Care Quality Commission

National Mental Health Development Unit
policy into practice

Count me in 2010

Results of the 2010 national census of inpatients and patients on supervised community treatment in mental health and learning disability services in England and Wales

April 2011

About the Care Quality Commission

The Care Quality Commission is the independent regulator of health care and adult social care services in England. We also protect the interests of people whose rights are restricted under the Mental Health Act.

Whether services are provided by the NHS, local authorities, or by private or voluntary organisations, we focus on:

- Identifying risks to the quality and safety of people's care.
- Acting swiftly to help eliminate poor-quality care.
- Making sure care is centred on people's needs and protects their rights.

Contents

Summary

This is the sixth and last national census of the ethnicity of inpatients in NHS and independent mental health and learning disability services in England and Wales, conducted on 31 March 2010.

The census has been undertaken annually since 2005 in support of the Department of Health's five-year action plan for improving mental health services for Black and minority ethnic communities in England, *Delivering Race Equality in Mental Health Care* (DRE). It 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. The aim of the census was to support these action plans by:

1. Obtaining accurate figures relating to patients 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 achieve the goals of the action plans.

The DRE five-year action plan for England came to a close in 2010. While this report reviews changes in the census results since 2005, it is **not** a review or evaluation of the DRE programme overall (The National Mental Health Development Unit published *Race Equality Action Plan: a five year review* in December 2010). DRE's underlying goal of promoting equity in health care for Black and minority ethnic communities in England continues to be reflected in government policy on tackling inequalities in health and outcomes of healthcare, and is central to demonstrating compliance with equality legislation.

Key findings

Mental health

Information was obtained for 32,799 patients who were either inpatients on the mental health wards of 261 NHS and independent healthcare organisations in England and Wales or were outpatients on a community treatment order (CTO) on census day. There were 3,034 patients on a CTO; of these, 2,959 were outpatients on census day and 75 were inpatients who were either recalled or were voluntary inpatients. The overall patterns emerging from this census are broadly similar to those observed in previous years. This is not surprising, as 31% of the patients in 2010 were also patients in 2009, and 20% of them had also been in hospital at the time of the 2008 census.

The key findings are:

Number of patients	32,799 (including 2,959 outpatients on a CTO), of whom 23% were from Black and minority ethnic groups (that is, not White British)
Distribution of patients	16% of all patients were in independent hospitals. 70% of patients from Black and minority ethnic groups were at 25 of the 261 organisations involved
Rates of admission (excluding outpatients on a CTO)	Lower than average for the White British, Indian and Chinese groups In line with the average for the Pakistani and Bangladeshi groups Higher than average for the other minority ethnic groups (particularly for the Black Caribbean, Black African, Other Black, White/Black Caribbean Mixed and White/Black African Mixed groups, who had rates two to six times higher than average)
Referral from the criminal justice system	Higher than average rates for some Black and White/Black groups
Detention under the Mental Health Act on admission*	Higher than average rates for the Black Caribbean, Black African, Other Black and White/Black Caribbean Mixed groups, White Irish, Other White and Other Mixed groups
Detention under section 37/41	Higher than average rates for the Black Caribbean and Other Black groups
Community treatment order	Higher than average rates for the South Asian and Black groups
Seclusion	Higher than average rates for the White/Black Caribbean Mixed, White/Black African Mixed, Black Caribbean and Black African groups
Self-harm	Higher than average rates for the White British group Lower than average rates for the Black and South Asian groups
Accidents	Higher than average rates for the White British group Lower than average rates for the Black groups
Hands-on restraint and physical assault	Few ethnic differences were apparent
Length of stay (from admission to census day)	31% of patients had been in hospital for one year or more; 20% for more than two years Length of stay longest for patients from the Black Caribbean and White/Black Caribbean Mixed groups; shortest for patients from the Chinese and Bangladeshi groups
Single sex accommodation	61% of men and 77% of women not in a designated single sex ward; 13% of men/16% of women without access to designated single sex toilet and bathing facilities; 37% of men/39% of women without access to a designated single sex lounge area/day space (these proportions generally lower among minority ethnic groups) (see page 27 for definition of single sex accommodation)

Note: The terms "higher" and "lower" than average rates, used in this table, relate to differences in rates from the national average that are statistically significant. Ethnic differences were not apparent except where stated.

* Excluding outpatients on a CTO. Rates for the different ethnic groups for overall applications of the Mental Health Act, including CTOs, showed broadly similar patterns to detention rates on admission day that excluded patients on a CTO. In both cases, rates were higher than average among the Black Caribbean, Black African, Other Black and White/Black Caribbean Mixed groups.

Learning disabilities

Information was obtained for 3,642 patients 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 previous censuses, as 67% of the inpatients in 2010 were also inpatients in 2009, and 53% were also inpatients in 2008.

The key findings are:

Number of inpatients	3,642, of whom 13% were from Black and minority ethnic groups (that is, not White British)
Distribution of patients	70% of patients from Black and minority ethnic groups were at 25 of the 129 organisations involved
Rates of admission	Lower than average among the Other White, Indian, Pakistani, Other Asian, Black African, Chinese and Other groups Higher than average, by 2-3 times, among the White/Black Caribbean Mixed, Black Caribbean, Other Black and Other Mixed groups
Detention under the Mental Health Act on admission	Few ethnic differences were apparent
Seclusion, self-harm, accidents, hands-on restraint and physical assault	Few ethnic differences were apparent, probably due to small numbers of patients in minority ethnic groups.
Length of stay (from admission to census day)	67% of patients had been in hospital for one year or more; 31% for more than five years
Single sex accommodation	47% of men and 69% of women not in a designated single sex ward; 19% of men/27% of women without access to designated single sex toilet and bathing facilities; 32% of men/44% of women without access to a designated single sex lounge area/day space (these proportions generally lower among minority ethnic groups) (see page 27 for definition of single sex accommodation)

See note under previous table for meaning of the terms "higher" and "lower" than average rates.

Conclusions

Overall, the results of the 2010 census show little change from those reported for previous years. A detailed comparison between the 2005 baseline and the 2010 census is on page 32.

Although the numbers of inpatients overall have fallen since 2005, ethnic differences in rates of admission, detention under the Mental Health Act and seclusion – three of DRE's 12 goals – have not altered materially since the inception of DRE in 2005:

- Admission rates remain higher than average among some minority ethnic groups, especially Black and White/Black Mixed groups for whom rates were two or more times higher than average in 2010 (six times higher than average for the Other Black group). In contrast, admission rates have consistently been lower than average among the Indian and Chinese groups, and about average in the Pakistani and Bangladeshi groups.
- Detention rates have almost consistently been higher than average among the Black, White/Black Caribbean Mixed and Other White groups. The rates for being placed on a CTO were higher among the South Asian and Black groups.
- Although there have been annual fluctuations in seclusion rates, they have been higher than average for the Black, White/Black Mixed and Other White groups, in at least three of the six censuses.

These findings, however, do not in themselves show that mental health and learning disability services are failing to meet the needs of people using services from Black and minority ethnic groups.

Ethnic differences in rates of mental illness, pathways to care and factors such as socioeconomic disadvantage all contribute to the patterns observed. Our previous reports have consistently highlighted the need for prevention, early intervention and collaboration across sectors to reduce the risk of admission and detention, without compromising the care given to patients. Mental health services have a key role to play. But partnership between all statutory agencies and organisations outside the healthcare sector, Black and minority ethnic communities and those who use services themselves will be needed to achieve this.

This message – about preventing mental ill-health, by addressing the contributory factors and intervening early – is at the heart of *No health without mental health*, the government's new strategy for the future of mental health care in England. The strategy aims to tackle the economic, social and environmental determinants and consequences of mental health problems, and to improve outcomes and reduce inequalities.

It is complemented by other government proposals for reforms in the NHS, public health and adult social care in England, all similarly aimed at improving outcomes and reducing inequalities. In this new healthcare landscape, the proposed NHS Commissioning Board and GP consortia will have a statutory obligation to promote equality and reduce inequalities in healthcare (something also enshrined in the Equality Act 2010). As the lead commissioners of healthcare services, it will be up to GP consortia to assess with local authorities the needs of their local populations and commission the right services that meet their requirements. And the strengthened public health role of local authorities offers significant potential for addressing the socio-economic disadvantages faced by Black and minority ethnic communities, which adds to the burden of mental illness in these communities.

Data in the future: Moving beyond a one-day census

The Count me in census has come to a close. For the last six years, it has played a key role in providing information about inpatients using mental health and learning disability services. But ethnicity recording must be seen as an all-year round statutory requirement, not a one-day annual event. And there is a need to move on from counting patients to understanding more about care pathways for patients from Black and minority ethnic groups and the factors leading to their hospital admission and detention.

We have consistently highlighted the need for commissioners and providers to make full use of the Mental Health Minimum Data Set (MHMDS) – the statutory data set submitted by providers of specialist mental health services in England. It provides rich data on these issues.

Covering both community and hospital services – and now independent and third sector providers as well as NHS – it includes a wide range of information about individual patients, the services provided to those admitted to hospital and to the much larger number who don't need admission to hospital, and the outcomes of care. And because it includes year-round activity, it is more representative of the overall picture of, for example, admission, detention and readmission rates, length of stay, years in psychiatric care and contacts with services and professionals.

We call on the Information Centre to routinely publish data on all admissions and uses of the Mental Health Act, including CTOs, in England (in both NHS and independent healthcare providers) by the ethnicity of patients, making the MHMDS the definitive source of information about mental health and learning disability patients. This data should be risk-adjusted for age, gender and other variables as appropriate, to enable reliable comparisons to be made across groups.

If GP consortia and local authorities are to be effective in their needs assessment and commissioning roles, the Information Centre needs to make available and promote to them the data from the MHMDS and other sources. And researchers and academics must make full use of the MHMDS to explore the factors that underlie the observed ethnic patterns. As effective use of the data is dependent on its quality, we call on providers (NHS and independent) to ensure that the completeness and accuracy of their data meets required standards.

CQC's role

In the meantime, CQC will continue to focus strongly on the quality of care provided by mental health and learning disability services.

People who find themselves admitted to mental health services or detained under the Mental Health Act, and therefore counted by the Count me in census, are among the most mentally unwell people in our society. Our job is first and foremost to make sure that the care they receive meets the essential standards of quality and safety set out under the Health and Social Care Act 2008, and to work with providers to ensure this. We act swiftly when we find services that do not. Where we find systemic problems that organisations have not adequately addressed, we may impose conditions on the provider's registration to bring about the change needed to improve patients' experience of care.

The essential standards of quality and safety include the requirement to provide single sex accommodation and we will continue to closely check that these standards are met by all mental health services.

We intend to introduce a number of indicators, derived from the rich information in the MHMDS, into our quality and risk profiles for providers. This will put greater emphasis on the experience of Black and minority ethnic patients in our regulatory activity.

We will monitor the quality of MHMDS data submitted by providers (as reported by the NHS Information Centre), including independent service providers. Those with poor data quality may be considered at higher risk in terms of their quality of care.

In addition, we will continue to monitor the progress of services in relation to the issues raised in the census and other reports, including our report on the use of the Mental Health Act, through our visits to services and meetings with patients by our Mental Health Act Commissioners and second opinion appointed doctors (SOADs). We will draw on patients' experiences to monitor the operation of the Mental Health Act.

We will also assess the impact of advice and use of Local HealthWatch. Local HealthWatch will be in a good position to make sure that providers and commissioners are held to account on matters of choice and access to services for people from Black and minority ethnic groups.

National organisations coordinating the census

The Care Quality Commission (CQC) and the National Mental Health Development Unit (NMHDU) were the two key partners in delivering the 2010 census. CQC had lead responsibility.

Until March 2009, the Healthcare Commission had overall responsibility for delivering the census in partnership with the Mental Health Act Commission (MHAC) and the National Institute for Mental Health in England (NIMHE). On 1 April 2009, the regulatory functions of the Healthcare Commission, MHAC and the Commission for Social Care Inspection were superseded by CQC. At the same time, NIMHE was superseded by NMHDU.

Care Quality Commission

The Care Quality Commission is the independent regulator of health and adult social care services in England. We also protect the interests of people whose rights are restricted under the Mental Health Act. Whether services are provided by the NHS, local authorities or by private or voluntary organisations, we make sure that people get better care. We do this by:

- Acting swiftly to eliminate poor quality care.
- Ensuring care is centred on people's needs and reflects their human rights.

For more information, visit the website: www.cqc.org.uk.

National Mental Health Development Unit

The NMHDU ran from April 2009 to March 2011 and had a range of programmes funded by the Department of Health and the NHS. It provided national support for implementing mental health policy by advising on national and international best practice to improve mental health and mental health services. NMHDU did this by commissioning or providing:

- Specialist expertise in priority areas of policy and delivery.
- Effective knowledge transfer on research, evidence and good practice.
- Translation of national policies into practical deliverables that achieve outcomes.
- Coordination of national activity to help regional and local implementation.

The NMHDU worked closely with the Department of Health and the 10 strategic health authorities. It had strategic partnerships with a range of other groups such as the NHS Confederation, the Association of Directors of Adult Social Services (ADASS) and the major mental health third sector organisations (www.nmhdu.org.uk/nmhdu).

Acknowledgements

We acknowledge the role of the Mental Health Act Commission as the chief architect of the census, and of the Healthcare Commission and the National Mental Health Development Unit as joint coordinators with MHAC from 2005 to 2009. We acknowledge and thank Jo Simpson (2005-07) and Christina Marriott (2007-10) for project management of the census, Giovanna Maria Polato for coordinating the data analysis and Dr Veena Raleigh for being the main author of all six reports. Finally we acknowledge and thank Professor Swaran Singh for being the independent member of the Editorial Board.

Introduction

Equality in healthcare means that all patients receive the same high levels of care depending on their needs. To achieve this, the Government has introduced legislation with which all healthcare organisations must comply.

Subject to parliamentary approval, the new NHS Commissioning Board will be established in 2011 under the coalition government's reforms of the NHS. It will have an explicit duty to promote equality and reduce inequalities in people's access to healthcare and in the outcomes of healthcare services for people in England.[1] The new focus on improving outcomes of healthcare, as outlined in the White Paper *Equity and excellence: liberating the NHS*, is underpinned by the supporting NHS Outcomes Framework 2011/12, which notes that "tackling health inequalities and promoting equality is central if the NHS is to deliver health outcomes that are among the best in the world".[2] The requirement to promote equality is also enshrined in the Equality Act 2010, which replaces previous anti-discrimination laws with one single Act prohibiting discrimination on grounds of age, sex, gender reassignment, marriage and civil partnership, race, disability, pregnancy and maternity, religion or belief, sexual orientation.

On 31 March 2010, the Care Quality Commission (CQC) and the National Mental Health Development Unit (NMHDU) carried out a national census to record the ethnicity, and other selected details, of patients in hospital and outpatients on a community treatment order (CTO) in NHS and independent mental health and learning disability services in England and Wales. This is the sixth and final Count me in census. Similar censuses have been conducted annually since 2005.[3,4,5,6,7]

The 2010 census presents the results for patients using mental health services separately to those for patients using learning disability services. In this final census report, we also include two new sections:

- A comparison of the 2010 census results for mental health patients with the results in 2005, and
- A section on information that can be used in the future to analyse the quality of mental health services – both overall and for particular groups, including Black and minority ethnic groups.

Mental health

The Count me in censuses were carried out in support of the Department of Health's five-year action plan introduced in 2005, *Delivering Race Equality in Mental Health Care* (DRE), which aimed to improve mental health services for Black and minority ethnic communities in England.[8] The DRE action plan had three building blocks:

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

The census was designed to help healthcare organisations with the third building block, by providing information that can be used to plan and deliver services that are relevant to all groups in the community. The NMHDU developed a 'dashboard' of indicators that enabled healthcare organisations to measure their progress towards DRE's goals. Further details are available at: www.nmhdu.org.uk/our-work/mhdp/delivering-race-equality/dre-dashboard/.

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 DRE five-year action plan for England came to a close in 2010 and as such, Count me in 2010 is the last in this sequence of annual censuses conducted since 2005. DRE's underlying goal of promoting equity in healthcare for Black and minority ethnic communities in England continues to be reflected in the Government's reforms of the NHS, and is essential for demonstrating compliance with equality legislation.

The Government's recently announced strategy for mental health in England commits to improving "outcomes for people with mental health problems through high-quality services that are equally accessible to all".[10] *No health without mental health* puts a focus on the mental health and wellbeing of the whole population and makes mental health "everyone's business". The strategy outlines six objectives:

- More people will have good mental health.
- More people with mental health problems will recover.
- More people with mental health problems will have good physical health.
- More people will have a positive experience of care and support.
- Fewer people will suffer avoidable harm.
- Fewer people will experience stigma and discrimination.

No health without mental health has a cross-government and cross-sectoral focus on prevention and the mental wellbeing of the population through public health measures, early intervention and personalised care. It also recognises that levels of mental illness and the ways in which mental health services are used vary between different ethnic groups, reflecting the socioeconomic and other disadvantages that people from Black and minority ethnic groups often experience. The strategy provides extra funding for psychological therapies, with expanded provision for specific groups including children, young people and those with severe mental illness.

This strategy follows on from *New horizons*, introduced by the previous government in 2009, which similarly adopted a wider public health approach to promoting the mental health and wellbeing of the population.[11]

Learning disabilities

In 2001, *Valuing people*, set out the previous government's vision for people with a learning disability, based on four key principles of rights, independence, choice and inclusion.[12] *Valuing people now: a new three year strategy for people with learning disabilities*, published in 2009, set out the strategy for the next three years.[13] It also provided the previous government's response to the recommendations in *Healthcare for all*, the report of the independent inquiry into access to healthcare for people with learning disabilities[14], and to the report of the Joint Committee on Human Rights, *A life like any other?*[15] The vision remained as set out in *Valuing people*: that all people with a learning disability have the right to lead their lives like any others, with the same opportunities and responsibilities, and to be treated with the same dignity and respect. *Valuing people now* also set out cross-government commitments and actions to increase the capacity and capability to deliver services locally.

In 2010, the Department of Health published a report describing progress made under *Valuing people now*.[16] It focused on the key priorities of improving outcomes for people with learning disabilities in health, housing, and employment, and showed where more work is needed to improve their lives. The report includes additional guidance containing good practice examples about different aspects of the *Valuing people now* programme.

A report by the Disability Rights Commission provides evidence that people with learning disabilities or severe mental health problems are more likely to develop serious health conditions and to die of them

sooner than other people. 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.[17] *Learning difficulties and ethnicity* noted that the disadvantage experienced by people from minority ethnic communities because of their ethnicity (for example, in education and employment) is compounded by the disadvantage they experience because of their learning disability.[18]

Aims of the census

The goals of the 2010 census are the same as those in previous years:

- To obtain robust figures for all inpatients in mental health and learning disability services in England and Wales. The 2010 census also includes information about outpatients on CTOs.
- To encourage service providers to implement systems for recording patients' ethnicity, and for using this information for ethnic monitoring.
- To provide information that will help service providers to take practical steps to achieve the goals of DRE.

In 2005, the census only included inpatients in mental health services in England and Wales, including those detained in hospital under the Mental Health Act 1983. From 2006 the census was extended to include inpatients in learning disability services. CTOs, introduced in November 2008 as a result of the Mental Health Act 2007, allow for supervised treatment of patients in the community. Therefore, in 2009 and 2010 the census included patients subject to supervised treatment in the community under the Mental Health Act, most of whom were therefore outpatients in the community and were not in hospital on census day.

As one of the aims of the census is to provide figures on inpatients **and** all those subject to the Mental Health Act on census day, the analysis in this report is not limited to inpatients, and also includes outpatients on CTOs (except where stated otherwise). If we excluded outpatients on a CTO from the analysis, we would have an incomplete profile of ethnic differences in the rates of patients subject to the Mental Health Act. We therefore considered it important to include these patients. This provides a more rounded basis for examining the use of the Act – overall and in relation to CTOs – among different ethnic groups, and is consistent with the analytical approach used in the 2009 census report.

Although the census included some children and young people, the terms "men" and "women" are used throughout this report to refer to people of all ages – including children, young people and older people. The census does not include children and young people in residential settings such as paediatric wards and those 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.cqc.org.uk/countmein.

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

Coverage of learning disability establishments

The 2010 census included all healthcare providers in England registered with CQC on 31 March 2010 and all healthcare providers in Wales registered with the Healthcare Inspectorate Wales to provide inpatient learning disability services. It did not include care homes.

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 CQC, they were included.

Distinguishing between mental health inpatients and learning disability inpatients

Some healthcare providers offer both mental health and learning disability services, and there is considerable overlap between them. The census asked providers to distinguish between services by describing wards as either "mainly providing mental health services" or "mainly providing learning disability services". This separation by ward type enables us to compare the results across years, and ensures that no patient is counted twice.

It is important to note, however, that some patients on mental health wards may have a learning disability or Autistic Spectrum Disorder, including Asperger's syndrome. Similarly, some patients on learning disability wards may have a mental health problem. The distinction of mental health and learning disability patients on the basis of ward is therefore an approximation.

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 in 2007 were used as denominators. The Black and minority ethnic population of England and Wales has increased significantly since the 2001 ONS census. ONS has produced updated population estimates by ethnic group for 2007 (the latest year for which these estimates are available), which reflect the demographic changes since 2001. The number of people from Black and minority ethnic groups (ie excluding the White British group) in England and Wales is estimated to have increased from 6.5 million in 2001 to 8.5 million in 2007, a rise of 30%. As a result, the proportion of the total population that is not from the White British group increased from 13% to 16% over this period. We used the 2007 population estimates to calculate the admission rates in order to present a more up-to-date and accurate picture of ethnic differences. However, these figures do not reflect any demographic changes between 2007 and 2010, the year of this census.

To make a comparison with the DRE baseline, we also present admission rates from the 2005 census, derived using the 2005 ONS population estimates by ethnic group as denominators. These figures will not be the same as those published in the 2005 census report, which were based on the 2001 ONS census population estimates, because updated estimates of populations by ethnic group were not available at that time.

For all other analyses (for example, rates of use of the Mental Health Act, seclusion etc), the patient numbers in the census were used as denominators.

Unlike the censuses of 2005 to 2008 that counted only inpatients, the 2009 and 2010 censuses also included outpatients on a CTO on census day. This is because (a) the census aims to cover all patients subject to the Mental Health Act on census day, and (b) we would not have been able to analyse standardised ratios for CTOs for different ethnic groups if CTO patients had been excluded from the analysis. However, CTO outpatients are excluded from selected analyses where appropriate, including the analysis of rates for: admissions, detentions on admission; source of referral; single sex accommodation; and recorded incidents of seclusion, restraint, accidents, assault and self-harm. The issue relating to the analysis of outpatients on a CTO only affects the sections of the report relating to mental health patients, as there were very few learning disability patients on CTOs.

Some results in this report are standardised for age and gender (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 different ethnic groups by taking account of variations in age and gender. The report uses the conventionally accepted statistical methods for standardisation.

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 population-based rates of patients who were in hospital or subject to the Mental Health Act on census day, and not rates for admissions actually made on the census day itself. The number of admissions on 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:

1. The admission rates presented for minority ethnic groups in this report are higher than would be expected because they are based on ONS population estimates by ethnic group for 2007[19], the latest year available, rather than population estimates for 2010. Therefore the admission rates do not take into account demographic changes between 2007 and 2010. Furthermore, these population estimates are described by ONS as "experimental" and are subject to margins of error.
2. The results are not adjusted for diagnosis and other clinical information, so they may reflect differences between ethnic groups in the levels, nature or severity of mental illness or disability.
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. 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 and regression to the mean.
5. The census does not assess the quality of services, the experience of patients or the reasons for any differences between ethnic groups.
6. We have explained the rationale for including outpatients on CTOs in this report. While this enables us to comment on CTOs on census day, in addition to those who are inpatients, it does mean that the overall census population is not restricted to inpatients as in the reports for the years preceding 2009 and 2010.
7. The census is a one-day count designed to give the number and ethnic composition of patients on that day. Its value is in providing a year-by-year snapshot profile. However, by its very nature, it cannot give the picture for the whole year. As we have shown in the section 'Data in the future: Moving beyond a one-day census', a one-day picture can differ from results based on a full year's data, because a one-day picture over-represents long-stay patients and under-represents short stay admissions.

Results: mental health

We collected information on 32,799 patients from the mental health services of 261 NHS and independent healthcare organisations in England and Wales. This included 29,840 inpatients, of whom 75 were inpatients on a CTO, and a further 2,959 patients on a CTO who were outpatients on census day. The number of inpatients in each census has declined each year from 33,785 in 2005 to 29,840 in 2010 (excluding the 2,959 outpatients on a CTO), a fall of 12% since 2005 (see Table 1).

All eligible establishments took part in the census. The total number of providers increased from 207 in 2005 to 261 in 2010, primarily due to an increase in the number of independent healthcare providers in both England and Wales. In contrast, the number of NHS providers in England was lower than in the baseline year 2005, and did not change much in Wales. The proportion of patients cared for by independent providers has risen from 10% in 2005 to 16% in 2010.

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

	NHS (England)	Independent (England)	NHS (Wales)	Independent (Wales)	Total
2010 census					
Number of providers	78	160	9	14	261
Number of all patients (including outpatients on a CTO)	25,653	4,787	1,958	401	32,799 (including 2,959 outpatients on a CTO)
% of all patients	78.2	14.6	6.0	1.2	100
2009 census					
Number of providers	79	158	10	17	264
Number of all patients (including outpatients on a CTO)	24,941	4,594	1,845	406	31,786 (including 1,253 outpatients on a CTO)
% of all patients	78.5	14.5	5.8	1.3	100
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 98% of patients. Of these patients, 75% were White British and 23% belonged to Black and minority ethnic groups, defined as all groups that are not White British. This compares with 20% in 2005.

Compared with the baseline year of 2005, the 2010 census recorded a lower proportion of patients from the White British, White Irish and Other Black groups (see Table 2). There were increases in the proportions of patients from the Other White, White/Black Caribbean Mixed, Black Caribbean and Black African groups. Other ethnic groups showed only minor differences over the baseline year.

Table 2: Mental health patients by ethnic group

Ethnic group	2010 census		2009 census		2008 census		2007 census		2006 census		2005 census	
	%	Number	%	Number	%	Number	%	Number	%	Number	%	Number
White British	75.0	24,593	75.7	24,067	76.5	23,738	77.6	24,198	78.6	25,170	79.2	26,762
White Irish	1.6	514	1.9	591	1.8	567	1.7	538	1.8	582	2.2	727
Other White	4.3	1,407	4.3	1,360	4.5	1,399	4.6	1,449	3.8	1,210	3.1	1,055
White and Black Caribbean	1.3	418	1.1	336	1.1	336	0.9	288	0.9	287	0.8	255
White and Black African	0.4	139	0.3	91	0.4	110	0.3	91	0.3	102	0.2	71
White and Asian	0.4	141	0.4	137	0.4	117	0.3	91	0.3	109	0.3	104
Other Mixed	0.6	200	0.7	213	0.5	148	0.6	180	0.5	173	0.5	167
Indian	1.6	529	1.4	460	1.4	426	1.3	393	1.3	411	1.3	434
Pakistani	1.3	440	1.3	409	1.3	396	1.0	315	1.1	349	1.0	325
Bangladeshi	0.6	203	0.5	171	0.5	144	0.4	130	0.5	158	0.5	153
Other Asian	0.9	311	0.9	273	1.0	300	0.8	261	0.8	262	0.8	264
Black Caribbean	4.9	1,608	4.7	1,504	4.7	1,468	4.3	1,330	3.9	1,264	4.1	1,369
Black African	2.9	957	2.6	834	2.3	715	2.1	648	2.0	652	1.9	645
Other Black	1.1	368	1.2	384	1.2	376	1.7	545	1.7	535	1.7	569
Chinese	0.3	83	0.3	82	0.3	91	0.3	82	0.2	78	0.2	81
Other	0.9	296	1.0	322	1.2	362	1.1	356	1.1	338	1.1	357
Not stated	1.8	592	1.7	552	1.1	327	0.9	292	1.1	342	1.2	416
Invalid		0								1	0.1	31
Total	**100**	**32,799**	**100**	**31,786**	**100**	**31,020**	**100**	**31,187**	**100**	**32,023**	**100**	**33,785**

As in the previous censuses, patients from Black and minority ethnic groups were concentrated in a relatively small number of organisations: 70% were patients in 25 of the 261 organisations that took part in the census. Of all organisations, 194 had fewer than 50 patients from Black and minority ethnic groups each, and another 32 organisations had no patients at all from these groups.

Reporting of ethnicity

Eighty-one per cent of patients reported their own ethnic group. Where patients did not do so, staff or relatives did so on their behalf (10% and 6% respectively). We cannot be certain that ethnicity was recorded accurately for these patients. The proportion of patients who reported their own ethnicity ranged from about 81% in the White groups to 90% in the White/Black African Mixed group.

Age and gender

Ethnic differences in the age profiles of patients largely reflect the age profiles of different minority ethnic populations. The White British, White Irish and Other White populations have an older age structure than other minority ethnic populations, and therefore, patients from the White groups are significantly older than patients from other ethnic groups (see Table 3).

Overall, 58% of patients were men. Men outnumbered women in all ethnic groups (see Table 3). The White British, White Irish, Other White and Chinese groups had smaller differences in the proportions of men and women compared with other ethnic groups.

Table 3: Age and gender of patients

Ethnic group	Age (%)					Gender (%)		Total (n)
	0-17	18-24	25-49	50-64	65+	Men	Women	
White British	1	7	41	20	31	56	44	100 (24,593)
White Irish	0	4	36	19	41	56	44	100 (514)
Other White	2	7	47	19	25	58	42	100 (1,407)
White and Black Caribbean	1	13	68	12	5	73	27	100 (418)
White and Black African	1	13	73	9	4	67	33	100 (139)
White and Asian	4	18	63	11	5	65	35	100 (141)
Other Mixed	2	13	69	11	6	62	38	100 (200)
Indian	1	4	58	21	15	63	37	100 (529)
Pakistani	2	10	73	12	4	74	26	100 (440)
Bangladeshi	2	15	69	8	6	72	28	100 (203)
Other Asian	2	12	61	13	13	70	30	100 (311)
Black Caribbean	1	6	61	20	13	70	30	100 (1,608)
Black African	1	10	75	9	5	67	33	100 (957)
Other Black	1	6	78	11	3	78	22	100 (368)
Chinese	2	10	59	17	12	52	48	100 (83)
Other	2	12	57	18	11	67	33	100 (296)
Total	**1 (n= 471)**	**7 (n= 2,352)**	**46 (n= 14,998)**	**19 (n= 6,093)**	**27 (n= 8,885)**	**58 (n= 19,071)**	**42 (n= 13,684)**	**100 (n= 32,799)**

Language and religion

Similar to previous censuses, 5% of patients reported that their first language was not English (see Table 4). The Chinese and Bangladeshi groups had the highest proportions of patients whose first language was not English (51% and 46% respectively). Among the Other White group, 27% had a first language other than English. Again similar to previous censuses, about 2% of patients said they needed an interpreter, and of these, 24% were from the White British group.

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

Ethnic group	% with first language other than English
White British	1
White Irish	3
Other White	27
White and Black Caribbean	2
White and Black African	10
White and Asian	6
Other Mixed	11
Indian	26
Pakistani	35
Bangladeshi	46
Other Asian	34
Black Caribbean	2
Black African	22
Other Black	13
Chinese	51
Other	41
Total	**5**

Religion was not stated for 21% of patients, and 15% of patients said they had no religion. The proportions stating they did not have a religion were highest among the White/Black Caribbean and White/Asian Mixed groups (23% and 21% respectively), and lowest among the South Asian groups (4%). Table 5 shows the religion of patients.

Table 5: Religion of patients by ethnic group

Ethnic group	Religion and faith groups (%)								
	None	Christian	Buddhist	Hindu	Jewish	Muslim	Sikh	Any other religion	Not stated
White British	16%	58%	1%	0%	1%	0%	0%	3%	21%
White Irish	8%	73%	0%		0%	0%		5%	13%
Other White	13%	53%	1%	0%	3%	5%		7%	18%
White and Black Caribbean	23%	47%	0%	1%	0%	3%		7%	17%
White and Black African	16%	41%	1%		1%	15%		6%	20%
White and Asian	21%	33%	1%	1%		21%	3%	3%	18%
Other Mixed	15%	41%	3%	3%		16%		8%	17%
Indian	5%	10%	0%	29%		15%	28%	2%	11%
Pakistani	4%	3%	0%	1%	1%	80%	1%	2%	10%
Bangladeshi	4%	1%	1%	1%		76%	1%	5%	11%
Other Asian	6%	14%	5%	12%		39%	5%	3%	16%
Black Caribbean	12%	59%	1%	0%	0%	2%		8%	17%
Black African	10%	45%	0%	0%		22%	0%	3%	19%
Other Black	12%	41%	1%	1%	0%	16%		7%	22%
Chinese	18%	30%	16%			1%		4%	31%
Other	8%	24%	3%	1%	3%	34%		6%	21%
Total	**15%**	**54%**	**1%**	**1%**	**1%**	**4%**	**1%**	**4%**	**21%**

Sexual orientation

The results for sexual orientation were not valid for 1% of patients, and for 20% the response was recorded as "not known". Seventy-six per cent of patients said they were heterosexual, 1% said gay/lesbian, 1% said bisexual, and less than 1% said "other". The number of minority ethnic patients who were gay/lesbian or bisexual was very low.

The overall figure of 1% who said they were gay/lesbian or bisexual is lower than some estimates of the proportions of gay/lesbian or bisexual people in the general population (5% to 7%).[20,21] However, in the 2009/10 Integrated Household Survey of a representative sample of 238,206 people in UK conducted by the Office for National Statistics, 1% identified themselves as gay or lesbian, 0.5% as bisexual, 0.5% as "other", 3% responded as "do not know" or refused to answer and 95% identified themselves as heterosexual/straight.[22]

Disability

About 75% of patients said they did not have a disability, and 25% said they had one or more disabilities. Of these, 7% were blind or visually impaired, 1% were deaf or had a hearing impairment, 1% had Autistic Spectrum Disorder, 2% had a learning disability, 4% had a mobility impairment and 2% used a wheelchair. The remaining 8% had more than one disability. The proportion of patients with a disability was highest among the White British, White Irish and Other White groups (about 28%), which could reflect the higher age profiles of these patients compared with other ethnic groups.

Rates of admission

(see section on interpreting the results on page 13)

The rates of admission, derived using the 2007 ONS ethnic population estimates as denominators, are given in Appendix B, Tables B1 (all ages) and B2 (ages 65 and over). Outpatients on a CTO are excluded from these results.

All ages

Admission rates were lower than average for patients from the White British, Indian and Chinese groups, and were average for the Pakistani and Bangladeshi groups. Rates were higher than average for other minority ethnic groups: they were particularly high for the Black Caribbean, Black African, White/Black Caribbean Mixed and White/Black African Mixed groups, who had rates two to four times higher than average, and for the Other Black group with a rate six times higher.

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, with rates two to three times higher than average among the Black and White/Black Mixed groups. Rates were high also in the White Irish, Other White, Other Asian and Other groups.

Numbers of older Black and minority ethnic patients were too few in most ethnic groups to support analyses of subgroups within them, for example those detained.

Source of referral

People can be referred to healthcare services in a number of ways. Referrals for inpatient care often come from community mental health teams rather than the original source such as GPs and accident and emergency (A&E) departments. Therefore, referrals from these teams may include referrals from other sources. Furthermore, about a quarter of patients (26%) were referred from tertiary care, and information about their original referral source was not available. We had no information about the source of referral for 13% of patients. The results reflect the proportions of patients from each ethnic group that are referred from each source, so a higher proportion of referrals from one source will inevitably mean that proportions from other referral sources are lower. Outpatients on a CTO are excluded from these data.

The referral patterns are broadly similar to those reported previously, and the key results are presented below.

GP referrals: 7% of patients

Rates were 8% higher than average among the White British group. They were lower than average among the Other White, Black Caribbean, Black African and White/Black Caribbean Mixed groups by 28% to 72%. The rates of referral by GPs are given in Appendix B, Table B3.

Referrals from A&E departments: 5% of patients

The White British group had a 9% lower than average rate of such referrals. The White/Black African Mixed, Indian, Bangladeshi, Black African and Other groups were more likely than average to be referred in this way.

Referrals from community mental health teams: 26% of patients

For the White British group, such referrals were 5% higher than the average rate. They were lower than average among the Other White, White/Black African Mixed, Black Caribbean, Black African and Other Black groups by 16% to 48%. The rates of referral are given in Appendix B, Table B4.

Referrals from the criminal justice system: 9% of patients

This is defined as the police, courts, probation service, prison, and court liaison and diversion service.

Patients from the White British group were less likely than average to be referred by the criminal justice agencies, whereas the Black Caribbean, Black African, Other Black, White/Black African Mixed and Other Asian groups were 30% to 83% more likely than average to be referred in this way. We observed no differences from the average rate for other ethnic groups. Rates of referral by the criminal justice system are given in Appendix B, Table B5.

A significant proportion (26%) of all referrals were from tertiary care:

Tertiary care: referrals from medium or high secure units: 5% of patients

The rate for such referrals (in NHS or independent sectors) was lower than average among the Other White and Indian groups. It was higher than average among the Black Caribbean and White/Black Caribbean Mixed groups by about 75%.

Tertiary care: referrals from other inpatient services: 21% of patients

The rate for such referrals (NHS and independent) was higher than average among the White Irish and Other White groups by 29% and 59% respectively. The rate was lower than average in the Indian and Other Black groups.

Tertiary care: referrals from other clinical specialties: 9% of patients

Rates of such referrals were higher than average among the White British and Indian groups, and lower than average among the Other White, White/Black Caribbean Mixed, Other Asian, Black African, Other Black and Chinese groups.

Detention under the Mental Health Act 1983 on day of admission

The Mental Health Act 2007 made a number of changes to the Mental Health Act 1983. These changes were reflected in the census of 2009 and 2010, which collected information on new provisions establishing supervised community treatment (section 17A) and excluded supervised discharge (section 25A), which was abolished.

As in previous reports, we present below the results for detention rates on the day of admission. Outpatients on a CTO are excluded from these analyses. After that, we present rates for all patients subject to the Mental Health Act on census day (including outpatients on a CTO), followed by rates for patients on a CTO on census day.

All detentions

Forty-nine per cent (14,637) of patients were detained under the Mental Health Act on admission to hospital. This was a higher proportion than recorded in the previous censuses (40% in 2005 and 2006, 43% in 2007, 45% in 2008 and 47% in 2009).

Detention rates were 6% lower than average among White British patients, and between 19% and 32% higher than average among the Black Caribbean, Black African, Other Black and White/Black Caribbean Mixed groups. Detention rates were also higher in the White Irish and Other White groups by about 13% and in the Other Mixed group by 22%. No other ethnic differences were observed. The results are given in Appendix B, Table B6.

These patterns are broadly similar to those reported in previous censuses.

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 patients detained on admission, 22% were detained under section 2. Rates of detention under this section were lower than average among the White British, White/Black Caribbean Mixed and Black Caribbean groups, and higher than average among the Bangladeshi, Other Asian, Black African, Chinese and Other groups by between 50% and 103% (see Appendix B, Table B7).

Detention under section 3

Section 3 of the 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 after this.

Of all patients detained on admission, 43% were detained under this section. Rates were higher than average among the White Irish and Black Caribbean groups by 24% and 29% respectively, and lower among than average among the Bangladeshi group. No other ethnic differences were observed. The rates of detention under section 3 are given in Appendix B, Table B8.

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 all patients detained on admission, 14% were detained under section 37 with a section 41 restriction order applied. The rates of detention are given in Appendix B, Table B9. In all minority ethnic groups, very few women were detained under section 37/41. Among men, the rate of detention for the White British group was 16% lower than average, and it was higher than average in the White/Black Caribbean Mixed group by 77%, the Black Caribbean group by 100%, the Black African group by 27% and the Other Black group by 52%.

A consistent pattern across all six 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 Ministry of Justice to issue a direction to transfer a person detained in prison to a hospital for treatment.

Of all patients detained on admission, 7% were detained under these sections. The only ethnic differences observed were a 107% higher than average detention rate among men from the White/Black African Mixed group, and a lower than average rate for the Indian group. We observed no other ethnic differences, probably because the numbers of detentions under these sections were low in most minority ethnic groups. These rates of detention are given in Appendix B, Table B10.

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

Patients subject to the Mental Health Act 1983 on day of census

All patients subject to the Mental Health Act

Of all the 32,399 patients in the census, a total of 53% (17,299) were subject to the Mental Health Act on census day, including 2,959 outpatients and 75 inpatients on a CTO (either voluntarily or recalled). Ratios for the different ethnic groups for overall applications of the Mental Health Act, including CTOs, showed broadly similar patterns to detention rates on admission day, from which patients on a CTO were excluded. In both cases, rates were higher than average among the Black Caribbean, Black African, Other Black and White/Black Caribbean Mixed groups. However, the higher than average detention rates for the White Irish, Other White and Other Mixed groups on admission day were not apparent on census day.

The rates are given in Appendix B, Table B11.

Supervised community treatment under section 17A

Community treatment orders (CTOs) were introduced in November 2008, as a result of the Mental Health Act 2007. They allow for supervised community treatment to be provided for up to six months, with the possibility of an extension after this. These orders are designed to help patients to maintain stable mental health outside hospital and to promote recovery by providing professionals with the power to set conditions on discharge from hospital and a power to recall patients if arrangements in the community are not working.

Nine per cent of all patients in the census were on CTOs, compared with 4% in 2009. Of all the 17,299 patients subject to the Mental Health Act on census day, almost 18% (3,034) were on CTOs. Of the patients on a CTO, 2,959 were outpatients and 75 were inpatients (50 voluntary and 25 recalled).

The rate of supervised community treatment among all patients included in the census was lower than average in the White British and White Irish groups, and higher than average in the South Asian (Indian, Pakistani, Bangladeshi) and Black (Black Caribbean, Black African, Other Black) groups by 22% to 106%. The ratios are given in Appendix B, Table B12.

Consent

About 25% of informally admitted patients were deemed incapable of consenting to treatment. The only ethnic difference observed was a higher than average rate for the Pakistani group, but this was based on very few patients.

About 18% of patients who were detained or on CTOs were deemed incapable of consenting to treatment. These rates were lower than average by 7% in the White British group, and were higher than average among the Other White, White/Black Caribbean Mixed and Black African groups by 21%, 35% and 36% respectively.

In addition, 13% of patients who were detained or on CTOs on census day 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, and rates were higher than average among the White Irish, White/Black Caribbean Mixed, Other Mixed, Black Caribbean and Black African groups by between 39% and 71%.

Care programme approach

The Care Programme Approach (CPA) is the process by which treatment, care and support for people with serious mental health problems, and accompanying health and social care needs, are agreed, coordinated and understood by all involved. From October 2008, changes to the CPA in England mean that it is no longer categorised into two parts ('standard' and 'enhanced') and just the one category of enhanced CPA applies. This makes CPA policy in England different to that in Wales, where the distinction still applies. The CPA data presented here therefore includes all CPA patients in England, and both 'standard' and 'enhanced' CPA patients in Wales.

About 89% of all patients were on a CPA, 3% were on a single assessment process (SAP) whereby assessments are made for adults with health and/or social care needs, and 8% were on neither CPA nor SAP. As most patients were on a CPA, no ethnic differences were observed.

Recorded incidents

The 2010 census asked about the number of times that patients experienced seclusion, hands-on restraint, self-harm, accident and physical assault in a current hospital spell, or, if the patient's hospital spell was longer than three months, the number that took place within the last three months. Outpatients on a CTO are excluded from these data. It should be noted that the rates of such events among minority ethnic groups can show yearly variation because of the low numbers of events in several groups.

Seclusion

Seclusion was defined as the supervised confinement of a patient in a room, which may be locked, to protect others from significant harm. Four per cent of patients had experienced one or more episodes of seclusion. The White British group had a seclusion rate that was 9% lower than average. Rates were higher than average among the White/Black Caribbean Mixed, White/Black African Mixed, Black Caribbean and Black African groups by 80%, 90%, 36% and 56% respectively.

Although the number of incidents of seclusion was low in several minority ethnic groups, some general patterns over the six censuses to date are:

- The proportion of all patients who had an episode of seclusion stayed fairly constant over the six censuses at about 4%.
- Although there have been annual fluctuations, the seclusion rate has been higher than average for the Black and White/Black Mixed groups in three or four of the six censuses, and in the Other White group in three censuses.

Hands-on restraint

This was defined as the physical restraint of a patient by one or more members of staff in response to aggressive behaviour or resistance to treatment. About 12% of patients had experienced one or more episodes of hands-on restraint. No ethnic differences were observed. In fact, very few ethnic differences have been observed in the previous censuses also, and they have not shown a consistent pattern.

Self-harm

Eight per cent of patients had harmed themselves on one or more occasions. Only the White British group had a rate that was higher than average (by 14%). Rates were lower than average among several minority ethnic groups: the three Black groups (Black Caribbean, Black African and Other Black) by about 70%, the three south Asian groups (Indian, Pakistani, Bangladeshi) by between 37% and 78%, and the Other Mixed and Other Asian groups by about 60%.

In terms of comparison with previous years:

- The proportion of all patients who had harmed themselves stayed fairly constant at about 7–8%.
- In all censuses, the White British group had a higher than average rate of self-harm, and the Black and South Asian groups had lower than average rates of self-harm.

Accidents

About 11% of patients had experienced one or more accidents. Patients from the White British group experienced a rate of accidents that was 6% higher than average. Rates were lower than average in the Black Caribbean, Black African, Other Black and Other Asian groups by about 50% to 70%. No accidents were reported for the Chinese group.

In terms of comparisons with previous years:

- The proportion of all patients who had had an accident stayed fairly constant.
- The rate of accidents in the different censuses was higher than average in the White British group and lower than average in the Black Caribbean group. Few other ethnic differences were observed and they were not consistent.

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 of patients were involved in one or more episodes of physical assault. The only ethnic difference observed was a 19% lower than average rate among the Black Caribbean group.

In terms of comparisons with previous years:

- The proportion of all patients who had experienced a physical assault stayed fairly constant.
- Very few ethnic differences in rates of assault were observed in the different censuses and they did not show a consistent pattern.

Duration of stay in hospital from admission to census day

We analysed the length of the period between each inpatient'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. Outpatients on a CTO are excluded from the following analyses.

- 25% of inpatients had been in hospital for one month or less
- 20% 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
- 12% had been in hospital between two and five years
- 8% had been in hospital for more than five years

These results are similar to those of previous censuses. About 31% of patients in the 2010 census had been in hospital for more than a year, and had therefore also been included in the 2009 census. About 20% of patients had been in hospital for more than two years, and will have been included in both the 2008 and 2009 censuses.

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 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, and as in previous years, the median amount of time that women had spent in hospital was about 2.5 months, and the median for men was about 5.8 months (see Table 6). In most ethnic groups, the median time spent in hospital was two to three times longer for men than for women; in the Other Black group, men had been in hospital four times longer than women.

Median lengths of stay were longest for men from the Black Caribbean, White/Black Caribbean Mixed and Other Black groups, and shortest for men from the Chinese, Bangladeshi and Other groups. Median lengths of stay were longest for women from the White/Black Caribbean Mixed and Black Caribbean groups, and shortest for women from the Chinese and Bangladeshi groups.

A number of important factors influence a patient's length of stay in hospital, including age, gender, whether or not they are detained under the Mental Health Act (and the section under which they are detained and whether there is an additional 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.

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

Ethnic group	Men	Women
White British	161	71
White Irish	218	114
Other White	238	113
White and Black Caribbean	275	191
White and Black African	182	92
White and Asian	226	78
Other Mixed	173	112
Indian	172	70
Pakistani	153	56
Bangladeshi	134	55
Other Asian	167	61
Black Caribbean	345	122
Black African	141	66
Other Black	248	58
Chinese	135	51
Other	131	76
Total	**174**	**75**

Ward security

As in previous years, about 11% of all patients were on a medium or high secure ward, as opposed to a general (76%) or low secure (13%) ward.

Patients from the White British, Indian and Bangladeshi groups were less likely than average to be on a medium or high secure ward, by 7%, 30% and 67% respectively. Patients from the White Irish, White/Black Caribbean Mixed, Black Caribbean and Other Black groups had a higher than average rate by between 43% and 55%.

Age range on wards

Among patients under 18 years of age, 61 were being cared for on wards for working-age adults on census day, and five patients were on a ward for older people. Seven per cent of patients on wards for working-age adults were 65 or over, and 8% of those on wards for older people were adults of working age. There were very few 'out of age' placements among minority ethnic groups.

Patients in wards designated as single sex or mixed*

Providers were asked whether patients were on a ward designated as men or women only, or mixed gender. All the analyses of single sex accommodation and facilities exclude outpatients on a CTO. Overall, 61% of men and 77% of women were not in a ward designated for single sex use, similar proportions as in previous years. The proportion of patients not in a designated single sex ward was lower among almost all minority ethnic groups than among the White British group. In all ethnic groups, the proportion of men who were not in a designated single sex ward was lower than among women (see Table 7a).

Two further questions examined the single sex facilities that were available to patients.

* At the time of the 2010 census, the following guidance from the Department of Health applied in England:
A ward can be described as single sex (i.e. 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).

  The coalition government's revised Operating Framework for 2010/11 requires NHS organisations to eliminate mixed-sex accommodation, except under exceptional circumstances, from 2011. The national guidance relating to mixed sex accommodation was issued in November 2010, and states that "No areas are exempt, and every decision to mix must be justified by reference to the patient's clinical needs, not organisational convenience or custom and practice." For mental health and learning disability trusts, it states: "There is no acceptable justification for admitting a mental health patient to mixed-sex accommodation"… It "may be acceptable, in a clinical emergency, to admit a patient temporarily to a single, ensuite room in the opposite-gender area of a ward. In such cases, a full risk-assessment must be carried out and complete safety, privacy and dignity maintained." The guidance is available at: www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Professionalletters/Chiefnursingofficerletters/DH_121848

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

Ethnic group	Sex of patients and ward			
	Male		Female	
	Male ward	Female or mixed ward*	Female ward	Male or mixed ward*
White British	35	65	21	79
White Irish	41	59	28	72
Other White	44	56	28	72
White and Black Caribbean	56	44	31	69
White and Black African	48	52	41	59
White and Asian	43	57	34	66
Other Mixed	49	51	24	76
Indian	37	63	25	75
Pakistani	48	52	35	65
Bangladeshi	23	77	18	82
Other Asian	46	54	22	78
Black Caribbean	55	45	32	68
Black African	49	51	28	72
Other Black	49	51	30	70
Chinese	42	58	30	70
Other	43	57	20	80
Total	**39**	**61**	**23**	**77**

* The vast majority of patients in this category were in mixed wards; very few (under 0.5%) male patients were on female-only wards, or vice versa.

Patients' access to toilet and bathing facilities designated for single sex use

We asked providers if the patient had access to toilet and bathing facilities designated for single sex use. Overall, 13% of men and 16% of women were reported as not having access to such facilities designated for single sex use. This was an improvement over 2009, when these proportions were 19% and 24% respectively. The proportion of patients not having access to toilet and bathing facilities designated for single sex use was lower among almost all minority ethnic groups than among the White British group (see Table 7b for details).

Table 7b: Percentage of patients not having access to toilet and bathing facilities designated for single sex use by ethnic group

	Access to designated single sex bathing and toilet facilities			
	Male		Female	
Ethnic group	Male facilities	Female or mixed facilities*	Female facilities	Male or mixed facilities*
White British	86	14	84	16
White Irish	87	13	87	13
Other White	89	11	86	14
White and Black Caribbean	93	7	93	7
White and Black African	90	10	93	7
White and Asian	90	10	84	16
Other Mixed	98	2	96	4
Indian	91	9	90	10
Pakistani	95	5	94	6
Bangladeshi	92	8	98	2
Other Asian	92	8	86	14
Black Caribbean	92	8	90	10
Black African	91	9	91	9
Other Black	92	8	89	11
Chinese	82	18	83	17
Other	87	13	90	10
Total	**87**	**13**	**84**	**16**

* The vast majority of patients in this category had access to mixed facilities; very few (1%) of male patients had access to female-only facilities, or vice versa.

Patients' access to a lounge area/ day space designated for single sex use

We also asked providers if patients had access to a lounge area or day space designated for single sex use. Overall, 37% of men and 39% of women were reported as not having access to these facilities. This was an improvement over 2009, when these proportions were 48% and 51% respectively. The proportion of patients not having access to a lounge area/day space designated for single sex use was lower among most minority ethnic groups than among the White British group (see Table 7c for details).

Table 7c: Percentage of patients not having access to a lounge area/day space designated for single sex use by ethnic group

Ethnic group	Access to a lounge area/day space designated for single sex use			
	Male		Female	
	Male facilities	Female or mixed facilities*	Female facilities	Male or mixed facilities*
White British	59	41	60	40
White Irish	63	37	70	30
Other White	68	32	63	37
White and Black Caribbean	82	18	73	27
White and Black African	83	18	76	24
White and Asian	72	28	75	25
Other Mixed	79	21	67	33
Indian	59	41	66	34
Pakistani	80	20	72	28
Bangladeshi	53	47	52	48
Other Asian	70	30	61	39
Black Caribbean	78	22	70	30
Black African	73	27	70	30
Other Black	79	21	72	28
Chinese	59	41	60	40
Other	67	33	67	33
Total	**63**	**37**	**61**	**39**

* The vast majority of patients in this category had access to mixed facilities; very few (1%) of male patients had access to female-only facilities, or vice versa.

Patients' subject to deprivation of liberty safeguards

People who lack the mental capacity to consent to the care or treatment they need should be cared for in a way that is least restrictive of their rights or freedom of action. In 2007, the Mental Capacity Act 2005 was amended to introduce Deprivation of Liberty Safeguards for people who lack capacity to decide about their care or treatment, and who need to be deprived of their liberty to protect them from harm. The Safeguards came into effect in April 2009 and strengthen the rights of hospital patients and those in care homes, as well as ensuring compliance with the European Convention on Human Rights (ECHR).

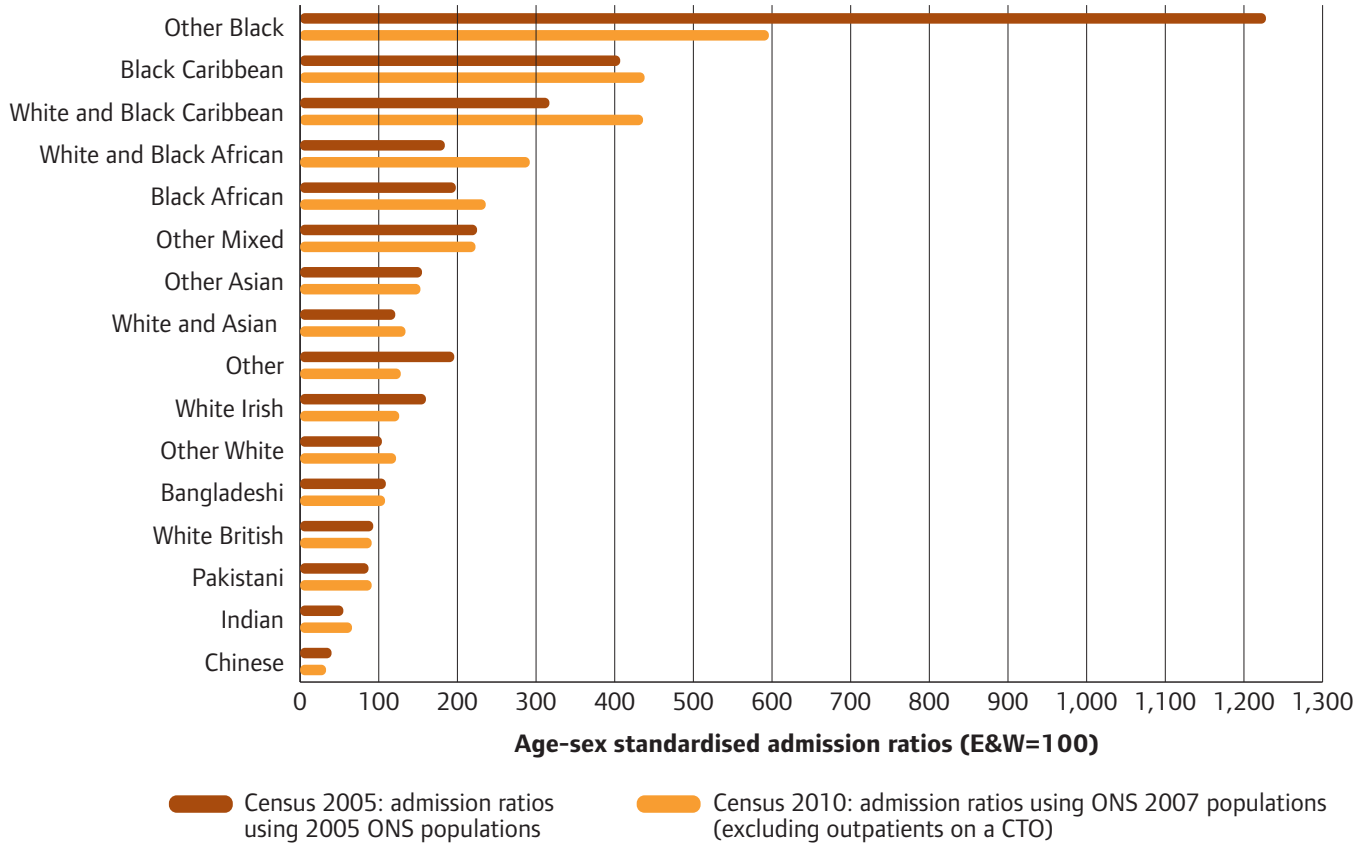
The 2010 census introduced a new question "Is the patient subject to deprivation of liberty authorisation on 31 March 2010?" Under 1% (269) patients were reported as being subject to a deprivation of liberty authorisation on census day. No ethnic differences in the rates were observed, which may be due to the low numbers of patients among minority ethnic groups (69).

A comparison between the 2005 baseline and the 2010 census

The changes we have seen in the census results between 2005 and 2010, the timespan of the *Delivering Race Equality* (DRE) action plan, are set out below. This is **not** a review of the DRE programme. The aim is to give an overview of how some variables in the census have changed during the course of DRE, and the findings should be seen in the light of the caveats described on page 13.

- The number of inpatients went down from 33,785 to 29,840 – a fall of 12%.
- The proportion of patients in independent hospitals rose from 10% to 16%.
- The overall proportion of patients from minority ethnic groups increased from 20% to 23%. However, there have been demographic changes during this time – the population from Black and minority ethnic groups in England and Wales rising from 7.9 million in 2005 to 8.5 million in 2007 (the latest year for which these figures are available), an increase of 8% in two years.
- Admission rates showed similar patterns across all censuses:
  - Lower than average rates among the White British, Indian and Chinese groups.
  - About average rates among the Pakistani and Bangladeshi groups.
  - Higher than average rates among other minority ethnic groups – particularly in the Black and White/Black Mixed groups, for whom rates were two or more times higher than average in 2010. The Other Black group continues to have exceptionally high rates of admission (even after the apparent reduction since 2005, see next point).
- One of the 12 goals of DRE was a decline in admission rates among Black and minority ethnic groups. Figure 1 provides a comparison between 2005 and 2010. Although admission rates for many ethnic groups show relatively little change since 2005, the rate for the Other Black group is considerably lower in 2010 (six times higher than average) compared with 2005 (12 times higher than average). However, rates for the other Black and White/Black Mixed groups show small increases.
- In general, rates of referral from GPs and community mental health teams were lower than average among some Black and White/Black groups, and referral from the criminal justice system was higher. Patterns were less consistent for other minority ethnic groups.
- There was a steady increase in the overall proportion of patients subject to the Mental Health Act. Compared with 40% in 2005, 49% of all patients were subject to the Mental Health Act in 2010 (53% if outpatients on a CTO are excluded).
- Another DRE goal was to reduce detention rates among Black and minority ethnic groups. However, detention rates have been higher than average among the Black Caribbean, Black African and Other Black groups in all six censuses, and almost consistently higher in the White/Black Caribbean Mixed and Other White groups. Rates have been average for other minority ethnic groups.
- A consistent pattern was the higher than average detention rate under section 37/41 for the Black Caribbean and Other Black groups.
- Another DRE goal was to reduce seclusion among Black and minority ethnic groups. Although there have been annual fluctuations in seclusion rates, they have been higher than average for the Black and White/Black Mixed groups, and the Other White group, in at least three of the six censuses. Other minority ethnic groups did not show high rates.

Figure 1: Admission ratios in the 2005 and 2010 Count me in censuses by ethnic group: England and Wales*



- Minority ethnic groups do not compare unfavourably for other incidents. Rates of self-harm have consistently been lower than average among the Black and South Asian groups. Very few ethnic differences in hands-on restraint, physical assault and accidents were observed across the different censuses, and they did not show a consistent pattern.
- About 31% of patients in all censuses had been in hospital for one year or more, and were therefore included in more than one census. (This is one reason why the census shows little change over the six years. It should be noted again that, because the census is a one-day count, it over-represents long-stay admissions and under-represents short-stay admissions.)
- Mixed accommodation was reported for many patients across all censuses, although patients from Black and minority ethnic groups were more likely to be in single sex accommodation than White British patients.

* The admission ratios for the 2005 census shown here are different from those published in the 2005 report. This is because we updated the analysis of the 2005 admission ratios by using 2005 ONS census populations for ethnic groups as denominators. These populations were not available at the time of the 2005 report, which instead used the 2001 ONS population data.

Results: learning disabilities

We obtained information about 3,642 patients in 129 organisations providing services for people with learning disabilities in England and Wales. Of these, two were inpatients on CTOs. The total number of inpatients has declined each year, and by 21% from 4,609 in 2006 to 3,642 in 2010. The total number of providers did not change much from the baseline year of 2006, although the number of NHS providers has fallen steadily and the number of independent healthcare organisations has increased (see Table 8). The proportion of inpatients in independent healthcare organisations increased from 20% in 2006 to 33% in 2010. This is likely to be a result of closing NHS campuses, with people moving from hospital to community settings.

The pattern of results for learning disability patients in 2010 is broadly similar to that reported in previous censuses. This is not surprising, since many of the patients had been in hospital for a considerable period of time, and they therefore appear in successive censuses.

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

	NHS (England)	Independent (England)	NHS (Wales)	Independent (Wales)	Total
2010 census					
Number of providers	55	61	4	9	129
Number of all patients (including patients on a CTO)	2,304	1,072	154	112	3,642
% of all patients	63.3	29.4	4.2	3.1	100
2009 census					
Number of providers	60	54	5	4	123
Number of all patients (including patients on a CTO)	2,487	1,014	139	55	3,695
% of all patients	67.3	27.4	3.8	1.5	100
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

Ethnicity

Information about ethnicity was available for 98% of patients. Of these, 13% belonged to Black and minority ethnic groups, defined as all groups that are not White British (see Table 9). This figure is somewhat higher than in previous years (11% in 2006), and is significantly lower than the 23% of mental health patients from minority ethnic groups, as reported in the mental health section of this report.

Although the patterns by ethnicity are broadly similar to previous years, there was an increase between 2006 and 2010 in the proportion of patients from the Other White group, and a fall in those from the White British group. Some ethnic groups had very few patients.

As in the previous censuses, patients from Black and minority ethnic groups were concentrated in a relatively small number of organisations: 70% were

Table 9: Learning disability patients by ethnic group

Ethnic group	2010 census		2009 census		2008 census		2007 census		2006 census	
	%	Number	%	Number	%	Number	%	Number	%	Number
White British	85.3	3,106	86.7	3,205	88.9	3,616	88.3	3,642	88.7	4,037
White Irish	1.3	46	1.5	57	1.3	53	1.0	40	1.4	66
Other White	2.9	106	2.3	85	2.6	104	2.6	109	1.7	77
White and Black Caribbean	1.0	38	1.0	36	0.7	29	0.8	34	0.7	32
White and Black African	0.2	8	0.1	4	0.0	2	0.2	10	0.1	3
White and Asian	0.4	13	0.4	14	0.3	12	0.3	13	0.2	9
Other Mixed	0.7	24	0.5	19	0.3	14	0.4	16	0.3	14
Indian	0.9	32	0.9	35	0.7	28	0.8	32	1.1	49
Pakistani	0.7	24	0.9	33	0.7	30	0.8	32	0.7	34
Bangladeshi	0.5	20	0.6	21	0.3	11	0.3	11	0.2	9
Other Asian	0.4	13	0.3	10	0.3	12	0.2	8	0.3	12
Black Caribbean	2.6	93	2.2	81	2.3	94	2.6	108	2.8	129
Black African	0.8	28	0.9	35	0.7	29	0.8	33	0.7	33
Other Black	0.4	15	0.4	14	0.4	15	0.4	18	0.4	17
Chinese	0.0	1	0.1	2	0.1	5	0.2	8	0.2	7
Other	0.2	7	0.2	8	0.4	15	0.2	10	0.5	24
Not stated	1.9	68	1.0	36	0.9	38	0.7	29	1.2	57
Total	**100**	**3,642**	**100**	**3,695**	**100**	**4,069**	**100**	**4,124**	**100**	**4,552**

patients in 25 of the 129 organisations that took part in the census. Seventy-four organisations had fewer than 10 patients from Black and minority ethnic groups each, and another 42 organisations had no inpatients at all from these groups.

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.

Reporting of ethnicity

About half (56%) of patients reported their own ethnic group. Staff reported the ethnic group for 17% of patients, and relatives for 21%. This means that ethnicity could have been misreported for some patients. We do not know how ethnicity was assessed for 6% of patients.

Age and gender

Two per cent (59) of patients were under 18 years old. The number of young inpatients from minority ethnic groups was low or zero in several ethnic minority groups.

Overall, 73% of patients were under 50 years old, and 27% were aged 50 or over. The proportion of patients under 50 was higher among patients from Black and minority ethnic groups (88%) than among the White British group (71%). This is not surprising, given that minority ethnic populations are generally younger than the White population.

Seventy per cent of patients in learning disability services were men, whereas in mental health services 58% of patients were men.

Language and religion

Eight per cent of patients reported that their first language was not English. Non-verbal communication was the most often selected language after English, accounting for 4% of patients. Two per cent (84) of patients, most of whom were from the White British group, said they needed an interpreter.

Religion was not stated for 22% of patients, and 15% of patients said they had no religion. South Asians (Indians, Bangladeshis and Pakistanis) were mostly Muslim, Hindu or Sikh, and those from the White, Black Caribbean and Black African groups were mostly Christian.

Sexual orientation

Overall, the result was not known for almost half (49%) of patients, 45% said they were heterosexual, 2% said gay/lesbian, 3% said bisexual, and 1% said "other". The numbers of patients from minority ethnic groups were too low for meaningful analysis.

Disability

Of all inpatients in learning disability services:

- 4% were reported as having no disabilities
- 44% had a learning disability only
- 51% had multiple disabilities.

The patterns among minority ethnic groups were similar, in that most patients had either a learning disability or multiple disabilities.

Rates of admission

The rates of admission, based on ONS estimates of the general population in 2007, are given in Appendix C, Table C1.

Admission rates were lower than average among several minority ethnic groups: Other White, Indian, Pakistani, Other Asian, Black African, Chinese and Other. Rates were two to three times higher than average among the White/Black Caribbean Mixed, Black Caribbean, Other Black and Other Mixed groups. The lower rates among the South Asian and Chinese groups, and the higher rates among some Black groups, are similar to patterns for inpatients in mental health establishments.

These patterns of admission are similar to those we reported in previous census reports.

Source of referral

As we reported in the section on mental health patients, data about sources of referral must be interpreted with care, as we do not always know the original referral source. Furthermore, in the case of inpatients with learning disabilities, this information was invalid, missing or unknown for 12% of patients.

Because of the small numbers of patients in most minority ethnic groups, we observed few ethnic differences in sources of referral.

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

The Mental Health Act 2007 made a number of changes to the Mental Health Act 1983, one of which was supervised community treatment (section 17A). These are reflected in the 2010 census.

All detentions

Of all the patients in learning disability services, 48% were detained under the Mental Health Act on admission. Rates of detention on the day of admission by ethnic group are in Appendix C, Table C2, and no ethnic differences were observed. 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.

Rates of detention on census day also showed no ethnic differences, with the exception of a lower than average rate for the Other White group.

Consent

About 66% of informally admitted inpatients were deemed incapable of consenting to treatment, which is a similar proportion to that reported previously.

Among detained patients, 38% were deemed incapable of consenting to treatment and 6% were deemed capable of consenting to treatment but refused.

The numbers of patients from minority ethnic groups were too low for comment. There were no or very few such patients among minority ethnic groups.

Care programme approach

Details of the Care Programme Approach (CPA) are given on page 24.

We found that 73% of all patients were on a CPA, 2% on a single assessment process (SAP) and 25% on neither. No ethnic differences were observed.

Recorded incidents

The 2010 census asked about the number of times that patients experienced seclusion, hands-on restraint, self-harm, accident and physical assault in a patient's current hospital spell, or, if the patient's hospital spell was longer than three months, the number that took place within the last three months. As in previous years, we observed very few ethnic differences.

Seclusion

Five per cent of patients had experienced one or more episodes of seclusion. The only ethnic differences observed were the higher than average rates among the White Irish and Other White groups, but these were based on small numbers of patients.

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% of patients had been involved in one or more episodes of physical assault. No ethnic differences were observed.

Hands-on restraint, self-harm, accidents

Thirty per cent of inpatients had experienced one or more episodes of hands-on restraint, 22% had attempted to harm themselves and 24% had suffered an accident. The numbers were very low in minority ethnic groups and we did not observe any ethnic differences except for a lower than average rate for self-harm among the Black Caribbean group, but this was based on very few 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.

- 10% of inpatients had been in hospital for one month or less
- 6% had been in hospital between one and three months
- 7% had been in hospital between three and six months
- 10% had been in hospital between six months and one year
- 14% had been in hospital between one and two years
- 22% had been in hospital between two and five years
- 31% had been in hospital for over five years.

The patterns are very similar to those in previous censuses. About 67% of patients in the 2010 census had been in hospital for more than a year, and were therefore also included in the 2009 census. In addition, over half (53%) of patients had been in hospital for more than two years, and will have been included in both the 2008 and 2009 censuses. A third of patients will have been included in each census since 2006.

We also calculated the median length of stay (see page 26 for the definition of median). Overall, the median amount of time that women had spent in hospital was about 31 months, and the median for men was about 27 months. This compares with a median for mental health patients of 2.5 months for women and 5.8 months for men. It is not possible to reliably compare length of stay by ethnic group because of the small numbers of patients among several minority ethnic groups.

Ward security

About 12% of all inpatients were on a medium or high secure ward, as opposed to a general (54%) or low secure (34%) ward.

As in the three previous years, rates of patients on medium or high secure wards were about double the average among the White Irish and Other White groups. Most other minority ethnic groups had very few patients on medium or high secure wards.

Age range on wards

There were five patients under 18 years of age being cared for on wards for working-age adults and none were on wards for older people. About 5% of patients on wards for working-age adults were aged 65 or over, and there were very few patients (23) on wards for older people. There were very few 'out of age' placements among minority ethnic groups.

Patients in wards designated as single sex or mixed*

We asked providers whether the patient was on a ward designated as men or women only, or mixed gender. Overall, 47% of men and 69% of women were not in a ward designated for single sex use. The numbers of such patients among minority ethnic groups were very low.

Two further questions examined the single sex facilities that were available to patients. Again, due to the small numbers, we do not present results by ethnicity for these questions.

Patients' access to toilet and bathing facilities designated for single sex use

Overall, 19% (497) of men and 27% (295) of women were reported as not having access to toilet and bathing facilities designated for single sex use.

Patients' access to a lounge area/ day space designated for single sex use

Overall, 32% (829) of men and 44% (470) of women were reported as not having access to a lounge area/ day space designated for single sex use.

Patients subject to deprivation of liberty safeguards

For details of deprivation of liberty safeguards, please see page 31.

The 2010 census introduced a new question "Is the patient subject to deprivation of liberty authorisation on 31 March 2010?" Two per cent (74) patients were reported as being subject to a deprivation of liberty order on census day, but very few of these patients (15) were from minority ethnic groups.

* See footnote on single sex accommodation on page 27

Data in the future: Moving beyond a one-day census

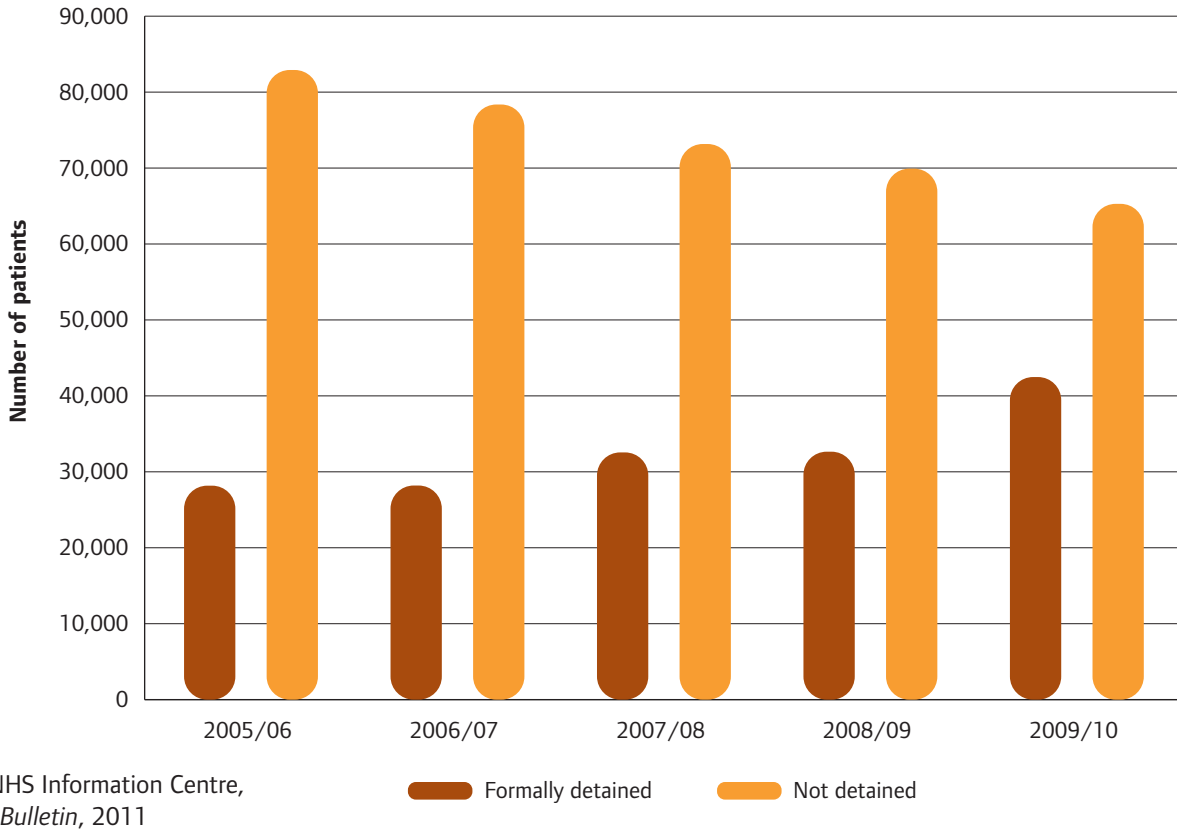
For six years, the Count me in census has provided a valuable one-day snapshot of inpatients in mental health and learning disability services. And with the proportion of inpatients who are detained increasing steadily (from 25% in 2005/06 to 39% in 2009/10 – see Figure 2), ongoing ethnic monitoring of admissions and detentions becomes more vital than ever.

However, a one-day census only captures some events, and the profile of patients can differ across a whole year. For example, there were:

- 29,840 inpatients in the 2010 census, compared with 107,765 inpatients overall during 2009/10.
- 17,299 patients in the 2010 census who were detained or on CTOs, compared with 42,479 new detentions and some 4,100 new CTOs overall in England in 2009/10.
- 26% of patients in hospital for under one month and 31% for over one year per the census, whereas the MHMDS data consistently shows that for over 50% of records the average length of an inpatient stay was under one month, and for 4% it was over one year.

Looking ahead, it is vital that robust data is available on **all** admitted patients and **all** those subject to the Mental Health Act, not just those in hospital on one particular day. Moreover, patterns of use and outcomes of community care can have an impact on the need for admission to hospital and the risk of detention – therefore information about the care provided to patients before admission to hospital, during their hospital stay, and after they leave is also vital. Furthermore, under 8.4% of the 1.27 million people using specialist mental health services are admitted to hospital[23], and so it is very important to examine the quality of community care for the 90% of patients who are not admitted to hospital.

Figure 2: Number of people spending time in hospital, 2005/06 to 2009/10



Source: NHS Information Centre, *MHMDS Bulletin*, 2011

The Mental Health Minimum Data Set (MHMDS) is a rich source of data on people using specialist mental health services in England. It covers both community and hospital services, and includes a wide range of information about the demographic, clinical and socioeconomic characteristics of individual patients, and the services provided to those admitted to hospital and to the much larger number of those who don't need a stay in hospital. The data includes information about contact with services, uses of the Mental Health Act, and the Care Programme Approach for each individual patient. All these details enable the use of services, patterns of care and patient outcomes to be tracked, including along pathways of care. The MHMDS therefore provides a robust basis for ongoing monitoring of access to and outcomes of care for users of specialist – both community and hospital – mental health services.

The MHMDS also enables an analysis of the numbers and rates of people from different ethnic groups using specialist mental health services overall (both inpatient and community), which provides an indication of the levels of mental illness and therefore the need for specialist care in different communities.

At present, the MHMDS does not cover high secure services, and independent sector providers only started to provide data during 2010/11. However, to support payment by results for mental health, the scope of the data set will be extended to cover high secure services during 2011/12 (version 4 MHMDS). Further proposed changes to the dataset (version 4.1) will incorporate NHS-funded learning disability services and primary care mental health services. A separate dataset for child and adolescent mental health services (CAMHS) has been developed and is awaiting formal approvals. It is designed to include the same information about uses of the Mental Health Act as provided in the MHMDS.

The latest MHMDS bulletin for 2009/10 provides a description of people using specialist mental health services in England, including ethnic profiles of people using services, hospital admissions, detentions, and the number of people on CPA.[24] It also provides information on differences by age and gender. The bulletin illustrates some of the sorts of analyses that are possible using data from the MHMDS.

The NHS Information Centre can provide guidance on these and other potential analyses based on MHMDS data.

Conclusions

While this report reviews changes in the census results since 2005, it is **not** a review or evaluation of the DRE programme overall. Similarly, the census cannot provide explanations for the patterns observed, or examine whether mental health services are meeting the needs of individual ethnic minority groups. As we have noted previously, the results are subject to caveats, in particular that the census provides a one-day snapshot that may not be representative of patients admitted to hospital throughout the year.

Overview of findings

Overall, the findings from the 2010 census show little change from those reported for previous annual censuses conducted since 2005. This is partly because many patients had been in hospital for a considerable period of time, and had therefore been included in successive censuses. The findings of this sixth and last census continue to show differences between Black and minority ethnic groups and White groups, and also differences within these groups.

In particular, ethnic differences in rates of admission, detention under the Mental Health Act and seclusion – three of DRE's 12 goals – have not altered materially since the inception of DRE in 2005:

- Admission rates remain higher than average among minority ethnic groups, especially among Black and White/Black Mixed groups for whom rates were two or more times higher than average in 2010. The Other Black group continues to have the highest admission rate – six times higher than average – although this is lower than in 2005. In contrast, admission rates have consistently been lower than average among the Indian and Chinese groups, and about average in the Pakistani and Bangladeshi groups.
- Detention rates remain higher than average among the Black and White/Black Caribbean Mixed groups, and among the Other White group. A consistent pattern across all censuses was the higher than average detention rate under section 37/41 for the Black Caribbean and Other Black groups. We also found that rates for being placed on a CTO were higher among the South Asian and Black groups.
- Although there have been annual fluctuations in seclusion rates, they have been higher than average for the Black, White/Black Mixed and Other White groups, in at least three of the six censuses.

Overall, the level of provision of single sex areas for patients continues to be unsatisfactory, although there was no evidence that minority ethnic patients were disadvantaged in these respects. Government policy for the NHS in England now requires that all providers of NHS-funded care, including mental health trusts, are expected to eliminate mixed-sex accommodation in accordance with the guidance set out in CNO/2010/3.[25,26] From 2011, all providers of NHS-funded care must report breaches of sleeping accommodation, which will attract sanctions.

Implications for ways forward

The census findings do not in themselves show that mental health and learning disability services are failing to meet the needs of Black and minority ethnic service users.

As noted in previous reports, they need to be interpreted in the context of available evidence on ethnic differences in rates of mental illness, pathways to care, and factors such as socioeconomic disadvantages that all contribute to these differences. Our previous reports have consistently highlighted the need for prevention, early intervention, and working collaboratively across sectors to reduce the risk of admission and detention where possible, without compromising the care given to patients. Mental health services have a key role to play, but to achieve this, all statutory agencies and organisations outside the healthcare sector, Black and minority ethnic communities and people who use services themselves will need to work in partnership.

This message – about preventing mental ill-health, by addressing the contributory factors and intervening early – is at the heart of *No health without mental health*, the Department of Health's new strategy for the future of mental health care in England.[27] The strategy aims to tackle the economic, social and environmental determinants and consequences of mental health problems, and to improve outcomes and reduce inequalities.

It specifies that by 2014, people in contact with the criminal justice system will have improved access to mental health services, as set out in the Ministry of Justice Green Paper *Breaking the Cycle: Effective punishment, rehabilitation and sentencing of offenders*, which confirms the approach outlined in Lord Bradley's report for early intervention and diversion from custody.[28,29]

Accompanying the new strategy is a supporting document that explains how its objectives will improve mental health outcomes, the effective interventions, and the underpinning evidence base.[30]

The strategy is complemented by other government proposals for reforms in the NHS, public health and adult social care as outlined in the NHS White Paper *Equity and excellence: liberating the NHS*[31], the public health strategy *Healthy lives, healthy people*[32], and the adult social care strategy *A vision for adult social care: capable communities and active citizens*.[33] Three outcomes frameworks have been developed alongside these strategies; improving mental health outcomes and reducing inequalities is integral to them all.

In this new healthcare landscape, the proposed NHS Commissioning Board and GP consortia will have a statutory obligation to promote equality and reduce inequalities in healthcare (something also enshrined in the Equality Act 2010). As the lead commissioners of healthcare services, it will be up to GP consortia to assess with local authorities the needs of their local populations and commission the right services that meet their requirements.

And the strengthened public health role of local authorities offers significant potential for addressing the socioeconomic disadvantages faced by Black and minority ethnic communities, which add to the burden of mental illness in these communities.

Race Equality Action Plan: A five-year review looked back at the work of the DRE action plan and describes some of the key challenges, successes and learning.[34] Based on the experience and outcome of the DRE programme, the report suggests ways forward for the next stage of mental health strategy development and implementation.

Since April 2009, CQC has had a duty under the Mental Health Act 1983 to monitor how services exercise their powers in relation to patients who are detained in hospital, or subject to CTOs or guardianship under the Act. In its first annual report on the use of the Act, CQC recommends a number of areas where improvements are needed, for example, over-occupancy on inpatient wards, patient engagement, use of control and restraint, seclusion, and capacity and consent.[35]

In particular, CQC highlighted a number of issues relating to the use of CTOs, including concern about appropriate usage (30% of the patients in CQC's sample did not have a reported history of non-compliance or disengagement with services after discharge) and over-representation of Black and minority ethnic groups. CQC advised that research on the possible race equality impact of CTOs should be undertaken. There were 6,237 CTOs from their introduction in November 2008 to 31 March 2010, a much greater use of them than forecast for this period by the Department of Health before the power was introduced. Just 31% of these orders had ended by end March 2010, suggesting that some people are being kept on supervised community treatment for long periods.

Data in the future: Moving beyond a one-day census

Good information is the foundation of an effective healthcare system. It is imperative for ensuring that services meet the needs of local populations and are equitable, and that improvements are made where needed. The availability of fit-for-purpose and comprehensive patient-level data sets, with ethnicity and other key variables fully coded, is therefore vitally important.[36] It enables the care provided to patients of all ethnic backgrounds to be monitored on an ongoing basis, including for monitoring compliance with the Equality Act.

Race Equality Action Plan: A five-year review notes that better collection, monitoring and use of ethnicity data to inform commissioning and provision in health and social care is required.[37] Key areas include good ethnic monitoring; improving demographic information; and ensuring good links between infomatics, audit and equality and diversity leads within trusts in order to effectively use the information to inform service development, monitoring and review at board, management, ward and community levels.

The government's proposed changes to the NHS will be supported by an information revolution aimed at improving and extending the information available to the NHS, patients and the public on the quality and outcomes of NHS services, including by equality dimensions.[38]

Having information that is fit for purpose is vital for the effective regulation of mental health and learning disability services. CQC uses routinely available data sets on an ongoing basis to assess the performance of health and social care organisations, and their compliance with government policies and legislation. We therefore expect those who commission and provide mental healthcare in the NHS and independent sector to have information systems that provide good quality data, with fully comprehensive recording and monitoring of ethnicity on an ongoing basis.

Since 2005, the Count me in census has played a key role in providing information about the ethnicity and other characteristics of inpatients in mental health and learning disability services, and on patients subject to the Mental Health Act. It did this by providing a valuable one-day snapshot. But ethnicity recording must be seen as an all-year round statutory requirement, not a one-day annual event. The number of inpatients throughout the year is much higher than the counts on one day, and some patients will have more than one admission. And there is a need to move on from counting patients to understanding more about care pathways for Black and minority ethnic patients and the factors leading to hospital admission and detention.

We have consistently highlighted the need for commissioners and providers to make full use of the Mental Health Minimum Data Set (MHMDS) – the statutory data set submitted by providers of specialist mental health services in England. It provides rich data on these issues and provides a robust information source for ongoing ethnic monitoring after this last census.

Covering both community and hospital services – and now independent and third sector providers as well as NHS – it includes a wide range of information about individual patients, the services provided to those admitted to hospital and to the much larger number who don't need admission to hospital, and the outcomes of care. And because it includes year-round activity, it is more representative of the overall picture of, for example, admission, detention and readmission rates, length of stay, years in psychiatric care and contacts with services and professionals.

We call on the Information Centre to routinely publish data on all admissions and uses of the Mental Health Act, including CTOs, in England (in both NHS and independent healthcare providers) by the ethnicity of

patients, making the MHMDS the definitive source of information about mental health and learning disability patients. This data should be risk-adjusted for age, gender and other variables as appropriate, to enable reliable comparisons to be made across groups.

It is important that all providers – NHS and independent – make strenuous efforts to improve the quality of the data they submit. The Information Centre publishes reports on the quality of MHMDS data by provider (see www.ic.nhs.uk/services/mhmds/dq), and we urge providers to monitor this information and use it to improve their data quality.

If GP consortia and local authorities are to be effective in their needs assessment and commissioning roles, the Information Centre needs to make available and promote to them the data from the MHMDS and other sources. And researchers and academics must make full use of the MHMDS to explore the factors that underlie the observed ethnic patterns.

CQC's role

In the meantime, CQC will continue to focus strongly on the quality of care provided by mental health and learning disability services.

People who find themselves admitted to mental health services or detained under the Mental Health Act, and therefore counted by the Count me in census, are among the most mentally unwell people in our society. Our job is first and foremost to make sure that the care they receive meets the essential standards of quality and safety set out under the Health and Social Care Act 2008, and to work with providers to ensure this. We act swiftly when we find services that do not. Where we find systemic problems that organisations have not adequately addressed, we may impose conditions on the provider's registration to bring about the change needed to improve patients' experience of care.

The essential standards of quality and safety include the requirement to provide single sex accommodation and we will continue to closely check that these standards are met by all mental health services.

We intend to introduce a number of indicators, derived from the rich information in the MHMDS, into our quality and risk profiles for providers. This will put greater emphasis on the experience of Black and minority ethnic patients in our regulatory activity.

We will monitor the quality of MHMDS data submitted by providers (as reported by the NHS Information Centre), including independent service providers. Those with poor data quality may be considered at higher risk in terms of their quality of care.

In addition, we will continue to monitor the progress of services in relation to the issues raised in the census and other reports, including our report on the use of the Mental Health Act, through our visits to services and meetings with patients by our Mental Health Act Commissioners and second opinion appointed doctors (SOADs). We will draw on patients' experiences to monitor the operation of the Mental Health Act.

We will also assess the impact of advice and use of Local HealthWatch. Local HealthWatch will be in a good position to make sure that providers and commissioners are held to account on matters of choice and access to services for people from Black and minority ethnic groups

References

1. Department of Health, *Equity and excellence: liberating the NHS*, 2010

2. Department of Health, *The NHS outcomes framework 2011/12*, 2010

3. Healthcare Commission, Mental Health Act Commission, National Institute for Mental Health in England, *Count me in: results of a national census of inpatients in mental health hospitals and facilities in England and Wales*, 2005

4. Healthcare Commission, Mental Health Act Commission, National Institute for Mental Health in England. *Count me in: results of the 2006 national census of inpatients in mental health and learning disability services in England and Wales*, 2006

5. Healthcare Commission, Mental Health Act Commission, National Institute for Mental Health in England, *Count me in: results of the 2007 national census of inpatients in mental health and learning disability services in England and Wales*, 2007

6. Healthcare Commission, Mental Health Act Commission, National Institute for Mental Health in England, *Count me in: results of the 2008 national census of inpatients in mental health and learning disability services in England and Wales*, 2008

7. Care Quality Commission, National Mental Health Development Unit, *Results of the 2009 national census of inpatients and patients on supervised community treatment in mental health and learning disability services in England and Wales*, 2009

8. Department of Health, *Delivering race equality in mental health care: an action plan for reform inside and outside services*, 2005

9. Welsh Assembly Government, Adult Mental Health Services, *Raising the standard – Race Equality Action Plan for Adult Mental Health Services in Wales*, 2006

10. Department of Health, *No health without mental health: a cross-government mental health outcomes strategy for people of all ages*, 2011. www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_124058.pdf

11. Department of Health, *New horizons: towards a shared vision for mental health*, 2009. www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_109708.pdf

12. Department of Health, *Valuing people: a new strategy for learning disability for the 21st century*, 2001

13. Department of Health, *Valuing people now: a new three year strategy for people with learning disabilities*, 2009

14. Department of Health, *Healthcare for all, report of the independent inquiry into access to healthcare for people with learning disabilities*, 2008

15. Joint Committee on Human Rights, *A life like any other? human rights of adults with learning disabilities* (2008 HL Paper 401 HC 731), House of Lords, House of Commons, 2008

16. Department of Health, *Valuing people now summary report March 2009 – September 2010*, 2010

17. Disability Rights Commission, *Equal treatment investigation*, 2005

18. Department of Health, Mir G, Nocon A, Ahmad W, Jones L, *Learning difficulties and ethnicity*, 2000

19. ONS experimental population estimates by ethnic group, 2007. www.statistics.gov.uk/statbase/product.asp?vlnk=14238

20. *Six percent of population are gay or lesbian, according to Whitehall figures*, 2005. www.telegraph.co.uk/news/main.jhtml?xml=/news/2005/12/12/ngay12.xml&s Sheet=/news/2005/12/12/ixhome.html

21. Department of Trade and Industry, Amendment to Employment Equality (Sexual Orientation) Regulations 2003, 2003

22. Office for National Statistics, *Measuring sexual identity: an evaluation report*, 2010

23. Information Centre, *Mental Health Bulletin: Fourth report from Mental Health Minimum Dataset (MHMDS) annual returns, 2010*, 2011. www.ic.nhs.uk/pubs/mhbmhmds0910

24. Information Centre, *Mental Health Bulletin: Fourth report from Mental Health Minimum Dataset (MHMDS) annual returns, 2010*, 2011. www.ic.nhs.uk/pubs/mhbmhmds0910

25. The operating framework for the NHS in England 2011/12. Department of Health, 2010. www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_122736.pdf

26. www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Professionalletters/Chiefnursingofficerletters/DH_121848

27. Department of Health, *No health without mental health: a cross-government mental health outcomes strategy for people of all ages*, 2011. www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_124058.pdf

28. Ministry of Justice, *Breaking the cycle: effective punishment, rehabilitation and sentencing of offenders*, 2010

29. Department of Health, *The Bradley report: Lord Bradley's review of people with mental health problems or learning disabilities in the criminal justice system*, 2009

30. Department of Health, *No health without mental health: delivering better mental health outcomes for people of all ages*, 2011

31. Department of Health, *Equity and excellence: liberating the NHS*, 2010. www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_117794.pdf

32. Department of Health, *Healthy lives, healthy people: our strategy for public health in England*, 2010. www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_122347.pdf

33. Department of Health, *A vision for adult social care: capable communities and active citizens*, 2010. www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_121971.pdf

34. Wilson M, NMHDU, *Race equality action plan: a five year review. Delivering race equality in mental health care*, 2010. www.nmhdu.org.uk/our-work/mhep/

35. Care Quality Commission, *Monitoring the use of the Mental Health Act in 2009/10*, 2010

36. Raleigh V S, *Collection of data on ethnic origin in England*. Editorial, BMJ 2008;337:6456

37. Wilson M, NMHDU, *Race equality action plan: a five year review. Delivering race equality in mental health care*, 2010. www.nmhdu.org.uk/our-work/mhep/

38. Department of Health, *Liberating the NHS: an information revolution*, 2010

Appendix A: Methods of analysis

Standardisation by age and gender

Standardisation allows us to make comparisons 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.

We used the ONS estimates of total population by ethnic group for England and Wales in 2007 to standardise the rates of admission for different ethnic groups. This takes account of the significant rises in the Black and ethnic minority population of England and Wales since the 2001 ONS census, and hence gives more accurate and up to date estimates of admission ratios for different ethnic groups (although it does not take account of any further changes in the ethnic populations between 2007 and 2010, the date of this census). For comparison with the DRE baseline, we also present admission rates from the 2005 census, derived using the 2005 ONS estimates of populations by ethnic group. These figures will not be the same as published in the 2005 census report, which were based on the 2001 ONS census population estimates because updated estimates of populations by ethnic group were not available at that time.

For other analyses, we used the total number of inpatients and patients on CTOs in the census as the basis for standardisation. However, CTO outpatients are excluded from selected analyses where appropriate, namely the analysis of rates for: admissions, detentions on admission; source of referral; single sex accommodation; and recorded incidents of seclusion, restraint, accidents, assault and self-harm. 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 125, it indicates that the 10% excess over the national average is not statistically significant. We did not attempt to adjust the confidence intervals for multiple comparisons.

Appendix B: Mental health tables

Table B1: Standardised admission ratios by ethnic group for England and Wales (excluding outpatients on a CTO), using 2007 ONS census population denominators (England and Wales = 100). All ages

Ethnic group	Men				Women				Persons			
	Standardised admission ratio	95% confidence interval		Observed numbers	Standardised admission ratio	95% confidence interval		Observed numbers	Standardised admission ratio	95% confidence interval		Observed numbers
White British	88	86	89	12,435	94	93	96	10,157	91	89	92	22,592
White Irish	130	115	146	274	122	106	140	215	126	115	138	489
Other White	117	109	126	731	129	118	141	533	122	115	129	1,264
White and Black Caribbean	557	493	627	276	274	223	333	101	436	393	483	377
White and Black African	312	247	388	80	259	186	351	41	292	242	349	121
White and Asian	140	110	174	79	124	90	166	44	134	111	159	123
Other Mixed	230	189	278	108	213	165	270	67	223	192	259	175
Indian	67	59	75	286	66	56	76	172	66	60	73	458
Pakistani	105	93	119	269	65	53	79	96	91	81	100	365
Bangladeshi	123	102	147	120	82	60	109	46	108	92	126	166
Other Asian	161	139	185	192	136	107	169	79	153	135	172	271
Black Caribbean	538	505	572	980	306	277	336	418	438	415	462	1,398
Black African	246	226	267	550	219	194	247	277	236	221	253	827
Other Black	792	691	903	222	314	240	403	61	596	529	670	283
Chinese	27	20	38	39	43	30	59	35	33	26	41	74
Other	140	120	162	177	110	88	136	87	128	113	145	264
Total	**100**			**16,818**	**100**			**12,429**	**100**			**29,247**

Table B2: Standardised admission ratios by ethnic group for England and Wales (excluding outpatients on a CTO), using 2007 ONS census population denominators (England & Wales = 100). Ages 65 and over

Ethnic group	Men				Women				Persons			
	Standardised admission ratio	95% confidence interval		Observed numbers	Standardised admission ratio	95% confidence interval		Observed numbers	Standardised admission ratio	95% confidence interval		Observed numbers
White British	95	92	99	3,265	95	92	98	3,887	95	93	97	7,152
White Irish	142	116	172	106	102	82	125	92	120	104	138	198
Other White	207	174	244	141	213	183	248	171	210	188	235	312
White and Black Caribbean	406	210	710	12	333	152	632	9	371	230	568	21
White and Black African	231	28	836	2	198	24	714	2	213	58	546	4
White and Asian	28	1	156	1	110	30	281	4	69	23	162	5
Other Mixed	146	40	374	4	228	92	470	7	189	95	339	11
Indian	97	70	132	41	83	57	116	33	90	71	113	74
Pakistani	39	17	77	8	46	18	94	7	42	23	69	15
Bangladeshi	115	53	218	9	69	14	201	3	98	51	172	12
Other Asian	234	143	361	20	215	120	354	15	225	157	313	35
Black Caribbean	216	170	269	77	310	253	376	103	261	224	302	180
Black African	142	73	248	12	365	241	531	27	246	175	337	39
Other Black	164	34	479	3	366	134	796	6	259	119	493	9
Chinese	41	8	120	3	95	38	195	7	68	33	125	10
Other	253	126	453	11	390	238	602	20	327	222	464	31
Total	**100**			**3,715**	**100**			**4,393**	**100**			**8,108**

Table B3: Standardised ratios by ethnic group for patients referred by a GP (England and Wales = 100)

Ethnic group	Men				Women				Persons			
	Standardised referral ratio	95% confidence interval		Observed numbers	Standardised referral ratio	95% confidence interval		Observed numbers	Standardised referral ratio	95% confidence interval		Observed numbers
White British	110	103	117	904	107	101	114	1,065	108	104	113	1,969
White Irish	85	50	134	18	93	57	144	20	89	63	123	38
Other White	74	51	103	33	70	49	97	36	72	56	91	69
White and Black Caribbean	27	5	78	3	30	4	109	2	28	9	65	5
White and Black African	0			0	74	9	268	2	35	4	125	2
White and Asian	165	54	386	5	0			0	86	28	201	5
Other Mixed	48	6	172	2	68	14	198	3	58	19	136	5
Indian	69	34	123	11	79	39	141	11	73	46	111	22
Pakistani	88	42	162	10	59	16	151	4	77	42	130	14
Bangladeshi	81	22	207	4	61	7	221	2	73	27	159	6
Other Asian	80	32	166	7	108	43	223	7	92	50	155	14
Black Caribbean	35	20	56	17	37	20	62	14	36	24	51	31
Black African	57	29	100	12	66	35	113	13	61	40	91	25
Other Black	62	23	135	6	40	5	144	2	54	23	107	8
Chinese	56	1	314	1	139	38	356	4	108	35	251	5
Other	106	46	208	8	0			0	53	23	105	8
Total	**100**			**1,041**	**100**			**1,185**	**100**			**2,226**

Table B4: Standardised ratios by ethnic group for patients referred by a community mental health team (including crisis resolution, home treatment) or community learning disability team (England and Wales = 100)

Ethnic group	Men				Women				Persons			
	Standardised referral ratio	95% confidence interval		Observed numbers	Standardised referral ratio	95% confidence interval		Observed numbers	Standardised referral ratio	95% confidence interval		Observed numbers
White British	107	104	111	3,255	103	100	107	3,386	105	103	108	6,641
White Irish	90	69	116	61	89	68	114	61	90	74	107	122
Other White	59	48	71	105	79	67	94	141	69	61	78	246
White and Black Caribbean	106	83	135	68	75	49	111	25	96	77	117	93
White and Black African	43	19	84	8	66	30	124	9	52	31	84	17
White and Asian	95	56	150	18	84	43	147	12	90	61	129	30
Other Mixed	78	48	121	20	72	41	118	16	76	53	105	36
Indian	106	83	132	76	100	76	130	56	103	86	122	132
Pakistani	108	84	135	73	89	60	128	30	102	83	123	103
Bangladeshi	98	66	141	29	90	50	148	15	95	69	128	44
Other Asian	88	63	120	40	105	70	150	29	94	73	119	69
Black Caribbean	69	59	80	167	85	71	102	123	75	67	84	290
Black African	84	70	102	112	82	65	103	77	84	72	96	189
Other Black	52	36	74	31	64	36	106	15	56	41	74	46
Chinese	112	53	205	10	101	52	176	12	105	66	160	22
Other	86	60	120	35	106	71	151	30	94	73	120	65
Total	**100**			**4,108**	**100**			**4,037**	**100**			**8,145**

Table B5: Standardised ratios by ethnic group for patients referred by criminal justice routes (police, prison, probation, courts, court liaison and diversion) (England and Wales = 100)

Ethnic group	Men				Women				Persons			
	Standardised referral ratio	95% confidence interval		Observed numbers	Standardised referral ratio	95% confidence interval		Observed numbers	Standardised referral ratio	95% confidence interval		Observed numbers
White British	90	86	95	1,495	95	86	104	421	91	87	95	1,916
White Irish	133	94	183	38	59	19	138	5	116	84	157	43
Other White	112	93	134	119	103	68	150	27	111	93	130	146
White and Black Caribbean	117	89	151	58	145	69	266	10	120	94	153	68
White and Black African	190	127	273	29	141	38	361	4	183	126	256	33
White and Asian	75	39	131	12	160	52	373	5	89	52	143	17
Other Mixed	104	65	157	22	151	61	311	7	112	75	161	29
Indian	86	61	118	38	79	32	163	7	85	62	113	45
Pakistani	118	91	150	65	89	33	194	6	115	90	145	71
Bangladeshi	74	44	115	19	29	1	162	1	68	42	105	20
Other Asian	130	95	174	45	164	71	323	8	134	101	176	53
Black Caribbean	131	114	150	208	124	81	181	26	130	114	148	234
Black African	132	112	156	145	143	93	211	25	134	114	156	170
Other Black	141	109	180	65	236	113	435	10	149	117	187	75
Chinese	83	27	194	5	146	30	426	3	99	43	195	8
Other	129	93	175	41	113	37	264	5	127	93	170	46
Total	**100**			**2,404**	**100**			**570**	**100**			**2,974**

Table B6: Standardised detention ratios by ethnic group: all detentions on day of admission (excluding outpatients on a CTO) (England and Wales = 100)

Ethnic group	Men				Women				Persons			
	Standardised detention ratio	95% confidence interval		Observed numbers	Standardised detention ratio	95% confidence interval		Observed numbers	Standardised detention ratio	95% confidence interval		Observed numbers
White British	94	92	97	6,449	94	91	97	3,628	94	92	96	10,077
White Irish	112	95	131	154	118	96	145	94	114	101	129	248
Other White	108	98	118	451	120	106	136	251	112	104	120	702
White and Black Caribbean	123	107	141	220	129	99	167	59	124	110	140	279
White and Black African	128	99	162	68	113	70	173	21	124	100	153	89
White and Asian	96	71	126	50	109	68	164	22	99	78	125	72
Other Mixed	115	92	143	82	139	100	188	42	122	102	146	124
Indian	97	83	113	164	110	86	137	77	101	88	114	241
Pakistani	109	94	126	194	102	74	136	44	108	94	122	238
Bangladeshi	86	67	109	69	91	55	142	19	87	70	107	88
Other Asian	109	92	130	133	120	86	163	40	112	96	130	173
Black Caribbean	129	121	139	774	143	125	162	238	132	124	141	1,012
Black African	115	104	127	422	131	111	153	159	119	110	129	581
Other Black	117	100	136	170	148	105	202	39	122	106	140	209
Chinese	108	71	159	26	129	78	202	19	116	85	156	45
Other	111	92	132	126	116	83	157	41	112	96	130	167
Total	**100**			**9,552**	**100**			**4,793**	**100**			**14,345**

Table B7: Standardised detention ratios by ethnic group: detention on day of admission – section 2 of the Mental Health Act (England and Wales = 100)

Ethnic group	Men				Women				Persons			
	Standardised detention ratio	95% confidence interval		Observed numbers	Standardised detention ratio	95% confidence interval		Observed numbers	Standardised detention ratio	95% confidence interval		Observed numbers
White British	97	91	102	1,156	93	87	98	1,133	95	91	99	2,289
White Irish	78	47	120	20	116	79	166	30	97	72	128	50
Other White	100	78	126	70	134	108	166	88	116	99	136	158
White and Black Caribbean	55	30	93	14	60	24	124	7	57	35	87	21
White and Black African	91	37	188	7	150	60	308	7	113	62	190	14
White and Asian	80	29	174	6	119	44	258	6	96	49	167	12
Other Mixed	68	28	141	7	116	53	221	9	89	51	145	16
Indian	130	91	179	37	124	81	182	26	127	98	163	63
Pakistani	126	87	176	34	138	79	225	16	130	96	171	50
Bangladeshi	166	101	256	20	140	61	276	8	158	105	228	28
Other Asian	142	93	209	26	163	93	264	16	150	108	202	42
Black Caribbean	73	57	92	70	97	72	128	51	82	68	98	121
Black African	164	131	202	87	190	146	244	62	174	147	204	149
Other Black	114	75	166	27	140	72	245	12	121	86	165	39
Chinese	165	60	358	6	212	97	402	9	190	106	313	15
Other	218	153	302	36	179	108	280	19	203	153	264	55
Total	**100**			**1,623**	**100**			**1,499**	**100**			**3,122**

Table B8: Standardised detention ratios by ethnic group: detention on day of admission – section 3 of the Mental Health Act (England and Wales = 100)

Ethnic group	Men				Women				Persons			
	Standardised detention ratio	95% confidence interval		Observed numbers	Standardised detention ratio	95% confidence interval		Observed numbers	Standardised detention ratio	95% confidence interval		Observed numbers
White British	99	95	103	2,684	96	91	100	1,852	98	95	101	4,536
White Irish	116	89	149	60	135	101	177	52	124	102	149	112
Other White	112	96	129	186	110	92	132	121	111	99	124	307
White and Black Caribbean	114	91	143	79	130	90	183	33	119	98	143	112
White and Black African	97	60	148	21	107	54	192	11	100	69	141	32
White and Asian	84	50	133	18	97	48	173	11	89	59	127	29
Other Mixed	121	84	168	35	117	72	181	20	120	90	156	55
Indian	96	75	122	67	110	79	148	42	101	83	122	109
Pakistani	91	71	115	69	88	55	134	22	90	73	111	91
Bangladeshi	63	39	95	22	64	28	127	8	63	43	90	30
Other Asian	90	65	120	44	94	56	149	18	91	70	117	62
Black Caribbean	116	102	130	279	164	138	192	148	129	117	142	427
Black African	95	80	112	143	102	79	129	68	97	85	111	211
Other Black	75	55	99	49	99	58	159	17	80	62	102	66
Chinese	119	59	213	11	99	43	194	8	110	66	171	19
Other	85	60	116	38	84	48	136	16	84	63	110	54
Total	**100**			**3,805**	**100**			**2,447**	**100**			**6,252**

Table B9: Standardised detention ratios by ethnic group: detention on day of admission – section 37/41 of the Mental Health Act (England and Wales = 100)

Ethnic group	Men				Women				Persons			
	Standardised detention ratio	95% confidence interval		Observed numbers	Standardised detention ratio	95% confidence interval		Observed numbers	Standardised detention ratio	95% confidence interval		Observed numbers
White British	84	79	89	991	101	88	115	220	86	82	91	1,211
White Irish	140	96	198	32	48	6	175	2	126	87	176	34
Other White	112	89	139	81	156	95	241	20	118	96	144	101
White and Black Caribbean	177	133	232	53	179	66	390	6	178	135	229	59
White and Black African	149	82	251	14	224	46	654	3	159	92	254	17
White and Asian	141	75	241	13	195	40	569	3	149	85	241	16
Other Mixed	144	85	227	18	264	97	575	6	162	104	242	24
Indian	86	56	126	26	44	5	160	2	80	53	116	28
Pakistani	122	87	166	40	0			0	111	79	152	40
Bangladeshi	66	32	122	10	0			0	60	29	110	10
Other Asian	99	61	151	21	0			0	89	55	136	21
Black Caribbean	200	174	229	210	78	34	153	8	189	165	216	218
Black African	127	101	157	82	84	34	172	7	122	98	150	89
Other Black	152	110	205	43	94	11	341	2	148	108	198	45
Chinese	100	27	255	4	0			0	80	22	204	4
Other	118	75	177	23	44	1	245	1	110	71	164	24
Total	**100**			**1,661**	**100**			**280**	**100**			**1,941**

Table B10: 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)

Ethnic group	Men				Women				Persons			
	Standardised detention ratio	95% confidence interval		Observed numbers	Standardised detention ratio	95% confidence interval		Observed numbers	Standardised detention ratio	95% confidence interval		Observed numbers
White British	97	90	106	583	104	81	131	73	98	91	106	656
White Irish	132	72	221	14	163	20	590	2	135	77	219	16
Other White	130	96	172	49	71	15	206	3	124	93	163	52
White and Black Caribbean	126	78	193	21	80	2	444	1	123	77	186	22
White and Black African	207	103	370	11	0			0	189	95	339	11
White and Asian	57	12	166	3	169	4	941	1	68	19	175	4
Other Mixed	112	48	221	8	233	28	843	2	125	60	230	10
Indian	57	26	108	9	0		252	0	52	24	99	9
Pakistani	92	54	147	17	0		314	0	86	50	138	17
Bangladeshi	46	12	117	4	167	4	930	1	53	17	125	5
Other Asian	101	52	177	12	0			0	95	49	166	12
Black Caribbean	126	98	159	70	125	34	319	4	126	99	158	74
Black African	74	48	107	27	104	21	303	3	76	51	108	30
Other Black	127	78	197	20	138	3	769	1	128	79	195	21
Chinese	0			0	0			0	0			0
Other	83	38	157	9	0			0	77	35	147	9
Total	**100**			**857**	**100**			**91**	**100**			**948**

Table B11: Standardised ratios for all applications of the Mental Health Act (including outpatients on a CTO) by ethnic group: on day of census (England and Wales = 100)

Ethnic group	Men				Women				Persons			
	Standardised ratio for all MHA applications	95% confidence interval		Observed numbers	Standardised ratio for all MHA applications	95% confidence interval		Observed numbers	Standardised ratio for all MHA applications	95% confidence interval		Observed numbers
White British	97	94	99	7,659	95	93	98	4,335	96	94	98	11,994
White Irish	99	83	116	147	104	84	128	95	101	89	114	242
Other White	87	79	95	427	97	85	110	249	90	84	97	676
White and Black Caribbean	117	103	133	245	130	103	163	76	120	107	134	321
White and Black African	120	95	150	79	93	58	141	22	113	92	137	101
White and Asian	101	78	128	65	119	81	169	31	106	86	129	96
Other Mixed	110	89	134	96	125	93	165	49	114	97	135	145
Indian	103	90	118	215	122	100	147	109	109	97	121	324
Pakistani	111	97	125	254	117	90	148	67	112	100	125	321
Bangladeshi	92	75	112	97	101	68	145	29	94	78	112	126
Other Asian	103	88	121	152	126	95	164	56	109	94	124	208
Black Caribbean	123	115	131	893	141	126	158	300	127	120	134	1,193
Black African	112	103	122	511	121	104	140	188	114	106	123	699
Other Black	116	102	132	232	148	112	191	59	122	108	136	291
Chinese	97	64	140	27	101	61	157	19	98	72	131	46
Other	104	87	122	140	103	75	137	46	103	89	119	186
Total	**100**			**11,239**	**100**			**5,730**	**100**			**16,969**

Table B12: Standardised CTO ratios by ethnic group: CTOs on day of census – section 17a of the Mental Health Act (England and Wales = 100)

Ethnic group	Men				Women				Persons			
	Standardised CTO ratio	95% confidence interval		Observed numbers	Standardised CTO ratio	95% confidence interval		Observed numbers	Standardised CTO ratio	95% confidence interval		Observed numbers
White British	94	89	99	1,289	88	82	94	730	92	88	96	2,019
White Irish	51	27	88	13	77	41	132	13	62	40	90	26
Other White	97	77	120	83	125	95	162	58	107	90	126	141
White and Black Caribbean	79	53	113	29	141	77	237	14	92	67	124	43
White and Black African	111	59	190	13	125	41	292	5	115	68	181	18
White and Asian	104	54	182	12	136	50	297	6	113	67	178	18
Other Mixed	102	59	166	16	136	62	257	9	112	73	166	25
Indian	134	99	177	48	152	98	226	24	139	109	175	72
Pakistani	145	110	187	59	174	101	279	17	151	119	189	76
Bangladeshi	142	93	206	27	205	99	378	10	155	109	213	37
Other Asian	107	71	155	28	182	99	305	14	124	89	168	42
Black Caribbean	121	103	142	152	171	132	218	65	133	116	152	217
Black African	116	94	142	94	139	98	192	37	122	102	145	131
Other Black	186	144	238	65	305	189	466	21	206	165	254	86
Chinese	83	23	213	4	152	49	354	5	111	51	211	9
Other	87	54	134	21	152	79	266	12	103	71	145	33
Total	**100**			**1,953**	**100**			**1,040**	**100**			**2,993**

Appendix C: Learning disability tables

Table C1: Standardised admission ratios by ethnic group for England and Wales, using 2007 ONS population denominators (England & Wales = 100). All ages

Ethnic group	Men				Women				Persons			
	Standardised admission ratio	95% confidence interval		Observed numbers	Standardised admission ratio	95% confidence interval		Observed numbers	Standardised admission ratio	95% confidence interval		Observed numbers
White British	104	100	109	2,163	108	101	115	941	105	102	109	3,104
White Irish	108	72	156	28	151	89	238	18	121	89	162	46
Other White	81	65	101	85	49	30	75	21	72	59	87	106
White and Black Caribbean	280	186	405	28	246	118	453	10	270	191	371	38
White and Black African	102	33	239	5	165	34	482	3	119	51	235	8
White and Asian	66	26	135	7	154	56	335	6	89	47	152	13
Other Mixed	181	104	295	16	229	99	451	8	195	125	290	24
Indian	32	21	48	24	28	12	55	8	31	21	44	32
Pakistani	48	30	72	22	12	1	43	2	38	25	57	24
Bangladeshi	102	60	161	18	31	4	113	2	83	51	128	20
Other Asian	33	13	69	7	92	34	201	6	47	25	81	13
Black Caribbean	265	210	332	77	117	67	190	16	218	176	267	93
Black African	53	33	80	22	40	15	87	6	50	33	72	28
Other Black	228	118	399	12	134	28	392	3	200	112	330	15
Chinese	4	0	21	1					3	0	16	1
Other	26	9	56	6	11	0	59	1	21	9	44	7
Total	**100**			**2,521**	**100**			**1,051**	**100**			**3,572**

Table C2: Standardised detention ratios by ethnic group: all detentions on day of admission (England and Wales = 100)

	Persons			
Ethnic group	Standardised detention ratio	95% confidence interval		Observed numbers
White British	97	93	103	1,431
White Irish	127	84	184	28
Other White	117	91	149	68
White and Black Caribbean	120	77	179	24
White and Black African	114	37	267	5
White and Asian	75	24	176	5
Other Mixed	94	49	165	12
Indian	119	72	186	19
Pakistani	110	61	181	15
Bangladeshi	144	84	231	17
Other Asian	59	16	150	4
Black Caribbean	119	90	155	57
Black African	138	85	210	21
Other Black	62	20	145	5
Chinese	0			0
Other	104	28	267	4
Total	**100**			**1,715**

Published April 2011.

How to contact us

Phone: 03000 616161
Email: enquiries@cqc.org.uk
Web: www.cqc.org.uk

Write to us at:

Care Quality Commission
National Correspondence
Citygate
Gallowgate
Newcastle upon Tyne
NE1 4PA

Please contact us if you would like a summary of this publication in other formats or languages.

Registered office:

Care Quality Commission
Finsbury Tower
103–105 Bunhill Row
London
EC1Y 8TG