability, religion and sexual orientation) in health data sets.

The use of other information

Table D1 in Appendix D shows the level of ethnicity coding in HES and MHMDS at national (England) level among for the periods 2006/07 and the first two quarters of 2006/07 respectively. As in previous years, indicators on ethnicity coding in these data sets at provider level were included in the Healthcare Commission's 2007/08 annual health check of NHS organisations.

The census counts inpatients on one day of the year. It is important to remember that the number of inpatients throughout the year is much higher, and that some patients will have more than one admission. The key points to note from table D1 are:

- Ethnicity coding for mental health inpatients in NHS trusts was 95% complete in HES and 94% complete in MHMDS.
- Ethnicity coding for MHMDS care spells without a hospital admission (ie where care was provided outside hospital) was significantly lower, at 79%.
- Reporting of ethnicity in HES and MHMDS, following guidance from the Department of Health, is required to be self-reported. In the census, ethnicity for 25% of inpatients was reported by staff or relatives.
- Overall, there were almost 157,000 mental health-related first admissions during 2006/07 (HES).

- In the first two quarters of 2006/07, there were almost 737,000 care spells that did not involve an inpatient stay (MHMDS).
- The ethnicity profile of patients in MHMDS and HES is very similar to that in the census for most groups. However, ethnic differences in lengths of stay could contribute to any differences, because long-stay patients are over-represented in the census.

The latest data to be used for the 2007/08 annual health check show that ethnicity coding for Q1-Q3 2007/08 in the MHMDS was 97% complete, with individual providers ranging from 80% to 100%. The data demonstrates that ethnicity coding in these data sets is now virtually complete. We therefore expect providers and commissioners to use the data to good effect for monitoring and improving the access to and quality of care for patients of all ethnic groups on an ongoing basis. Although the level of ethnicity coding has improved over previous years, it still needs to be more complete, especially for patients receiving care out of hospital. The Healthcare Commission, MHAC and NIMHE also expect providers in the independent sector to adopt comprehensive ethnic coding and monitoring, as this is good practice for any healthcare provider and professional.

The Information Centre has recently published a bulletin on the MHMDS, with "experimental" statistics for years up to 2007.[48] The bulletin highlights the usefulness of the MHMDS in providing information for planning services and monitoring the processes and outcomes of care.

Learning disabilities

Observations on the census data

As with mental health, the census showed an increasing proportion of inpatients in hospitals run by independent providers. Apart from this, the patterns were very similar to those reported previously. Rates of admission remained lower than average among the South Asian and Chinese groups, and were between two and three times higher than average in the Black and White/Black Mixed groups. The data suggests that some of these inpatients were in hospital primarily for a mental health problem rather than a learning disability. The number of detained patients among black and minority ethnic groups was very low, and there were no ethnic differences in detention rates. We also found almost no differences between ethnic groups in the rates of seclusion, hands-on restraint, self-harm, accidents and physical assault, and again, the number of inpatients from minority ethnic groups involved in these cases was low.

The Healthcare Commission's investigations into services for people with learning disabilities showed that patients were receiving poor quality, unsafe services and experiencing abuse. The Commission's national audit of learning disability services identified that general health services, care planning, and other aspects of care are poorer for people with learning disabilities in some organisations. The Commission is taking follow-up action with organisations where standards are poor, to ensure that remedial measures are put in place.

The importance of better information

High quality information is imperative for improving services for people with learning disabilities, including those from minority ethnic communities. It is not possible to monitor the quality of care provided to people with learning disabilities, or to target improvements, without information about the number of people affected and details of the care they receive. It is vital that learning disability services, from both NHS and independent providers, have accurate and sustainable ethnic monitoring arrangements in place, in the same way as mental health services.

A further issue relating to patients with a learning disability concerns the recording of disability, including learning disability, which is currently not a requirement in the data routinely collected by the Department of Health. The lack of a nationally agreed classification for disability has hampered data collection, but such a classification is currently under development for use across all government departments. The Healthcare Commission is promoting these developments through participation in the Department of Health's Equality Monitoring Group. This initiative is aimed at improving the coverage of information on equality dimensions (age, gender, ethnicity, disability, religion and sexual orientation) in health data sets.

Recommendations

A number of recommendations can be drawn from the key findings of this report, some of which were also set out in the 2007 census report and which we reiterate here.

1. DRE outlines an action plan for improving mental health services for black and minority ethnic communities. Healthcare organisations must work towards achieving the goals set out in the plan.
2. We recommend that statutory agencies, working in partnership with others, make every effort to understand the local demographic and clinical needs of the population, and to commission and deliver services that are personalised, effective, fair and which improve the pathways to mental healthcare taken by black and minority ethnic groups. Commissioners and providers of services also need to take into consideration the changing demographic profile of local populations.
3. We urge all providers of learning disability services to review the findings of the Healthcare Commission's reports into learning disability services, learn any lessons from them and act on the recommendations, to avoid the risk of serious failures of care recurring and to ensure services meet required standards.
4. We recommend that commissioners and providers of mental health and learning disability services make renewed and strenuous efforts to improve the provision of designated single sex wards for inpatients.

5. We expect commissioners and providers of mental healthcare, in both the NHS and the independent sector, to have fully comprehensive systems to record and monitor ethnicity. In the same way, it is also vital that learning disability services have accurate and sustainable ethnic monitoring arrangements in place.

We strongly recommend to the Department of Health and the Information Centre for Health and Social Care that:

6. Some changes and extensions should be made to the MHMDS (the Healthcare Commission and MHAC have responded to the review of mental health information undertaken recently by the Information Centre, with proposals for changes to the MHMDS). In particular, changes and enhancements to current data collections (MHMDS and HES) need to be suitable for supporting effective monitoring of the Mental Health Act 2007.
7. Submission of the MHMDS and HES should be made mandatory for all independent providers of inpatient mental health services, especially in view of the growing number and proportion of all mental health inpatients cared for in these establishments.[49] Submission of these data sets should be a requirement in the mental health standard contract under development by the Department of Health.
8. The Information Centre should routinely monitor and publish reports on the quality of MHMDS data submitted by all providers of mental health services, including those in the independent sector.
9. Collection of ethnicity data about patients should be extended to primary care.
10. We recommend that the Information Centre regularly publishes data on all detentions and supervised community treatment orders under the Mental Health Act in England (in both NHS and independent healthcare providers) by the ethnicity of patients, to supplement its current publication on all detentions,[1] and with the longer term aim of the MHMDS being the definitive source of information about mental health patients, including on detentions.

High quality, appropriate data is essential for monitoring the way patients gain access to healthcare, the quality of care they receive and the outcomes of that care. This applies to all patients with mental health problems and learning disabilities, including those from black and minority ethnic groups. Information that is fit for purpose is also vital for the effective regulation of mental healthcare services.

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Appendix A: Methods of analysis

Standardisation by age and gender

Standardisation allows comparisons to be made between groups of the population, by taking account of variations in age and gender. Some differences in patterns of service use are related to the age or gender of the people using them, so adjustments to the data have to be made to ensure that the interpretation of ethnic differences is reliable. For example, formal admissions are higher at a younger age, so some black and minority ethnic groups may have high formal admission rates simply because they have a high proportion of younger people. Without adjustments for age and gender differences, comparisons would be misleading.

In this report, most results are standardised for age and gender, including those relating to admission, detention, source of referral, care programme approach, seclusion, restraint, accidents, assault, self-harm, consent and presence on a secure ward. The report uses the accepted statistical method of taking account of age and gender differences between groups when calculating these rates.

The total population of England and Wales, based on figures from the 2001 census by the Office for National Statistics (ONS), was used to standardise the rates of admission. In addition, we calculated the admission rates using the ONS population estimates for 2005 (England only). For other analyses, we used the total population of inpatients in the census as the basis for standardisation. We used the statistical package STATA version 8.2 to derive the standardised results.

It was not possible to adjust the analyses for ethnic differences in social and economic factors, and in diagnosis and severity of illness. Such factors could affect the ethnic differences observed in the results.

For descriptive variables, such as religion and language, we did not use standardisation.

Confidence intervals as indicators of significant statistical differences

For all standardised results, the national rates for England and Wales are taken as 100, and the usual 95% confidence intervals are given. Rates of less than 100 or greater than 100 for specific ethnic groups show a lower or higher rate respectively than the national average, after adjusting for age and gender. Whether or not the difference is statistically significant from the national average depends on the confidence interval. If the confidence interval overlaps 100, the difference from the national average is not statistically significant. If both values are lower or higher than 100, it indicates that the difference compared with the national average is statistically significant at the 95% level.

For example, if a rate is 110, with the lower confidence interval being 105 and the upper confidence interval being 115, it indicates that the 10% excess over the national average of 100 is statistically significant. But if a ratio is 110, with the lower confidence interval being 95 and the upper confidence interval being 105, it indicates that the 10% excess over the national average is not statistically significant. No attempt was made to adjust the confidence intervals for multiple comparisons

Appendix B: Mental health tables

Table B1a: Standardised admission ratios by ethnic group for England and Wales, using 2001 ONS census population denominators (England and Wales = 100). All ages.

	Males				Females				Persons			
	Standardised admission ratio	95% confidence interval		Observed	Standardised admission ratio	95% confidence interval		Observed	Standardised admission ratio	95% confidence interval		Observed
Ethnic group		Lower	Upper			Lower	Upper			Lower	Upper	
White British	84	82	85	13,008	91	89	93	10,662	87	86	88	23,670
White Irish	124	110	138	310	128	113	145	257	126	115	136	567
Other White	167	155	179	792	184	170	199	605	174	165	183	1,397
White and Black Caribbean	626	548	712	231	393	321	476	105	528	473	588	336
White and Black African	402	313	508	69	367	262	500	40	388	319	468	109
White and Asian	183	143	230	73	175	127	235	44	180	149	216	117
Other Mixed	314	257	381	104	184	134	248	43	261	220	306	147
Indian	82	72	92	272	75	64	88	154	79	72	87	426
Pakistani	142	126	160	274	109	90	130	121	130	117	143	395
Bangladeshi	131	106	160	93	126	94	166	51	129	109	152	144
Other Asian	254	222	289	223	189	149	236	77	233	208	261	300
Black Caribbean	557	523	593	984	378	345	413	481	482	458	508	1,465
Black African	374	342	408	506	250	217	287	208	327	303	352	714
Other Black	1,267	1,124	1,423	285	580	467	713	91	985	888	1,090	376
Chinese	68	50	90	49	88	63	119	42	76	61	93	91
Other	422	373	475	273	184	148	227	89	320	288	355	362
Total	**100**			**17,546**	**100**			**13,070**	**100**			**30,616**

Table B1b: Standardised admission ratios by ethnic group for England and Wales, using 2001 ONS census population denominators (England & Wales = 100). All aged 65 and over.

	Persons			
	Standardised admission ratio	95% confidence interval		Observed
Ethnic group		Lower	Upper	
White British	93	91	95	7,954
White Irish	151	133	171	247
Other White	296	269	325	441
White and Black Caribbean	232	127	388	14
White and Black African	324	119	704	6
White and Asian	74	24	172	5
Other Mixed	18	0	98	1
Indian	92	70	118	60
Pakistani	118	81	166	33
Bangladeshi	163	87	278	13
Other Asian	183	115	278	22
Black Caribbean	389	339	445	213
Black African	180	108	281	19
Other Black	551	321	882	17
Chinese	90	43	165	10
Other	1,003	769	1,286	62
Total	**100**			**9,117**

Table B2: Standardised admission ratios by ethnic group for England, 2005 and 2008, using 2005 ONS census population denominators (England = 100). All ages.

	2008 census				2005 census			
	Standardised admission ratio	95% confidence interval		Observed	Standardised admission ratio	95% confidence interval		Observed
Ethnic group		Lower	Upper			Lower	Upper	
White British	88	87	90	21,617	92	91	93	24,356
White Irish	135	124	147	551	149	138	161	665
Other White	143	135	151	1,346	99	93	105	995
White and Black Caribbean	427	382	476	327	298	262	337	248
White and Black African	290	238	351	106	172	133	219	67
White and Asian	137	113	165	113	112	91	136	99
Other Mixed	200	169	236	141	216	184	252	163
Indian	65	59	72	418	63	57	69	428
Pakistani	108	98	120	392	84	75	93	322
Bangladeshi	103	87	121	140	101	85	119	147
Other Asian	181	161	202	297	149	132	169	259
Black Caribbean	455	432	479	1,456	393	372	415	1,350
Black African	223	207	240	706	188	174	204	631
Other Black	824	743	912	372	1,161	1,067	1,262	560
Chinese	45	36	55	86	38	30	48	78
Other	196	176	218	343	185	166	206	343
Total	**100**			**28,411**	**100**			**30,711**

Table B3: Standardised ratios of proportions of patients referred by self, carer or employer (England and Wales = 100)

	Males				Females				Persons			
	Standardised ratio	95% confidence interval		Observed	Standardised ratio	95% confidence interval		Observed	Standardised ratio	95% confidence interval		Observed
Ethnic group		Lower	Upper			Lower	Upper			Lower	Upper	
White British	107	95	121	259	96	85	108	266	101	93	110	525
White Irish	111	41	241	6	80	26	187	5	94	47	169	11
Other White	72	34	132	10	86	44	150	12	79	49	119	22
White and Black Caribbean	85	23	218	4	237	95	487	7	144	72	257	11
White and Black African	79	2	440	1	93	2	518	1	85	10	308	2
White and Asian	69	2	385	1	252	52	737	3	152	41	389	4
Other Mixed	49	1	275	1	170	21	614	2	94	19	274	3
Indian	96	31	224	5	275	137	492	11	174	99	282	16
Pakistani	37	5	135	2	65	8	233	2	47	13	121	4
Bangladeshi	58	1	323	1	160	19	578	2	101	21	295	3
Other Asian	48	6	172	2	102	12	368	2	65	18	166	4
Black Caribbean	61	30	109	11	105	56	179	13	79	50	117	24
Black African	137	73	234	13	77	21	198	4	116	68	186	17
Other Black	56	11	162	3	84	10	305	2	64	21	150	5
Chinese	0		409	0	197	24	713	2	104	13	377	2
Other	125	46	271	6	137	28	399	3	128	59	244	9
Total	**100**			**325**	**100**			**337**	**100**			**662**

Table B4: Standardised ratios of proportions of patients referred by GP (England and Wales = 100)

	Males				Females				Persons			
	Standardised ratio	95% confidence interval		Observed	Standardised ratio	95% confidence interval		Observed	Standardised ratio	95% confidence interval		Observed
Ethnic group		Lower	Upper			Lower	Upper			Lower	Upper	
White British	106	100	112	1,283	104	99	109	1,548	105	101	109	2,831
White Irish	79	52	114	27	86	57	123	29	82	62	107	56
Other White	80	60	105	52	93	72	118	67	87	72	104	119
White and Black Caribbean	39	13	91	5	35	7	102	3	37	16	74	8
White and Black African			109		131	43	306	5	70	23	162	5
White and Asian	52	6	187	2	23	1	128	1	37	8	107	3
Other Mixed	62	13	182	3	113	31	290	4	84	34	173	7
Indian	89	52	142	17	83	46	140	14	86	59	122	31
Pakistani	44	18	90	7	39	11	99	4	42	21	75	11
Bangladeshi	111	36	259	5	23	1	127	1	68	25	147	6
Other Asian	165	102	252	21	91	33	198	6	140	92	203	27
Black Caribbean	72	53	95	47	67	47	93	36	70	55	86	83
Black African	76	45	120	18	64	31	117	10	71	47	103	28
Other Black	76	39	133	12	27	3	98	2	60	33	101	14
Chinese	59	7	213	2	52	6	187	2	55	15	141	4
Other	85	48	141	15	97	46	178	10	90	58	132	25
Total	**100**			**1,516**	**100**			**1,742**	**100**			**3,258**

Table B5: Standardised ratios of proportions of patients referred by community mental health teams (including crisis resolution, home treatment) or community learning disability team (England and Wales = 100)

	Males				Females				Persons			
	Standardised ratio	95% confidence interval		Observed	Standardised ratio	95% confidence interval		Observed	Standardised ratio	95% confidence interval		Observed
Ethnic group		Lower	Upper			Lower	Upper			Lower	Upper	
White British	105	102	109	3,186	103	100	106	3,497	104	102	107	6,683
White Irish	69	51	91	50	98	77	123	75	84	70	100	125
Other White	68	56	81	117	72	60	86	124	70	62	79	241
White and Black Caribbean	77	56	105	41	78	52	113	28	78	60	98	69
White and Black African	106	59	174	15	92	47	160	12	99	65	144	27
White and Asian	116	70	181	19	90	48	154	13	104	71	147	32
Other Mixed	85	51	132	19	91	48	156	13	87	60	123	32
Indian	101	78	130	63	94	69	126	46	98	81	118	109
Pakistani	123	97	154	75	125	92	166	47	124	103	148	122
Bangladeshi	114	71	173	22	112	65	179	17	113	80	155	39
Other Asian	75	52	103	36	84	51	129	20	78	59	101	56
Black Caribbean	78	67	91	168	84	70	100	128	81	72	90	296
Black African	87	70	107	92	68	49	92	43	80	67	95	135
Other Black	94	71	121	58	90	59	132	26	93	74	115	84
Chinese	65	26	133	7	89	44	159	11	78	46	123	18
Other	93	70	122	53	112	75	160	30	99	79	123	83
Total	**100**			**4,021**	**100**			**4,130**	**100**			**8,151**

Table B6: Standardised ratios of proportions of patients referred by criminal justice routes (police, prison, probation, courts, court liaison and diversion) (England and Wales = 100)

	Males				Females				Persons			
	Standardised ratio	95% confidence interval		Observed	Standardised ratio	95% confidence interval		Observed	Standardised ratio	95% confidence interval		Observed
Ethnic group		Lower	Upper			Lower	Upper			Lower	Upper	
White British	90	86	95	1,528	88	79	98	347	90	86	94	1,875
White Irish	113	79	158	34	124	62	223	11	116	85	155	45
Other White	109	90	131	112	110	70	163	24	109	92	129	136
White and Black Caribbean	121	91	158	54	162	81	290	11	126	98	161	65
White and Black African	65	28	129	8	48	1	266	1	63	29	119	9
White and Asian	170	108	256	23	168	46	431	4	170	112	247	27
Other Mixed	100	61	155	20	111	23	324	3	102	64	152	23
Indian	99	71	135	41	58	16	149	4	93	68	125	45
Pakistani	126	96	161	62	176	88	316	11	131	103	165	73
Bangladeshi	148	96	219	25	0	0	142	0	128	83	190	25
Other Asian	139	104	182	52	75	15	219	3	133	100	173	55
Black Caribbean	141	123	162	204	226	165	301	46	152	133	172	250
Black African	134	111	160	122	170	102	265	19	138	116	163	141
Other Black	94	68	125	45	158	68	311	8	100	75	130	53
Chinese	128	58	242	9	215	59	551	4	146	78	250	13
Other	121	89	159	49	135	44	316	5	122	91	159	54
Total	**100**			**2,388**	**100**			**501**	**100**			**2,889**

Table B7: Standardised detention ratios by ethnic group: detention on day of admission (England and Wales = 100)

	Males				Females				Persons			
	Standardised ratio	95% confidence interval		Observed	Standardised ratio	95% confidence interval		Observed	Standardised ratio	95% confidence interval		Observed
Ethnic group		Lower	Upper			Lower	Upper			Lower	Upper	
White British	95	92	97	6,340	93	90	96	3,428	94	92	96	9,768
White Irish	98	82	116	137	102	82	126	90	100	87	113	227
Other White	110	100	120	460	113	99	128	240	111	103	119	700
White and Black Caribbean	115	98	134	169	137	106	175	64	120	105	137	233
White and Black African	116	86	152	51	127	79	194	21	119	93	149	72
White and Asian	99	73	132	46	110	67	170	20	102	79	130	66
Other Mixed	124	99	154	84	110	68	169	21	121	99	147	105
Indian	93	79	110	145	100	76	129	59	95	82	109	204
Pakistani	111	96	128	189	146	114	183	74	119	105	134	263
Bangladeshi	98	75	126	59	101	64	154	22	99	79	123	81
Other Asian	118	100	138	161	113	79	156	36	117	101	134	197
Black Caribbean	125	116	134	709	149	132	168	272	131	123	139	981
Black African	116	105	128	380	140	117	167	127	121	111	132	507
Other Black	130	114	148	229	161	124	207	63	136	121	152	292
Chinese	120	83	168	33	136	86	205	23	126	95	164	56
Other	95	80	111	150	120	86	163	40	99	85	114	190
Total	**100**			**9,342**	**100**			**4,600**	**100**			**13,942**

Table B8: Standardised detention ratios by ethnic group: detention on day of admission – section 2 of the Mental Health Act (England and Wales = 100)

	Males				Females				Persons			
	Standardised ratio	95% confidence interval		Observed	Standardised ratio	95% confidence interval		Observed	Standardised ratio	95% confidence interval		Observed
Ethnic group		Lower	Upper			Lower	Upper			Lower	Upper	
White British	95	89	101	966	93	87	99	990	94	90	98	1,956
White Irish	80	48	124	19	70	41	111	18	75	53	103	37
Other White	104	80	133	65	100	76	128	60	102	85	122	125
White and Black Caribbean	74	41	125	14	136	72	232	13	95	63	138	27
White and Black African	107	39	232	6	213	92	421	8	149	82	251	14
White and Asian	50	10	148	3	97	26	248	4	70	28	143	7
Other Mixed	59	19	137	5	127	41	297	5	80	39	148	10
Indian	106	67	159	23	155	98	233	23	126	92	168	46
Pakistani	162	113	224	36	213	136	317	24	179	137	231	60
Bangladeshi	197	110	325	15	232	116	416	11	211	138	309	26
Other Asian	183	126	257	33	97	39	200	7	159	113	216	40
Black Caribbean	90	71	114	71	118	89	154	55	101	84	120	126
Black African	123	92	162	51	241	176	321	46	161	130	196	97
Other Black	134	91	191	31	178	100	294	15	146	107	195	46
Chinese	103	28	263	4	201	87	397	8	152	79	266	12
Other	192	138	260	42	116	55	212	10	170	127	223	52
Total	**100**			**1,384**	**100**			**1,297**	**100**			**2,681**

Table B9: Standardised detention ratios by ethnic group: detention on day of admission – section 3 of the Mental Health Act (England and Wales = 100)

	Males				Females				Persons			
	Standardised ratio	95% confidence interval		Observed	Standardised ratio	95% confidence interval		Observed	Standardised ratio	95% confidence interval		Observed
Ethnic group		Lower	Upper			Lower	Upper			Lower	Upper	
White British	99	95	102	2,897	93	89	97	1,884	96	94	99	4,781
White Irish	88	66	114	53	128	98	164	62	106	87	127	115
Other White	104	90	120	192	114	95	135	135	108	97	120	327
White and Black Caribbean	116	91	145	76	149	107	202	41	126	104	151	117
White and Black African	122	78	181	24	115	57	205	11	119	83	166	35
White and Asian	73	41	120	15	94	45	173	10	80	52	118	25
Other Mixed	140	101	189	42	89	42	163	10	126	94	165	52
Indian	102	79	129	69	101	70	141	34	101	83	123	103
Pakistani	88	69	112	67	142	103	192	42	104	85	125	109
Bangladeshi	74	45	114	20	86	43	154	11	78	53	111	31
Other Asian	73	53	98	44	129	83	193	24	86	67	109	68
Black Caribbean	109	96	122	269	161	138	188	166	124	113	136	435
Black African	112	96	131	163	111	84	143	59	112	98	127	222
Other Black	123	99	150	95	167	118	229	38	133	111	157	133
Chinese	150	89	238	18	124	64	216	12	138	93	198	30
Other	78	59	102	55	116	73	175	22	86	68	108	77
Total	**100**			**4,099**	**100**			**2,561**	**100**			**6,660**

Table B10: Standardised detention ratios by ethnic group: detention on day of admission – section 37/41 of the Mental Health Act (England and Wales = 100)

	Males				Females				Persons			
	Standardised ratio	95% confidence interval		Observed	Standardised ratio	95% confidence interval		Observed	Standardised ratio	95% confidence interval		Observed
Ethnic group		Lower	Upper			Lower	Upper			Lower	Upper	
White British	85	79	90	964	99	86	113	203	87	82	92	1,167
White Irish	110	73	160	27	83	23	212	4	106	72	150	31
Other White	120	96	148	85	96	50	168	12	116	94	142	97
White and Black Caribbean	162	115	221	39	58	7	210	2	149	107	202	41
White and Black African	165	85	289	12	181	22	654	2	167	92	281	14
White and Asian	145	72	259	11	159	19	575	2	147	78	251	13
Other Mixed	190	118	291	21	210	43	612	3	193	123	286	24
Indian	89	57	134	23	55	7	198	2	85	55	125	25
Pakistani	135	96	186	38	29	1	161	1	124	88	169	39
Bangladeshi	71	28	146	7	0	0	236	0	61	25	126	7
Other Asian	183	131	248	41	139	29	406	3	179	130	240	44
Black Caribbean	195	168	226	183	138	77	228	15	189	164	218	198
Black African	107	81	138	57	140	64	266	9	110	85	140	66
Other Black	177	132	233	51	184	60	429	5	178	134	231	56
Chinese	22	1	122	1	0	0	338	0	18	0	99	1
Other	72	43	112	19	47	1	265	1	70	43	108	20
Total	**100**			**1,579**	**100**			**264**	**100**			**1,843**

Table B11: Standardised detention ratios by ethnic group: detention on day of admission – sections 47, 48, 47/49 of the Mental Health Act (England and Wales = 100)

	Males				Females				Persons			
	Standardised ratio	95% confidence interval		Observed	Standardised ratio	95% confidence interval		Observed	Standardised ratio	95% confidence interval		Observed
Ethnic group		Lower	Upper			Lower	Upper			Lower	Upper	
White British	100	92	109	547	97	73	127	53	100	92	108	600
White Irish	143	80	236	15			289	0	128	71	210	15
Other White	126	92	169	44	88	18	258	3	123	90	163	47
White and Black Caribbean	90	46	157	12	198	24	716	2	98	53	164	14
White and Black African	74	15	215	3	0	0	1,191	0	69	14	200	3
White and Asian	119	39	279	5	0	0	1,027	0	110	36	257	5
Other Mixed	81	26	189	5	236	6	1,314	1	91	33	198	6
Indian	54	22	110	7	0	0	370	0	50	20	103	7
Pakistani	78	40	137	12	102	3	567	1	80	42	136	13
Bangladeshi	179	86	329	10	0	0	805	0	165	79	304	10
Other Asian	83	40	153	10	164	4	914	1	87	44	156	11
Black Caribbean	122	93	158	58	206	76	449	6	127	98	162	64
Black African	84	54	124	25	54	1	302	1	82	54	121	26
Other Black	104	59	168	16	129	3	719	1	105	61	168	17
Chinese	0	0	162	0	330	8	1,837	1	39	1	216	1
Other	51	20	105	7	170	4	947	1	56	24	110	8
Total	**100**			**776**	**100**			**71**	**100**			**847**

Appendix C: Learning disabilities tables

Table C1: Standardised admission ratios by ethnic group for England and Wales, using 2001 ONS census population denominators (England & Wales = 100). All ages.

	Males				Females				Persons			
	Standardised admission ratio	95% confidence interval		Observed	Standardised admission ratio	95% confidence interval		Observed	Standardised admission ratio	95% confidence interval		Observed
Ethnic group		Lower	Upper			Lower	Upper			Lower	Upper	
White British	100	96	104	2,414	105	99	111	1,183	102	98	105	3,597
White Irish	89	61	126	32	112	69	171	21	97	73	127	53
Other White	105	84	130	84	50	30	78	19	87	71	106	103
White and Black Caribbean	317	201	476	23	182	67	397	6	275	184	395	29
White and Black African	30	1	168	1	70	2	391	1	42	5	152	2
White and Asian	145	72	259	11	32	1	181	1	112	58	196	12
Other Mixed	158	76	291	10	138	38	353	4	152	83	254	14
Indian	38	24	57	23	19	6	44	5	32	21	47	28
Pakistani	77	51	111	28	14	2	50	2	59	40	84	30
Bangladeshi	67	31	128	9	38	5	137	2	59	29	106	11
Other Asian	49	21	97	8	75	20	192	4	56	29	97	12
Black Caribbean	229	178	291	67	171	113	249	27	209	169	256	94
Black African	82	51	126	21	62	25	128	7	76	51	110	28
Other Black	260	130	466	11	198	54	508	4	240	135	396	15
Chinese	22	4	63	3	32	4	114	2	25	8	58	5
Other	106	56	181	13	30	4	108	2	79	44	130	15
Total	**100**			**2,758**	**100**			**1,290**	**100**			**4,048**

Table C2: Standardised admission ratios by ethnic group for England, 2006 and 2008, using 2005 ONS census population denominators (England = 100). All ages.

	2008 census				2006 census			
	Persons				Persons			
	Standardised admission ratio	95% confidence interval		Observed	Standardised admission ratio	95% confidence interval		Observed
Ethnic group		Lower	Upper			Lower	Upper	
White British	106	102	109	3,418	107	104	110	3,859
White Irish	112	84	146	53	119	92	152	64
Other White	71	58	87	103	48	38	61	77
White and Black Caribbean	203	134	295	27	221	151	313	32
White and Black African	31	4	113	2	43	9	126	3
White and Asian	86	45	151	12	60	27	113	9
Other Mixed	118	65	198	14	108	59	182	14
Indian	26	17	38	27	43	32	57	49
Pakistani	50	33	71	30	52	36	72	34
Bangladeshi	48	24	86	11	36	17	69	9
Other Asian	43	22	76	12	40	21	70	12
Black Caribbean	193	155	236	93	240	200	285	129
Black African	49	32	71	27	55	38	77	33
Other Black	193	108	318	15	199	116	318	17
Chinese	15	5	36	5	20	8	41	7
Other	50	28	83	15	73	47	109	24
Total	**100**			**3,864**	**100**			**4,372**

Table C3: Standardised detention ratios by ethnic group: detention on day of admission (England and Wales = 100)

Ethnic group	Persons			
	Standardised ratio	95% confidence interval		Observed
		Lower	Upper	
White British	98	93	103	1,438
White Irish	107	69	159	24
Other White	127	98	161	67
White and Black Caribbean	153	95	233	21
White and Black African	106	3	589	1
White and Asian	77	25	180	5
Other Mixed	125	54	247	8
Indian	93	48	163	12
Pakistani	105	61	169	17
Bangladeshi	150	68	284	9
Other Asian	86	28	201	5
Black Caribbean	124	92	164	50
Black African	135	82	208	20
Other Black	68	22	158	5
Chinese	86	10	312	2
Other	86	34	176	7
Total	**100**			**1,691**

Appendix D: Analysis of ethnicity coding in HES and MHMDS data

Table D1: Annual numbers and percentages of mental health and learning disability patients in NHS providers

Ethnic group	Count me in census 2008: mental health patients only (includes independent sector)	HES admission episodes for mental health specialties 2006/07 (England)	MHMDS 2006/07 Q2 (England)		Count me in census 2008: mental health patients only (includes independent sector)	HES admission episodes for mental health specialties 2006/07 (England)	MHMDS 2006/07 Q2 (England)	
			With bed days	No bed days			With bed days	No bed days
White British	23,738	119,508	33,747	437,654	76.5%	76.1%	74.0%	59.4%
White Irish	567	2,239	674	7,193	1.8%	1.4%	1.5%	1.0%
Other White	1,399	7,283	2,102	31,571	4.5%	4.6%	4.6%	4.3%
White and Black Caribbean	336	799	230	2,025	1.1%	0.5%	0.5%	0.3%
White and Black African	110	348	83	807	0.4%	0.2%	0.2%	0.1%
White and Asian	117	388	106	1,037	0.4%	0.2%	0.2%	0.1%
Other Mixed	148	637	183	1,999	0.5%	0.4%	0.4%	0.3%
Indian	426	1,891	593	7,874	1.4%	1.2%	1.3%	1.1%
Pakistani	396	1,835	521	7,096	1.3%	1.2%	1.1%	1.0%
Bangladeshi	144	695	199	2,669	0.5%	0.4%	0.4%	0.4%
Other Asian	300	1,468	470	5,517	1.0%	0.9%	1.0%	0.7%
Black Caribbean	1,468	3,827	1,336	10,045	4.7%	2.4%	2.9%	1.4%
Black African	715	2,888	866	6,676	2.3%	1.8%	1.9%	0.9%
Other Black	376	2,655	691	5,086	1.2%	1.7%	1.5%	0.7%
Chinese	91	388	113	911	0.3%	0.2%	0.2%	0.1%
Other	362	1,769	477	7,800	1.2%	1.1%	1.0%	1.1%
Not stated	327	1,707			1.1%	1.1%		
Invalid	0	6,674	2,704	156,385	0.0%	4.3%	5.9%	21.2%
Total	**31,020**	**156,999**	**45,584**	**736,784**	**100.0%**	**100.0%**	**100.0%**	**100.0%**

Appendix E: Survey of the census process and use of data by providers and commissioners

Count me in 2008 is the fourth census of inpatients in mental health and learning disability services. During summer 2008, the Healthcare Commission invited organisations that participated in the 2008 census, and primary care trusts (PCTs) as commissioners of these services, to provide feedback. The following is a brief summary of the findings.

Responses were received from 118 organisations providing services (a response rate of 38%), and from 38 PCTs (27%). As these response rates are low, the results should be interpreted with care, particularly those relating to commissioners. Forty-three per cent of the 101 NHS providers, and 36% of the 209 independent healthcare providers, responded to the survey. Geographically, 92% of those who responded were based in England and 8% were based in Wales.

Providers

Technical actions required to take part in the census (for example, registering an account) were a problem for only a small number of providers. More than eight in 10 found such functions "very" or "quite easy" to perform. In contrast, more than one in three providers said gathering and collating the data for census returns was difficult. There were widely differing views on how long it took to collect the data and complete the return, although this could be related to the range in size of providers: 44% said the whole process took three person days or less, while 19% said that the whole process took 11 or more person days.

Just under half of providers (49%) said their organisation uses data generated by the census, while 29% confirmed they did not use data. The main reason that providers gave for not using the data was that there were too few ethnic minority service users in their area, so the issue was not prominent.

When asked how their organisation had used the data, over a third of respondents (36%) said it was used to improve the recording of ethnicity; 19% said that planning services had been influenced by the census data, while 6% of respondents said that recruitment of staff had been influenced.

Respondents were asked to identify the barriers preventing them from successfully implementing plans arising from the census data: 36% said they found it difficult to identify specific actions to take arising from the census; 25% cited lack of time; 24% said that there was a general lack of interest in the issue; and 23% said that they did not have examples of what had worked elsewhere. Only 15% of all respondents said that services had improved significantly or slightly because of the census. Sixty four per cent of all respondents said that it had made no difference.

Commissioners

Around half of the commissioners that responded (49%) said there was an established process for using census data; 63% said there was a person responsible for acting on the results. Most responsibility for leading implementation was placed on middle managers.

Commissioners gave similar responses to providers when asked about the barriers that existed to implementing plans arising from the census: 47% said they found it difficult to identify specific actions to take and 37% said they did not have examples of commissioning actions that had worked elsewhere.

Commissioners were more enthusiastic than providers about the positive impact of the census on services. Fifty-three per cent said that census data had made an important contribution to commissioning services and over half said that monitoring service provision had improved as a result of the census.

Just under half (46%)of the commissioners said that services for black and minority ethnic groups had improved slightly or significantly because of the census.

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