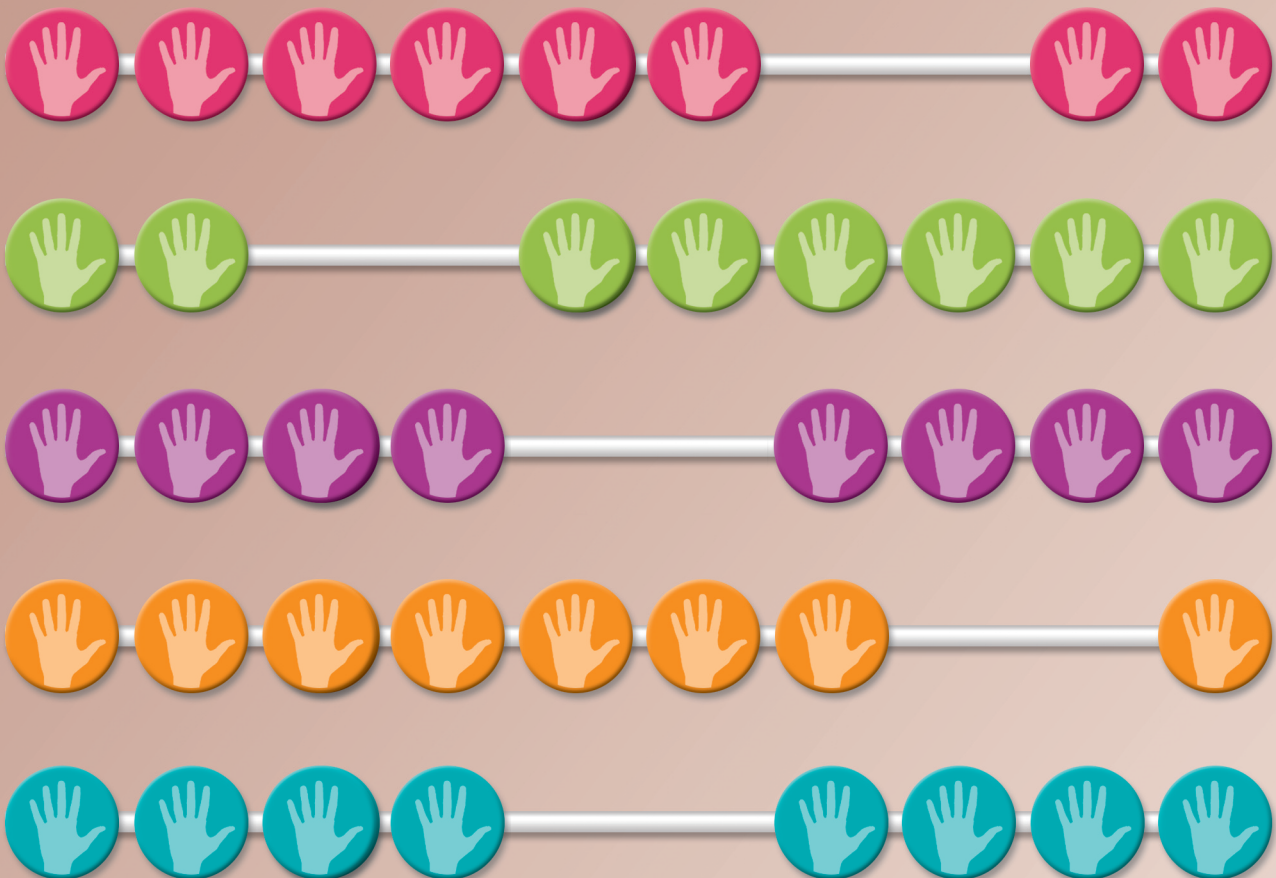


Count me in 2009

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



About the 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 private or voluntary organisations, we make sure that people get better care. We do this by:

- Driving improvement across health and adult social care.
- Putting people first and championing their rights.
- Acting swiftly to remedy bad practice.
- Gathering and using knowledge and expertise, and working with others.

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Summary

This is the fifth 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 2009 and undertaken jointly by the Healthcare Commission, the Mental Health Act Commission (MHAC), the Care Services Improvement Partnership and the National Institute for Mental Health in England (NIMHE). While it follows a similar census carried out each year since 2005, this year it also includes all patients who were subject to a Community Treatment Order (CTO), which were introduced in 2008 following changes to the Mental Health Act 1983.

Following changes to the regulation of health and adult social care introduced by the Health and Social Care Act 2008, the Healthcare Commission, MHAC and the Commission for Social Care Inspection were superseded by the new regulatory agency for health and adult social care, the Care Quality Commission (CQC). CQC came into effect from 1 April 2009, and takes over responsibility for the census.

All patients are entitled to receive the same high level of healthcare, regardless of their race, religion, age, gender, sexual orientation, and whether they have a disability. Patterns of mental illness and use of mental health and learning disability services differ between ethnic groups. The census is undertaken 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 introduced in 2005, *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 census aims 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.

Key findings

Mental health

Information was obtained for 31,786 patients who were either inpatients on the mental health wards of 264 NHS and independent healthcare organisations in England and Wales or on a CTO on census day (1,371 patients were on a CTO and of these, 1,253 were outpatients on census day). The overall patterns emerging from this census are broadly similar to those observed in previous years. This is not surprising, as 29% of the patients in 2009 were also inpatients in 2008, and 20% of them had also been in hospital at the time of the 2007 census.

The key findings are*:

- The number of inpatients in each census declined each year from 33,785 in 2005 to 31,020 in 2008, and to 30,533 in 2009 (excluding the 1,253 outpatients on CTO).
- The proportion of patients in independent hospitals has increased steadily from 10% of the total in 2005 to 16% in 2009, with a corresponding decline in the proportion of patients in NHS services.
- Information about ethnicity was available for 98% of all patients, of whom:
 - 76% were White British
 - 10% were from Black or White/Black Mixed groups
 - 4% were from Other White groups

* As the census includes inpatients and patients subject to the Mental Health Act, the results presented relate to all these patients, including outpatients on CTOs.

Summary continued

- 3% were from South Asian (Indian, Pakistani and Bangladeshi) groups
- 2% were White Irish
- 3% were from other ethnic groups (including Chinese).

Overall, 22% of all patients were from minority ethnic groups, compared with 20% in the 2005 census. There have been demographic changes in the population of England and Wales during this period.

- 70% of all patients from black and minority ethnic groups were patients at 28 of the 264 organisations involved in the census.
 - 6% of all patients reported that English was not their first language.
 - Rates of admission were lower than the national average among the White British, Indian and Chinese groups, and were average for the Pakistani and Bangladeshi groups. They were higher than average among other minority ethnic groups – particularly in the Black Caribbean, Black African, Other Black, White/Black Caribbean Mixed and White/Black African Mixed groups – with rates over three times higher than average, and nine times higher in the Other Black group. These patterns are similar to those observed in previous censuses, with no evidence of a decline in admission rates among black and minority ethnic groups, one of the 12 goals of DRE.
 - Rates of referral from GPs and community mental health teams were lower than average among some Black and White/Black groups, and rates of referral from the criminal justice system were higher. Patterns were less consistent for other minority ethnic groups.
 - 46% of all patients were detained under the Mental Health Act on admission, an increase from 40% in 2005. Overall rates of patients subject to the Mental Health Act (including CTOs) were higher than average among the Black Caribbean, Black African, Other Black and White/Black Caribbean Mixed groups, and in the Other White group. Another DRE goal is to reduce detention rates among black and minority ethnic groups. However, detention rates have remained higher than average among the Black Caribbean, Black African and Other Black groups in the four annual censuses conducted from 2005 to 2008; the same pattern was seen in the 2009 census in terms of overall use of the Mental Health Act, including CTOs.
- A consistent pattern across all five annual censuses was the higher than average detention rate under section 37/41 for the Black Caribbean and Other Black groups.
 - 4% of all patients (1,371) were on a CTO (section 17A of the Mental Health Act). The rate was higher than average among some minority ethnic groups, however, these results are subject to caution because information about ethnicity was “not stated” for 8% of patients on section 17A.
 - Another of DRE’s 12 goals is to reduce seclusion among black and minority ethnic groups. Although seclusion rates were higher than average among the Other White and White/Black Caribbean Mixed groups, the high rates that were evident for Black groups in some previous censuses were not apparent in 2009.
 - In all five censuses, the rate of self-harm was higher than average for the White British group, and was lower than average among the Black and South Asian groups.
 - Ethnic differences in hands-on restraint and physical assault have not shown a consistent pattern over the five censuses.
 - As in previous years, 29% of patients had been in hospital for one year or more, and almost 20% for over two years. The median duration of stay from the day of admission to the day of census was two and a half months for women and five and a half months for men. Median lengths of stay were among the longest for patients from

the Black Caribbean and White/Black Caribbean Mixed groups, and among the shortest for patients from the Chinese, South Asian, Black African, White British and Other groups.

- 67% (similar to 2007 and 2008) of patients were not in a single sex ward (see definition of single sex accommodation on page 28). Overall, 19% of men and 24% of women were reported as not having access to toilet and bathing facilities designated for single sex use, and about half of all patients were reported as not having access to a lounge and day space area designated for single sex use. These proportions were generally lower among minority ethnic groups than among the White British group.

Learning disabilities

Information was obtained for 3,695 patients in 123 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 68% of the inpatients in 2009 were also inpatients in 2008, and 55% were also inpatients in 2007.

The key findings are:

- The total number of patients fell from 4,609 in 2006 to 3,695 in 2009. The proportion of patients in independent healthcare organisations increased from 20% in 2006 to 27% in 2009. The proportion of patients in NHS services fell correspondingly.
- Information about ethnicity was available for 99% of patients, of whom:
 - 87% were White British
 - 5% were from Black or White/Black mixed groups
 - 2% were from Other White groups
 - 2% were from South Asian groups
 - 1% were White Irish
 - under 1% were from other ethnic groups (including Chinese).

Overall, 13% of patients were from black and minority ethnic groups. Numbers of patients were low for several minority ethnic groups.

- Approximately 70% of patients from black and minority ethnic groups were patients at 30 of the 123 organisations involved in the census.
- 8% of patients reported that English was not their first language. Non-verbal languages were recorded for 6% of patients.
- Admission rates were lower than average among the Other White, Indian, Pakistani, Other Asian, Chinese and Other groups. They were two to three times higher than average among the White/Black Caribbean Mixed, Black Caribbean, Other Black and Other Mixed groups. These results are similar to those reported previously.
- 45% of patients were detained under the Mental Health Act on admission. Few ethnic differences were apparent, as in previous years.
- Due to small numbers of patients in minority ethnic groups, few ethnic differences were observed in rates of seclusion, physical assault, hands-on restraint, self-harm and accidents.
- As in 2008, 68% of patients had been in hospital for one year or more, and 32% for over five years. The median duration of stay from the day of admission to the day of census was 33 months for women and 32 months for men.
- Overall, 48% of men and 73% of women were not in a single sex ward (see definition of mixed ward accommodation on page 38).

Conclusions

As in previous years, the findings of this fifth census show differences **between** mental health patients from the White British group and black and minority ethnic groups, and also differences **within** these groups. The census also shows that since 2005, there has been no reduction in rates of admission, detention and seclusion – key goals of DRE – among black and minority ethnic groups. However, the findings do not of themselves indicate that mental health and learning disability services are failing to meet the needs of black and minority ethnic service users.

The findings 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 socio-economic disadvantage that contribute to these differences. 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 partnership between all statutory agencies and organisations outside the healthcare sector, black and minority ethnic communities and service users themselves will be needed to achieve this. Within health and social care, CQC has a unique opportunity to ensure that services retain a strong focus on these factors through the forthcoming registration of provider organisations, assessment of commissioning bodies, and its responsibility for coordinating regulatory activity within the system.

This message about preventing mental ill-health, by addressing the contributory factors and intervening early, is at the heart of *New Horizons*, the Government's vision for the future of mental health care in England. If effectively implemented, such policies have the potential for reducing the burden of mental illness and the need for secondary care services among black and minority ethnic groups. The recommendations outlined in Lord Bradley's report to address the needs of those with mental health problems or learning disabilities in the criminal justice system also have the potential for improving care pathways and outcomes for minority ethnic groups. CQC strongly endorses both these initiatives.

Overall, there is a need for improvement in the provision of single sex accommodation in both mental health and learning disability services. Those who commission and provide mental health and learning disability services need to address this as a matter of **high** priority.

The data collected for the census shows a snapshot of inpatients and outpatients subject to a CTO on one day only. CQC will explore patterns of ethnicity and mental health further in other data sets.

Recommendations

Based on these findings, we recommend the following actions for mental health, learning disability and social care services:

1. Health and social care organisations should work with other statutory bodies (including police, courts, housing and education), non-statutory or voluntary agencies, and with minority ethnic communities, towards achieving the goals of DRE and the vision of mental wellbeing set out in *New Horizons*.
2. Statutory bodies, working in partnership with others, should understand the demographic and clinical needs of their local populations, and commission and deliver fair, personalised and effective services that reduce mental ill-health among black and minority ethnic groups, improve pathways to healthcare for those who become mentally unwell, and improve the experience of those who are admitted to hospital.
3. Those who commission and provide mental health and learning disability services should make renewed and strenuous efforts to improve the provision of single sex accommodation for inpatients.
4. Those who commission and provide mental health and learning disability services, in both the NHS and the independent sector, should have fully comprehensive systems to record and monitor ethnicity.

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

5. Submission of the Mental Health Minimum Data Set (MHMDS) and Hospital Episode Statistics (HES) is made mandatory for all independent providers of mental health and learning disability services, especially in view of the growing number and proportion of all mental health and learning disability inpatients cared for in these establishments. Submission of these data sets should be a requirement in the mental health standard contract that is being developed by the Department of Health.
6. The Information Centre should routinely monitor and publish reports on the quality of MHMDS data submitted by all providers of mental health services, including those in the independent sector. These data quality assessments should include the quality of data on community treatment orders.
7. The Information Centre should routinely publish data on all admissions, detentions and community treatment orders under the Mental Health Act in England (in both NHS and independent healthcare providers) by the ethnicity of patients, with the longer term aim of the MHMDS being the definitive source of information about mental health patients, including use of the Mental Health Act.

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

Introduction

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

The NHS Next Stage Review set out a foundation for a health service that helps people to stay healthy, empowers staff, gives patients choice, and ensures that healthcare will be personalised, fair, effective and safe.¹ In addition, the World Class Commissioning programme aims to help the NHS to meet the changing needs of the population and deliver a service that is clinically driven, patient-centred and responsive to local needs. It aims to do this by developing a strategic, long-term and community-focused approach to buying or 'commissioning' services, where those who commission the care and healthcare professionals work together to deliver improved health outcomes.²

On 31 March 2009, the Healthcare Commission, the Mental Health Act Commission (MHAC) and the National Institute for Mental Health in England (NIMHE) carried out a national census to record the ethnicity, and other selected details, of inpatients 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 fifth Count me in census. Similar censuses have been conducted annually since 2005.³⁻⁶

Mental health

The censuses are undertaken in support of the Department of Health's five-year action plan for improving mental health services for black and minority ethnic communities introduced in 2005, *Delivering Race Equality in Mental Health Care* (DRE).⁷ The DRE action plan has three building blocks:

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

The Count me in census helps healthcare organisations with the third building block, by providing information that can be used to plan and deliver services that are relevant to all groups in the community. A 'dashboard' enabling healthcare organisations to measure their progress towards DRE's goals monitors six headline priorities:

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

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

The census also supports the Welsh Assembly Government's *Raising the Standard: Race Equality Action Plan for Adult Mental Health Services in Wales*, published in October 2006.⁸ 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.

New Horizons (the successor to the National Service Framework (NSF) for mental health from 2009) outlines the Department of Health's proposed vision for mental health to 2020.⁹ *New Horizons* has a cross-government and cross-sectoral focus on prevention and the mental wellbeing of the population, early intervention and personalised care. It marks a widening of the policy's focus from specialist services in isolation, to a public health approach to mental wellbeing, making mental health "everybody's business". 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 socio-economic disadvantage that people from black and minority ethnic groups often experience.

Learning disabilities

The Department of Health's 2001 White Paper, *Valuing People*, set out the Government's vision for people with a learning disability, based on four key principles of rights, independence, choice and inclusion.¹⁰ *Valuing People Now: A New Three Year Strategy for people with learning disabilities*, published in 2009, sets out the Government's strategy for the next three years.¹¹ It also provides the 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,¹² and to the report of the Joint Committee on Human Rights, *A Life Like Any Other?*¹³ The vision remains 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 sets out cross-government commitments and actions to increase the capacity and capability to deliver services locally.

A report by the Disability Rights Commission provides evidence that people with learning disabilities or 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.¹⁴ *Learning Difficulties and Ethnicity* noted that the disadvantage experienced by people from minority ethnic communities because of their ethnicity (in education and employment, for example) is compounded by the disadvantage they experience because of their impairment.¹⁵

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

Aims of the census

The goals of the 2009 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 2009 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.

The four annual censuses from 2005–2008 counted all inpatients in mental health and learning disability services in England and Wales, including those detained in hospital under the Mental Health Act 1983. Community treatment orders (CTOs), introduced in November 2008 as a result of the Mental Health Act 2007, allow for supervised treatment of patients in the community. The 2009 census therefore includes some mental health patients subject to supervised treatment in the community under the Mental Health Act, and who are therefore outpatients in the community and are not in hospital on census day.

As one of the aims of the census is to provide figures on inpatients and those subject to the Mental Health Act on census day, the analysis in this report on the 2009 census is not limited to mental health inpatients, and also includes mental health outpatients on CTOs. This provides a more rounded basis for examining the use of the Act – overall and in relation to CTOs – among different ethnic groups. It also means that CTO patients are included in the descriptive profiles (eg religion, language) of patients included in the report.

There are two separate sections in this report – the first covers inpatients using mental health services and the second looks at those using learning disability services.

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 services looked after by social services.

More information about the census and how it was carried out, including the full set of results, is available at: www.cqc.org.uk/guidanceforprofessionals/healthcare/allhealthcarestaff/countmeincensus.cfm

National organisations coordinating the census

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). However, under the Health and Social Care Act 2008, the regulatory functions of the Healthcare Commission, the Mental Health Act Commission and the Commission for Social Care Inspection were superseded by the Care Quality Commission (CQC) on 1 April 2009. At the same time, NIMHE was also superseded by the National Mental Health Development Unit (NMHDU). CQC and NMHDU are now the two key partners in delivering the census, although CQC has lead responsibility.

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

The National Mental Health Development Unit

The National Mental Health Development Unit (NMHDU) was launched in April 2009 and consists of a small central team and a range of programmes funded by both the Department of Health and the NHS. It provides national support for implementing mental health policy by advising on national and international best practice to improve mental health and mental health services.

NMHDU does 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.

NMHDU's work is being developed through co-production between DH and the 10 strategic health authorities (SHAs), and strategic partnerships with 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).

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 and Black Caribbean	Black Caribbean
White and Black African	Black African
White and Asian	Other Black
Other Mixed	Chinese
Indian	Other

Coverage of learning disability establishments

The 2009 census included all independent providers in England registered with the Healthcare Commission on 31 March* and all independent providers in Wales registered with the Healthcare Inspectorate Wales, under section 2 of the Care Standards Act 2000 to provide inpatient learning disability services. It did not include care homes registered only with the Commission for Social Care Inspection (CSCI).

In the NHS, there is a continuum from inpatient services through to registered and supported homes. All of these can have some links to the NHS, either directly or through seconded staff. Where such NHS facilities were both registered as care homes under the Care Standards Act 2000 and regulated by the Healthcare Commission, they were included.

* On 1 April 2009, the regulatory functions of the Healthcare Commission, the Mental Health Act Commission and the Commission for Social Care Inspection were taken over by the Care Quality Commission as the new regulator for health and adult social care.

Those regulated by CSCI were not eligible for inclusion in the census.

Distinguishing between mental health patients and learning disability patients

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 the services by describing wards as either “mainly providing mental health services” or “mainly providing learning disability services”. The 2005 census only included wards that provided mainly mental health services. This separation of results by type of ward gives us a means of comparing the results across years, and also ensures that no patient was counted twice.

It is important to note, however, that some patients on mental health wards may have a learning disability or Autistic Spectrum Disorder, including Asperger’s syndrome, and some patients on learning disability wards may have a mental health problem.

Methods of statistical analysis

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

For the admission rates, we used the ONS estimates of the general population as denominators. 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, including outpatients on community treatment orders (CTOs).

Unlike the previous censuses that counted only inpatients, the 2009 census also included outpatients on CTOs on census day. These patients have been included in the analysis presented in this report, even though they are not inpatients, because the census aims to cover all patients subject to the Mental Health Act on census day. Furthermore, analysis of standardised ratios for CTOs for different ethnic groups would not have been possible if CTO patients had been excluded from the analysis. In addition, analysis of the standardised ratios for different sections of the Mental Health Act, for example, would not have been robust if CTO patients had been excluded from the numbers of all patients subject to the Mental Health Act on census day. This issue only affects the sections relating to mental health patients, as there were very few patients with learning disabilities 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 to be made reliably, by taking account of variations in age and gender. The report uses the conventionally accepted statistical methods for taking account of age and gender differences between ethnic groups when calculating these rates.

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

Interpreting the results

In this report, for convenience, we refer to “admission rates” for mental health and learning disability patients. However, these are in fact 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. The “admission rates” for mental health patients include the 3.9% of all mental health patients who were CTO outpatients on census day – ie the rates measure population-based rates for inpatients and for all other patients on a CTO on census day. There were very few learning disability patients on CTOs.

As with any study, our results have some caveats:

1. As in previous years, we used the 2001 census population estimates from ONS to derive the rates of admission. ONS advises that these estimates tend to underestimate the number of people from black and minority ethnic groups.^{16,17} Furthermore, the 2001 estimates are now eight years out of date, during which time there have been significant increases in the size of black and minority ethnic populations. This means that the admission rates presented for them in this report are higher than would be expected. ONS has published population estimates by ethnic group for 2007 for England, and these have also been used for analysing rates of admission by ethnic group for England.¹⁸ However, these estimates are described by ONS as “experimental” and are subject to margins of error. Furthermore, they are not available for Wales, so rates of admission for England and Wales cannot be derived using updated population denominators.

2. The results are not adjusted for diagnosis and other clinical information, so the results 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 socio-economic 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 socio-economic and social factors are known to be associated with the risk of mental illness, and can affect pathways into care and the nature of patients' interaction with services.
4. In some instances, the numbers for some ethnic groups are so small that statistical differences from the general population cannot be demonstrated.
5. 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.
6. 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.
7. The census does not assess the quality of services, the experience of patients or the reasons for any differences found between ethnic groups.
8. 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 previous reports, but includes a small proportion of outpatients (3.9%).

Results: mental health

We collected information on 31,786 patients from the mental health services of 264 NHS and independent healthcare organisations in England and Wales. This included all inpatients and 1,253 patients placed on a Community Treatment Order (CTO) who were not inpatients. The number of inpatients in this census (30,533) was approximately 1.6% lower than in 2008 (31,020 inpatients), continuing the decline in inpatient numbers observed in each census since 2005. The number of inpatients in 2009 was 10% lower than in 2005 (33,785 inpatients) (see Table 1).

All establishments identified as eligible took part in the census. The total number of providers in 2009 continued to show a rise over previous years, primarily due to an increase in the number of independent healthcare providers. In contrast, the number of NHS providers in England was lower than in the baseline year 2005, and did not change in Wales. The proportion of all mental health inpatients cared for by independent providers has risen from 10% in 2005 to 16% in 2009.

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

	NHS (England)	Independent (England)	NHS (Wales)	Independent (Wales)	Total
2009 census					
Number of providers	79	158	10	17	264
Number of of all patients (including CTO outpatients)	24,941	4,594	1,845	406	31,786
% 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 all patients, 76% were White British and 22% belonged to black and minority ethnic groups, defined as all groups that are not White British (White Irish and Other White groups are counted among the black and minority ethnic groups). This compares with 20% in 2005.

Compared with the baseline year of 2005, the 2009 census recorded a lower proportion of patients from the White British and White Irish groups (see Table 2). There were increases in the proportions of patients from the Other White, Black Caribbean and Black African groups, and a fall in the proportion from the Other Black group. Other ethnic groups showed only minor differences over the baseline year.

Table 2: Mental health patients by ethnic group

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

Results: mental health continued

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 28 of the 264 organisations that took part in the census. Of all organisations, 195 had fewer than 50 patients from black and minority ethnic groups each, and another 31 organisations had no patients at all from these groups.

Reporting of ethnicity

Seventy-seven per cent of patients reported their own ethnic group. Where patients did not report their own ethnic group, staff or relatives did so on their behalf (14% and 5% 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 83% in the White groups to about 75% among the Black groups.

Age and gender

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

Overall, 57% of patients were men, a similar proportion to previous years. Men outnumbered women in all ethnic groups except the Chinese (see Table 3). In the White British, White Irish, Other White and Chinese groups, there were 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	3	8	40	18	31	55	45	100 (24,067)
White Irish	2	6	35	18	39	55	44	100 (591)
Other White	3	9	45	18	25	58	42	100 (1,360)
White and Black Caribbean	2	17	71	7	2	71	29	100 (336)
White and Black African	5	16	69	7	2	73	27	100 (91)
White and Asian	9	18	60	11	3	67	33	100 (137)
Other Mixed	9	18	61	7	5	59	41	100 (213)
Indian	2	8	58	19	12	63	37	100 (460)
Pakistani	4	12	64	11	8	73	27	100 (409)
Bangladeshi	4	16	67	6	6	72	28	100 (171)
Other Asian	5	15	59	12	8	69	31	100 (273)
Black Caribbean	1	9	63	14	13	70	30	100 (1,504)
Black African	3	15	71	8	4	65	35	100 (834)
Other Black	3	14	71	8	4	74	26	100 (384)
Chinese	10	6	65	15	5	45	55	100 (82)
Other	3	16	57	11	14	68	31	100 (322)
Total	3	9	44	17	27	57	43	100
	(n=932)	(n=2,733)	(n=14,116)	(n=5,376)	(n=8,627)	(n=18,209)	(n=13,505)	(n=31,786)

Language and religion

As in previous censuses, 6% 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. Among the White Other group, 28% had a first language other than English. About 2% of patients said they needed an interpreter, and of these, 21% were from the White British group.

Religion was not stated for 19% 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/Asian Mixed group, and lowest among the South Asian groups. Table 5 shows the religion of patients.

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

Ethnic group	% with first language other than English (n)
White British	2 (423)
White Irish	2 (12)
Other White	28 (374)
White and Black Caribbean	3 (9)
White and Black African	8 (7)
White and Asian	7 (9)
Other Mixed	10 (22)
Indian	32 (146)
Pakistani	35 (143)
Bangladeshi	50 (86)
Other Asian	42 (116)
Black Caribbean	5 (71)
Black African	26 (221)
Other Black	21 (80)
Chinese	56 (46)
Other	49 (159)
Total	6 (1,970)

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	16.1	59.8	0.5	0.0	0.6	0.4	0.0	3.2	19.3
White Irish	7.6	72.8	0.7	0.0	0.2	0.5	0.0	8.5	9.8
Other White	13.4	56.7	0.7	0.1	2.4	4.2	0.1	5.1	17.3
White and Black Caribbean	19.3	52.4	0.6	0.0	0.6	3.3	0.0	5.4	18.5
White and Black African	11.0	41.8	1.1	0.0	2.2	9.9	0.0	8.8	25.3
White and Asian	22.6	32.1	0.0	5.1	0.0	15.3	2.9	2.2	19.7
Other Mixed	19.7	39.4	0.5	2.3	0.9	10.3	0.5	5.2	21.1
Indian	6.5	9.8	0.4	32.6	0.0	14.3	23.0	1.1	12.2
Pakistani	3.7	4.6	0.0	1.2	0.0	76.5	1.5	1.5	11.0
Bangladeshi	4.1	0.6	0.6	0.6	0.0	78.9	1.8	0.6	12.9
Other Asian	6.2	12.8	4.4	12.5	0.0	34.1	7.0	4.0	19.0
Black Caribbean	14.9	56.9	0.2	0.1	0.1	2.5	0.1	6.8	18.4
Black African	9.1	50.4	0.4	0.4	0.4	20.6	0.1	3.5	15.2
Other Black	11.7	43.2	0.3	0.3	0.3	15.6	0.3	5.7	22.7
Chinese	19.5	31.7	12.2	0.0	0.0	3.7	0.0	3.7	29.3
Other	11.8	23.0	2.2	0.9	2.8	34.2	0.0	5.9	19.3
Total	15.0	55.8	0.6	0.7	0.7	3.9	0.5	3.6	19.3

Sexual orientation

The results for sexual orientation were not valid for 1% of patients, and for 19% of patients the response was recorded as “not known”. Seventy-seven per cent of patients said they were heterosexual, 1% said gay/lesbian, 1% said bisexual, and less than 1% said “other”.

The overall figure of 2% who said they were gay/lesbian or bisexual is lower than the estimated proportions of gay/lesbian or bisexual people in the general population (5% to 7%).^{19,20} The number of minority ethnic patients who were gay/lesbian or bisexual was very low.

Disability

About 73% of patients said they did not have a disability, and 27% said they had one or more disability. Of these, 7% were blind or visually impaired, 2% were deaf or had a hearing impairment, 2% had a learning disability, 1% had Autistic Spectrum Disorder, 4% had a mobility impairment and 2% used a wheelchair. The remaining 9% had more than one disability. The proportion of patients with a disability was highest among the White British, White Irish and Other White groups (between 30-32%), which could reflect the higher age profiles of these patients compared with other ethnic groups.

Rates of admission

(see section on interpreting the results)

The rates of admission are given in Appendix B, in Tables B1a (all ages) and B1b (ages 65 and over). We used the estimates from the Office for National Statistics (ONS) of the general population as denominators in deriving the admission rates.

All ages

Using the 2001 census population estimates from the ONS, admission rates for both men and women from the White British, Indian and Chinese groups were lower than the average, and those for other ethnic groups were higher than the average. They were particularly high for the Black and White/Black Mixed groups, with rates three or more times higher than the average. As in previous years, the highest rate – nine times higher than average – was among the Other Black group, although this was a decline over 2005 when it was almost 14 times higher than average.

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

Ages 65 and over

Age-standardised admission rates for minority ethnic groups at older ages show broadly similar patterns to those reported for all ages, although results for some minority groups failed to reach significance because of the small numbers involved.

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

Changes in population estimates

The number of people from black and minority ethnic groups in England and Wales has increased significantly since 2001. ONS has produced updated population estimates by ethnic group for 2007, which aim to reflect these changes. ONS describes these estimates as “experimental”, and they are subject to margins of error. These updated population estimates are available for England but not for Wales. Furthermore, they do not reflect the demographic changes between 2007 and 2009. With these caveats, we have used the 2007 population estimates to re-calculate the admission rates for England (Appendix B, Table B2). Admission rates using the 2001 populations are also presented for comparison.

The results show that using the 2007 ONS population estimates instead of the 2001 estimates results in a slight increase in the admission rates for the White British and White Irish groups, and significantly reduces the admission rates for minority ethnic groups. Overall admission patterns remain largely the same.

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, so the results for referrals from community mental health teams may include referrals from other sources, such as GPs and accident and emergency (A&E) departments. Furthermore, about a third of patients were referred from tertiary care, and information about their original referral source was not available. In the case of 7% of all patients, information about the source of referral was not known. Finally, 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.

The referral patterns are broadly similar to those reported previously, and the key results are presented below. The detailed results for sources of referral are available at:

www.cqc.org.uk/guidanceforprofessionals/healthcare/allhealthcarestaff/countmeincensus.cfm

GP referrals

Ten per cent of patients were referred by a GP. Rates were 8% higher than average among the White British group. They were lower than average among the Other White, Black Caribbean, White/Black Caribbean Mixed, Black African and Other groups by 26% to 64%. The rates of referral by GPs are given in Appendix B, Table B3.

Referrals from A&E departments

Five per cent of patients were referred by A&E departments. The White British group had a 7% lower than average rate of such referrals. The Bangladeshi, Other Asian, Black African and Chinese groups were more likely than average to be referred in this way.

Referrals from community teams

Just over a quarter (27%) of patients were referred by community teams. For the White British group, such referrals were 4% higher than the average rate. They were about 23% lower than average among the Black Caribbean, Black African and White/Black Caribbean Mixed groups, and about 18% lower among the White Irish and Other White groups. The rates of referral are given in Appendix B, Table B4.

Referrals from the criminal justice system

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

Patients from the White British and Other White groups were less likely than average to be referred in this way, whereas the Black Caribbean, Black African and White/Black Caribbean Mixed groups were 40–60% more likely than average to be referred via the criminal justice agencies. We observed no differences from the average rate for other ethnic groups. Rates of referral via the criminal justice system are given in Appendix B, Table B5.

Tertiary care: referrals from medium or high secure units

A significant proportion (36%) of all referrals were from tertiary care. Five per cent of patients were referred from medium or high secure units in both the NHS or independent sectors. The rate for such referrals was lower than average among the Other White, Indian and Bangladeshi groups. It was higher than average among the White Irish and Black Caribbean groups by 42% and 80% respectively.

Tertiary care: referrals from other inpatient services

Twenty-one per cent of patients were referred from other inpatient services, NHS and independent. The rate for such referrals was higher than average among the White Irish, Other White and White/Black Caribbean Mixed groups by 19%, 58% and 26% respectively. The rate was lower than average in the White British and Bangladeshi groups.

Tertiary care: referrals from other clinical specialties

Ten per cent of patients were referred by other clinical specialties. Rates of such referrals were higher than average among the Indian group, and lower than average among the White Irish, Other White, White/Black African Mixed and Black African 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 are reflected in the 2009 census, 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. After that, we present an analysis of community treatment orders (CTOs) on census day.

All detentions

Forty-seven per cent (15,092) of patients were detained under the Mental Health Act on the day of admission to hospital. This was a higher proportion than recorded in the previous censuses: 45% in 2008, 43% in 2007, and 40% in 2005 and 2006.

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 Other White group by 13%, but no other ethnic differences were observed. The rates of detention are given in Appendix B, Table B6.

These patterns are broadly similar to those reported in previous censuses. Detention rates have been higher than average among the Black Caribbean, Black African and Other Black groups in all five annual censuses conducted from 2005 to 2009, with no evidence of a decline from the baseline of 2005. Detention rates were higher than average among the Other White group in the three most recent 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 the patients detained under the Mental Health Act, 20% were detained under section 2. Rates of detention under this section were higher than average among the Other White, Bangladeshi, Other Asian, Black African, Other Black, Chinese and Other groups by between 22% and double (see Appendix B, Table B7).

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

Detention under section 3

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

Of all the patients detained under the Mental Health Act, 45% were detained under this section. Rates were higher than average among the Black Caribbean, Other Black and White/Black African Mixed groups by 30%, 27% and 44% respectively. The rate was also higher in the Other White group by 13%. The rates of detention under section 3 are given in Appendix B, Table B8.

No ethnic differences were observed for detentions under section 3 in 2005 and 2006, although detention rates in the most recent three censuses were higher than average among the Black Caribbean and Other Black groups.

Detention under section 37/41

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

Of the patients detained under the Mental Health Act, 13% were detained under section 37 with a section 41 restriction order applied. The rates of detention are given in Appendix B, Table B9. The rate of detention for the White British group was 12% lower than average, but was higher than average in the White/Black Caribbean Mixed group by 89%, the Black Caribbean group by 107% and the Other Black group by 28%. In all ethnic groups, very few women were detained under section 37/41.

A consistent pattern across all five 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 the patients detained under the Mental Health Act, 6% were detained under these sections. The only ethnic difference observed was a 49% higher than average detention rate among Black Caribbean 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.

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

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

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 necessary.

Of the 1,371 patients on CTOs, 9% were aged between 18 to 24 years, 63% were aged between 24 to 49 years, and the remaining patients were over 50. Almost two thirds (65%) of these patients were men.

Four per cent of all patients were on CTOs. The ratios are given in Appendix B, Table B11. Information about ethnicity was “not stated” for about 8% of the 1,371 patients subject to section 17A, and these patients had to be omitted from the analysis. The results presented here are therefore subject to caution. The rate of supervised treatment for the White British group was 9% lower than average. The rate was lower also for the White Irish group, but this was based on very few patients. The rate was higher than average in the Indian, Bangladeshi, Black Caribbean and Other Black groups by 43% to 87%.

Consent

About 26% of informally admitted patients were deemed incapable of consenting to treatment. We did not observe any ethnic differences.

About 20% 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 Black Caribbean and Black African groups by 27% and 41% respectively.

In addition, 13% of patients who were detained or on CTOs were deemed capable of consenting to treatment but refused to do so. The White British group had a rate of refusals that was 11% lower than average, and rates were higher than average among the three Black groups (Black Caribbean, Black African, Other Black) and the White/Black Caribbean Mixed groups. Rates were also higher among the Indian group.

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, co-ordinated and understood by all involved. The characteristics of those needing ‘enhanced’ CPA are people who need: multi-agency support; active engagement; intense intervention; support with dual diagnoses and who are at higher risk, whereas ‘standard’ CPA is used to describe those with more straightforward needs in secondary mental health services. However, from October 2008, changes to the CPA in England mean that there is no longer a two-part categorisation of CPA into ‘standard’ and ‘enhanced’ and just the one category of enhanced CPA applies. This makes CPA policy in England different to that in Wales, where there has been no policy change and the distinction still applies. The CPA data presented here therefore include only enhanced CPA patients in England, and both ‘standard’ and ‘enhanced’ CPA patients in Wales.

About 87% 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 10% were on neither CPA nor SAP. As most patients were on a CPA, no ethnic differences were observed.

Recorded incidents

The 2009 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. 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

Four per cent of patients had experienced one or more episodes of seclusion. The White British group had a seclusion rate that was 10% lower than average. The only ethnic differences observed were the higher than average rates among the Other White and White/Black Caribbean Mixed groups, by 64% and 90% respectively.

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

- The proportion of all patients who had an episode of seclusion stayed fairly constant over the five censuses at about 4%.
- The seclusion rate was higher than average for the three Black groups (Black Caribbean, Black African, Other Black) in two or more of the first four censuses to 2008, but not in 2009.

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 11% of patients had experienced one or more episodes of hands-on restraint. The only ethnic difference observed was the 28% lower than average rate among the Black Caribbean group. Ethnic differences in rates of hands-on restraint have not shown a consistent pattern over the five censuses.

Self-harm

Seven 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 the three Black groups (Black Caribbean, Black African and Other Black) by 52% to 79%, and among the Asian groups by 61% to 73%.

In terms of comparison with previous years:

- The proportion of all patients who had harmed themselves stayed fairly constant at about 7%.
- In all censuses, the White British group had a higher than average rate of self-harm, and the Black and South Asian groups had a lower than average rate 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 4% higher than average. Rates were lower than average in the Black Caribbean and Pakistani groups by 61% and 54% respectively.

In terms of comparisons with previous years:

- The proportion of all patients who had had an accident stayed fairly constant.
- The Black Caribbean group had a lower than average rate of accidents in all censuses, but rates for other minority ethnic groups were variable.

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. Ten per cent of patients were involved in one or more episodes of physical assault. The only ethnic difference observed was a 53% higher than average rate among the White/Black Caribbean Mixed group.

In terms of comparisons with previous years:

- The proportion of all patients who had experienced a physical assault stayed fairly constant.
- Patterns for minority ethnic groups were variable.

Duration of stay in hospital

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.

- 25% of inpatients had been in hospital for one month or less
- 21% 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
- 10% had been in hospital between one and two years
- 11% had been in hospital between two and five years
- 8% had been in hospital for more than five years
- It was not possible to derive length of stay for 1% (380) of inpatients.

These patterns in the length of stay are very similar to those of previous censuses. About 29% of patients in the 2009 census had been in hospital for more than a year, and had therefore also been included in the 2008 census. Another 20% of patients had been in hospital for more than two years, and will have been included in both the 2007 and 2008 censuses, and 8% of patients will have been included in all the censuses since 2005.

We calculated the median length of stay for different ethnic groups. The median is the midpoint of the range of values, so the median length of stay for a given ethnic group is the one at which half the patients of that ethnic group had a length of stay less than the median, and half had a stay longer than the median. Overall, and as in previous years, the median amount of time that women had spent in hospital was about two and a half months, and the median for men was about five and a half months (see Table 6). In most ethnic groups, men had been in hospital for about twice as long as women.

Median lengths of stay were among the longest for patients from the Black Caribbean and White/Black Caribbean Mixed groups, and among the shortest for patients from the Chinese, South Asian, African and White British groups. These patterns are similar to those observed for previous years.

It is important to note that a number of factors influence a patient's length of stay in hospital, including age, gender, whether or not they are detained 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	Persons	Men	Women
White British	106	152	71
White Irish	149	201	102
Other White	155	218	106
White and Black Caribbean	258	322	154
White and Black African	154	208	112
White and Asian	184	215	180
Other Mixed	175	267	96
Indian	104	142	76
Pakistani	112	144	60
Bangladeshi	75	87	49
Other Asian	85	103	76
Black Caribbean	207	262	123
Black African	110	152	61
Other Black	140	146	116
Chinese	85	195	56
Other	80	92	58
Total	112	159	75

Ward security

As in 2007 and 2008, about 12% of all patients were on a medium or high secure ward, as opposed to a general (74%) or low secure (14%) 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 10%, 37% and 36% respectively. Patients from the Black Caribbean, Black African, White/Black Caribbean Mixed and White/Black African Mixed groups had a higher than average rate (by up to 72%) for being on a medium or high secure ward. Patients from the White Irish and Other Mixed groups were also more likely to be on such wards.

Age range on wards

There were 107 patients under 18 years of age being cared for on wards for working-age adults and one patient was on a ward for older people. Almost 6% of patients on wards for working-age adults were 65 or over, and 9% 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. Overall, 67% of patients (men 59%, women 76%) were not in a single sex ward, similar proportions as in 2007 and 2008. The proportion of patients not in a 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 single sex ward was lower than among women (see Table 7a on the next page).

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

* 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).

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

Ethnic group	Sex of patients intended to use a ward					
	Male		Female		Persons	
	Male ward	Female or mixed ward*	Female ward	Male or mixed ward*	Appropriate ward	Inappropriate or mixed ward*
White British	37	63	22	78	30	70
White Irish	41	59	25	75	34	66
Other White	42	58	29	71	36	63
White and Black Caribbean	62	38	36	64	54	46
White and Black African	58	42	28	72	49	50
White and Asian	49	51	29	71	42	58
Other Mixed	52	48	29	71	42	57
Indian	41	59	27	73	36	64
Pakistani	52	47	38	62	49	51
Bangladeshi	38	62	29	71	36	64
Other Asian	45	55	27	73	40	60
Black Caribbean	62	38	33	67	53	47
Black African	58	42	38	62	51	49
Other Black	46	54	30	70	42	58
Chinese	32	68	16	84	23	77
Other	51	49	21	79	41	58
Total	41	59	23	77	33	67

* The vast majority of patients in this category were in mixed wards; very few (0.1%) 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 has access to toilet and bathing facilities designated for single sex use.

Overall, 19% of men and 24% of women were reported as not having access to toilet and bathing facilities designated for single sex use. 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

Ethnic group	Access to single sex bathing and toilet facilities					
	Male		Female		Persons	
	Male facilities	Female or mixed facilities*	Female facilities	Male or mixed facilities*	Appropriate facilities	Inappropriate or mixed facilities*
White British	80	20	76	24	78	22
White Irish	83	17	78	22	81	19
Other White	82	18	75	25	79	20
White and Black Caribbean	91	9	85	15	89	11
White and Black African	83	17	80	20	82	18
White and Asian	85	15	89	11	86	14
Other Mixed	87	13	91	9	88	11
Indian	80	20	80	19	80	19
Pakistani	88	12	79	21	86	14
Bangladeshi	84	16	90	10	85	15
Other Asian	86	14	86	14	86	14
Black Caribbean	85	15	78	22	83	17
Black African	86	14	84	16	85	14
Other Black	79	21	84	16	80	20
Chinese	76	24	67	33	71	29
Other	88	12	77	23	84	16
Total	81	19	76	24	79	21

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

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

We also asked providers if patients had access to a lounge and area/day space designated for single sex use. Overall, 48% of men and 51% of women

were reported as not having access to a lounge and area/day space designated for single sex use. The proportion of patients not having access to a lounge and 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 and area/day space designated for single sex use by ethnic group

Ethnic group	Access to a lounge and area/day space					
	Male		Female		Persons	
	Male facilities	Female or mixed facilities*	Female facilities	Male or mixed facilities*	Appropriate facilities	Inappropriate or mixed facilities*
White British	50	50	49	51	49	51
White Irish	48	52	50	50	49	51
Other White	54	46	52	48	53	47
White and Black Caribbean	70	30	59	41	67	33
White and Black African	64	36	72	28	66	34
White and Asian	60	40	56	44	58	42
Other Mixed	62	38	59	41	60	40
Indian	48	52	48	52	48	52
Pakistani	55	45	53	47	54	46
Bangladeshi	46	54	56	44	49	51
Other Asian	53	47	57	43	54	46
Black Caribbean	64	36	50	50	59	41
Black African	62	38	59	41	61	39
Other Black	51	49	54	46	52	48
Chinese	54	46	47	53	50	50
Other	58	42	52	48	56	44
Total	52	48	49	51	41	49

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

Results: learning disabilities

We obtained information about 3,695 patients in 123 organisations providing services for people with learning disabilities in England and Wales. Of these, four were outpatients on CTOs. These organisations comprised all 65 NHS trusts and 58 independent healthcare organisations that were eligible to take part in the census.

The total number of providers did not change much from the baseline year (see Table 8). However, the number of inpatients has declined each year, and by 20% from 4,609 in 2006 to 3,691 in 2009.

The proportion of inpatients in independent healthcare organisations increased from 20% in 2006 to 27% in 2009, with a corresponding decline in the proportion of patients in NHS providers.

The pattern of results for learning disability patients in 2009 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
2009 census					
Number of providers	60	54	5	4	123
Number of all patients (including CTO outpatients)	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 99% of patients. Of all patients, 13% belonged to black and minority ethnic groups, defined as all groups that are not White British (White Irish and Other White groups are counted among the black and minority ethnic groups) (see Table 9). This figure is slightly higher than in previous years, and is significantly lower than the 22% 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 2009 in the proportion of patients from the Other White group, and a fall in those from the Black Caribbean group. Some ethnic groups had very few patients.

Table 9: Learning disability patients by ethnic group

Ethnic group	2009 census		2008 census		2007 census		2006 census	
	%	Number	%	Number	%	Number	%	Number
White British	86.7	3205	88.9	3,616	88.3	3,642	88.7	4,037
White Irish	1.5	57	1.3	53	1.0	40	1.4	66
Other White	2.3	85	2.6	104	2.6	109	1.7	77
White and Black Caribbean	1.0	36	0.7	29	0.8	34	0.7	32
White and Black African	0.1	4	0.0	2	0.2	10	0.1	3
White and Asian	0.4	14	0.3	12	0.3	13	0.2	9
Other Mixed	0.5	19	0.3	14	0.4	16	0.3	14
Indian	0.9	35	0.7	28	0.8	32	1.1	49
Pakistani	0.9	33	0.7	30	0.8	32	0.7	34
Bangladeshi	0.6	21	0.3	11	0.3	11	0.2	9
Other Asian	0.3	10	0.3	12	0.2	8	0.3	12
Black Caribbean	2.2	81	2.3	94	2.6	108	2.8	129
Black African	0.9	35	0.7	29	0.8	33	0.7	33
Other Black	0.4	14	0.4	15	0.4	18	0.4	17
Chinese	0.1	2	0.1	5	0.2	8	0.2	7
Other	0.2	8	0.4	15	0.2	10	0.5	24
Not stated	1.0	36	0.9	38	0.7	29	1.2	57
Invalid								
Total	100	3,695	100	4,069	100	4,124	100	4,552

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 30 of the 123 organisations that took part in the census. Eighty-one organisations had fewer than 10 patients from black and minority ethnic groups each, and another 32 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 (49%) of patients reported their own ethnic group. Staff reported the ethnic group for 24% of patients, and relatives for 22%. It is therefore possible that ethnicity could have been misreported for some patients. It is not known how ethnicity was assessed for 5% of patients.

Age and gender

Four per cent (145) of patients were under 18 years old. The number of young inpatients from minority ethnic groups was low in several ethnic minority groups.

Overall, 76% of patients were under 50 years old, and 24% were aged 50 or over. The proportion of patients under 50 was higher among patients from black and minority ethnic groups (over 86%) than among the White British group (74%). 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 57% 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 6% of inpatients.

Religion was not recorded for 22% of patients, and 13% of patients said they had none. 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 (47%) of patients. Of those who answered the question about sexual orientation, 45% said they were heterosexual, 2% said gay/lesbian, 3% said bisexual, and 1% said 'other'. The numbers of patients in minority ethnic groups were too low for meaningful analysis.

Disability

Of all patients in learning disability services:

- 3% were reported as having no disabilities
- 44% had a learning disability only
- 52% 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 are given in Appendix C, Table C1. We used the ONS estimates of the general population as denominators in deriving the admission rates.

Admission rates were lower than average among the Other White, Indian, Pakistani, Other Asian, Chinese and Other groups by 22% to 90%. They 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 Indian 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 very similar to those we reported in previous census reports.

Changes in population estimates

The number of people from black and minority ethnic groups in England and Wales has increased significantly since 2001. ONS has produced updated population estimates by ethnic group for 2007, which aim to reflect these changes. ONS describes these estimates as “experimental”, and they are subject to margins of error. These updated population estimates are available for England but not for Wales. Furthermore, they do not reflect the demographic changes between 2007 and 2009. With these caveats, we have used the 2007 population estimates to re-calculate the admission rates for England (Appendix C, Table C2).

The results show that using the 2007 ONS population estimates instead of the 2001 estimates results in a slight increase in the admission rates for the White British and White Irish groups, and significantly reduces the admission rates for minority ethnic groups. Overall admission patterns remain largely the same.

Source of referral

As we reported in the section on mental health patients, we must be careful when interpreting data about sources of referral, since the original referral source is not always known. Furthermore, in the case of inpatients with learning disabilities, this information was invalid, missing or unknown for 14% of patients.

Because of the small numbers of patients in most minority ethnic groups, we observed few ethnic differences in sources of referral. The results are available at: www.cqc.org.uk

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. These changes are reflected in the 2009 census, which collected information on new provisions establishing supervised community treatment (section 17A).

All detentions

Of all the patients in learning disability services, 45% were detained under the Mental Health Act on admission. Of these, 18% were from minority ethnic groups.

Rates of detention on the day of admission by ethnic group are in Appendix C, Table C3. As in previous years, few ethnic differences were observed. The only exceptions were the higher than average rates among the Other White and Black African groups.

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

Consent

About 70% of informally admitted inpatients were deemed incapable of consenting to treatment, which is a similar proportion to that reported previously. The numbers of such patients in minority ethnic groups were too low for comment.

Among detained patients, 37% were deemed incapable of consenting to treatment. The only ethnic difference observed was the higher than average rate for the Black African group, but this was based on small numbers of patients.

In addition, 7% of detained patients were deemed capable of consenting to treatment but refused. There were no or very few such patients among minority ethnic groups.

Care programme approach

The care programme approach (CPA) provides support for people with long-term mental health needs. From October 2008 there were changes to CPA in England, whereby there is no longer a two-part categorisation of CPA into 'standard' and 'enhanced'. The term 'standard' was used to describe those with more straightforward needs in secondary mental health services, as distinct to 'enhanced' services for those with more complex needs. From 2008 just the one category of enhanced CPA applies. The current characteristics of those needing enhanced CPA are described as people who need: multi-agency support; active engagement; intense intervention; support with dual diagnoses; and who are at higher risk. This makes CPA policy in England different to that in Wales, where there has been no policy change and the distinction still applies. The CPA data presented here therefore include only enhanced CPA patients in England, and both 'standard' and 'enhanced' CPA patients in Wales.

We found that 69% of all inpatients were on a CPA, 2% on a single assessment process (SAP) and 29% on neither. The only ethnic difference observed was the higher than average rate for being on a CPA among the Black Caribbean group.

Recorded incidents

The 2009 census asked about the number of times that patients experienced seclusion, hands-on restraint, self-harm, accident and physical assault in the 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. The patterns are similar to those observed previously.

Seclusion

Five per cent of inpatients had experienced one or more episodes of seclusion. The only ethnic difference observed was a higher than average rate among the Other White group.

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 25% of inpatients had been involved in one or more episodes of physical assault. The only ethnic difference observed was a higher than average rate among the White/Black Caribbean group, however, this was based on only 17 patients.

Hands-on restraint, self-harm, accidents

Twenty-seven per cent of inpatients had experienced one or more episodes of hands-on restraint, 21% had attempted to harm themselves and 22% had suffered an accident. The numbers were very low in minority ethnic groups, and we did not observe any ethnic differences.

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.

- 8% 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
- 11% had been in hospital between six months and one year
- 13% had been in hospital between one and two years
- 23% had been in hospital between two and five years
- 32% had been in hospital for over five years.

The patterns were very similar to those in previous censuses. About 68% of patients in the 2009 census had been in hospital for more than a year, and were therefore included also in the 2008 census. In addition, over half (55%) of patients had been in hospital for more than two years, and will have been included in both the 2007 and 2008 censuses. A third of patients will have been included in each census since 2006.

We also calculated the median length of stay. The median is the mid-point of the range of values, so the median length of stay is the one at which half

the patients had a length of stay less than the median, and half had a stay longer than the median. Overall, the median amount of time that women had spent in hospital was about 33 months, and the median for men was about 31 months. This compares with a median for mental health patients of two and a half months for women and five and a half 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 (58%) or low secure (30%) ward.

As in 2007 and 2008, rates of inpatients on medium or high secure wards were about double the average among the White Irish and Other White groups. The rate was higher also in the Black Caribbean group. Most minority ethnic groups had very few inpatients on medium or high secure wards.

Age range on wards

There were 18 inpatients under 18 years of age being cared for on wards for working-age adults and none were on wards for older people. About 4% (150) of inpatients on wards for working-age adults were aged 65 or over, and there were very few patients (36) on wards for older people. These figures are similar to those for previous years. 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, 48% of men and 73% of women were not in a single sex ward. The numbers of such patients among minority ethnic groups were very low.

Three 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

We asked providers if the patient has access to toilet and bathing facilities designated for single sex use. Overall, 22% (563) of men and 35% (394) of women were reported as not having access to toilet and bathing facilities designated for single sex use.

Please note that guidance by the Department of Health states that "toilet and washing facilities don't need to be designated as same-sex, as long as they accommodate only one patient at a time, and can be locked by the patient (with an external override for emergency use only)."

www.dh.gov.uk/en/Healthcare/Samesex/accommodation/Questionsandanswers/index.htm

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

We asked providers if the patient has access to a lounge and area/day space designated for single sex use. Overall, 37% (948) of men and 53% (590) of women were reported as not having access to a lounge and area/day space designated for single sex use.

* 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).

Conclusions

Implications for ways forward

Overall, the findings from the 2009 census are similar to those of previous annual censuses conducted since 2005. This is not surprising, as many patients had been in hospital for a considerable period of time, and had therefore been included in previous censuses. The findings of this fifth census continue to show differences between black and minority ethnic groups and white groups, and also differences within these groups.

It provides us with some information about patients on community treatment orders (CTOs), newly introduced in 2008 under the Mental Health Act 2007. These rates were higher than average among some minority ethnic groups, however, as ethnicity was not available for many of these patients, the results should be viewed with caution. The Care Quality Commission makes recommendations in this report for improved data on all patients in mental health and learning disability services, including those on CTOs. We will also be undertaking analyses of other data sets to examine issues relating to patients on CTOs.

The census was designed to support the goals of the Government's five-year DRE plan by providing an annual profile of inpatients in mental health services and those detained under the Mental Health Act. It cannot in itself provide explanations for the patterns observed, or examine whether mental health services are meeting the needs of individual ethnic minority groups. However, since the first census in 2005, the data does show that there has been no reduction in rates of admission, detention under the Mental Health Act and seclusion – key goals of DRE – among black and minority ethnic groups. The results contain caveats that must be considered when interpreting the results (see section on data, methods of analysis and interpretation).

As noted in previous reports, the census findings 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 socio-economic disadvantage that contribute to these differences (see the 2008 census report⁶ for details of references). Previous reports have also 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 service users themselves will need to work in partnership. Within health and social care, CQC has a unique opportunity to ensure that services retain a strong focus on these factors through the forthcoming registration of provider organisations, assessment of commissioning bodies, and its responsibility for coordinating regulatory activity within the system.

This message about preventing mental ill-health, by addressing the contributory factors and intervening early, is now at the heart of *New Horizons*, the Department of Health's vision for the future of mental health care in England to 2020.⁹ *New Horizons*, the successor to the National Service Framework (NSF) for mental health from 2009, has a cross-government and cross-sectoral focus on prevention and the mental wellbeing of the population, early intervention and personalised care. It marks a widening of policy focus from specialist services in isolation to a public health approach to mental wellbeing as well, making mental health "everybody's business". It also recognises that levels of mental illness and the ways in which people use mental health services vary between different ethnic groups, reflecting the socio-economic disadvantage that people from black and minority ethnic groups often experience.

Lord Bradley's review of services for people with mental health problems or learning disabilities in the criminal justice system highlights the need for early intervention and diversion from custody.²¹ It makes a number of recommendations for those who commission services in the NHS and other statutory agencies for improving the health (primary and specialist inpatient) and social care services available for such groups, including those with dual diagnosis, and those in prison. It highlights the need for health, social care and criminal justice services to work in partnership to achieve this, and makes a number of recommendations for compulsory inclusion in the NHS standard contract for mental health and learning disabilities. Its recommendations include the need for better data collection about people with mental health problems or learning disabilities in the criminal justice system.

CQC strongly endorses both these initiatives. If implemented effectively, they offer real prospects for addressing the underlying causes of mental ill health in black and minority ethnic communities, and for improving care pathways and outcomes for those who require mental health and social care services, including for those who enter the criminal justice system.

Overall, the level of provision of single sex wards continues to show considerable room for improvement, with 67% of patients in mixed wards. However, there was no evidence that minority ethnic patients were disadvantaged in these respects.

The data collected for the census shows a snapshot of patients on one day only. CQC will explore patterns of ethnicity and mental health further in other data sets.

The importance of information

The availability of comprehensive patient-level data sets with ethnicity and other key variables fully coded is vitally important for a range of reasons.²² It enables the care provided to patients of all ethnic backgrounds to be monitored on an ongoing basis, irrespective of the place of treatment. It also supports the monitoring of compliance with the Race Relations Act and the Department of Health's standards. Having information that is fit for purpose is also vital for the effective regulation of mental health and learning disability services. The Hospital Episode Statistics (HES) and Mental Health Minimum Data Set (MHMDS) are mandated data sets for NHS trusts, in which the recording of ethnicity for patients is compulsory. However, the quality, coverage and completeness of ethnicity data in mental health services is not comprehensive, and improved recording and data quality must be a priority for the NHS and, in particular, for independent providers.²³⁻²⁵

CQC expects those who commission and provide mental healthcare in the NHS and independent sector to have systems for fully comprehensive recording and monitoring of ethnicity on an ongoing basis, in accordance with guidance provided by the Department of Health.²⁶ We use these data sets to assess the performance of NHS organisations, and those with poor quality data will be penalised in our reviews of performance. The Information Centre's bulletin on the MHMDS highlights its usefulness in providing information for planning services and monitoring the processes and outcomes of care, although the MHMDS does not currently cover independent providers of mental healthcare.²⁷

A further issue relating to patients with a learning disability concerns the recording of disability, including learning disability, which is currently not a requirement in the data routinely collected by the Department of Health. The lack of a nationally agreed classification for disability has hampered data collection, but such a classification is currently under development for use across all government departments.

The census counts patients on one day of the year. It is important to remember that the number of inpatients throughout the year is much higher, and that some patients will have more than one admission. Previous census reports have consistently highlighted the need for commissioners and providers to make full use of other available data sets, such as (HES and the MHMDS, which provide information about all patients receiving mental healthcare during the year, including those receiving community mental health services (MHMDS). The Information Centre's recent report on access to community and inpatient services by various demographic characteristics, including ethnicity, illustrates the wealth of information that is available to providers and commissioners of services.²⁷

Recommendations

Based on these findings, we recommend the following actions for mental health, learning disability and social care services:

1. Health and social care organisations should work with other statutory agencies (including police, courts, housing and education), non-statutory or voluntary agencies, and with minority ethnic communities, towards achieving the goals of DRE and the vision of mental wellbeing set out in *New Horizons*.
2. Statutory agencies, working in partnership with others, should understand the demographic and clinical needs of their local populations, and commission and deliver fair, personalised and effective services that reduce mental ill-health among black and minority ethnic groups, improve pathways to healthcare for those who need mental health care, and improve the experience of those who are admitted to hospital.
3. Commissioners and providers of mental health and learning disability services should make renewed and strenuous efforts to improve the provision of single sex accommodation for inpatients.

4. Commissioners and providers of mental health and learning disability services, in both the NHS and the independent sector, should have fully comprehensive systems to record and monitor ethnicity.

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

5. Submission of the MHMDS and HES is made mandatory for all independent providers of mental health and learning disability services, especially in view of the growing number and proportion of all mental health and learning disability patients cared for in these establishments. Submission of these data sets should be a requirement in the mental health standard contract, currently under development by the Department of Health.
6. The Information Centre should routinely monitor and publish reports on the quality of MHMDS data submitted by all providers of mental health services, including those in the independent sector. These assessments of data quality should also include the quality of data on community treatment orders.
7. The Information Centre should routinely publish data on all admissions, detentions and community treatment orders under the Mental Health Act in England (in both NHS and independent healthcare providers) by the ethnicity of patients, with the longer term aim of the MHMDS being the definitive source of information about mental health patients, including on detentions.

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

References

1. Department of Health, *High quality care for all: NHS Next Stage Review final report*, June 2008
2. Department of Health, *World class commissioning: competencies*, December 2007
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. Department of Health, *Delivering race equality in mental health care: an action plan for reform inside and outside services*, 2005
8. Welsh Assembly Government, Adult Mental Health Services, *Raising the standard – Race Equality Action Plan for Adult Mental Health Services in Wales*, October 2006. www.wales.nhs.uk/documents/raceequalityEBOOK-15-11-6.pdf
9. Department of Health, *New horizons: a shared vision for mental health*, 2009. www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_109708.pdf
10. Department of Health, *Valuing people: a new strategy for learning disability for the 21st century*, 2001
11. Department of Health, *Valuing people now: a new three year strategy for people with learning disabilities*, 2009
12. Department of Health, *Healthcare for all, report of the independent inquiry into access to healthcare for people with learning disabilities*, 2008
13. Joint Committee on Human Rights, *A life like any other? human rights of adults with learning disabilities* (2008 HL Paper 40-1 HC 73-1), House of Lords, House of Commons, 2008
14. Disability Rights Commission, *Equal treatment investigation*, 2005
15. Department of Health, Mir G, Nocon A, Ahmad W, Jones L *Learning difficulties and ethnicity*, 2000
16. Office for National Statistics, Table ST101 Sex and age by ethnic group 2001 Census: Standard Tables
17. Office for National Statistics www.statistics.gov.uk/census2001/onc.asp www.statistics.gov.uk/StatBase/Product.asp?vlnk=10721&Pos=2&ColRank=1&Rank=272
18. ONS experimental population estimates by ethnic group, 2007. www.statistics.gov.uk/StatBase/Product.asp?vlnk=14238

References continued

19. *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&sSheet=/news/2005/12/12/ixhome.html
20. Department of Trade and Industry, Amendment to Employment Equality (Sexual Orientation) Regulations 2003, 2003
21. 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. www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_098699.pdf
22. Raleigh V S, *Collection of data on ethnic origin in England*. Editorial, *BMJ* 2008;337:645-6
23. Aspinall P J, *Informing progress towards race equality in mental healthcare: is routine data collection adequate?* *Advances in Psychiatric Treatment*, 2006;12:141-151
24. Deery A, Raleigh V S, *Care quality data is too hard to pin down: data about the care of people with mental illness in the independent sector is inadequate*. *HSJ*, 10 April 2008
25. Raleigh V S, Polato G M, Bremner S A, Dhillon S, Deery A, *Inpatient mental healthcare in England and Wales: patterns in NHS and independent healthcare providers*. *J Royal Society of Medicine* 2008;101:544-551
26. Department of Health, *Collecting ethnic category data – training materials and guidance*: www.dh.gov.uk/en/Publicationsandstatistics/Statistics/StatisticalCollection/DH_4049499, 2005
27. NHS Information Centre for Health and Social Care, *Mental Health Bulletin: third report from Mental Health Minimum Dataset (MHMDS) annual returns, 2004-2009*, November 2009. www.ic.nhs.uk/pubs/mhbmhmnds0809

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

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

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

Confidence intervals as indicators of significant statistical differences

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

For example, if a rate is 110, with the lower confidence interval being 105 and the upper confidence interval being 115, it indicates that the 10% excess over the national average of 100 is statistically significant. But if a ratio is 110, with the lower confidence interval being 95 and the upper confidence interval being 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 B1a: Standardised admission ratios by ethnic group for England and Wales, using 2001 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	84	82	85	13,210	91	89	93	10,807	87	86	88	24,016
White Irish	130	117	145	328	129	114	146	262	130	120	141	590
Other White	160	149	171	784	167	153	181	571	163	154	172	1355
White and Black Caribbean	594	521	674	238	326	264	397	98	479	429	533	336
White and Black African	361	279	459	66	210	136	310	25	301	243	370	91
White and Asian	216	174	264	92	163	119	219	45	195	164	231	137
Other Mixed	354	295	422	125	343	274	423	87	349	304	400	212
Indian	83	74	94	290	77	66	90	169	81	74	89	459
Pakistani	145	129	162	297	92	76	111	112	125	113	138	409
Bangladeshi	162	135	194	123	107	79	142	48	142	121	165	171
Other Asian	206	178	238	189	193	154	239	84	202	179	227	273
Black Caribbean	579	544	615	1051	334	303	366	448	475	451	499	1499
Black African	379	348	412	540	322	286	361	289	357	333	382	829
Other Black	1,188	1,053	1,334	283	593	483	721	101	940	848	1039	384
Chinese	49	34	67	37	88	64	117	45	64	51	80	82
Other	323	282	369	220	196	160	239	101	269	240	300	321
Total	100			17,873	100			13,292	100			31,164

Appendix B: Mental health tables continued

Table B1b: Standardised admission ratios by ethnic group for England and Wales, using 2001 ONS census population denominators (England and Wales = 100), all aged 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	94	90	97	3,226	94	92	97	4,165	94	92	96	7,391
White Irish	163	134	196	110	133	109	159	113	146	127	166	223
Other White	241	205	282	159	235	201	273	170	238	213	265	329
White and Black Caribbean	143	39	365	4	73	9	262	2	108	40	235	6
White and Black African	124	3	691	1	110	3	612	1	117	14	421	2
White and Asian					121	33	309	4	63	17	162	4
Other Mixed	128	26	373	3	276	119	544	8	210	105	375	11
Indian	65	40	99	21	104	71	148	31	83	62	109	52
Pakistani	124	74	193	19	134	75	220	15	128	89	179	34
Bangladeshi	134	54	277	7	160	44	409	4	143	71	255	11
Other Asian	241	135	398	15	155	67	306	8	202	128	304	23
Black Caribbean	320	258	393	91	390	315	478	94	352	303	407	185
Black African	202	101	362	11	413	249	645	19	299	202	427	30
Other Black	544	235	1,073	8	496	199	1022	7	521	291	859	15
Chinese	39	5	142	2	37	4	132	2	38	10	97	4
Other	638	372	1,021	17	787	510	1162	25	719	518	972	42
Total	100			3,694	100			4,668	100			8,362

Appendix B: Mental health tables continued

Table B2: Standardised admission ratios by ethnic group for England, using 2007 ONS population denominators (England = 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	12,354	95	93	96	9,965	91	90	92	22,319
White Irish	146	130	163	311	133	117	151	239	140	129	152	550
Other White	114	106	123	743	119	109	130	495	116	110	123	1238
White and Black Caribbean	418	365	476	227	244	197	299	93	346	309	386	320
White and Black African	236	182	301	65	143	90	214	23	202	162	248	88
White and Asian	147	118	181	90	116	83	156	42	135	113	161	132
Other Mixed	235	195	282	119	249	197	309	80	241	208	276	199
Indian	62	55	69	282	59	51	69	161	61	55	67	443
Pakistani	104	92	116	286	70	57	84	106	92	83	101	392
Bangladeshi	113	94	136	119	83	61	110	48	103	88	119	167
Other Asian	142	122	164	181	130	103	162	78	138	122	156	259
Black Caribbean	529	497	562	1,026	293	266	322	420	428	407	451	1,446
Black African	211	193	230	513	202	178	228	265	208	194	223	778
Other Black	875	774	986	270	475	385	579	97	715	644	793	367
Chinese	23	16	32	35	49	35	67	41	32	25	40	76
Other	158	137	180	214	121	98	148	97	144	128	161	311
Total	100			16,835	100			12,250	100			29,085

Appendix B: Mental health tables continued

Table B3: Standardised ratios of proportions of patients referred by 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	109	103	115	1,319	107	101	112	1,431	108	104	112	2,750
White Irish	91	62	130	31	82	55	119	28	87	66	112	59
Other White	83	63	108	57	64	46	87	42	74	60	90	99
White and Black Caribbean	37	12	87	5	63	21	148	5	47	22	86	10
White and Black African	32	1	176	1	0		183	0	19	0	108	1
White and Asian	40	5	145	2	53	6	193	2	46	12	117	4
Other Mixed	73	24	169	5	98	39	202	7	86	44	149	12
Indian	106	66	162	21	108	65	169	19	107	77	146	40
Pakistani	60	30	107	11	70	28	144	7	63	38	100	18
Bangladeshi	98	36	213	6	25	1	140	1	69	28	143	7
Other Asian	49	18	107	6	136	62	259	9	80	45	131	15
Black Caribbean	44	31	62	33	49	31	74	23	46	35	60	56
Black African	40	21	70	12	30	12	63	7	36	22	56	19
Other Black	87	48	146	14	52	14	134	4	76	45	120	18
Chinese	125	26	365	3	80	16	232	3	97	36	211	6
Other	51	21	106	7	20	2	73	2	38	17	73	9
Total	100			1,533	100			1,590	100			3,123

Appendix B: Mental health tables continued

Table B4: Standardised ratios of proportions of patients referred by community mental health teams (including crisis resolution, home treatment) or community learning disability team (England and Wales 100)

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	104	101	108	3,129	103	100	106	3,486	104	101	106	6,615
White Irish	70	53	91	54	95	75	118	79	83	69	98	133
Other White	84	71	98	148	80	68	94	144	82	73	92	292
White and Black Caribbean	71	51	98	38	88	58	127	28	77	60	99	66
White and Black African	89	46	155	12	134	64	247	10	105	66	159	22
White and Asian	97	59	150	20	91	49	156	13	95	65	133	33
Other Mixed	85	54	127	23	105	71	150	30	95	71	124	53
Indian	112	87	141	71	104	79	135	57	108	90	129	128
Pakistani	128	103	159	85	122	88	165	42	126	105	150	127
Bangladeshi	98	63	146	24	110	63	178	16	102	73	139	40
Other Asian	105	77	141	45	97	62	144	24	102	79	129	69
Black Caribbean	78	67	90	182	74	60	89	104	76	68	86	286
Black African	83	67	101	99	69	53	89	63	77	66	90	162
Other Black	86	64	114	50	80	51	120	24	84	66	106	74
Chinese	121	58	222	10	77	39	138	11	93	58	142	21
Other	85	61	116	41	111	77	155	34	95	75	119	75
Total	100			4,031	100			4,165	100			8,196

Appendix B: Mental health tables continued

Table B5: Standardised ratios of proportions of patients referred by criminal justice routes (police, prison, probation, courts, court liaison and

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	1,503	93	84	102	423	91	87	95	1,926
White Irish	132	97	175	48	74	32	146	8	119	90	154	56
Other White	86	69	106	90	64	37	102	17	81	67	98	107
White and Black Caribbean	132	100	171	57	202	108	346	13	141	110	178	70
White and Black African	124	69	204	15	229	47	669	3	134	79	212	18
White and Asian	115	70	177	20	70	8	252	2	108	68	164	22
Other Mixed	143	98	202	32	115	46	237	7	137	98	188	39
Indian	96	69	130	42	79	32	164	7	93	69	123	49
Pakistani	119	91	153	62	114	46	234	7	119	92	150	69
Bangladeshi	131	87	189	28	116	24	340	3	129	88	184	31
Other Asian	113	79	156	37	102	33	237	5	111	80	151	42
Black Caribbean	144	126	164	221	171	120	236	37	147	130	167	258
Black African	151	128	177	148	217	154	297	39	161	139	186	187
Other Black	96	69	129	42	121	49	249	7	99	73	130	49
Chinese	81	26	190	5	143	39	367	4	101	46	191	9
Other	115	83	155	43	96	31	224	5	113	83	149	48
Total	100			2,393	100			587	100			2,980

Appendix B: Mental health tables continued

Table B6: Standardised detention ratios by ethnic group: detention on day of admission (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	95	92	97	6,617	92	89	95	3,714	94	92	96	10,331
White Irish	102	87	119	166	102	82	124	97	102	90	115	263
Other White	106	96	116	451	127	112	142	282	113	105	121	733
White and Black Caribbean	118	101	136	180	136	104	175	61	122	107	139	241
White and Black African	116	86	152	51	155	90	248	17	124	96	157	68
White and Asian	110	85	139	66	147	100	211	30	119	96	145	96
Other Mixed	113	91	138	91	120	89	159	48	115	97	136	139
Indian	99	85	115	171	119	94	147	82	105	92	119	253
Pakistani	107	93	123	200	116	88	151	56	109	96	123	256
Bangladeshi	95	75	119	77	105	66	159	22	97	79	119	99
Other Asian	104	87	125	122	120	87	160	45	108	92	126	167
Black Caribbean	129	120	138	792	145	128	164	262	132	125	141	1,054
Black African	120	109	132	419	139	120	161	181	125	115	136	600
Other Black	110	95	126	195	157	122	198	71	119	105	135	266
Chinese	116	76	169	26	145	97	208	29	129	98	168	55
Other	106	89	125	144	135	102	175	56	113	98	129	200
Total	100			9,768	100			5,053	100			14,821

Appendix B: Mental health tables continued

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	95	90	101	1,057	93	88	99	1,098	94	90	98	2,155
White Irish	98	65	142	27	77	48	116	22	87	64	115	49
Other White	122	97	152	80	122	96	153	75	122	104	143	155
White and Black Caribbean	66	35	113	13	112	56	200	11	81	52	121	24
White and Black African	92	30	214	5	39	1	219	1	75	28	163	6
White and Asian	79	29	172	6	22	1	122	1	58	23	119	7
Other Mixed	126	67	215	13	114	55	210	10	120	76	181	23
Indian	104	67	153	25	124	78	188	22	112	82	149	47
Pakistani	106	69	155	26	182	113	278	21	130	95	173	47
Bangladeshi	197	120	304	20	142	57	293	7	179	118	260	27
Other Asian	147	93	220	23	164	90	275	14	153	108	211	37
Black Caribbean	72	55	92	63	108	80	142	51	85	70	102	114
Black African	154	120	195	69	174	130	229	51	162	135	194	120
Other Black	166	118	227	39	147	82	242	15	160	120	209	54
Chinese	195	72	425	6	240	120	430	11	222	129	356	17
Other	126	80	189	23	245	160	360	26	170	126	224	49
Total	100			1,495	100			1,436	100			2,931

Appendix B: Mental health tables continued

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	98	95	102	2,815	91	87	95	1,907	95	92	98	4,722
White Irish	86	65	111	57	119	91	154	59	100	83	120	116
Other White	106	91	122	186	124	105	146	146	113	101	126	332
White and Black Caribbean	99	76	126	62	127	86	180	31	106	86	130	93
White and Black African	131	84	195	24	186	93	332	11	144	101	201	35
White and Asian	104	68	152	26	188	116	287	21	130	95	173	47
Other Mixed	111	78	153	37	131	88	188	29	119	92	151	66
Indian	109	86	137	77	133	99	176	49	118	98	140	126
Pakistani	100	79	125	77	100	65	147	26	100	82	121	103
Bangladeshi	77	50	113	26	89	43	163	10	80	56	111	36
Other Asian	95	70	127	46	136	90	197	28	107	84	135	74
Black Caribbean	115	102	129	289	168	143	196	160	130	118	142	449
Black African	101	86	119	146	135	109	165	96	113	99	128	242
Other Black	115	92	142	84	162	116	220	40	127	105	151	124
Chinese	141	75	240	13	119	63	204	13	129	84	189	26
Other	84	61	111	47	103	65	155	23	89	69	113	70
Total	100			4,012	100			2,649	100			6,661

Appendix B: Mental health tables continued

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	86	81	92	999	94	82	108	200	88	83	93	1,199
White Irish	129	90	180	35	82	22	210	4	122	87	167	39
Other White	94	72	119	66	145	86	229	18	101	81	126	84
White and Black Caribbean	187	137	249	46	205	75	445	6	189	141	247	52
White and Black African	126	58	239	9	300	36	1,083	2	141	70	252	11
White and Asian	113	56	201	11	366	119	854	5	144	82	233	16
Other Mixed	107	58	179	14	108	22	317	3	107	62	172	17
Indian	90	58	132	25	25	1	140	1	82	53	119	26
Pakistani	122	86	168	37	34	1	188	1	114	81	157	38
Bangladeshi	99	53	169	13	0		296	0	90	48	155	13
Other Asian	84	48	137	16	0		149	0	74	43	121	16
Black Caribbean	211	184	242	211	160	91	259	16	207	181	235	227
Black African	126	98	159	71	143	74	250	12	128	102	159	83
Other Black	101	68	145	29	172	56	400	5	107	74	150	34
Chinese	55	7	198	2	0		284	0	40	5	146	2
Other	117	77	172	26	0		148	0	105	69	155	26
Total	100			1,610	100			273	100			1,883

Appendix B: Mental health tables continued

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	89	105	550	102	79	129	67	97	90	105	617
White Irish	157	96	243	20	136	16	492	2	155	97	235	22
Other White	119	86	161	42	126	41	294	5	120	88	160	47
White and Black Caribbean	120	68	195	16	98	2	544	1	118	69	189	17
White and Black African	175	70	361	7	0		1,696	0	166	67	342	7
White and Asian	19	0	103	1	201	5	1,122	1	34	4	123	2
Other Mixed	112	48	220	8	195	24	704	2	122	59	225	10
Indian	55	24	109	8	0		287	0	51	22	100	8
Pakistani	116	70	181	19	0		370	0	109	66	171	19
Bangladeshi	68	22	159	5	253	6	1,408	1	78	29	169	6
Other Asian	88	40	168	9	0		420	0	81	37	154	9
Black Caribbean	151	119	188	77	129	35	331	4	149	119	186	81
Black African	81	53	120	25	34	1	192	1	77	51	113	26
Other Black	58	27	111	9	99	3	552	1	61	29	112	10
Chinese	52	1	288	1	0		799	0	42	1	233	1
Other	67	29	133	8	119	3	663	1	71	32	134	9
Total	100			805	100			86	100			891

Appendix B: Mental health tables continued

Table B11: Standardised ratios of patients on CTOs by ethnic group on day of census section 17A of the Mental Health Act (England and Wales 100)*

Ethnic group	Men				Women				Persons			
	Standardised ratio on CTOs	95% confidence interval		Observed numbers	Standardised ratio on CTOs	95% confidence interval		Observed numbers	Standardised ratio on CTOs	95% confidence interval		Observed numbers
White British	93	85	101	534	86	77	97	305	91	85	97	839
White Irish	46	17	101	6	36	7	104	3	42	19	80	9
Other White	93	64	131	33	108	67	165	21	98	74	128	54
White and Black Caribbean	90	47	157	12	208	90	411	8	116	71	180	20
White and Black African	151	55	328	6	212	26	766	2	163	70	320	8
White and Asian	74	20	191	4	57	1	317	1	70	23	164	5
Other Mixed	84	31	183	6	116	32	297	4	94	45	174	10
Indian	145	90	222	21	251	140	413	15	176	123	243	36
Pakistani	98	56	159	16	217	99	411	9	122	79	180	25
Bangladeshi	206	115	340	15	112	14	403	2	187	109	300	17
Other Asian	157	90	255	16	154	50	360	5	157	97	239	21
Black Caribbean	125	96	159	64	205	140	289	32	143	116	175	96
Black African	124	88	170	38	134	75	221	15	127	95	166	53
Other Black	169	110	247	26	231	106	439	9	181	126	252	35
Chinese	103	13	374	2	290	94	676	5	191	77	394	7
Other	101	52	176	12	166	61	361	6	116	69	184	18

*These figures should be interpreted with caution because 8% of these patients had ethnicity "not stated" (108 out of 1,371)

Appendix C: Learning disability tables

Table C1: Standardised admission ratios by ethnic group for England and Wales, using 2001 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	99	95	103	2,197	104	98	111	1,004	101	97	104	3,201
White Irish	116	82	160	37	128	78	198	20	120	91	156	57
Other White	96	75	121	72	39	21	66	13	78	63	97	85
White and Black Caribbean	358	236	521	27	293	134	556	9	339	238	470	36
White and Black African	91	19	267	3	77	2	428	1	87	24	223	4
White and Asian	131	63	241	10	142	39	363	4	134	73	225	14
Other Mixed	222	121	373	14	189	61	441	5	212	128	331	19
Indian	49	32	70	28	30	12	62	7	43	30	60	35
Pakistani	67	43	100	24	68	31	130	9	68	47	95	33
Bangladeshi	152	93	234	20					110	67	170	20
Other Asian	33	11	76	5	106	34	247	5	50	24	92	10
Black Caribbean	243	188	309	66	110	62	181	15	198	158	247	81
Black African	110	72	160	27	79	34	156	8	101	70	141	35
Other Black	264	132	473	11	165	34	481	3	234	128	392	14
Chinese	15	2	54	2					10	1	38	2
Other	60	24	123	7	17	0	94	1	45	20	89	8
Total	100			2,550	100			1,104	100			3,654

Appendix C: Learning disability tables continued

Table C2: Standardised admission ratios by ethnic group for England, using 2007 ONS population denominators (England 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	105	101	110	2,095	109	102	116	946	107	103	110	3,041
White Irish	139	97	193	35	137	80	219	17	138	103	181	52
Other White	69	54	87	71	31	17	53	13	58	46	72	84
White and Black Caribbean	255	168	371	27	217	99	412	9	244	171	338	36
White and Black African	60	12	176	3	55	1	308	1	59	16	151	4
White and Asian	91	44	167	10	102	28	262	4	94	51	157	14
Other Mixed	154	84	259	14	143	47	334	5	151	91	236	19
Indian	37	25	54	28	24	10	50	7	34	24	47	35
Pakistani	47	29	71	22	54	25	103	9	49	33	69	31
Bangladeshi	111	68	171	20					82	50	127	20
Other Asian	19	5	48	4	61	17	157	4	29	12	57	8
Black Caribbean	221	171	282	65	103	58	170	15	182	144	227	80
Black African	61	40	90	26	53	23	104	8	59	41	83	34
Other Black	200	100	359	11	128	26	374	3	179	98	300	14
Chinese	8	1	28	2					6	1	20	2
Other	30	12	62	7	11	0	61	1	25	11	48	8
Total	100			2,440	100			1,042	100			3,482

Appendix C: Learning disability tables continued

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

Ethnic group	Persons			
	Standardised detention ratio	95% confidence interval		Observed numbers
White British	96	91	101	1,343
White Irish	123	85	173	33
Other White	151	118	191	70
White and Black Caribbean	128	81	193	23
White and Black African	47	1	264	1
White and Asian	95	38	196	7
Other Mixed	158	88	260	15
Indian	96	56	154	17
Pakistani	104	63	163	19
Bangladeshi	132	75	214	16
Other Asian	102	33	239	5
Black Caribbean	125	93	166	49
Black African	152	101	219	28
Other Black	93	38	192	7
Chinese	211	26	761	2
Other	71	15	206	3
Total	100			1,638

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Where we are

The Care Quality Commission's head office is at
Finsbury Tower
103–105 Bunhill Row
London EC1Y 8TG

How to contact us

Phone: 03000 616161
Email: enquiries@ccq.org.uk

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