

Count me in 2007

Results of the 2007 national census of inpatients in mental health and learning disability services in England and Wales



Care Services Improvement Partnership **CSIP**

National Institute for
Mental Health in England



First published in November 2007

© 2007 Commission for Healthcare Audit and Inspection

Items may be reproduced free of charge in any format or medium provided that they are not for commercial resale. This consent is subject to the material being reproduced accurately and provided that it is not used in a derogatory manner or misleading context.

The material should be acknowledged as © 2007 Commission for Healthcare Audit and Inspection with the title of the document specified.

ISBN 978-1-84562-165-0

Cover photographs from www.johnbirdsall.co.uk

Contents

Executive summary	2
Introduction	8
Information about learning disabilities	10
National organisations coordinating the census	12
Data, methods of analysis and interpretation	15
Results:	18
Mental health	18
Learning disabilities	39
Ethnicity of staff in NHS mental health and learning disability services	50
Conclusions:	52
Mental health	52
Learning disabilities	56
References	58
Appendix A: Methods of analysis	62
Appendix B: Mental health tables	64
Appendix C: Learning disabilities tables	76
Appendix D: Ethnicity coding in Hospital Episode Statistics (HES) and the Mental Health Minimum Data Set (MHMDS)	79

Executive summary

This is the third national census of the ethnicity of all inpatients in NHS and independent mental health and learning disability hospitals and facilities in England and Wales. It was conducted on 30 March 2007, and follows a similar census carried out in 2006, and a census of inpatients in mental health services only in 2005.

The census is a joint initiative between the Healthcare Commission, the Mental Health Act Commission (MHAC), which was also responsible for coordinating the censuses in 2005 and 2006, the Care Services Improvement Partnership and the National Institute for Mental Health in England (NIMHE).

We have highlighted in previous reports that all patients should receive the same high level of healthcare, regardless of factors such as race, religion, age, gender, sexual orientation, and whether they have a disability. People with varying patterns of mental illness use mental health and learning disability services in different ways. In order to address the differences in the way these services are used, Government agencies need to coordinate effectively with voluntary agencies, minority ethnic communities and the people who use services themselves.

The aim of this census is to:

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

This report presents a section with information on inpatients receiving mental health services and a section on inpatients receiving learning disability services. These two areas have been separated to allow comparison with the 2005 census (which did not include patients in learning disability services) and the 2006 census.

Key findings*

Mental health

We obtained information about 31,187 inpatients on the mental health wards of 257 NHS and independent healthcare organisations in England and Wales. The overall patterns emerging from this census are very similar to those observed in 2006 and 2005. This is perhaps not surprising, as 30% of the inpatients in 2007 were also inpatients in 2006, and 20% of them had also been in hospital at the time of the 2005 census.

The key findings are:

- the number of inpatients in each census has declined from 33,785 in 2005, to 32,023 in 2006, and to 31,187 in 2007
- the proportion of inpatients in independent hospitals increased from 10% of the total in 2005, to 11% in 2006 and to 14% in 2007. The proportion of inpatients in NHS hospitals has decreased from 90% of the total in 2005 to 89% in 2006 and 86% of the total in 2007
- information about ethnicity was available for 99% of inpatients, of whom:
 - 78% were White British
 - 9% were from Black or White/Black Mixed groups
 - 5% were from Other White groups
 - 3% were from South Asian (Indian, Pakistani and Bangladeshi) groups
 - 2% were White Irish
 - 3% were from other ethnic groups (including Chinese)

Overall, 22% of inpatients were from minority ethnic groups, compared with 21% in the 2006 census and 20% in the 2005 census. The increase was largely due to the increased proportion of the Other White group

- seventy two per cent of inpatients from black and minority ethnic groups were inpatients at 27 of the 257 organisations involved in the census
- six per cent of inpatients reported that English was not their first language
- rates of admission were lower than the national average among the White British, Indian and Chinese groups, and were average for the Pakistani and Bangladeshi groups. They were higher than average among other minority ethnic groups for both genders – particularly in the Black Caribbean, Black African, Other Black, White/Black Caribbean Mixed and White/Black African Mixed groups – with rates of over three times higher than average, and over 10 times higher in the Other Black group. These patterns are very similar to those observed in 2006 and 2005
- although rates of admission remain fairly consistent for most ethnic groups across 2005, 2006 and 2007, an exception is the Other White group, for whom both the admission ratio and the underlying numbers of patients have risen consistently across the three years
- in the Black Caribbean, Black African and Other Black groups, rates of referral from GPs and community mental health teams were lower than average, and rates of referral from

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

the criminal justice system were higher than average in the Black Caribbean and Other Black groups. The Other White group also had lower rates of referral from GPs and community mental health teams. Overall, 36% of patients were referred from tertiary services. However, the information on sources of referral does not capture the original source of referral

- forty three per cent of inpatients were detained under the Mental Health Act on admission, compared with 40% in 2006 and 39% in 2005. Overall rates of detention were higher than average among the Black Caribbean, Black African, Other Black and White/Black Caribbean Mixed groups (by 19% to 38%), and detention under section 37/41 (imposed by courts) was also higher in these groups (except Black African). These patterns are similar to those for the previous two years
- rates of seclusion were higher than average among men from the Black Caribbean and Other Black groups, and among the Other White group in both genders
- no ethnic differences were observed regarding the use of hands-on restraint
- as in 2006, rates of self-harm and accidents were generally low in the Black Caribbean, Black African and Other Black groups of patients, as were rates of self-harm in Indian, Pakistani and Bangladeshi groups, whereas the White British group had a higher than average rate of self-harm in both years
- no ethnic differences were observed in the rates of physical assault
- as in 2006, 30% of patients had been in hospital for one year or more. The median duration of stay from the day of admission to the day of census was two and a half months for women and five months for men. The median lengths of stay were longest among patients from the White/Asian Mixed and Black Caribbean groups. Patients from the White/Black Caribbean Mixed, White/Black African Mixed and Other White groups also had among the longest lengths of stay. As in 2006, patients from the Chinese, South Asian and White British groups had shorter durations of stay
- sixty eight per cent of patients were not in a single sex ward. The proportion was lower among most minority ethnic groups than among the White British group (see definition of mixed ward accommodation on page 38)

Learning disabilities

We obtained information about 4,153 inpatients in 120 organisations providing services for people with learning disabilities in England and Wales. The overall patterns are very similar to those observed in the 2006 census. This is perhaps not surprising, as 72% of the inpatients in 2007 were also inpatients in 2006.

The key findings are:

- the total number of providers fell from 124 to 120, and the number of patients fell from 4,609 to 4,153. The proportion of inpatients in independent healthcare organisations increased from 20% of the total in 2006 to 23% in 2007. The proportion of patients in NHS organisations decreased from 80% of the total in 2006 to 77% in 2007

- information about ethnicity was available for 99% of inpatients, of whom:
 - 88% were White British
 - 1% were White Irish
 - 3% were from Other White groups
 - 5% were from Black or White/Black mixed groups
 - 2% were from South Asian groups
 - 2% were from other ethnic groups (including Chinese)

Overall, 12% of inpatients were from black and minority ethnic groups. Numbers of inpatients were low for several minority ethnic groups. These patterns are very similar to those reported in 2006, except for the increase in the number of patients from the Other White group

- approximately 71% of inpatients from black and minority ethnic groups were inpatients at 27 of the 121 organisations involved in the census
- ten per cent of inpatients reported that English was not their first language. Non-verbal languages were recorded for 7% of inpatients
- rates of admission were lower than the national average among the South Asian, Chinese and White Irish groups, and were between two and three times higher than average in the White/Black Caribbean Mixed, White/Black African Mixed, Black Caribbean and Other Black groups. These results are similar to those reported in 2006, and those for inpatients in mental health establishments. It is likely that some of the patients from the Black groups are mental health patients
- as in 2006, the rate for referrals by carers was twice the average among the Black Caribbean group
- thirty nine per cent of inpatients were detained under the Mental Health Act on admission, compared with 35% in 2006. The only ethnic difference observed was a rate of 50% higher than the average among the Other White group. No ethnic differences were observed in 2006
- the rate of seclusion among the White Irish and Other White group was higher than average, although this was based on a small number of patients
- the rate of assault was higher than average among the Black Caribbean group, but we do not have information on who committed the assault
- there were no ethnic differences in the rates of self-harm, accidents and the use of hands-on restraint
- seventy two per cent of patients had been in hospital for one year or more, and 38% for over five years. The median duration of stay from the day of admission to the day of census was 38 months for women and 35 months for men
- sixty per cent of patients were not in a single sex ward. The proportion was lower among most minority ethnic groups than among the White British group (see definition of mixed ward accommodation on page 38)

Conclusions

The findings of this third census show differences **between** black and minority ethnic groups and white groups, and also differences **within** these groups. The patterns are broadly similar to those observed in both the 2005 and 2006 censuses.

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

The factors that contribute to these findings are complex and may differ between ethnic groups and areas. They need to be examined in the context of available evidence on variations in the rates of mental illness and the different pathways to care taken by black and minority ethnic groups, and the possible contributory factors for these.

Delivering race equality in mental health is complex, and a multi-agency response is needed to understand the problems and deliver the solutions. Mental health services have a key role to play, but partnership with statutory organisations outside the healthcare sector, black and minority ethnic communities, and service users themselves will be needed to help achieve this.

Recommendations

A number of recommendations can be drawn from the key findings of this report.

1. *Delivering Race Equality* outlines an action plan for improving mental health services for black and minority ethnic communities. Healthcare organisations must work towards achieving the goals set out in the plan.
2. We recommend that statutory agencies, working in partnership with others, make every effort to understand the local demographic and clinical needs of the population, and to plan and commission services that will improve the pathways to mental healthcare taken by black and minority ethnic groups. Commissioners and providers of services also need to take into consideration the changing demographic profile of local populations.
3. The Healthcare Commission's recent investigations into services for people with learning disabilities provided by Sutton and Merton Primary Care Trust and Cornwall Partnership NHS Trust, and the recently published intervention at Bromley Primary Care Trust, showed that patients with learning disabilities were receiving poor standards of care, unsafe services and abuse. We urge all providers of learning disability services to review the findings of these investigations, and to learn any lessons from them to avoid the risk of such serious failures of care recurring.

4. We expect commissioners and providers of mental healthcare, in both the NHS and the independent sector, to have fully comprehensive systems to record and monitor ethnicity. In the same way, it is also vital that learning disability services have accurate and sustainable ethnic monitoring arrangements in place.
5. The current systems for recording data about patients must be improved. The Healthcare Commission strongly recommends to the Department of Health and the Information Centre for Health and Social Care that:
 - recording the ethnicity of **all** patients should be made mandatory as a matter of urgency, regardless of whether they are treated in the community or in a hospital
 - some changes and extensions should be made to the Mental Health Minimum Data Set (MHMDS), including the recording of religion and language
 - in particular, changes and enhancements to current data collections (MHMDS and Hospital Episode Statistics (HES)) are urgently needed to support effective monitoring of the Mental Health Act 2007
 - submission of the MHMDS and HES should be made mandatory for all independent providers of inpatient mental health services, especially in view of the growing number and proportion of all mental health inpatients cared for in these establishments

We made most of these recommendations previously in the reports of both the 2006 and 2005 *Count me in* censuses, and we now reiterate the need for their urgent implementation.

These initiatives have the strong support of the Mental Health Act Commission.

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

A further issue relates to the recording of disability, including learning disability, which is currently not a requirement in the data routinely collected by the Department of Health. We are therefore working with the Department of Health and the Information Centre for Health and Social Care to move forward on including information about disability in patients' records.

Introduction

One of the Government's goals is 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.

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

On 30 March 2007, the Healthcare Commission, the Mental Health Act Commission (MHAC) and the National Institute for Mental Health in England (NIMHE) carried out a national census to record the ethnicity of inpatients in NHS and independent mental health and learning disability hospitals and facilities in England and Wales. The census also captured selected details concerning a patient's stay in hospital, such as how they were referred, how long they had been an inpatient, and whether they had been detained under the Mental Health Act. We collected information from 31,187 inpatients in mental health hospitals and 4,153 inpatients in learning disability hospitals.

This is the third *Count me in* census. A similar census was conducted in both 2006 and 2005, although in 2005, only inpatients in mental health hospitals and facilities were included.^{1,2} The censuses are undertaken in support of the Department of Health's five-year action plan for improving mental health services for black and minority ethnic communities, *Delivering Race Equality in Mental Health Care*.³ The Department of Health requires healthcare organisations to work towards achieving the goals set out in this action plan, and to ensure compliance with its standards for improving healthcare set out in its framework document of 2004, *National Standards, Local Action*.⁴

The action plan for *Delivering Race Equality in Mental Health Care* states that services should have 12 desirable characteristics in place by 2010. It details more than 70 actions that healthcare organisations should take to ensure that these characteristics are achieved. The 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, and informed by, the concerns and values of all groups within the community.

The census also supports the Welsh Assembly Government's *Raising the Standard: Race Equality Action Plan for Adult Mental Health Services in Wales*,⁵ published in October 2006. The action plan aims to improve equality of access, treatment and outcomes in the provision of adult mental health services for minority ethnic groups in Wales. The headline actions of this plan are:

- developing the evidence base – inpatient and community-based patient monitoring
- designing appropriate and responsive services, including conducting race impact assessments on all new major policies and procedures, where relevant
- training and recruitment
- delivery of services
- performance management, monitoring and audit

The goals of the 2007 census are the same as those in 2005 and 2006:

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

As in 2006, 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. This allows comparisons to be made with the 2005 and 2006 censuses.

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

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

Information about learning disabilities

The terms learning *disabilities* and learning *difficulties* are often used interchangeably. This report uses the term *disability*, unless referencing a specific source that uses an alternative term. The Department of Health's White Paper *Valuing People*⁶, published in 2001, sets out the Government's strategy for addressing the needs of people with learning disabilities. It describes a learning disability as the presence of a significantly reduced ability to understand new or complex information and to learn new skills, as well as a reduced ability to cope independently, which has a lasting effect on development into adulthood. The *Count me in* census uses this definition of learning disabilities. In addition, it collected information on inpatients with Autistic Spectrum Disorder, including Asperger's syndrome.

It is estimated that there are 210,000 people with severe and profound learning disabilities in England. Of these, 65,000 are children and young people, 120,000 are adults of working age, and 25,000 are older people. In addition, there are estimated to be 1.2 million people in England with mild or moderate learning disabilities – a ratio of one person in every 40. The number of people with severe and profound learning disabilities is expected to increase by 1% each year. This is for a number of reasons, including increasing life expectancy and the growing number of children with such disabilities who survive into adulthood. All socio-economic groups have similar proportions of people with severe and profound learning disabilities, but people living in deprived and urban areas are more likely than those elsewhere to have mild or moderate learning disabilities.⁶

In Wales, the number of people with learning disabilities who were registered with their local authority in 2005 was 13,500.⁷

People with learning disabilities have a lower life expectancy than those who do not have them, and they are more likely to experience mental illness, long-term health problems, epilepsy, and physical and sensory disabilities.^{6,8}

Despite their greater needs, coordination of care for people with learning disabilities – between GPs, primary healthcare teams and providers of specialist services – is generally poorer than that for other people, and their needs for physical and mental healthcare are often not met. There is a risk that access to good quality mental healthcare may be compromised because of poor coordination between providers of mainstream psychiatry services and providers of learning disability psychiatry services – care is fragmented and delivered by organisations with a poor understanding of their needs.⁹

The recent report from the Disability Rights Commission *Equal Treatment: Closing the Gap* provides important new evidence that people with learning disabilities and people with mental health problems are more likely to experience major illness, to develop serious health conditions at an earlier age and to die of them sooner than other people. Nevertheless, they are also less likely to receive some of the treatments and health checks than others with the same condition but without a mental health condition or learning disability.¹⁰

The British Institute of Learning Disabilities estimates, for example, that 50% of people with learning disabilities and challenging behaviour will experience physical interventions, such as restraint.⁸ A report by the National Patient Safety Agency (NPSA) also found that people with learning disabilities, and the staff caring for them, were concerned that the use of physical interventions in acute mental health wards did not always conform with guidance about good practice.¹¹

People from minority ethnic communities who have learning disabilities have still greater problems. The Department of Health's White Paper, *Valuing People*⁶, and its report, *Learning Difficulties and Ethnicity*¹², describe how their needs are often overlooked (although the latter also found examples of good practice). *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. It also found that women are even more disadvantaged.

Improving the Life Chances of Disabled People, a report by the Prime Minister's Strategy Unit, said that "by 2025, disabled people in Britain will be respected and included as equal members of society"¹³ and in *Valuing People*, the Government said it would help those with learning disabilities "to live full and independent lives as part of their local communities"⁶. However, the latter also detailed problems and challenges that need to be overcome, including:

- poorly coordinated services
- poor planning for supporting young disabled people as they grow into adulthood
- insufficient support for carers
- inconsistency in expenditure and delivery of services
- poor partnership between providers of health and social care
- limited opportunities for employment
- the limited choice and control that people with learning disabilities have over their lives

Similar problems and challenges were also described by a recent report from the Department of Health's Learning Disability Taskforce.¹⁴ It expressed concern that many people with a learning disability are sent to live a long way from home and that many providers of learning disability services do not have the skills to work with people from minority ethnic communities.

Death by Indifference, a report by Mencap,¹⁵ looked at six case studies of patients with learning disabilities who received care in NHS settings. The report highlights the poor quality of acute care received by these patients, and believes there is "a fundamental lack of understanding and respect towards people with a learning disability and their families and carers".

The number of inpatients with learning disabilities is expected to decrease gradually over the next few years as patients are moved from NHS campuses to community settings, which encourages independence.

National organisations coordinating the census

The Healthcare Commission is the health watchdog in England and promotes improvements in the quality of healthcare and public health in England and Wales. Issues of concern relating to mental health and learning disabilities (also known as referrals) are brought to the attention of the Commission. During 2006/2007, the Commission managed 69 referrals, of which 15 related to mental health services and five to learning disability services.

The concerns regarding safety in mental health services included suicide rates amongst service users, allegations of abuse by staff, assaults on one service user by another, and lack of observation or supervision of service users. These are often accompanied by operational concerns such as a perceived lack of permanent staff, a greater reliance on bank and agency staff who may be unfamiliar with the trust's procedures, lack of training and poor risk management procedures. A common theme in referrals made to the Commission about mental health services is a failure by trusts to learn from serious untoward incidents.

When reviewing the detail of concerns, expert advisors are often consulted to enable an informed decision to be made on the issues raised. None of the concerns referred in 2006/2007 applied to particular ethnic groups.

The Healthcare Commission is committed to ensuring that services for people with learning disabilities improve. Referrals relating to learning disability services have included concerns about adult protection, inappropriate use of restraint and the standard of care.

The Commission's formal investigations into serious failures in learning disability services have shown that patients were receiving poor standards of care, unsafe services and abuse. The recent investigations into services for people with learning disabilities provided by Sutton and Merton Primary Care Trust and Cornwall Partnership NHS Trust highlighted extensive failings and abuse of patients, and a failure to provide safe and adequate care. Some of the findings included:

- inappropriate environment and living conditions, impacting on the privacy and dignity of patients
- over-reliance on medication to control behaviour
- illegal and prolonged use of restraint
- failure of senior managers to identify and correct situations involving physical and emotional abuse and poor environmental conditions

Following these investigations, the Commission piloted an audit of learning disability services that involved peer groups of people with learning disabilities, family carers and professionals, to assess the quality of services in England. Over 600 self-assessment questionnaires were returned and 155 individual services were audited by the peer review teams. The national findings were published in November 2007, and identified the following key issues:

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

The aim of this work is to develop a set of indicators to help assess the performance of learning disability services.

The Healthcare Commission is also working closely with the Commission for Social Care Inspection on the creation of an improvement board, chaired jointly by both organisations. It is also producing a joint work plan for the forthcoming year.

In 2005, the Commission undertook an audit of violence in mental health settings, and in 2006 it published an action plan based on the findings.¹⁶ The results of wave two of the audit will be published at the end of 2007. The Commission's programme of work for mental health services covers both community and inpatient services to help provide a more rounded picture of performance. In 2006, the Commission conducted a joint review of specialist community mental health services in England. The results provided a mixed picture of performance, with many services showing progress on staff training in diversity issues but less progress on some of the strategic changes required to implement disability rights equality effectively.

The Commission also carried out a review of acute inpatient mental health services in 2007 and similarly addressed diversity issues. The results will be available towards the end of the year. The Healthcare Commission is also funding a clinical audit of access to psychological therapies, which will seek to assess the access to such treatments for service users from different ethnic groups.

The Commission also conducts a large, national programme of surveys concerning the experiences of patients. In 2007, it conducted its fourth survey of the experiences of people using NHS community mental health services in England. The Commission is also undertaking development work to conduct a survey of inpatients in NHS mental health services

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

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

MHAC visits all NHS and independent hospitals and mental health units that care for detained patients, and identifies serious abuses of patients' rights. It seeks to visit all hospitals and units at least once a year, and every ward with detained patients once every 18 months.

MHAC has placed extra emphasis on learning disability services since 2005/2006, as a result of worrying findings about unlawfully detained patients. From its first biennial report in 1985, MHAC has consistently drawn attention to the disproportionate admission and detention of patients from black and minority ethnic groups. Its most recent report, *In Place of Fear*,¹⁷ again draws attention to the difficulties faced by patients from black and minority ethnic groups and the importance of tackling discrimination, developing culturally relevant and appropriate services, and using the *Delivering Race Equality* action plan as the basis for achieving real and lasting change.

The Care Services Improvement Partnership (CSIP) was created in 2005 by the integration of a number of initiatives supporting the development of services to help improve people's lives. Its overall purpose is to support improvements in health and wellbeing. CSIP's key relationships with the Department of Health are through the new Social Care, Local Government and Care Partnerships Directorate within the Department. CSIP works with communities, systems and organisations that are engaged with meeting the health and social care needs of:

- people with mental health problems
- people with learning disabilities
- older people
- children, young people and families
- people in the criminal justice system
- the families, carers and supporters of these groups

The National Institute for Mental Health in England (NIMHE) supports improvements in mental health and mental health services. Working as part of the Care Services Improvement Partnership, it helps all those involved in mental health to implement positive change, providing a gateway to learning and development. Through eight regional development centres and national programmes of work, NIMHE aims to put policy into practice with a view to helping resolve local challenges in developing effective mental health services.

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

* To avoid confusion, the commentary in this report uses the terms White/Black Caribbean Mixed, White/Black African Mixed and White/Asian Mixed

Coverage of learning disability establishments

The 2007 census did not include all independent providers of learning disability services. We included only those establishments registered with the Healthcare Commission under section 2 of the Care Standards Act (2000) to provide inpatient learning disability services, but not those care homes registered only with social services.

Finding the necessary equivalent criteria for eligibility for NHS establishments was more challenging. 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 Commission for Social Care Inspection (CSCI), rather than by the Healthcare Commission, they were not eligible for inclusion in the census.

Distinguishing between mental health inpatients and learning disability inpatients

Making the distinction between patients using mental health services and those using learning disability services was not straightforward. Some healthcare providers offer both services and there is considerable overlap between them. The census asked providers to distinguish between the services by describing wards as either “mainly providing mental health services” or “mainly providing learning disability services”. The 2005 census only included wards that provided mainly mental health services. This separation of results by type of ward gives us a robust means of comparing the results for 2005, 2006 and 2007, and also ensures that no patient was counted twice.

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

Methods of statistical analysis

The statistical methods used for data analysis in this report are given in Appendix A. The terms ‘higher’ and ‘lower’ than average, used in the text for ethnic comparisons, relate to percentage differences from the national average that are statistically significant at the 5% level.

Interpreting the results

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

- as in 2005 and 2006, we used the 2001 census population estimates from the Office for National Statistics (ONS) to derive the rates of admission. ONS advises that these estimates are approximate and that they tend to underestimate the number of people from black and minority ethnic groups^{18, 19}. Furthermore, the 2001 estimates are now six years old, 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 2004 for England, and we have used these also for analysing rates of admission by ethnic group for England.²⁰ However, these estimates are described by ONS as “experimental” and are subject to margins of error. Furthermore, they are not available for Wales, so we cannot derive rates of admission for England and Wales using updated population denominators. These issues are considered further in the results section

- the results are not adjusted for diagnosis and other clinical information, so any differences between ethnic groups in the nature and severity of illness or disability may be reflected in the results
- the data collected for the census does not allow analysis which controls 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 providers of services
- in some instances, the numbers for some ethnic groups are so small that we cannot statistically demonstrate differences from the general population
- the census is a one-day count designed to give the number and ethnic composition of inpatients. Its value is in providing a year-by-year snapshot profile of the whole inpatient population. However, by its very nature, it cannot give the picture for the whole year
- some changes in patterns from one census to the next (for example in rates of seclusion) may be due to changes in the small numbers of affected patients in the individual minority ethnic groups on census day, leading to a statistical phenomenon known as 'regression to the mean'. This means that rates based on small and fluctuating numbers of patients can change in either direction (high to low or vice versa), from one year to the next, as a result of random rather than real variation
- the census does not assess the quality of services, the experience of patients or the reasons for any differences found between ethnic groups

Results: mental health

We collected information on 31,187 patients from the mental health wards of 257 NHS and independent healthcare organisations in England and Wales. All providers who were eligible to take part in the census supplied information, including 93 NHS organisations and 164 independent healthcare organisations. The number of inpatients was approximately 3% lower than in 2006 (32,023 inpatients) and 8% lower than in 2005 (33,785 inpatients) (see Table 1). The number of providers was higher than in the previous two years at 257 (238 in 2006 and 207 in 2005). There has been an increase in the number of independent healthcare providers, and the proportion of all mental health inpatients cared for by such providers has risen from 10% of the total in 2005, to 11% in 2006 and to 14% in 2007. The proportion and number of patients cared for by NHS providers has declined.

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

Provider	2007 census			2006 census			2005 census		
	No. of providers	No. of inpatients	% of inpatients	No. of providers	No. of inpatients	% of inpatients	No. of providers	No. of inpatients	% of inpatients
NHS (England)	82	25,020	80.2	97	26,565	83.0	92	28,590	84.6
Independent (England)	153	4,030	12.9	125	3,341	10.4	98	3,078	9.1
NHS (Wales)	11	1,875	6.0	11	1,962	6.1	10	1,939	5.7
Independent (Wales)	11	262	0.8	5	155	0.5	7	178	0.5
Total	257	31,187	100.0	238	32,023	100.0	207	33,785	100.0

Ethnicity

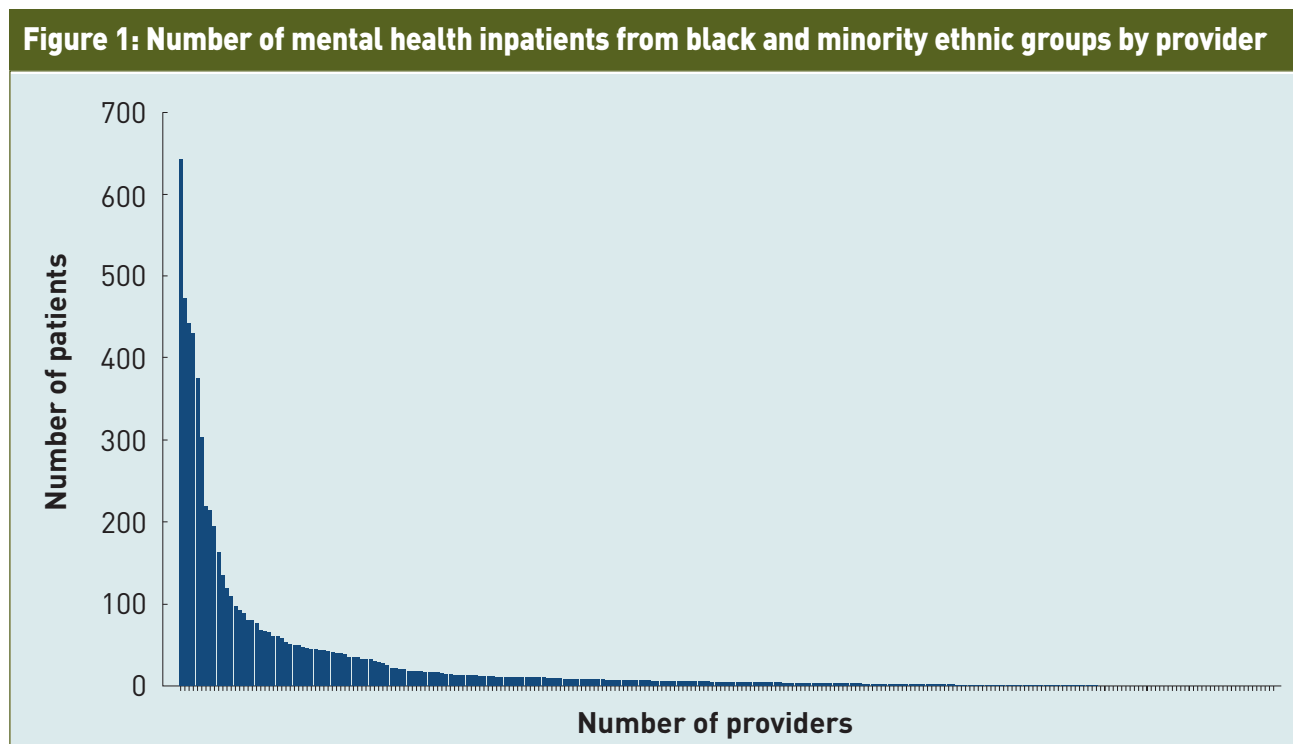
Information about ethnicity was available for 99.1% of inpatients, which is similar to past recording levels of 98.9% in 2006 and 98.7% in 2005.

Of these, 78% were White British, 9% were from Black or White/Black mixed groups, 3% were from South Asian groups (Indian, Pakistani and Bangladeshi), 2% were White Irish, 5% were from Other White groups, and 3% were from other ethnic groups (including Chinese). This showed that 22% of all inpatients belonged to black and minority ethnic groups, defined as all groups that are not White British (White Irish and Other White groups are counted among the black and minority ethnic groups). This compares with 21% in 2006 and 20% in 2005.

The 2007 census recorded a lower proportion of inpatients from the White British and White Irish groups than in 2006 and 2005, and a greater proportion from the Other White group. The proportions of other ethnic groups remained almost exactly the same as in 2006 and 2005. Table 2 shows the ethnic group of inpatients in each of the censuses.

Table 2: Mental health inpatients by ethnic group						
Ethnic group	2007 census		2006 census		2005 census	
	%	Number	%	Number	%	Number
White British	77.6	24,198	78.6	25,170	79.2	26,762
White Irish	1.7	538	1.8	582	2.2	727
Other White	4.6	1,449	3.8	1,210	3.1	1,055
White and Black Caribbean	0.9	288	0.9	287	0.8	255
White and Black African	0.3	91	0.3	102	0.2	71
White and Asian	0.3	91	0.3	109	0.3	104
Other Mixed	0.6	180	0.5	173	0.5	167
Indian	1.3	393	1.3	411	1.3	434
Pakistani	1.0	315	1.1	349	1.0	325
Bangladeshi	0.4	130	0.5	158	0.5	153
Other Asian	0.8	261	0.8	262	0.8	264
Black Caribbean	4.3	1,330	3.9	1,264	4.1	1,369
Black African	2.1	648	2.0	652	1.9	645
Other Black	1.7	545	1.7	535	1.7	569
Chinese	0.3	82	0.2	78	0.2	81
Other	1.1	356	1.1	338	1.1	357
Not stated	0.9	292	1.1	342	1.2	416
Invalid				1	0.1	31
Total	100	31,187	100	32,023	100	33,785

As in 2005 and 2006, inpatients from black and minority ethnic groups were concentrated in a relatively small number of organisations: 72% were inpatients in 27 of the 257 organisations that took part in the census. The remaining 28% were spread across 190 organisations that had fewer than 50 inpatients from black and minority ethnic groups each; a further 40 organisations had no inpatients at all from these groups. Figure 1 shows the distribution of minority ethnic patients across providers.



Reporting of ethnicity

Seventy-five per cent of inpatients reported their own ethnic group, and 25% did not. This is the same figure as recorded for 2006, but up from 23% in 2005. Where patients did not report their own ethnic group, staff or relatives did so on their behalf (18% and 6% respectively). We cannot be certain that ethnicity was recorded accurately for these patients.

The proportion of inpatients who reported their own ethnicity ranged from 70% among the Chinese group to 81% among the White/Black Caribbean Mixed, White/Asian Mixed and Black African groups. Reporting of ethnicity by staff was highest among inpatients from the Chinese (23%) and Bangladeshi (22%) groups. Reporting by relatives was highest among the White British and White Irish groups (both 6%), and the Other White group (5%).

Age and gender

Of all inpatients, 2% (581) were under 18 years of age, and 31% (9,715) were 65 or older. The proportion of young people was lower among inpatients from the Indian, Black Caribbean, Black African and Other Black groups than among other minority ethnic groups.

Overall, 56% of inpatients were men, compared to 55% in both 2006 and 2005. In the White British, White Irish, Other White and Chinese groups, there were similar proportions of men and women. In other ethnic groups, higher proportions were men, reaching 79% in the Other Black groups. Table 3 shows the age and gender composition of inpatients.

Table 3: Age and gender of inpatients

Ethnic group	Age (%)				Gender (%)		Total (n)
	0-17	18-24	25-49	50+	Men	Women	
White British	1.8	6.7	38.1	53.4	53.6	46.4	100 (24,198)
White Irish	1.5	2.6	30.7	65.2	56.8	43.2	100 (538)
Other White	2.3	7.5	42.7	47.5	56.6	43.4	100 (1,449)
White and Black Caribbean	3.8	16.7	69.8	9.7	69.4	30.6	100 (288)
White and Black African	3.3	22.0	68.1	6.6	73.6	26.4	100 (91)
White and Asian	3.3	13.2	70.3	13.2	64.8	35.2	100 (91)
Other Mixed	3.9	17.2	67.2	11.7	72.8	27.2	100 (180)
Indian	1.3	9.4	55.7	33.6	63.9	36.1	100 (393)
Pakistani	3.5	14.0	63.8	18.7	73.0	27.0	100 (315)
Bangladeshi	5.4	14.6	60.8	19.2	65.4	34.6	100 (130)
Other Asian	2.7	11.1	65.5	20.7	66.3	33.7	100 (261)
Black Caribbean	0.5	7.8	63.0	28.7	70.2	29.8	100 (1,330)
Black African	1.1	14.5	70.8	13.6	67.7	32.3	100 (648)
Other Black	1.7	10.5	79.6	8.3	78.5	21.5	100 (545)
Chinese	2.4	11.0	56.1	30.5	53.7	46.3	100 (82)
Other	0.8	14.0	57.6	27.5	68.3	31.7	100 (356)
Total	1.9	7.5	42.4	48.3	56.2	43.8	100
	(n= 581)	(n= 2,328)	(n= 13,213)	(n= 15,065)	(n= 17,500)	(n= 13,636)	(n= 31,187)

Language and religion

Six per cent of inpatients reported that their first language was not English – similar to 2006 and 2005. Table 4 shows the proportions of patients with a first language other than English. The groups with the highest proportions of people whose first language was not English were Bangladeshi (48%), Chinese (48%), Other (43%) and Pakistani (38%).

Although we collected information about patients' need for an interpreter, there were problems with this data, and we are therefore not reporting on it.

Table 4: Percentage of inpatients with a first language other than English	
Ethnic group	% with first language other than English
White British	1.6
White Irish	4.5
Other White	23.3
White and Black Caribbean	3.1
White and Black African	12.1
White and Asian	5.6
Other Mixed	6.7
Indian	30.5
Pakistani	37.8
Bangladeshi	47.7
Other Asian	36.0
Black Caribbean	5.6
Black African	25.0
Other Black	10.7
Chinese	47.6
Other	43.1
Total	5.4
Total number	1,674

Fourteen per cent of inpatients said they had no religion and another 15% did not state one. Added together, these proportions were highest among the Chinese group (53%), followed by the Other Mixed (40%), White/Black Caribbean Mixed (39%), White/Black African Mixed (36%), Other Black (31%) and White/Asian Mixed (31%) groups. They were lowest among the White Irish (14%) and South Asian (Indian, Pakistani and Bangladeshi) (under 12%) groups. Table 5 shows the religion of inpatients.

Table 5: Religion of inpatients by ethnic group									
Ethnic group	Religion and faith groups (%)								
	None	Christian	Buddhist	Hindu	Jewish	Muslim	Sikh	Any other religion	Not stated
White British	13.7	66.7	0.5		0.7	0.3		2.2	15.8
White Irish	5.8	80.3	0.7		0.2	0.4	0.2	4.1	8.4
Other White	15.0	59.8	0.6	0.1	2.6	3.6	0.1	3.9	14.3
White and Black Caribbean	22.6	54.5			0.3	2.4		4.2	16.0
White and Black African	20.9	40.7	2.2		1.1	17.6		2.2	15.4
White and Asian	14.4	42.2	2.2	2.2		15.6	3.3	3.3	16.7
Other Mixed	23.0	40.4		1.7	1.1	9.0		7.3	17.4
Indian	5.9	13.8	1.0	29.6	0.3	14.3	28.1	1.8	5.4
Pakistani	2.2	1.6		1.3		87.3	1.3	1.6	4.8
Bangladeshi	3.1	1.5		3.8		85.4	0.8	1.5	3.8
Other Asian	8.1	15.0	5.4	16.9		31.9	9.6	5.4	7.7
Black Caribbean	13.6	60.6	0.6	0.2	0.3	2.7	0.4	8.1	13.6
Black African	13.3	44.7	0.3	0.5	0.2	23.3		6.4	11.5
Other Black	15.7	50.5	0.6		0.4	12.3		5.0	15.7
Chinese	17.1	26.8	15.9					4.9	35.4
Other	13.0	26.8	0.8	2.3	2.0	33.6	0.3	5.4	15.8
Total	13.5	62.6	0.6	0.6	0.7	3.5	0.5	2.9	15.1
	(n= 4,213)	(n= 19,108)	(n= 183)	(n= 196)	(n= 214)	(n= 1,074)	(n= 156)	(n= 871)	(n= 4,611)

Sexual orientation

We asked inpatients who were aged 16 or over (30,804 in total) about their sexual orientation. The results were not valid for 2% of inpatients.

Of the remaining patients, 71% said they were heterosexual, 1% said gay/lesbian, 1% said bisexual, less than 1% said "other", 9% preferred not to say, and 16% chose the "not known" category.

The 16% in the "not known" category almost certainly includes inpatients who were not asked the question by staff, as 127 providers had no inpatients coded as gay/lesbian or bisexual. The overall figure of 2% who said they were gay/lesbian or bisexual is lower than the estimated proportions of gay/lesbian or bisexual people in the general population (these estimates range from 5% to 7%).^{21,22}

The number of non-heterosexuals in minority ethnic groups was very low, so it was not possible to compare the results between groups.

Disability

Approximately 10% (3,068) of inpatients said that they had one or more disability (similar to the 2006 figure of 11%). Of these, 1% were blind, 1% were deaf, 2% had a learning disability, 1% had Autistic Spectrum Disorder and 4% used a wheelchair. The remaining 1% had more than one disability. The proportion of inpatients with a disability was highest among White/Asian Mixed (12%), White British (11%), White Other (11%) and White Irish (10%).

Rates of admission

The rates of admission are given in Appendix B, in Tables 1a (all ages) and 1b (ages 65 and over).

All ages

Men from the White British, Indian and Chinese ethnic groups had lower admission rates than average, by 16%, 24% and 38% respectively. Admission rates were higher than average for men among all other ethnic groups, except Bangladeshi. As in 2006 and 2005, they were particularly high for men from the Black and White/Black Mixed groups, with rates three or more times higher than average. Also, as in the previous two years, the rate was highest among men from the Other Black group – 19 times higher than average.

Admission rates for women showed a broadly similar pattern: rates for White British, Indian and Pakistani ethnic groups were lower than average, by 8%, 32% and 24% respectively.

Women from some other groups, including Other White, had rates higher than average. As in 2006 and 2005, rates were particularly high for women from the Black and White/Black Mixed groups – two or more times higher than average – with the highest being among women from the Other Black group (seven times higher than average).

When we combined the admission rates for both genders, those from the White British, Indian and Chinese groups were lower than the average, and those for all other ethnic groups, except Pakistani and Bangladeshi, were higher than the average. Once again, they were particularly high for the Black and White/Black Mixed groups, with rates three or more times higher than average, and highest – 14 times higher than average – among the Other Black group. These admission patterns are very similar to those we reported in 2006 and 2005, with two exceptions:

- admission rates among the White Irish group were higher than average in both years, but by a smaller margin in 2007 than in 2006 and 2005
- admission rates among the Other White group were higher than average in both years, but by a higher margin in 2007 than in 2006 and 2005

Ages 65 and over

Age-standardised admission rates for minority ethnic groups at older ages show similar patterns to those reported for all ages. Results for a few minority groups (White/Black African Mixed, White/Asian Mixed, Other Mixed) 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

We calculated the admission rates reported above using the 2001 census population estimates from the Office for National Statistics (ONS). However, those estimates do not take account of the substantial increase in the number of people from black and minority ethnic groups in England and Wales since 2001. ONS recently produced updated population estimates by ethnic group for 2004, which aim to reflect some of these changes. ONS describes these estimates as “experimental”, and they are subject to margins of error.

These updated population estimates are only available for England. Furthermore, they do not reflect the demographic changes between 2004 and 2007. With these caveats, we have used these 2004 estimates to re-calculate the admission rates for England. To enable comparisons over time, we have also recalculated the admission rates for England for the censuses of 2005 and 2006, using the 2004 ONS population estimates. These are given in Appendix B, Table 2.

The results show that:

- using the 2004 ONS population estimates instead of the 2001 estimates results in a slight increase in the admission ratios for the White British and White Irish groups, and significantly reduces the admission ratios for minority ethnic groups, although the overall patterns remain the same (see Appendix B, Tables 1 and 2)
- admission ratios across 2005, 2006 and 2007 remain fairly stable and consistent for almost all ethnic groups, as shown by the overlapping confidence intervals for each ethnic group across the three years (see Appendix B, Table 2)
- an exception is the Other White group, for whom both the admission ratio and the underlying numbers of patients have risen consistently across the three years (see Appendix B, Table 2)

Source of referral

People can be referred to healthcare services in a number of ways, and the 2007 census used a more detailed classification of these sources of referral than in 2006 and 2005. For example, we included referrals from court liaison and diversion services. The detailed results are available at: www.healthcarecommission.org.uk/countmein.

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 GPs and accident and emergency (A&E) departments, and may require further interpretation. Furthermore, almost 38% of inpatients were referred from tertiary care, and in these cases, information as to the original referral source was not available. In the case of 6% of all records (1,973), the original source was invalid or unknown.

Because of the changes in classification, we cannot make detailed comparisons with 2006 and 2005. However, we can point to similarities between the two years, such as low rates of referrals from GPs among inpatients from the Black groups and high rates of referrals from the criminal justice system among inpatients from Black Caribbean and Black African groups.

Referrals by self, carer or employer

Of the 2% (641) of inpatients who were referred to hospital by their carer, employer or themselves, nearly all were self-referred or referred by a carer. Very occasionally, they were referred by an employer. Almost no ethnic differences were apparent. These rates of referral are given in Appendix B, Table 3. We can, however, make further observations if we examine referrals by self and carers separately. When examined separately, self-referral rates were higher than average among women from the Other White and men from the White/Black African Mixed groups, and rates for referrals by carers were higher than average among women from the Pakistani group. However, these findings are based on a small number of cases only.

GP referrals

Thirteen per cent (4,165) of inpatients were referred by a GP. Rates among the White British group were 8% higher than average. The three Black groups – Black Caribbean, Black African and Other Black – had rates that were between 54% and 74% lower than average. The Other White and White Irish groups also had a low rate of GP referrals. The rates of referral from GPs are given in Appendix B, Table 4.

Referrals from A&E departments

Five per cent (1,640) of inpatients were referred by A&E departments. The White British group had a 11% lower than average rate of such referrals, while the Bangladeshi, Black African, Other Black and Other groups were more likely to be referred in this way, as were the White Irish and Other White groups.

Referrals from social services

Three per cent (835) of inpatients were referred from social services. Rates of such referrals were lower than average among men from the Other White group, but higher among men from the Indian group and women from the Black Caribbean group. Again, some of these observations are based on a small number of cases.

Referrals from community teams

A quarter (25%) (7,733) of inpatients were referred from community teams. The White British group had a 4% higher than average rate of such referrals. Among the three Black groups (Black Caribbean, Black African and Other Black) and White/Black Caribbean Mixed and Other White groups, these rates were between 18% and 33% lower than average. The rates of referral are given in Appendix B, Table 5.

Referrals from the criminal justice system

Nine per cent of inpatients (2,869) were referred through the criminal justice system. People from the White British group were 7% less likely than average to be referred in this way, whereas the Black Caribbean, Black African and White/Black Caribbean Mixed groups had rates that were higher than average (by 56%, 33% and 33% respectively). Rates were also higher than average among the White/Asian Mixed group (by 86%). No differences from the average rate were observed for other ethnic groups. Rates of referral via the criminal justice system are given in Appendix B, Table 6.

Of all referrals from the criminal justice system, 30% (864) came from the police. Rates for the White British group were 8% lower than average, but they were higher than average among the Black Caribbean and Black African groups, by 56% and 92% respectively.

Just over half (52%) of the referrals from the criminal justice system (1,506) were from prisons. Rates for the White British group were 8% lower than average, but were 52% higher among the Black Caribbean group and 152% higher for the White/Asian Mixed group.

Finally, 16% (445) of the referrals from the criminal justice system were from the courts; rates for the Other White group were 56% lower than average, while for the Black Caribbean group they were 77% higher than average.

Tertiary care: referrals from medium or high secure units

A significant proportion (36%) of all referrals were from tertiary care. Five per cent of inpatients (1,611) were referred from medium or high secure units in the NHS or independent sectors. The rate for such referrals was 9% lower than average among the White British group and was higher than average among the Black Caribbean and Other Black groups – by 67% and 118% respectively, and among the Other Asian group by 53%. No other ethnic differences were observed.

Tertiary care: referrals from other inpatient services

Twenty-one per cent (6,684) of inpatients were referred from other inpatient services, 91% of which were NHS services. The rate for such referrals was 44% higher than average among the Other White group. The rate was lower than average in the Bangladeshi, Black African, Other Black and Other groups.

Tertiary care: referrals from other clinical specialties

Ten per cent (3,011) of inpatients were referred by other clinical specialties. Rates of such referrals were lower than average among the White Irish, Other Black and Other groups.

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

All detentions

Forty-three per cent (13,517) of inpatients were detained under the Mental Health Act on the day of admission to hospital, a slightly higher proportion to that found in 2005 and 2006 (40%). Of all detained patients, 29% (3,952) were from a minority ethnic group.

Detention rates were 6% lower than average among White British patients and 19% lower than average among men from the Indian group. Those from the Black Caribbean, Black African, Other Black and White/Black Caribbean Mixed groups were between 19% and 38% more likely than average to be detained. The Other White group had a 12% higher than average ratio of detention. No other ethnic differences were observed. The rates of detention are given in Appendix B, Table 7.

These patterns are very similar to those reported in 2006 and 2005. The exceptions are:

- the detention rate for the White/Black Caribbean Mixed group was about average in 2005, but was higher than average in 2006 and 2007
- the detention rate for the White/Black African Mixed group was about average in 2005, but was higher than average in 2006 and went back to average in 2007

We analysed detention rates under individual sections of the Mental Health Act, to examine what the high rates for some ethnic groups were attributable to.

Detention under section 2

Section 2 of the Mental Health Act gives authority for a person to be detained in hospital for assessment for a period not exceeding 28 days. It is mainly applied where the patient is unknown to the service or where there has been a significant interval between periods of inpatient treatment. Of all the patients detained under the Mental Health Act, 19% (2,523) were detained under this section.

Rates of detention under section 2 were higher than average among the Black African, Other Asian and Other groups by 68%, 86% and 114% respectively (see Appendix B, Table 8).

In addition we found that:

- the rate for the Pakistani group returned to average in 2007, having been average in 2005 and higher than average in 2006
- the rate for the Black Caribbean group was below average in 2005 and 2006, and average in 2007
- the Black African group had a higher than average rate in 2005, an average rate in 2006, and a higher than average rate in 2007
- the Other Black group had an average rate in 2005, a lower than average rate in 2006, and an average rate again in 2007

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. Of all the patients detained under the Mental Health Act, 48% (6,516) were detained under this section.

No ethnic differences were observed for detentions under section 3 in 2005 and 2006, but in 2007 detention rates among the Black Caribbean, Black African and Other Black groups were 24% to 35% higher than average. They were raised also in the Other White group, by 16%, and among women from the White Irish group by 49%. The rates of detention under section 3 are given in Appendix B, Table 9.

Detention under section 37/41

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

Of the patients detained under the Mental Health Act, 13% (1,759) were detained under section 37 with a section 41 restriction order applied. The rates of detention are given in Appendix B, Table 10. The rate of detention for the White British group was 14% lower than average. The only other ethnic differences observed were the higher than average rates of detention for the Black Caribbean group (111%), the Other Black group (97%) and the White/Black Caribbean group (60%). In all ethnic groups, very few women were detained under section 37/41.

These patterns are very similar to those reported in 2005 and 2006. For all three years, rates of detention were higher than average for the Black Caribbean and Other Black groups. The main changes were:

- the detention rate for the White/Black African Mixed group was higher than average in 2005, but average in 2006 and 2007
- the detention rate for White/Black Caribbean Mixed group was average in 2005 and 2006, but higher than average in 2007

Detention under sections 47, 48 and 47/49

These sections of the Mental Health Act allow the Home Office to issue a direction to transfer a person detained in prison to a hospital for treatment. Of the patients detained under the Mental Health Act, 4% (859) were detained under these sections. The only significant observations were that Black African men had a rate of detention that was 61% lower than the average, while the rate for Black Caribbean men was 42% higher than average and for White/Asian Mixed men it was higher than average by 167%. These rates of detention are given in Appendix B, Table 11. Very few women were detained under these sections, and no ethnic differences were observed. Similar patterns were found in 2006 and 2005.

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

There were no major differences between detention rates on the day of a patient's admission to hospital and on the day of the census. 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 observed also for the Other White group.

Consent

About 28% (4,870) of informally admitted inpatients were deemed incapable of consenting to treatment. The rates of such patients were lower than average among the Black Caribbean and Black African groups, by 23% and 39% respectively.

As for detained inpatients, 21% (2, 713) were deemed incapable of consenting to treatment. These rates were lower than average by 8% in the White British group. They were higher than average among the Black Caribbean, Other Black and White/Black African Mixed groups, and also among the Pakistani group.

In addition, 16% (2,009) of detained inpatients were deemed capable of consenting to treatment but refused to do so. The White British group had a rate of refusals that was 11% lower than average. Rates were higher than average among the three Black groups – Black Caribbean, Black African, Other Black – and the White/Black Caribbean Mixed group. They were also higher than average among the Other White, Bangladeshi and Other Asian groups.

Care programme approach

The care programme approach provides support for people with long-term mental health needs. Patients with complex needs are on an enhanced care programme approach, while others are on a standard care programme approach. We found that 72% of all inpatients were on an enhanced care programme approach. The only ethnic difference observed was that the rate of patients on enhanced care programme approach was 7% higher than average for the Black Caribbean group. There were some differences between 2007, 2006 and 2005:

- in 2007, 72% of all inpatients were on enhanced care programme approach, compared with 66% in 2006 and 58% in 2005
- in 2007, inpatients from the Black Caribbean group were more likely than average to be on enhanced care programme approach. This was also the case in 2005, but in 2006 their rates were average
- in 2007, as in 2005, the rate of inpatients in the Other White group that were on enhanced care programme approach was average, but it was lower than average in 2006

However, the way that trusts classify the standard and enhanced care programme approach can vary widely. The care programme approach is currently under review by the Department of Health.

Recorded incidents

In 2005, we asked about the number of times that patients had been secluded, subjected to 'control and restraint', or injured. In 2006, we expanded this list to include incidents of self-harm, accident and assault, but we did not include incidents of injury. Also, instead of asking about the full range of 'control and restraint' procedures (including incidents that may not have involved physical restraint, such as 'talking down' a patient), we asked only about incidents of 'hands-on restraint'. In 2007, as in 2006, we asked about the number of recorded incidents of self-harm, accidents, hands-on restraint and seclusion, but restricted the definition of assault to physical assault on the patient.

In all cases of recorded incidents, the results relate to the number of incidents in a patient's current hospital spell, or, if the patient's hospital spell was longer than three months, to the number that took place within the last three months.

Seclusion

Three per cent (957) of inpatients had experienced one or more episodes of seclusion. Men from the White British group had a seclusion rate that was 12% lower than average, while men from the Black Caribbean and Other Black groups had higher than average rates, by 33% and 79% respectively. In addition, men from the White/Black African Mixed group had a rate 136% higher than average, but this was based on small numbers. The Other White group had a higher than average rate in both genders, and overall by 60%. The number of incidents of seclusion was low in several minority ethnic groups, particularly among women.

The results show some changes from 2006 and 2005:

- the White British group had a low rate of 11% below average in 2005, an average rate in 2006, and a 12% below average rate in 2007
- the Other White group had an average rate in 2005 and 2006, but a higher than average rate in 2007 for both men and women
- the White/Black Caribbean Mixed group went from having an average rate in 2005 to a rate of 67% above average in 2006 and an average rate again in 2007
- the White/Black African Mixed group had an average rate in 2005 and 2006, but a higher than average rate in 2007 for men
- the Black Caribbean group had rates that were higher than average in 2005, average in 2006 and higher than average again in 2007

Hands-on restraint

Hands-on restraint was defined as the physical restraint of an inpatient by one or more members of staff in response to aggressive behaviour or resistance to treatment. About 11% (3,531) of inpatients had experienced one or more episodes of hands-on restraint. No ethnic differences were observed among either men or women. Similarly, no ethnic differences were observed in 2006, with the exception of patients from the White/Black Caribbean Mixed group, who had a higher than average rate of restraint, but this was not observed in 2007.

Self-harm

Seven per cent (2,234) of inpatients had harmed themselves on one or more occasions. Only the White British group had a rate that was higher than average (by 12%). Rates among the three Black groups (Black Caribbean, Black African and Other Black) were between 66% and 73% lower than average. Rates were also lower among all the South Asian groups: by 41% for Indians, 51% for Pakistanis and 62% for Bangladeshis.

These patterns are very similar to those observed in 2006, with the exception that:

- women in the Other White group had a lower than average rate in 2006, and an average rate in 2007
- the White/Black Caribbean Mixed group had a lower than average rate in 2006, and an average rate in 2007

Comparisons with 2005 are not possible, as this information was not collected for the 2005 census.

Accidents

Approximately 12% (3,668) of inpatients had experienced one or more accidents. Inpatients from the Other White group experienced a rate of accidents that was 28% higher than average. As in 2006, the Black Caribbean and Black African groups had rates that were lower than average, by 45% and 44% respectively. The rate for the Bangladeshi group was lower than average by 67%, but it was based on very few cases.

Again, these patterns are broadly similar to those observed in 2006, with some exceptions:

- the White British group had rates that were slightly higher than average in 2006, but average in 2007
- the Other White group had an average rate in 2006, and an above average rate in 2007
- the Indian group had a below average rate in 2006, but average in 2007
- the Other Black group had a below average rate in 2006, but average in 2007

Comparisons with 2005 are not possible, as this information was not collected for the 2005 census.

Physical assault on the patient

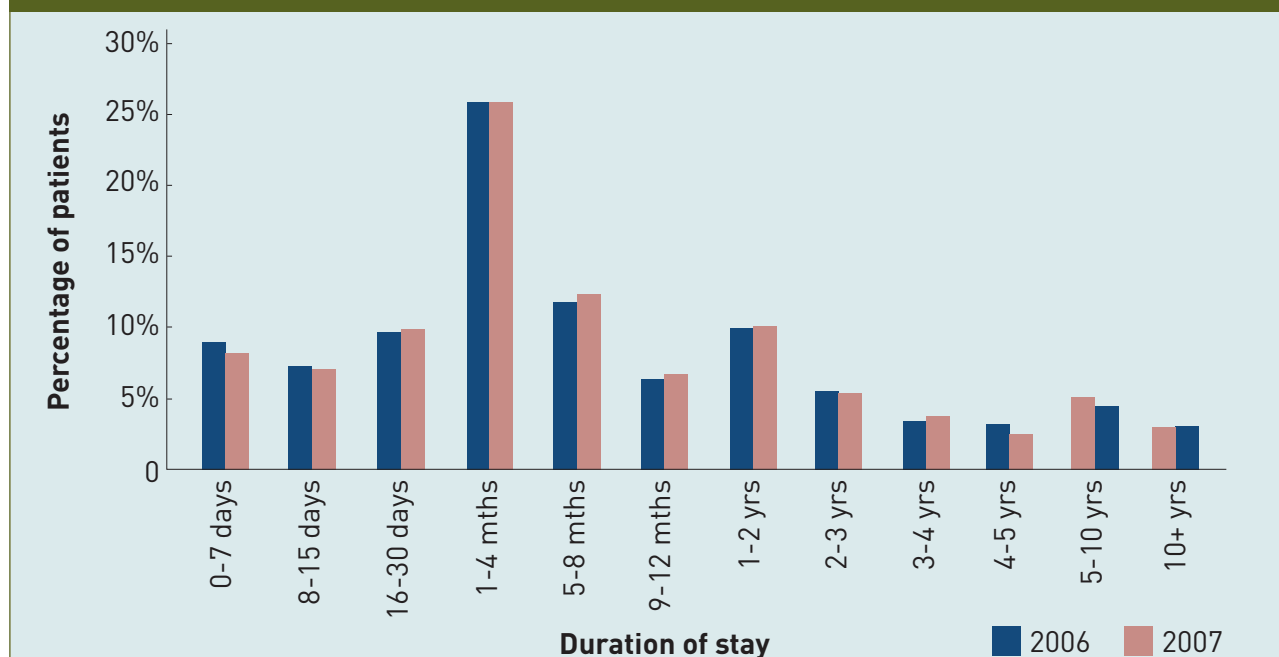
The definition of assault was changed in 2007 to include only incidents of physical assault on the patient, irrespective of who committed the assault (as opposed to all incidents of assault involving a patient). Twelve per cent (3,690) of inpatients were involved in one or more episodes of physical assault. We do not have information on who committed the assault. There were no differences between the rates for different ethnic groups.

Comparisons with previous years are not possible as this information was collected to a different definition in 2006 and not collected at all for the 2005 census.

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. Figure 2 shows the duration from the day of admission to the day of census for all patients in 2007, and a comparison with 2006, which showed very similar patterns.

Figure 2: Duration of patients' stay in hospital from the day of admission to the day of census in 2006 and 2007



The results on the day of the 2007 census found that:

- 25% of inpatients had been in hospital for one month or less
- 26% had been in hospital between one and four months
- 19% had been in hospital between five months and one year
- 10% had been in hospital between one and two years
- 12% had been in hospital between two and five years
- 8% had been in hospital for more than five years

As these figures show, 30% of patients had been in hospital for more than a year. Therefore, almost one-third of the patients covered by the 2007 census were also covered by the 2006 census. These figures are very similar to those reported in the 2006 census.

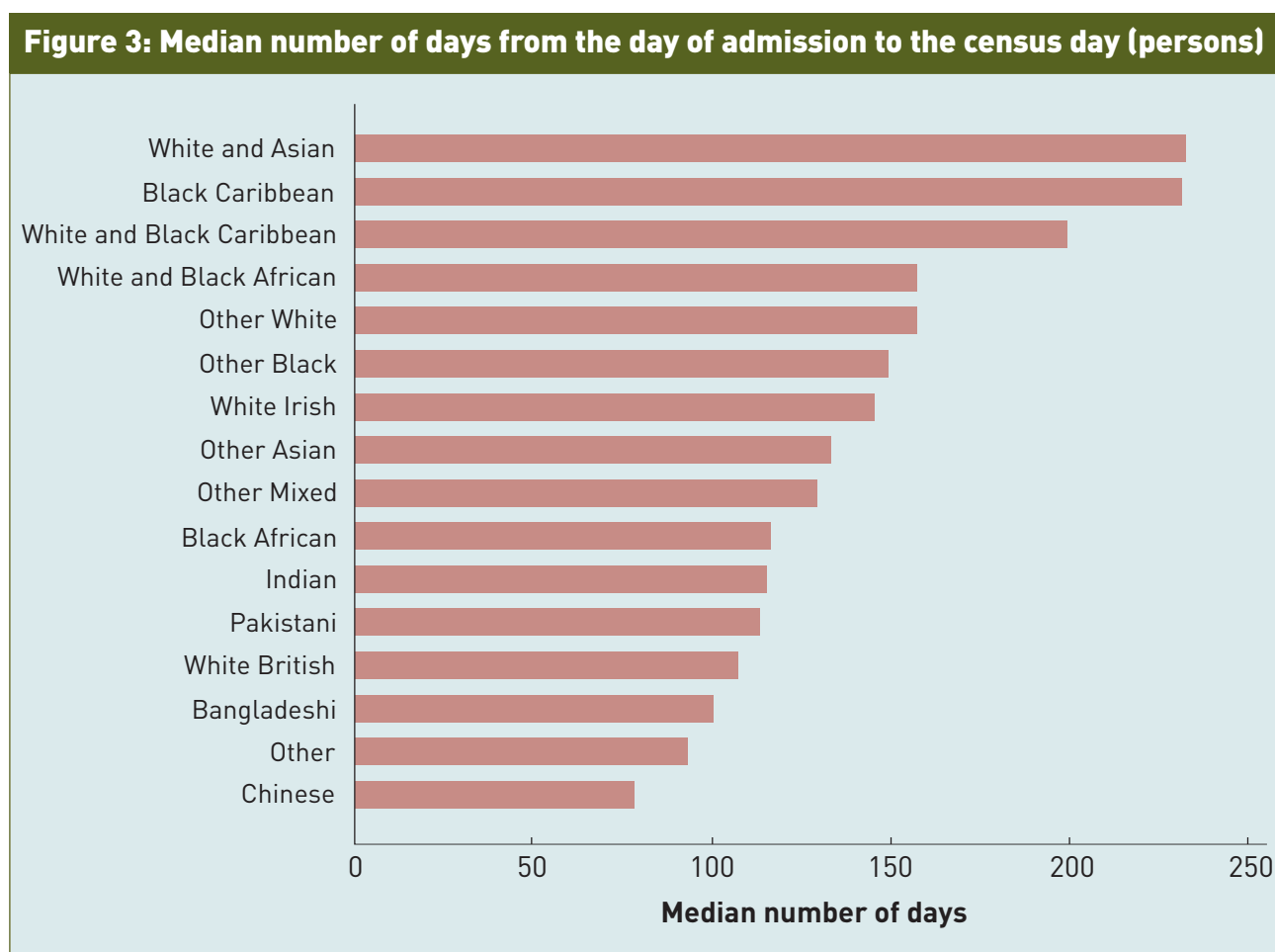
We calculated the median length of stay for different ethnic groups. The median is the mid-point of the range of values, so the median length of stay for a given ethnic group is the one at which half the patients of that ethnic group had a length of stay less than the median, and half had a stay longer than the median. Table 6 shows the median number of days from the day of admission to the day of the census. Overall, the median amount of time that women spent in hospital was about two and a half months, and the median for men was about five months. In most ethnic groups, men had been in hospital for about twice as long as women.

Table 6: Median number of days from the day of admission to the day of census			
Ethnic group	Men	Women	Persons
White British	148	74	107
White Irish	252	92	145
Other White	213	106	157
White and Black Caribbean	232	118	199
White and Black African	185	58	157
White and Asian	351	157	232
Other Mixed	138	98	129
Indian	151	66	115
Pakistani	131	73	113
Bangladeshi	145	71	100
Other Asian	157	76	133
Black Caribbean	282	146	231
Black African	140	74	116
Other Black	176	87	149
Chinese	107	69	78
Other	112	77	93
Total	157	78	115

For both men and women, the median lengths of stay were longest among patients from the White/Asian Mixed and Black Caribbean groups. These were two to three times longer than the shortest median lengths of stay. Patients from the White/Black Caribbean Mixed, White/Black African Mixed and Other White groups also had among the longest lengths of stay. Overall, patients from the Chinese, South Asian and White British groups had shorter durations of stay. Figure 3 shows the median lengths of stay by ethnic group for men and women combined.

These patterns are similar to 2006, when the Black Caribbean group had the longest median length of stay, and Chinese, South Asian, Black African and White British groups had shorter lengths of stay.

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



Ward security

Medium or high secure ward

As in 2006, 12% (3,760) of all patients were on a medium or high secure ward, as opposed to a general or low secure ward.

Patients from the White British and Indian groups were less likely than average to be on a medium or high secure ward, by 9% and 38% respectively. Rates for the Black Caribbean, Other Black and White/Black Caribbean Mixed groups were higher than average, by 60%, 53% and 42% respectively, reflecting similar patterns to those in 2006. The rate for the Other White group was also higher than average, by 27%. In most minority ethnic groups, the numbers of women on medium or high secure wards was low.

High secure ward

As in 2005 and 2006, 3% (824) of all inpatients were on a high secure ward. This figure represents 11% of all those on low, medium, and high secure wards combined.

We calculated the rate for being on a high secure ward out of all those on a secure ward of any type (either low, medium or high secure).

Men from the Other Black group were 47% more likely than average to be on a high secure ward, as opposed to a low or medium secure ward. The number of women on high secure wards was very low in all minority ethnic groups.

Age range on wards

There were 54 inpatients under 18 being cared for on wards for working-age adults and none were on wards for older people. This is a slight increase from 2006, when 43 children were on adult wards, but it is an improvement on 2005, when 128 children were on adult wards and seven were on wards for older people.

Almost 7% (1,469) of inpatients on wards for working-age adults were 65 or over, and 6% (519) of those on wards for older people were adults of working age. There were very few 'out of age' placements among minority ethnic groups, so we could make no significant observations about differences between ethnic groups.

Sex of patients intended to use a ward*

Sixty-eight per cent of patients (20,667) were not in a single sex ward. This was lower among most minority ethnic groups than among the White British group. In almost all ethnic groups, the proportion of men who were not in a single sex ward was lower than among women (see Table 7 for details).

Table 7: Percentage of patients not in a single sex ward by ethnic group						
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	36.0	64.0	22.1	77.9	29.6	70.4
White Irish	39.2	60.8	23.2	76.8	32.3	67.7
Other White	47.0	53.0	26.2	73.8	38.0	62.0
White and Black Caribbean	50.3	49.7	32.9	67.1	45.1	54.9
White and Black African	48.5	51.5	22.7	77.3	42.0	58.0
White and Asian	56.9	43.1	32.3	67.7	48.3	51.7
Other Mixed	47.7	52.3	31.3	68.8	43.3	56.7
Indian	44.9	55.1	19.4	80.6	35.6	64.4
Pakistani	49.6	50.4	36.1	63.9	45.9	54.1
Bangladeshi	34.1	65.9	17.8	82.2	28.5	71.5
Other Asian	50.6	49.4	31.6	68.4	44.5	55.5
Black Caribbean	58.6	41.4	31.9	68.1	50.5	49.5
Black African	49.5	50.5	28.8	71.2	42.9	57.1
Other Black	58.3	41.7	40.5	59.5	54.5	45.5
Chinese	26.2	73.8	21.1	78.9	23.8	76.3
Other	47.1	52.9	27.3	72.7	40.8	59.2
Total	39.6	60.4	23.2	76.8	32.4	67.6

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

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

Results: learning disabilities

We obtained information about 4,153 inpatients in 120 organisations providing services for people with learning disabilities in England and Wales. These organisations comprised all 69 NHS trusts that were eligible to take part in the census (of whom 57 also returned information for their mental health inpatients), and 51 independent healthcare organisations.

Table 8 shows the number of providers and inpatients in the 2007 census and a comparison with 2006. The total number of providers fell from 124 to 120, and the number of patients fell from 4,609 to 4,153. The proportion of inpatients in independent healthcare organisations increased from 20% in 2006 to 23% in 2007. The proportion and numbers of patients in NHS providers declined.

As in 2006, the results we reported in the section for mental health services almost certainly included some inpatients who have a learning disability or Autistic Spectrum Disorder. This was unavoidable due to the considerable overlap between the services for patients with mental health problems and those for patients with learning disabilities. People with a mental health problem who also have a learning disability may be treated in either type of service. However, people with learning disabilities may experience difficulties in accessing mental health services. To address this issue, the Government is encouraging providers of healthcare services to treat people with learning disabilities, who also have a diagnosed mental health problem, in mainstream mental health services.

This is evidenced by the fact that 6% (250) of the inpatients in learning disability services were recorded as being there for a mental health problem. Most of these inpatients did also have a learning disability or Autistic Spectrum Disorder (including Asperger's syndrome), but this was not the main reason they were in hospital. A few had neither a learning disability nor Autistic Spectrum Disorder, and were in hospital solely because of a mental health problem or personality disorder. For reasons explained in the earlier section on data, methods of analysis and interpretation, these patients are included in this section rather than in the section on mental health.

Provider	2007 census			2006 census		
	Number of providers	Number of inpatients	% of inpatients	Number of providers	Number of inpatients	% of inpatients
NHS (England)	64	3,063	73.8	70	3,505	76.0
Independent (England)	47	900	21.7	48	930	20.2
NHS (Wales)	5	154	3.7	5	164	3.6
Independent (Wales)	4	36	0.9	1	10	0.2
Total	120	4,153	100	124	4,609	100

Ethnicity

Information on ethnicity was available for 99% of inpatients. Of these, 12% were from black and minority ethnic groups, defined as all groups that are not White British (i.e. White Irish and Other White groups are counted among the black and minority ethnic groups). This figure is significantly lower than the 22% of inpatients using mental health services who were from minority ethnic groups, and is similar to the 11% reported in 2006.

The White British ethnic group comprised 88% of inpatients, 5% were from Black or White/Black Mixed groups, 2% were from South Asian groups (Indian, Pakistani, Bangladeshi and Other Asian), 1% were White Irish, 3% were from Other White groups, and 2% were from other ethnic groups (including Chinese). After the White British group, the largest groups of inpatients were Other White and Black Caribbean. These patterns are very similar to 2006, except for the increase in the number of patients from the Other White group. This is similar to the increase in mental health inpatients from the Other White group.

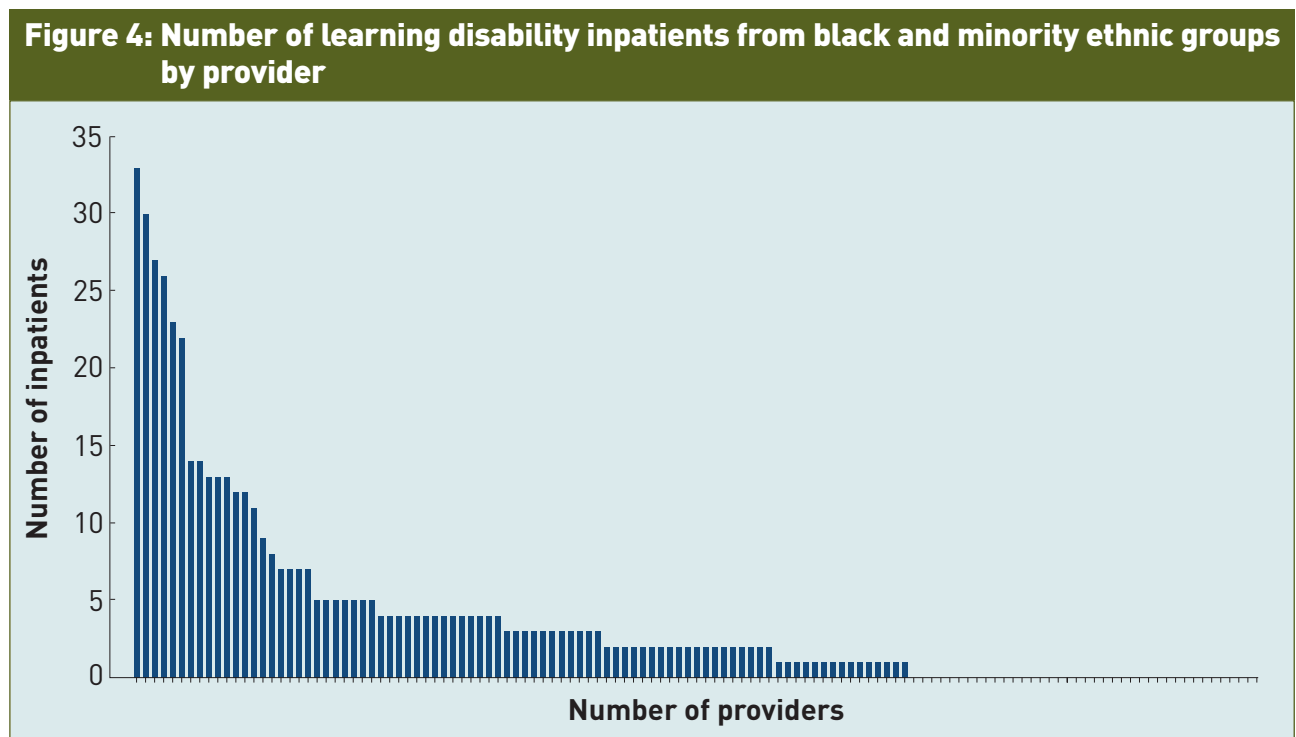
Table 9 shows the ethnic group of inpatients. Some ethnic groups had very few inpatients, which limits the observations that we were able to make.

Ethnic group	2007 census		2006 census	
	%	Number	%	Number
White British	88.3	3,642	88.7	4,037
White Irish	1.0	40	1.4	66
Other White	2.6	109	1.7	77
White and Black Caribbean	0.8	34	0.7	32
White and Black African	0.2	10	0.1	3
White and Asian	0.3	13	0.2	9
Other Mixed	0.4	16	0.3	14
Indian	0.8	32	1.1	49
Pakistani	0.8	32	0.7	34
Bangladeshi	0.3	11	0.2	9
Other Asian	0.2	8	0.3	12
Black Caribbean	2.6	108	2.8	129
Black African	0.8	33	0.7	33
Other Black	0.4	18	0.4	17
Chinese	0.2	8	0.2	7
Other	0.2	10	0.5	24
Total	100	4,124	100	4,552

Approximately 71% (343) of inpatients from black and minority ethnic groups were inpatients in 27 of the 120 organisations that took part in the census.

The remaining 29% were spread across a number of organisations: 58 of the 120 organisations had fewer than five inpatients each from black and minority ethnic groups, and 36 had none. Figure 4 shows the distribution of inpatients across providers.

It is important to note, however, 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

Less than half (41%) of inpatients reported their own ethnic group, compared with 75% of inpatients in mental health services who did so. Staff reported the ethnic group for 37% of inpatients, and relatives for 20%. It is, therefore, possible that ethnicity could have been misreported, and that this misreporting could vary by ethnic group.

The proportion of inpatients who reported their own ethnicity was lowest among the Other Asian, Black African, White/Asian Mixed and Black Caribbean groups.

Age and gender

Two per cent (82) of inpatients were under 18 and 28% (1,143) were 50 or over. As with mental health inpatients, the proportion of people under 50 was higher among inpatients from black and minority ethnic groups than among the White British group. This is not surprising, given the fact that the general population of England and Wales has a higher proportion of young people among most black and minority ethnic groups than among the British White group. Almost two-thirds (66%) of inpatients in learning disability services were men, whereas in mental health services 56% of inpatients were men. Table 10 gives the age and gender composition of inpatients.

Table 10: Age and gender of inpatients in learning disability services				
Ethnic group	Age (%)		Gender (%)	
	Under 50	50 and over	Men	Women
White British	70.0	30.0	65.3	34.7
White Irish	85.0	15.0	70.0	30.0
Other White	88.1	11.9	77.1	22.9
White and Black Caribbean	97.1	2.9	76.5	23.5
White and Black African	90.0	10.0	70.0	30.0
White and Asian	100.0	0.0	69.2	30.8
Other Mixed	87.5	12.5	68.8	31.3
Indian	78.1	21.9	68.8	31.3
Pakistani	90.7	9.4	87.5	12.5
Bangladeshi	100.0	0.0	90.9	9.1
Other Asian	100.0	0.0	75.0	25.0
Black Caribbean	94.4	5.6	72.0	28.0
Black African	90.6	9.4	84.4	15.6
Other Black	100.0	0.0	66.7	33.3
Chinese	75.0	25.0	75.0	25.0
Other	90.0	10.0	60.0	40.0
Total	72.4	27.6	66.4	33.6

Language and religion

Ten per cent (397) of inpatients reported that their first language was not English, an increase on 2006 of 5%. Non-verbal communication, a code newly added to the list, was the most often selected language after English, accounting for 7% of inpatients (288).

Regarding religion, 13% of inpatients said they had none, and another 18% did not state one. South Asians (Indians, Bangladeshis and Pakistanis) were mostly Muslim, Hindu or Sikh, and those from the Black and White/Black Mixed groups were mostly Christian.

Sexual orientation

We asked the 4,090 inpatients who were aged 16 and over about their sexual orientation. Of these, 16% declined to answer the question, and for another 42% of inpatients, the results were not known. Therefore we do not know the sexual orientation of about 59% (2,330) of inpatients who were eligible to be asked about it.

Of those who answered the question about sexual orientation, 36% said they were heterosexual, 2% said gay/lesbian, 2% said bisexual, and 1% said 'other'.

The proportion of non-heterosexuals in each minority ethnic group was very low (zero or in single figures), so further analysis of ethnic group by sexual orientation was not possible.

Disability

Of all inpatients in learning disability services:

- 61% (2,517) had either a learning disability or Autistic Spectrum Disorder, with some recorded as having both
- 34% (1,429), including many from minority ethnic groups, had more than one disability
- 4% (173) were reported to have no disability (although for 55 of these the reason given for their being treated in hospital was a learning disability)
- a few inpatients (17) were reported to be blind, deaf or using a wheelchair

Rates of admission

The rates of admission are given in Appendix C, Table 1.

Admission rates were lower than average for men from the Indian, Other Asian and Chinese groups, by 63%, 63% and 56% respectively. Admission rates were about three times higher than average for men from the White/Black Caribbean Mixed, Black Caribbean and Other Black groups.

Although the numbers of women were low in most minority ethnic groups, the patterns of admission were similar to those for men. Admission rates for women from the Other White, Indian, Pakistani and Black African groups were lower than average (40%, 64%, 73%, 59% respectively). Rates were about double the average among women from the White/Black Caribbean Mixed, Black Caribbean and Other Black groups.

The rates of admission for both genders combined were lower than average among the South Asian, Chinese and White Irish groups. They were lower for Indians by 64%, Pakistanis by 37%, Other Asians by 63% and Chinese by 61%. Rates for the White/Black Caribbean Mixed, White/Black African Mixed, Black Caribbean and Other Black groups were between two and three times higher than average. These results are similar to those for inpatients in mental health establishments, particularly the lower rates among Indian and Chinese groups and the higher rates among the Black groups.

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

Changes in population estimates

We calculated the admission rates reported above using the 2001 census population estimates from the Office for National Statistics (ONS). However, those estimates do not take account of the substantial increase in the number of people from black and minority ethnic groups in England and Wales since 2001. ONS recently produced updated population estimates by ethnic group for 2004, which aim to reflect some of these changes. ONS describes these estimates as “experimental”, and they are subject to margins of error.

These updated population estimates are only available for England. Furthermore, they do not reflect the demographic changes between 2004 and 2007. With these caveats, we have used these 2004 estimates to re-calculate the admission rates for England. To enable comparisons over time, we have also recalculated the admission rates for England for the census of 2006, using the 2004 ONS population estimates. These are given in Appendix C, Table 2.

The results show that:

- as with mental health, using the ONS population estimates from 2004 instead of 2001 results in a slight increase in the admission ratios for the White British and White Irish groups in 2007, and significantly reduces the admission ratios for minority ethnic groups, although the overall patterns remain the same (see Appendix C, Tables 1 and 2)
- admission ratios across 2006 and 2007 remain fairly stable and consistent for almost all ethnic groups, as shown by the overlapping confidence intervals for each ethnic group across the two years (see Appendix C, Table 2)
- an exception is the Other White group, for whom both the admission ratio and the underlying numbers of patients have risen between 2006 and 2007 (see Appendix C, Table 2)

Source of referral

As we stated in the section on results for mental health inpatients, we must be careful when interpreting data about sources of referral, particularly in the case of inpatients with learning disabilities, since this information was invalid, missing or unknown for 12% (482) of them. The detailed results are available at: www.healthcarecommission.org.uk/countmein.

Referrals by self, carer or employer

Of the 7% (283) of inpatients who were referred to hospital through these routes, nearly all (96%) were referred by carers. As in 2006, the rate for referrals by carers was double the average among the Black Caribbean group, although this is based on an observation of only 13 inpatients.

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

Five per cent (220) of inpatients were referred from medium or high secure units in the NHS or independent sector. The rate for such referrals was higher than average among the White Irish group, although this was based on just eight patients.

Other sources of referral

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

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

All detentions

Of all the inpatients in learning disability services, 39% (1,617) were detained under the Mental Health Act on admission. Of these, 17% (274) were from minority ethnic groups – a lower proportion than the 29% found among inpatients in mental health services, but slightly higher than the 15% reported for learning disability patients in 2006.

Rates of detention on the day of admission by ethnic group are in Appendix C, Table 2. The only ethnic difference observed was the higher than average rate among the Other White group, by 50%. 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.

On the day of the census, the rate of detention was higher than average for both the Other White and the White Irish groups.

Consent

About 73% (1,774) of informally admitted inpatients were deemed incapable of consenting to treatment. The only ethnic difference observed was the lower than average rates for the White Irish and Other White groups, but this was based on small numbers of patients.

Among detained patients, 38% (585) were deemed incapable of consenting to treatment. The only ethnic difference observed was the higher than average rates for the White Irish and Other White groups.

In addition, 8% (131) of detained patients were deemed capable of consenting to treatment but refused. No ethnic differences were observed.

Care programme approach

The care programme approach provides support for people with long-term mental health needs. Patients with complex needs are on an enhanced care programme approach, while others are on a standard care programme approach.

About 54% (2,247) of all inpatients in learning disability services were on the enhanced care programme approach. This compares to 72% of mental health patients. The only ethnic difference observed was the higher than average proportion of inpatients on the enhanced care programme approach amongst the Other White ethnic group (29% higher than average).

Recorded incidents

In 2007, as in 2006, we asked about the number of recorded incidents of self-harm, accidents, hands-on restraint, seclusion, and physical assault on the patient. In all cases, the results relate to the number of incidents in a patient's current hospital spell, or, if the patient's hospital spell was longer than three months, to the number that took place within the last three months. The results were similar to those for 2006.

Seclusion

Five per cent (208) of inpatients had experienced one or more episodes of seclusion. The rate of seclusion among the White Irish and Other White group was higher than average, although this was based on small numbers of patients.

Physical assault on the patient

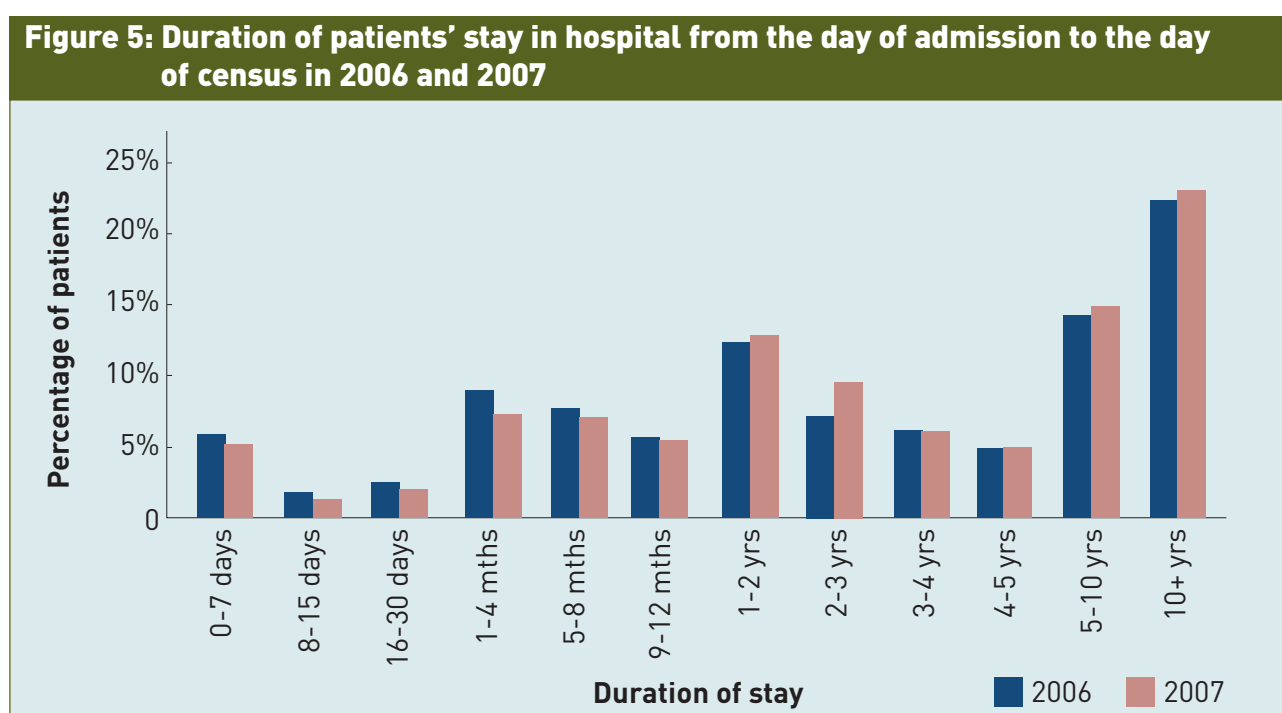
The definition of assault was changed in 2007 to include only incidents of physical assault on the patient, irrespective of who committed the assault (as opposed to all incidents of assault involving a patient). About 30% (1,229) of inpatients had been involved in one or more episodes of physical assault. We do not have information on who committed the assault. The only ethnic difference observed was the 39% higher than average rate among the Black Caribbean group.

Hands-on restraint, self-harm, accidents

Twenty-six per cent (1,067) of inpatients had experienced one or more episodes of hands-on restraint, 21% (876) had attempted to harm themselves and 24% (993) had suffered an accident. We observed no differences in the results for various ethnic groups.

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. Figure 5 shows the duration from the day of admission to the day of census for all patients in 2007, and a comparison with 2006, which showed very similar patterns.



The results on the day of the 2007 census found that:

- 8% of inpatients had been in hospital for a month or less
- 7% had been in hospital between one and four months
- 13% had been in hospital between five months and one year
- 13% had been in hospital between one and two years
- 21% had been in hospital between two and five years
- 38% had been in hospital for over five years

These figures are very similar to those reported in the 2006 census. As the figures show, 72% of patients had been in hospital for over a year. Therefore, almost three-quarters of the patients covered by the 2007 census were also covered by the 2006 census.

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 38 months, and the median for men was about 35 months, slightly longer than in 2006 (36 and 32 months respectively). This compares with a median for mental health patients of two and a half months for women and five months for men. It is difficult to compare length of stay by ethnic group because of the small numbers of patients among several of the groups.

Ward security

Eleven per cent (472) of all inpatients were on a medium or high secure ward, rather than a general or low secure ward. Rates of inpatients on medium or high security wards were about three times higher than average among the White Irish and Other White groups. However, this is based on small numbers. Most minority ethnic groups had very few inpatients on medium or high secure wards, and we could see no differences in the results between ethnic groups.

Age range on wards

Of the inpatients aged 18 or under, 16 were being cared for on wards for adults of working age. In addition, about 5% (210) of inpatients on wards for adults of working age were older people (aged 65 or over).

Sex of patients intended to use a ward*

Sixty per cent of inpatients (2,504) were not in a single sex ward. The proportion of patients in such accommodation was lower among most minority ethnic groups than among the White British. However, the number of people in some minority ethnic groups was very small.

* A ward can be described as single sex (ie the intended sex of the ward is **either** male **or** female and **not** mixed) when the accommodation complies with the following definition of single sex accommodation from the Department of Health: "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).

Ethnicity of staff in NHS mental health and learning disability services

Though we do not have information about the ethnicity of staff working in independent hospitals and facilities, figures from the Department of Health show that minority ethnic groups are well represented among staff working in NHS facilities (see Tables 11a and 11b). In 2006, about 54% of all medical staff in these NHS establishments were from black and minority ethnic groups, including about a quarter who were from Asian groups, 3% from Black groups, 2% from Mixed groups and 11% from non-British White groups. Among the non-medical staff, 28% were from black and minority ethnic groups, including 3% who were from Asian groups, 6% from Black groups, 1% from Mixed groups and 5% from non-British White groups. The ethnic group was not known for 7% of medical staff and for 10% of non-medical staff.

To comply with the Race Relations Amendment Act, NHS providers are required to undertake ethnic monitoring of all staff. We recommend they do so as a matter of urgency.

Table 11a: NHS Hospital and Community Health Services: ethnicity of medical and dental staff employed by trusts taking part in the 2007 census					
Ethnic category code		Specialties			
Census groups	Census categories	Mental health	Learning disabilities	Other specialties	Total
White	British	39.2%	38.3%	53.4%	45.6%
White	Irish	2.2%	2.4%	1.5%	1.9%
White	Any other White background	10.2%	5.2%	7.8%	9.0%
Mixed	White and Black Caribbean	0.1%	0.2%	0.2%	0.1%
Mixed	White and Black African	0.5%	0.4%	0.2%	0.4%
Mixed	White and Asian	0.6%	0.0%	0.7%	0.6%
Mixed	Any other mixed background	0.6%	0.6%	0.8%	0.7%
Asian or Asian British	Indian	21.1%	24.0%	14.7%	18.3%
Asian or Asian British	Pakistani	3.9%	4.2%	2.8%	3.4%
Asian or Asian British	Bangladeshi	0.6%	0.6%	0.4%	0.5%
Asian or Asian British	Any other Asian background	4.7%	6.5%	2.9%	4.0%
Black or Black British	Caribbean	0.2%	0.2%	0.4%	0.3%
Black or Black British	African	3.2%	4.0%	1.9%	2.6%
Black or Black British	Any other Black background	0.5%	0.6%	0.3%	0.4%
Other Ethnic Groups	Chinese	0.6%	1.0%	1.4%	1.0%
Other Ethnic Groups	Any other ethnic group	4.8%	4.8%	3.2%	4.1%
Not Stated	Not stated/invalid	7.0%	6.9%	7.3%	7.1%
Total		8,756	496	7,605	16,857

Source: The Information Centre for Health and Social Care, data from 2006 Workforce Census

Table 11b: NHS Hospital and Community Health Services: ethnicity of non-medical staff employed by trusts taking part in the 2007 Census

Ethnic category code		Census categories	Admin- istration & estates staff	Ambulance staff	General payments	Healthcare assistants & support staff	Healthcare scientists	Nursing, midwifery & health visiting learners	Nursing, midwifery & health visiting staff	Scientific therapeutic & technical staff	Total
Census groups											
White		British	82.3%	94.7%	86.2%	70.7%	76.7%	74.2%	66.7%	78.8%	72.3%
White		Irish	1.1%	0.0%	1.5%	0.9%	0.8%	0.9%	1.6%	1.6%	1.4%
White		Any other White background	3.3%	0.0%	1.1%	7.0%	4.1%	2.9%	2.8%	5.9%	3.8%
Mixed		White and Black Caribbean	0.3%	0.0%	0.0%	0.4%	0.2%	0.3%	0.3%	0.3%	0.3%
Mixed		White and Black African	0.1%	0.0%	0.0%	0.3%	0.1%	0.3%	0.3%	0.2%	0.2%
Mixed		White and Asian	0.1%	0.0%	0.0%	0.2%	0.2%	0.2%	0.2%	0.4%	0.2%
Mixed		Any other mixed background	0.3%	0.0%	0.0%	0.3%	0.3%	0.7%	0.3%	0.5%	0.3%
Asian or Asian British		Indian	1.7%	0.0%	1.9%	1.3%	2.4%	1.1%	1.7%	1.8%	1.7%
Asian or Asian British		Pakistani	0.5%	0.0%	0.0%	0.4%	1.2%	0.4%	0.2%	0.5%	0.3%
Asian or Asian British		Bangladeshi	0.1%	0.0%	0.0%	0.1%	0.3%	0.0%	0.1%	0.2%	0.1%
Asian or Asian British		Any other Asian background	0.5%	0.0%	0.0%	0.8%	1.2%	1.9%	1.9%	0.6%	1.3%
Black or Black British		Caribbean	1.8%	1.4%	0.0%	2.2%	1.1%	2.4%	2.1%	1.0%	1.9%
Black or Black British		African	0.9%	0.0%	0.0%	3.5%	2.3%	5.2%	4.9%	0.9%	3.3%
Black or Black British		Any other Black background	0.4%	0.0%	0.0%	0.6%	0.4%	0.9%	0.5%	0.3%	0.5%
Other Ethnic Groups		Chinese	0.2%	0.0%	0.0%	0.2%	0.7%	0.0%	0.5%	0.3%	0.4%
Other Ethnic Groups		Any other ethnic group	0.7%	0.0%	0.0%	1.6%	1.6%	1.8%	2.0%	1.0%	1.5%
Not Stated		Not stated/invalid	5.7%	3.9%	9.3%	9.5%	6.4%	6.7%	14.0%	6.0%	10.5%
Total			57,409	107	68	29,919	3,757	796	138,101	33,691	263,848

Source: The Information Centre for Health and Social Care, data from 2006 Workforce Census

Conclusions

Mental health

Observations on the census data

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

- the overall number of mental health inpatients in England and Wales fell by 8% between the 2005 and 2007 censuses (although the 2005 baseline may have included some patients with learning disabilities)
- the proportion of inpatients receiving care from independent providers is rising (an increase of 31% since 2005) and the proportion in NHS providers is falling (a decrease of 12% since 2005). The proportion of inpatients receiving care from independent providers increased from 10% of the total in 2005, to 11% in 2006 and to 14% in 2007
- while the numbers and proportions of patients in most minority ethnic groups have been relatively stable, the numbers and proportions of patients from the Other White group increased across the three years
- ethnic differences in rates of admission, detention among those admitted, sources of referral and length of stay from admission to census day, remained relatively stable across the three years
- in all three years, admission rates were higher than average among minority ethnic groups other than the Indian, Pakistani, and Chinese groups, with particularly high rates among the Black Caribbean, Black African, Other Black, White/Black Caribbean Mixed and White/Black African Mixed groups, and a rising rate among the Other White groups
- although the data on sources of referral is qualified, the Black Caribbean, Black African and Other Black groups had consistently lower than average rates of referral via GPs and community mental health teams and higher rates of referral via the criminal justice system
- overall rates of detention were consistently higher than average among the Black Caribbean, Black African and Other Black groups, and detention under section 37/41 (imposed by courts) was higher in the Black Caribbean and Other Black groups
- lengths of stay were longest in the Black Caribbean group and shortest among South Asian and Chinese groups
- rates of self-harm and accidents were generally low in the Black Caribbean, Black African and Other Black groups of patients, as were rates of self-harm in Indian, Pakistani and Bangladeshi groups

- some changes in patterns from one census to the next (for example in rates of seclusion) may be due to changes in the small numbers of affected patients in the individual minority ethnic groups on census day, leading to a statistical phenomenon known as 'regression to the mean'. This means that rates based on small and fluctuating numbers of patients can change in either direction (high to low or vice versa), from one year to the next, as a result of random rather than real variation
- it was not possible to obtain good quality data on sexual orientation

Implications for the way forward

The findings of this third census show differences **between** black and minority ethnic groups and white groups, and also differences **within** these groups. The patterns are broadly similar to those observed in both 2006 and 2005. The census was designed to support the goals of the Government's five-year plan *Delivering Race Equality in Mental Health Care* by providing an annual profile of inpatients in mental health services. It was not designed to provide explanations for the patterns observed, or examine whether mental health services are meeting the needs of individual ethnic minority groups, and the results contain caveats that must be considered when interpreting the results (see section on data, methods of analysis and interpretation).

The factors that contribute to these findings are complex and may differ between ethnic groups and areas. The findings need to be interpreted in the context of available evidence on variations in the rates of mental illness and the different pathways to care taken by black and minority ethnic groups and the possible contributory factors. Some recent publications provide further information on these issues.²³⁻⁴⁰ When interpreting the results, it must be noted that several factors may affect levels of mental illness and the likelihood of admission and detention for different black and minority ethnic groups. Studies of first episodes of psychosis show variations in incidence and that socio-economic factors influence pathways into admission for some ethnic groups.^{25-27, 36} Other studies focus on the role that services could play in bringing rates down.³⁴ All factors must be considered in order to understand the problems and deliver the solutions.

Healthcare organisations are required to work towards achieving the goals set out in the action plan in *Delivering Race Equality* to improve mental health services for black and minority ethnic communities.

However, delivering race equality in mental health is complex, and a multi-agency response is needed to understand the problems and deliver the solutions. Mental health services have a key role to play, but partnership with statutory organisations outside the healthcare sector, black and minority ethnic communities and service users themselves will be needed to help achieve this.

The importance of better information

Again, we stress the vital importance of having a comprehensive patient-level data set with ethnicity and other key variables fully coded. This enables the care provided to patients of all ethnic backgrounds to be monitored on an ongoing basis, irrespective of the place of treatment. The Hospital Episode Statistics (HES) and the Mental Health Minimum Data Set (MHMDS) are mandated data sets for NHS trusts, and improved recording and data quality must be a priority for the NHS. Recording ethnicity for patients is mandatory and supports compliance with the Race Relations Amendment Act and the Department of Health's core standards. However, the quality, coverage and completeness of ethnicity data in mental health services needs to improve.⁴¹

The Healthcare Commission, MHAC and NIMHE expect commissioners and providers of mental healthcare in the NHS and independent sector to have systems for fully comprehensive recording and monitoring of ethnicity on an ongoing basis, in accordance with guidance provided by the Department of Health.⁴² The Healthcare Commission uses these data sets in a range of assessments of the performance of NHS organisations, and organisations with poor quality data will be penalised in the annual review of performance.

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

- recording of the ethnicity of patients should urgently be made mandatory for all patients, regardless of whether they are treated in the community or a hospital
- some changes and extensions should be made to the MHMDS, including the recording of religion and language
- in particular, changes and enhancements to current data collections (MHMDS and HES) are urgently needed to support effective monitoring of the Mental Health Act 2007
- submission of the MHMDS and HES should be made mandatory for all independent providers of inpatient mental health services, especially in view of the growing number and proportion of all mental health inpatients cared for in these establishments

Such improvements in the information that is currently available for NHS providers and, in particular, for independent sector providers, are imperative for effective monitoring of the quality of care provided to **all** those who use mental health services, including those from black and minority ethnic groups. Having information that is fit for purpose is also vital for the effective regulation of mental healthcare services. We have made most of these recommendations in both the previous *Count me in* reports, and now reiterate the need for their urgent implementation.

The Healthcare Commission is also promoting these developments through participation in the Department of Health's programme of work on information for equality monitoring, led by the Permanent Secretary Hugh Taylor.

These initiatives have the strong support of the Mental Health Act Commission.

In addition, the Healthcare Commission is also working with the Department of Health and the Information Centre for Health and Social Care to move forward on including information about disability, including learning disability, in all patients' records.

Table 1 in Appendix D shows the variable level of ethnicity coding in both HES and MHMDS among mental health service providers in the NHS. This ranges from 55% to 100% in HES with a national average of 93%, and from 62% to 100% in MHMDS with a national average of 94%. These data were included in the Healthcare Commission's 2006/2007 annual health check of NHS organisations. (The list of trusts will not match those participating in the 2007 census for a variety of reasons.) While the level of ethnicity coding has improved over the previous year, it still needs to be more complete. The Healthcare Commission, MHAC and NIMHE also expect providers in the independent sector to adopt comprehensive ethnicity coding, as this is good practice for any healthcare provider and professional.

The census counts patients on one day of the year. It is important to remember that the number of inpatients in mental health and learning disability hospitals throughout the year is much higher, and that some patients will have more than one admission. Table 2 in Appendix D shows the estimated numbers of mental health patients in 2005/2006 from MHMDS and HES. The key points to note are:

- overall, there were almost 180,000 mental health-related first admissions during the year (HES)
- there were almost 26,000 learning disability-related first admissions during the year (HES)
- several patients had more than one admission (HES)
- there were 1.1 million care spells that did not involve an inpatient stay (MHMDS)
- ethnicity coding for mental health inpatients on HES and MHMDS is about 90% complete
- ethnicity coding for MHMDS care spells without a hospital admission (i.e. where care was provided outside hospital) was significantly lower, at 67%. It should, however, be noted that currently recording of ethnicity is mandated by the Department of Health only for inpatients
- ethnicity coding for learning disability inpatients on HES was almost 80% complete
- the ethnicity profile of patients in the MHMDS and HES is very similar. There are also similarities with the census for most groups. However, ethnic differences in length of stay could contribute to any differences, as long-stay patients will be over-represented in the census

The Healthcare Commission, MHAC and NIMHE expect NHS commissioners and providers to be using the census data and these data sets for monitoring care for patients of all ethnic groups all year round. Independent sector providers should also be using their information sources for comprehensive and continuous monitoring.

Learning disabilities

Observations on the census data

As with mental health, the census showed a decline in the number of inpatients in learning disability services between 2006 and 2007, and also an increasing proportion of inpatients in hospitals run by independent providers. Apart from this, the patterns were very similar to those reported in 2006. Rates of admission remained lower than average among the South Asian and Chinese groups, and were between two and three times higher than average in the Black and White/Black Mixed groups. The data suggests that some of these inpatients were in hospital primarily for a mental health problem rather than a learning disability. In contrast to 2006, when there were no ethnic differences in detention rates, the Other White group had a higher than average detention rate in 2007.

We found no differences between ethnic groups in the rates of hands-on restraint, self-harm and accidents, and some differences in rates of seclusion and assault. However, it is difficult to draw conclusions because the number of inpatients from minority ethnic groups involved in these cases was low, and the rates could reflect random variation as a result of this.

The Department of Health's *Valuing People* White Paper offers guidance on issues of ethnicity and cultural competence.⁶ In addition, its Learning Disability Taskforce has published *Learning difficulties and ethnicity: A framework for action*,⁴³ which partnership boards can use to ensure that their services are meeting the needs of people from minority ethnic communities. The Disability Discrimination Act aims to end discrimination against disabled people in a range of circumstances, and also places a range of duties upon the NHS regarding the provision of services to disabled people.

The Healthcare Commission's recent investigations into services for people with learning disabilities provided by Sutton and Merton Primary Care Trust and Cornwall Partnership NHS Trust, and the recently published intervention at Bromley Primary Care Trust, showed patients with learning disabilities receiving poor quality, unsafe services and abuse. We urge all providers of learning disability services to review the findings of these investigations, and learn any lessons from them, to avoid the risk of such serious failures of care recurring.

The importance of better information

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

A further issue relating to patients with a learning disability concerns the recording of disability, including learning disability, which is currently not a requirement in the data routinely collected by the Department of Health. We are working with the Department of Health and the Information Centre for Health and Social Care to move forward on including information about disabilities in patients' records.

References

1. Healthcare Commission, Mental Health Act Commission, National Institute for Mental Health in England (2005), *Count me in: results of a national census of inpatients in mental health hospitals and facilities in England and Wales*
www.healthcarecommission.org.uk/_db/_documents/04021830.pdf
2. Healthcare Commission, Mental Health Act Commission, National Institute for Mental Health in England (2007), *Count me in: results of the 2006 national census of inpatients in mental health and learning disability services in England and Wales*
www.healthcarecommission.org.uk/_db/_documents/Count_Me_In_2006.pdf
3. Department of Health (2005), *Delivering Race Equality in Mental Health Care: an action plan for reform inside and outside services*
4. Department of Health (2004), *National Standards, Local Action: Health and Social Care Standards and Planning Framework 2005/06-2007/08*
5. Welsh Assembly Government (2006), *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
6. Department of Health (2001), *Valuing people: a new strategy for learning disability for the 21st century*. www.archive.official-documents.co.uk/document/cm50/5086/5086.htm
7. Personal Social Services Statistics Wales 2004-05
www.lgdu-wales.gov.uk/eng/Project.asp?id=SXB0CC-A77F9233
8. British Institute of Learning Disabilities: www.bild.org.uk/
9. Hassiotis A, Barron P, O'Hara J (2000), *Mental health services for people with learning disabilities*. *BMJ* (2000) 321:583-584
10. Disability Rights Commission (2005), *Equal treatment investigation*
www.equalityhumanrights.com/en/publicationsandresources/Disability/Pages/Formalinvestigations.aspx
11. National Patient Safety Agency (2004), *Understanding the patient safety issues for people with learning disabilities*
12. Department of Health (2000), Mir G, Nocon A, Ahmad W, Jones L, *Learning difficulties and ethnicity* www.dh.gov.uk/assetRoot/04/01/46/99/04014699.pdf
13. Department of Health (2005), *Improving the life chances of disabled people*

14. Department of Health (2005), *Learning Disability Taskforce: annual report, 2004*
www.dh.gov.uk/assetRoot/04/11/25/54/04112554.pdf
15. Mencap: www.mencap.org.uk/html/campaigns/deathbyindifference/DBIreport.pdf
16. Healthcare Commission (2005), *The national audit of violence (2003-2005)*
www.healthcarecommission.org.uk/_db/_documents/04017451.pdf
17. Mental Health Act Commission (2006), *In Place of Fear: Eleventh Biennial Report 2003-2005*
18. Office for National Statistics (2003), Table ST101 Sex and age by ethnic group 2001
Census: Standard Tables
19. 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
20. Office for National Statistics (2006), *New Population Estimates by Ethnic Group*
www.statistics.gov.uk/StatBase/Product.asp?vlnk=14238
21. *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
22. Department of Trade and Industry (2003), *Amendment to Employment Equality (Sexual Orientation) Regulations 2003*
www.dti.gov.uk/files/file24232.pdf?pubpdfload=03%2F1700
23. Cantor-Graae E, Selten JP, Schizophrenia and migration: a meta-analysis and review,
American Journal of Psychiatry 2005;162:12-24
24. Cooper B, Immigration and schizophrenia: the social causation hypothesis revisited,
British Journal of Psychiatry 2005;186:361-363
25. Fearon P, Kirkbride JB, Morgan C, et al, Incidence of schizophrenia and other psychoses
in ethnic minority groups: results from the MRC AESOP study, *Psychological Medicine*
2006;36:1-10
26. Morgan C, Hutchinson G, Bagalkote H et al, Pathways to care and ethnicity. 1: sample
characteristics and compulsory admission. Report from the AESOP study. *British
Journal of Psychiatry* 2005;186:281-289

27. Morgan C, Hutchinson G, Bagalkote H et al, Pathways to care and ethnicity. 2: source of referral and help-seeking. Report from the AESOP study. *British Journal of Psychiatry* 2005;186:290-296
28. Bhui K, Stansfeld S, Hull S, et al, Ethnic variations in pathways to and use of specialist mental health services in the UK: systematic review. *British Journal of Psychiatry* 2003;182:105-116
29. Bhugra D, Bhui K, African-Caribbeans and schizophrenia: contributing factors. *Advances in Psychiatric Treatment* 2001;7:283-293
30. Bhui K, Bhugra D, Mental illness in Black and Asian ethnic minorities: pathways to care and outcomes. *Advances in Psychiatric Treatment* 2002;8:26-33
31. Sharpley MS, Hutchinson G, Murray RM, McKenzie K, Understanding the excess of psychosis among the African-Caribbean population in England: review of current hypotheses. *British Journal of Psychiatry* 2001;178:s60-s68
32. Bhugra D, Mallett R, Leff J, Schizophrenia and African-Caribbeans: a conceptual model of aetiology. *International Review of Psychiatry* 1999;11:145-152
33. Morgan C, Mallet R, Leff J, Negative pathways to psychiatric care and ethnicity: the bridge between social science and psychiatry. *Social Science and Medicine* 2004; 58: 739-752
34. McKenzie K, Bhui K. Institutional racism in mental health care, *BMJ* 2007;334:649-650 www.bmj.com/cgi/content/full/334/7595/649?maxtoshow=&HITS=10&hits=10&RESULTFORMAT=&fulltext=bhui&searchid=1&FIRSTINDEX=0&resourcetype=HWCIT
35. Singh SP, Burns T, Race and mental health: there is more to race than racism. *BMJ* 2006;333:648-651 www.bmj.com/cgi/content/full/333/7569/648
36. Morgan C, Kirkbride J, Leff J, Craig T, Hutchinson G, McKenzie K, Morgan K, Dazzan P, Doody GA, Jones P, Murray R, Fearon P. Parental separation, loss and psychosis in different ethnic groups: a case-control study. *Psychological Medicine*. 2007;37(4):495-503
37. King M, Nazroo J, Weich S, McKenzie K, Bhui K, Karlson S, Stansfeld S, Tyrer P, Blanchard M, Lloyd K, McManus S, Sproston K, and Erens B, Psychotic symptoms in the general population of England. A comparison of ethnic groups (The EMPIRIC study). *Soc Psychiatry Psychiatr Epidemiol* 2005; 40: 375-381
38. Singh SP, Greenwood N, White S, Churchill R, Ethnicity and the Mental Health Act 1983: systematic review. *British Journal of Psychiatry* 2007;191:99-105

39. Bhui K, Stansfield S, McKenzie K, et al, Racial/ethnic discrimination and common mental disorders among workers: findings from the EPIRIC Study of Ethnic Minority Groups in the United Kingdom. *American Journal of Public Health* 2005;95:406-501
40. Nazroo J, The structuring of ethnic inequalities in health: economic position, racial discrimination, and racism. *American Journal of Public Health* 2003;93:277-284
41. Aspinall PJ, Informing progress towards race equality in mental healthcare: is routine data collection adequate? *Advances in Psychiatric Treatment* 2006;12:141-151
42. Department of Health (2005), *Collecting ethnic category data – training materials and guidance*:
www.dh.gov.uk/en/Publicationsandstatistics/Statistics/StatisticalCollection/DH_4049499
43. Valuing People Support Team/Department of Health (2004), *Learning Difficulties and Ethnicity: A Framework for Action*
www.valuingpeople.gov.uk/dynamic/valuingpeople87.jsp

Appendix A: Methods of analysis

Standardisation by age and gender

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

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

The total population of England and Wales, based on figures from the 2001 census by the Office for National Statistics (ONS), was used to standardise the rates of admission. In addition, we calculated the admission rates using the ONS population estimates for 2004 (England only). For other analyses, we used the total population of inpatients in the census as the basis for standardisation. We used the statistical package STATA version 8.2 to derive the standardised results.

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

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

Confidence intervals as indicators of significant statistical differences

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

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

Appendix B: Mental health tables

Appendix B Table 1a: 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	Standardised admission ratio	95% confidence interval		Observed	Standardised admission ratio	95% confidence interval		Observed
		Lower	Upper			Lower	Upper			Lower	Upper	
White British	84	83	86	12,944	92	91	94	11,210	88	87	89	24,154
White Irish	123	109	137	305	111	97	127	232	118	108	128	537
Other White	175	163	187	820	187	173	203	628	180	171	189	1,448
White and Black Caribbean	550	476	632	200	330	265	407	88	457	406	513	288
White and Black African	397	308	504	67	220	141	328	24	328	264	402	91
White and Asian	150	114	193	59	127	87	179	32	141	114	173	91
Other Mixed	402	336	477	131	209	155	277	49	321	276	372	180
Indian	76	67	86	250	68	57	81	141	73	66	81	391
Pakistani	121	106	138	230	76	61	94	85	104	93	117	315
Bangladeshi	121	97	150	85	112	81	149	45	118	98	140	130
Other Asian	201	172	233	173	214	172	264	88	205	181	231	261
Black Caribbean	535	501	570	932	307	277	339	396	438	414	462	1,328
Black African	330	300	362	439	251	218	287	209	299	277	323	648
Other Black	1927	1749	2119	428	743	614	890	117	1436	1318	1562	545
Chinese	62	45	83	44	79	56	108	38	69	55	85	82
Other	383	336	434	243	233	192	280	113	318	285	352	356
Total	100			17,350	100			13,495	100			30,845

Appendix B Table 1b: Standardised admission ratios by ethnic group for England and Wales, using 2001 ONS census population denominators (England & Wales = 100). Ages 65 and over

Ethnic group	Persons aged 65 and over			
	Standardised admission ratio	95% confidence interval		Observed
		Lower	Upper	
White British	94	92	96	8,493
White Irish	133	116	152	228
Other White	286	260	313	446
White and Black Caribbean	268	156	428	17
White and Black African	103	12	372	2
White and Asian	70	23	164	5
Other Mixed	134	58	264	8
Indian	78	58	102	53
Pakistani	72	45	111	21
Bangladeshi	146	75	255	12
Other Asian	168	104	257	21
Black Caribbean	366	318	420	208
Black African	291	199	411	32
Other Black	434	237	728	14
Chinese	43	14	100	5
Other	649	468	877	42
Total	100			9,607

Appendix B Table 2: Standardised admission ratios by ethnic group for England, 2005, 2006, 2007, using 2004 ONS census population denominators (England = 100)

Ethnic group	2007 (persons)				2006 (persons)				2005 (persons)			
	Standardised admission ratio	95% confidence interval		Observed	Standardised admission ratio	95% confidence interval		Observed	Standardised admission ratio	95% confidence interval		Observed
		Lower	Upper			Lower	Upper			Lower	Upper	
White British	89	88	90	22,153	90	89	91	22,836	91	90	93	24,356
White Irish	121	111	132	511	123	113	134	531	147	136	158	665
Other White	155	147	164	1,385	127	119	134	1,133	104	98	111	995
White and Black Caribbean	377	334	424	273	374	331	422	271	312	274	353	248
White and Black African	264	212	324	90	298	243	362	101	182	141	232	67
White and Asian	114	92	141	88	138	113	167	106	119	96	144	99
Other Mixed	258	220	299	171	251	214	292	166	227	194	265	163
Indian	63	57	70	384	66	59	72	399	66	60	72	428
Pakistani	90	81	101	312	100	90	111	344	87	78	97	322
Bangladeshi	100	84	119	129	120	102	141	153	106	90	125	147
Other Asian	168	148	189	260	163	143	184	251	157	138	177	259
Black Caribbean	416	394	439	1,317	389	368	411	1,244	397	376	419	1,351
Black African	216	200	234	638	216	200	234	635	200	184	216	631
Other Black	1,253	1,150	1,363	544	1,212	1,111	1,320	527	1,195	1,098	1,298	560
Chinese	47	38	59	81	43	34	54	73	43	34	54	78
Other	222	199	247	352	205	183	229	323	202	182	225	343
Total	100			28,688	100			29,093	100			30,712

Appendix B Table 3: Standardised ratio of proportion of patients referred by self, carer or employer (England and Wales = 100)

Ethnic group	Men				Women				Persons			
	Standardised ratio	95% confidence interval		Observed	Standardised ratio	95% confidence interval		Observed	Standardised ratio	95% confidence interval		Observed
		Lower	Upper			Lower	Upper			Lower	Upper	
White British	99	87	113	235	90	79	103	232	95	86	104	467
White Irish	94	31	219	5	171	78	325	9	132	72	222	14
Other White	119	70	188	18	163	105	243	24	141	101	190	42
White and Black Caribbean	73	15	214	3	265	97	578	6	141	65	269	9
White and Black African	288	78	737	4	0	0	591	0	199	54	509	4
White and Asian	83	2	464	1	0	0	453	0	50	1	277	1
Other Mixed	37	1	204	1	162	20	585	2	76	16	221	3
Indian	165	71	324	8	174	64	378	6	168	92	283	14
Pakistani	107	35	251	5	230	75	537	5	146	70	269	10
Bangladeshi	57	1	317	1	175	21	634	2	104	21	303	3
Other Asian	115	31	294	4	46	1	254	1	88	29	206	5
Black Caribbean	89	51	145	16	84	36	166	8	87	56	130	24
Black African	55	18	129	5	133	53	274	7	84	43	147	12
Other Black	128	64	228	11	100	21	292	3	120	66	202	14
Chinese	0	0	416	0	109	3	607	1	55	1	309	1
Other	124	45	269	6	221	81	481	6	159	82	277	12
Total	100			323	100			312	100			635

Appendix B Table 4: Standardised ratio of proportion of patients referred by GP (England and Wales = 100)

Ethnic group	Men				Women				Persons			
	Standardised ratio	95% confidence interval		Observed	Standardised ratio	95% confidence interval		Observed	Standardised ratio	95% confidence interval		Observed
		Lower	Upper			Lower	Upper			Lower	Upper	
White British	110	104	115	1,614	107	102	112	2,081	108	105	112	3,695
White Irish	74	50	105	30	75	51	106	31	74	57	96	61
Other White	65	49	83	59	66	51	84	66	65	55	78	125
White and Black Caribbean	73	33	138	9	42	12	108	4	60	32	102	13
White and Black African	26	1	144	1	43	1	238	1	32	4	117	2
White and Asian	81	17	237	3	27	1	153	1	54	15	139	4
Other Mixed	106	46	208	8	52	11	152	3	82	41	147	11
Indian	101	62	154	21	75	41	125	14	89	62	123	35
Pakistani	52	22	102	8	76	31	157	7	61	34	101	15
Bangladeshi	110	40	239	6	19	0	108	1	66	27	136	7
Other Asian	109	58	187	13	40	11	102	4	77	45	124	17
Black Caribbean	28	18	43	22	54	36	77	30	39	29	51	52
Black African	30	13	60	8	21	7	48	5	26	14	44	13
Other Black	56	31	93	15	25	5	72	3	46	27	73	18
Chinese	65	8	235	2	66	14	194	3	66	21	153	5
Other	96	56	153	17	71	35	126	11	84	56	121	28
Total	100			1,836	100			2,265	100			4,101

Appendix B Table 5: Standardised ratio of proportion of patients referred by mental health community team (including crisis resolution, home treatment) or learning disability community team (England and Wales = 100)

Ethnic group	Men				Women				Persons			
	Standardised ratio	95% confidence interval		Observed	Standardised ratio	95% confidence interval		Observed	Standardised ratio	95% confidence interval		Observed
		Lower	Upper			Lower	Upper			Lower	Upper	
White British	106	102	110	2,852	103	100	107	3,285	104	102	107	6,137
White Irish	96	73	123	61	97	75	124	64	96	80	115	125
Other White	62	51	75	106	72	60	86	129	67	59	76	235
White and Black Caribbean	63	41	92	26	85	53	129	22	72	53	95	48
White and Black African	65	30	124	9	99	40	204	7	77	44	125	16
White and Asian	49	18	107	6	139	74	237	13	88	53	138	19
Other Mixed	89	57	132	24	91	48	155	13	90	63	124	37
Indian	120	92	153	62	113	82	150	46	117	96	141	108
Pakistani	128	98	165	61	104	68	153	26	120	96	148	87
Bangladeshi	80	44	134	14	114	64	188	15	95	63	136	29
Other Asian	112	80	152	40	110	73	159	28	111	86	141	68
Black Caribbean	86	73	100	165	76	61	94	87	82	72	93	252
Black African	80	62	100	72	79	58	104	48	79	66	95	120
Other Black	64	48	83	56	84	57	121	29	70	56	86	85
Chinese	88	38	173	8	84	38	159	9	86	50	137	17
Other	78	55	106	39	80	52	118	26	79	61	100	65
Total	100			3,601	100			3,847	100			7,448

Appendix B Table 6: Standardised ratio of proportion of patients referred by criminal justice routes (police, prison, probation, courts, court liaison and diversion) (England and Wales = 100)

Ethnic group	Men				Women				Persons			
	Standardised ratio	95% confidence interval		Observed	Standardised ratio	95% confidence interval		Observed	Standardised ratio	95% confidence interval		Observed
		Lower	Upper			Lower	Upper			Lower	Upper	
White British	93	88	98	1,510	95	86	105	388	93	89	97	1,898
White Irish	96	65	138	30	120	55	228	9	101	72	138	39
Other White	86	70	106	92	90	58	134	24	87	72	104	116
White and Black Caribbean	126	92	168	46	180	86	330	10	133	100	173	56
White and Black African	94	49	165	12	127	15	460	2	98	53	164	14
White and Asian	211	132	320	22	51	1	282	1	186	118	279	23
Other Mixed	118	80	168	30	35	1	197	1	110	75	156	31
Indian	82	56	116	31	43	9	126	3	76	52	106	34
Pakistani	104	75	141	42	19	0	106	1	95	68	127	43
Bangladeshi	123	75	190	20	0	0	139	0	106	65	163	20
Other Asian	101	68	145	30	122	45	265	6	104	73	144	36
Black Caribbean	151	131	173	206	199	139	277	35	156	137	177	241
Black African	127	104	155	102	171	104	264	20	133	110	159	122
Other Black	110	87	137	81	181	97	310	13	116	94	142	94
Chinese	105	45	207	8	0	0	193	0	84	36	165	8
Other	127	95	167	52	115	42	250	6	126	96	163	58
Total	100			2,314	100			519	100			2,833

Appendix B Table 7: Standardised detention ratios by ethnic group: detention on day of admission (England and Wales = 100)

Ethnic group	Men				Women				Persons			
	Standardised ratio	95% confidence interval		Observed	Standardised ratio	95% confidence interval		Observed	Standardised ratio	95% confidence interval		Observed
		Lower	Upper			Lower	Upper			Lower	Upper	
White British	94	92	97	5,989	94	91	97	3,427	94	92	96	9,416
White Irish	106	89	124	141	117	93	144	85	110	96	125	226
Other White	110	100	121	450	116	102	131	255	112	104	121	705
White and Black Caribbean	122	103	143	151	112	81	151	43	119	103	138	194
White and Black African	118	88	155	50	130	71	219	14	120	93	154	64
White and Asian	127	93	170	46	88	46	154	12	117	89	151	58
Other Mixed	102	81	126	85	93	56	146	19	100	82	121	104
Indian	81	67	97	113	105	79	136	57	88	75	102	170
Pakistani	92	77	110	128	115	83	155	42	97	83	113	170
Bangladeshi	100	75	130	53	122	77	183	23	105	83	132	76
Other Asian	110	91	132	114	112	80	152	41	111	94	130	155
Black Caribbean	131	121	141	673	161	141	183	236	138	129	147	909
Black African	116	103	129	316	155	130	184	134	125	114	137	450
Other Black	131	118	146	342	140	109	176	71	133	120	146	413
Chinese	95	61	140	25	132	80	203	20	108	79	145	45
Other	114	97	133	163	106	77	141	45	112	97	128	208
Total	100			8,839	100			4,524	100			13,363

Appendix B Table 8: 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 ratio	95% confidence interval		Observed	Standardised ratio	95% confidence interval		Observed	Standardised ratio	95% confidence interval		Observed
		Lower	Upper			Lower	Upper			Lower	Upper	
White British	98	91	104	916	96	90	102	977	97	92	101	1,893
White Irish	83	49	132	18	81	47	129	17	82	57	114	35
Other White	86	64	112	51	93	70	122	53	89	73	108	104
White and Black Caribbean	78	41	137	12	76	28	165	6	78	46	123	18
White and Black African	78	21	199	4	279	102	607	6	137	66	252	10
White and Asian	67	14	195	3	70	8	251	2	68	22	158	5
Other Mixed	168	98	270	17	0	0	84	0	117	68	188	17
Indian	107	66	166	20	102	54	175	13	105	72	148	33
Pakistani	80	44	134	14	105	45	207	8	88	55	133	22
Bangladeshi	153	74	282	10	148	54	323	6	151	87	246	16
Other Asian	198	130	291	26	164	87	281	13	186	132	254	39
Black Caribbean	78	59	102	54	123	89	165	44	93	76	114	98
Black African	149	110	196	50	202	143	277	38	168	135	207	88
Other Black	86	57	124	28	124	66	212	13	95	68	129	41
Chinese	90	19	263	3	263	120	499	9	178	92	310	12
Other	223	160	303	41	196	120	303	20	214	163	274	61
Total	100			1,267	100			1,225	100			2,492

Appendix B Table 9: 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 ratio	95% confidence interval		Observed	Standardised ratio	95% confidence interval		Observed	Standardised ratio	95% confidence interval		Observed
		Lower	Upper			Lower	Upper			Lower	Upper	
White British	97	93	101	2,713	92	88	96	1,883	95	92	98	4,596
White Irish	95	71	123	55	149	114	192	60	117	97	140	115
Other White	113	98	129	203	122	103	143	153	116	105	129	356
White and Black Caribbean	107	81	137	59	110	71	162	25	108	86	133	84
White and Black African	126	81	188	24	94	34	204	6	118	80	169	30
White and Asian	87	48	147	14	99	43	195	8	91	57	138	22
Other Mixed	106	76	145	40	92	46	164	11	103	77	135	51
Indian	78	58	104	48	124	88	170	39	94	75	116	87
Pakistani	89	67	116	55	139	93	198	30	102	81	126	85
Bangladeshi	79	48	123	19	144	82	233	16	99	69	138	35
Other Asian	94	68	126	43	116	75	172	25	101	78	128	68
Black Caribbean	118	104	133	265	180	152	211	150	135	122	148	415
Black African	114	96	135	139	146	115	184	74	124	108	141	213
Other Black	124	105	147	143	136	98	185	41	127	109	147	184
Chinese	111	59	190	13	114	54	209	10	112	71	168	23
Other	94	72	122	60	82	50	126	20	91	72	113	80
Total	100			3,893	100			2,551	100			6,444

Appendix B Table 10: 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 ratio	95% confidence interval		Observed	Standardised ratio	95% confidence interval		Observed	Standardised ratio	95% confidence interval		Observed
		Lower	Upper			Lower	Upper			Lower	Upper	
White British	84	79	90	915	96	83	111	183	86	81	91	1,098
White Irish	144	99	201	34	57	7	206	2	132	93	183	36
Other White	112	88	139	78	122	68	201	15	113	91	139	93
White and Black Caribbean	155	105	219	31	200	65	467	5	160	112	221	36
White and Black African	146	70	269	10	0	0	523	0	133	64	244	10
White and Asian	154	71	293	9	0	0	415	0	134	61	254	9
Other Mixed	67	31	127	9	235	48	687	3	81	42	142	12
Indian	69	40	113	16	32	1	176	1	65	38	104	17
Pakistani	133	90	190	30	42	1	236	1	124	84	176	31
Bangladeshi	139	72	242	12	84	2	467	1	132	70	226	13
Other Asian	95	54	154	16	44	1	246	1	89	52	143	17
Black Caribbean	212	182	245	180	198	113	322	16	211	182	242	196
Black African	118	88	155	52	94	31	220	5	115	87	150	57
Other Black	200	159	247	84	155	50	362	5	197	158	242	89
Chinese	47	6	168	2	111	3	621	1	58	12	169	3
Other	94	59	142	22	41	1	230	1	89	57	134	23
Total	100			1,500	100			240	100			1,740

Appendix B Table 11: 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 ratio	95% confidence interval		Observed	Standardised ratio	95% confidence interval		Observed	Standardised ratio	95% confidence interval		Observed
		Lower	Upper			Lower	Upper			Lower	Upper	
White British	96	88	105	527	96	72	125	56	96	89	104	583
White Irish	158	92	253	17	101	3	564	1	153	91	243	18
Other White	124	90	166	44	149	55	325	6	126	94	166	50
White and Black Caribbean	102	53	178	12	221	27	798	2	110	60	185	14
White and Black African	73	15	214	3	0	0	1452	0	69	14	201	3
White and Asian	267	122	507	9	0	0	1139	0	244	111	462	9
Other Mixed	98	42	193	8	446	54	1612	2	116	56	214	10
Indian	80	38	148	10	0	0	352	0	74	36	136	10
Pakistani	84	42	151	11	117	3	651	1	86	45	151	12
Bangladeshi	96	31	223	5	0	0	878	0	89	29	207	5
Other Asian	52	17	121	5	0	0	473	0	48	16	112	5
Black Caribbean	142	109	181	64	197	64	460	5	145	113	183	69
Black African	39	19	71	10	55	1	308	1	40	20	71	11
Other Black	125	84	178	30	89	2	495	1	123	84	175	31
Chinese	40	1	225	1	0	0	1237	0	36	1	201	1
Other	121	69	196	16	0	0	472	0	114	65	185	16
Total	100			772	100			75	100			847

Appendix C: Learning disabilities tables

Appendix C Table 1: Standardised admission ratios by ethnic group for England and Wales, using 2001 ONS census population denominators (England & Wales = 100)

Ethnic group	Men				Women				Persons			
	Standardised admission ratio	95% confidence interval		Observed	Standardised admission ratio	95% confidence interval		Observed	Standardised admission ratio	95% confidence interval		Observed
		Lower	Upper			Lower	Upper			Lower	Upper	
White British	100	96	104	2,375	104	99	110	1,261	101	98	104	3,636
White Irish	78	52	113	28	59	31	103	12	71	51	97	40
Other White	106	84	131	84	60	39	89	25	90	74	109	109
White and Black Caribbean	374	244	548	26	236	102	465	8	329	228	459	34
White and Black African	214	86	441	7	199	41	582	3	209	100	385	10
White and Asian	121	55	230	9	124	34	317	4	122	65	209	13
Other Mixed	178	89	318	11	164	53	382	5	173	99	281	16
Indian	37	23	56	22	36	17	66	10	36	25	51	32
Pakistani	78	52	113	28	27	7	68	4	63	43	89	32
Bangladeshi	76	37	140	10	18	0	101	1	59	30	106	11
Other Asian	37	14	81	6	35	4	127	2	37	16	72	8
Black Caribbean	264	208	330	77	175	118	250	30	231	189	279	107
Black African	106	70	155	27	41	13	96	5	85	58	120	32
Other Black	287	148	502	12	276	101	601	6	283	168	448	18
Chinese	44	16	95	6	30	4	108	2	39	17	77	8
Other	49	18	107	6	55	15	142	4	51	25	95	10
Total	100			2,734	100			1,382	100			4,116

Appendix C Table 2: Standardised admission ratios by ethnic group for England, 2006, 2007, using 2004 ONS census population denominators (England = 100)

Ethnic group	2007 (persons)				2006 (persons)			
	Standardised admission ratio	95% confidence interval		Observed	Standardised admission ratio	95% confidence interval		Observed
		Lower	Upper			Lower	Upper	
White British	104	101	108	3,452	104	101	107	3,790
White Irish	79	57	108	40	114	87	145	63
Other White	78	64	95	109	52	41	64	77
White and Black Caribbean	273	189	382	34	226	154	321	31
White and Black African	149	68	282	9	46	9	134	3
White and Asian	99	53	169	13	63	29	120	9
Other Mixed	133	74	219	15	106	57	182	13
Indian	30	20	42	30	44	33	59	48
Pakistani	54	37	77	32	54	37	75	34
Bangladeshi	50	25	90	11	38	17	72	9
Other Asian	30	13	59	8	42	22	73	12
Black Caribbean	217	177	262	106	239	199	284	128
Black African	61	42	86	32	58	40	81	33
Other Black	238	141	376	18	194	111	315	16
Chinese	27	12	53	8	22	9	46	7
Other	36	17	66	10	80	51	119	24
Total	100			3,927	100			4,297

Appendix C Table 3: Standardised detention ratios by ethnic group: detention on day of admission (England and Wales = 100)

Ethnic group	Persons			
	Standardised ratio	95% confidence interval		Observed
		Lower	Upper	
White British	96	91	102	1,324
White Irish	144	93	215	24
Other White	150	119	186	82
White and Black Caribbean	104	62	164	18
White and Black African	98	32	229	5
White and Asian	109	44	225	7
Other Mixed	92	37	189	7
Indian	89	46	156	12
Pakistani	121	73	189	19
Bangladeshi	129	56	254	8
Other Asian	52	6	187	2
Black Caribbean	116	87	152	53
Black African	116	69	184	18
Other Black	125	57	236	9
Chinese	120	33	307	4
Other	99	27	254	4
Total	100			1,596

Appendix D: Ethnicity coding in HES and MHMDS

Appendix D Table 1: Ethnicity coding in HES and MHMDS					
	Organisation	*HES (financial year 2006/2007, quarter 1 to quarter 3)	*MHMDS (financial year 2006/2007, quarter 1 data only)	MHMDS (financial year 2005/2006, records with no bed days recorded)	MHMDS (financial year 2005/2006, records with bed days recorded)
ENG	England	92.7%	94.2%	67.3%	92.7%
	5AN North East Lincolnshire Primary Care Trust	90.0%	89.0%	59.6%	79.6%
2	5AT Hillingdon Primary Care Trust			73.4%	84.2%
2	5CD North Dorset Primary Care Trust			96.8%	
	5CN Herefordshire Primary Care Trust	90.5%	98.5%	92.3%	94.4%
	5CQ Milton Keynes Primary Care Trust	93.6%	94.3%	68.5%	90.3%
2	5CY West Norfolk Primary Care Trust			83.8%	97.5%
2	5DD Morecambe Bay Primary Care Trust			60.9%	91.5%
2	5E2 Selby and York Primary Care Trust			76.7%	91.9%
	5EF North Lincolnshire Primary Care Trust	95.5%	94.8%	57.4%	89.7%
	5F1 Plymouth Teaching Primary Care Trust	98.0%	99.7%	60.5%	99.5%
2	5FD East Hampshire Primary Care Trust			81.0%	84.8%
	5FE Portsmouth City Teaching Primary Care Trust	91.3%	90.6%	70.5%	94.6%
2	5HV Dudley, Beacon & Castle Primary Care Trust			83.1%	100.0%
	5JE Barnsley Primary Care Trust	96.3%	98.8%	63.1%	90.3%
2	5KH Hambleton And Richmondshire Primary Care Trust			73.2%	93.1%
2	5KJ Craven, Harrogate and Rural District Primary Care Trust			74.8%	98.1%
	5M2 Shropshire County Primary Care Trust	94.8%	99.0%	38.5%	94.2%
	5M3 Walsall Teaching Primary Care Trust	98.9%	99.6%	93.6%	100.0%
2	5MD Coventry Primary Care Trust			60.8%	99.9%
2	5MP North Warwickshire Primary Care Trust			99.9%	100.0%

Appendix D Table 1: Ethnicity coding in HES and MHMDS (continued)						
		Organisation	*HES (financial year 2006/2007, quarter 1 to quarter 3)	*MHMDS (financial year 2006/2007, quarter 1 data only)	MHMDS (financial year 2005/2006, records with no bed days recorded)	MHMDS (financial year 2005/2006, records with bed days recorded)
2	5MQ	South Warwickshire Primary Care Trust			83.7%	100.0%
	5MV	Wolverhampton City Primary Care Trust	76.8%	73.3%	63.3%	71.5%
1	5N1	Leeds Primary Care Trust				
1	5N6	Derbyshire County Primary Care Trust				
	5NV	North Yorkshire And York Primary Care Trust	92.9%	96.6%		
	5PE	Dudley Primary Care Trust	94.2%	100.0%		
	5QM	Dorset Primary Care Trust	78.3%	89.3%		
	5QT	Isle Of Wight NHS Primary Care Trust	82.3%	73.0%		
	RAT	North East London Mental Health NHS Trust	99.7%	99.5%	55.9%	88.4%
1	RBS	Royal Liverpool Children's NHS Trust				
1	RCU	Sheffield Children's NHS Foundation Trust				
2	RDR	South Downs Health NHS Trust			32.8%	88.5%
	RDY	Dorset Health Care NHS Trust	100.0%	100.0%	54.2%	98.7%
	RGD	Leeds Mental Health Teaching NHS Trust	95.7%	95.3%	45.4%	94.8%
	RH5	Somerset Partnership NHS and Social Care Trust	96.6%	96.9%	70.0%	93.7%
	RHA	Nottinghamshire Healthcare NHS Trust	97.5%	96.2%	59.5%	95.5%
	RJ8	Cornwall Partnership NHS Trust	99.8%	100.0%	74.0%	98.7%
1	RK9	Plymouth Hospitals NHS Trust				
	RKL	West London Mental Health NHS Trust	96.5%	97.1%	61.6%	96.1%
	RLY	North Staffordshire Combined Healthcare NHS Trust	96.0%	97.9%	71.1%	97.8%
	RMY	Norfolk and Waveney Mental Health Partnership NHS Trust	93.8%	94.2%	68.2%	95.3%
1	RN3	Swindon and Marlborough NHS Trust				
	RNK	Tavistock and Portman NHS Foundation Trust			88.0%	
	RNN	Cumbria Partnership NHS Trust	97.7%	97.7%	99.3%	99.6%

Appendix D Table 1: Ethnicity coding in HES and MHMDS (continued)

		Organisation	*HES (financial year 2006/2007, quarter 1 to quarter 3)	*MHMDS (financial year 2006/2007, quarter 1 data only)	MHMDS (financial year 2005/2006, records with no bed days recorded)	MHMDS (financial year 2005/2006, records with bed days recorded)
2	RNP	Newcastle, North Tyneside & Northumberland Mental Health Services NHS Trust			63.2%	90.6%
	RNU	Oxfordshire And Buckinghamshire Mental Health Partnership NHS Trust	97.2%	97.3%	43.0%	95.6%
	RP1	Northamptonshire Healthcare NHS Trust		99.0%	77.3%	96.9%
1	RP4	Great Ormond Street Hospital for Children NHS Trust				
	RP7	Lincolnshire Partnership NHS Trust	97.2%	97.1%	85.8%	97.7%
	RPG	Oxleas NHS Foundation Trust	97.0%	96.9%	62.6%	97.0%
	RQY	South West London and St George's Mental Health NHS Trust	96.7%	96.8%	84.8%	98.1%
2	RR2	Isle Of Wight Healthcare NHS Trust			19.1%	72.7%
1	RR7	Gateshead Health NHS Foundation Trust			85.7%	98.2%
	RRD	North Essex Mental Health Partnership NHS Trust	97.6%	95.5%	92.7%	96.4%
	RRE	South Staffordshire Healthcare NHS Foundation Trust	96.0%	95.9%	39.3%	95.9%
	RRP	Barnet, Enfield and Haringey Mental Health NHS Trust	96.4%	96.9%		
1	RRV	University College London Hospitals NHS Foundation Trust				
	RT1	Cambridgeshire and Peterborough Mental Health Partnership NHS Trust	98.5%	98.2%	51.0%	93.3%
	RT2	Pennine Care NHS Trust	91.5%	87.6%	71.4%	86.5%
	RT5	Leicestershire Partnership NHS Trust	98.9%	98.9%	80.7%	97.9%
	RT6	Suffolk Mental Health Partnership NHS Trust	88.7%	95.3%	78.3%	94.3%
2	RTC	County Durham And Darlington Priority Services NHS Trust			98.3%	99.3%
1	RTF	Northumbria Healthcare NHS Foundation Trust				
2	RTM	East Kent NHS and Social Care Partnerships Trust			38.5%	99.4%
	RTQ	Gloucestershire Partnership NHS Trust	94.3%	95.9%	88.2%	91.5%

Appendix D Table 1: Ethnicity coding in HES and MHMDS (continued)					
	Organisation	*HES (financial year 2006/2007, quarter 1 to quarter 3)	*MHMDS (financial year 2006/2007, quarter 1 data only)	MHMDS (financial year 2005/2006, records with no bed days recorded)	MHMDS (financial year 2005/2006, records with bed days recorded)
	RTV 5 Boroughs Partnership NHS Trust	94.6%	98.0%	80.8%	86.8%
	RV3 Central and North West London Mental Health NHS Trust	96.6%	96.6%	93.3%	99.9%
	RV5 South London and Maudsley NHS Foundation Trust	95.0%	94.6%	67.0%	94.6%
	RV7 Bedfordshire and Luton Mental Health and Social Care NHS Trust	94.3%	98.0%	81.8%	97.1%
	RV9 Humber Mental Health Teaching NHS Trust	87.3%	87.1%	47.1%	91.5%
1	RVJ North Bristol NHS Trust				
	RVN Avon and Wiltshire Mental Health Partnership NHS Trust	97.3%	97.2%	50.4%	95.2%
2	RVX Tees & North East Yorkshire NHS Trust			73.7%	97.6%
	RW1 Hampshire Partnership NHS Trust	89.7%	94.2%	73.0%	95.3%
1	RW3 Central Manchester and Manchester Children's University Hospitals NHS Trust				
	RW4 Mersey Care NHS Trust	83.3%	84.7%	56.8%	78.7%
	RW5 Lancashire Care NHS Trust	83.8%	80.7%	65.0%	
2	RW8 West Sussex Health and Social Care NHS Trust			52.2%	95.7%
2	RW9 South Of Tyne And Wearside Mental Health NHS Trust			92.9%	93.4%
	RWK East London and The City Mental Health NHS Trust	98.1%	98.7%	61.7%	92.9%
	RWN South Essex Partnership NHS Foundation Trust	99.3%	99.7%	90.0%	99.1%
	RWQ Worcestershire Mental Health Partnership NHS Trust	74.2%	62.3%	35.7%	76.4%
	RWR Hertfordshire Partnership NHS Trust	85.2%	94.7%	57.4%	94.2%
2	RWT Buckinghamshire Mental Health NHS Trust			56.9%	93.1%
	RWV Devon Partnership NHS Trust	93.0%	97.6%	81.7%	96.3%
	RWX Berkshire Healthcare NHS Trust	99.3%	100.0%	42.8%	96.6%
	RX2 Sussex Partnership NHS Trust	89.3%	86.6%		
	RX3 Tees, Esk And Wear Valleys NHS Trust	98.0%	98.1%		

Appendix D Table 1: Ethnicity coding in HES and MHMDS (continued)

	Organisation	*HES (financial year 2006/2007, quarter 1 to quarter 3)	*MHMDS (financial year 2006/2007, quarter 1 data only)	MHMDS (financial year 2005/2006, records with no bed days recorded)	MHMDS (financial year 2005/2006, records with bed days recorded)
	RX4 Northumberland, Tyne And Wear NHS Trust	88.6%	78.7%		
	RXA Cheshire and Wirral Partnership NHS Trust	94.9%	92.0%	11.2%	42.2%
2	RXD East Sussex County Healthcare NHS Trust			54.7%	98.5%
	RXE Doncaster and South Humber Healthcare NHS Trust	93.9%	95.6%	64.8%	93.4%
	RXG South West Yorkshire Mental Health NHS Trust	95.3%	94.7%	66.4%	92.6%
2	RXJ West Kent NHS & Social Care Trust			73.6%	86.8%
	RXM Derbyshire Mental Health Services NHS Trust	95.3%	99.6%	62.1%	98.7%
	RXT Birmingham and Solihull Mental Health NHS Trust	98.7%	98.8%	77.7%	97.4%
	RXV Bolton, Salford and Trafford Mental Health NHS Trust	97.9%	97.3%	91.6%	98.6%
	RXX Surrey and Borders Partnership NHS Trust	55.4%	72.7%	16.0%	15.0%
	RXY Kent And Medway NHS And Social Care Partnership Trust	87.7%	94.3%		
	RYG Coventry And Warwickshire Partnership NHS Trust	99.3%	100.0%		
	TAD Bradford District Care Trust	92.4%	94.6%	73.2%	90.8%
	TAE Manchester Mental Health and Social Care Trust	97.3%	97.4%	89.1%	98.3%
	TAF Camden and Islington Mental Health and Social Care Trust	98.3%	100.0%	75.4%	
	TAH Sheffield Care Trust	100.0%	100.0%	74.4%	99.9%
	TAJ Sandwell Mental Health NHS and Social Care Trust	99.3%	99.1%		99.2%

Notes:

1 Provider included in 2007 Census, but not in HES or MHMDS for 2005/2006 or 2006/2007

2 Provider included in 2007 Census, but not in HES or MHMDS for 2006/2007

*** Data quality on ethnic group**

This indicator was used in the Healthcare Commission's 2006/2007 annual health check of NHS organisations. It was a two-part indicator, measuring the completeness of trust coding for ethnicity in patient data sets. The data sources used were HES and MHMDS. The indicator measures the proportion of care spells with valid 2001 census coding for ethnic category (excluding 'not stated' and 'not known').

Appendix D Table 2: Annual numbers and percentages of mental health and learning disability patients in NHS providers												
Ethnic group	Mental health and learning disability census 2007		HES 1st episode		MHMDS		Mental health and learning disability census 2007		HES 1st episode		MHMDS	
	(includes independent sector)		2005/2006 (England)		2005/2006 (England)		(includes independent sector)		2005/2006 (England)		2005/2006 (England)	
	Mental health	Learning disability	Mental health	Learning disability	With bed days	No bed days	Mental health	Learning disability	Mental health	Learning disability	With bed days	No bed days
White British	22,236	3,457	132,018	17,723	81,928	644,841	76.50%	87.20%	74.70%	69.00%	75.30%	56.80%
White Irish	512	40	2,323	22	1,577	9,381	1.80%	1.00%	1.30%	0.10%	1.40%	0.80%
Other White	1,387	109	8,529	1,224	5,126	39,109	4.80%	2.80%	4.80%	4.80%	4.70%	3.40%
White and Black Caribbean	273	34	746	63	461	2,561	0.90%	0.90%	0.40%	0.20%	0.40%	0.20%
White and Black African	90	9	352	27	209	900	0.30%	0.20%	0.20%	0.10%	0.20%	0.10%
White and Asian	88	13	354	14	216	1,379	0.30%	0.30%	0.20%	0.10%	0.20%	0.10%
Other Mixed	172	15	613	79	417	2,391	0.60%	0.40%	0.30%	0.30%	0.40%	0.20%
Indian	386	30	1,881	270	1,314	10,121	1.30%	0.80%	1.10%	1.10%	1.20%	0.90%
Pakistani	312	32	1,607	306	1,167	8,703	1.10%	0.80%	0.90%	1.20%	1.10%	0.80%
Bangladeshi	129	11	735	37	401	2,601	0.40%	0.30%	0.40%	0.10%	0.40%	0.20%
Other Asian	260	8	1,201	46	987	5,935	0.90%	0.20%	0.70%	0.20%	0.90%	0.50%
Black Caribbean	1,319	107	3,846	152	2,464	11,542	4.50%	2.70%	2.20%	0.60%	2.30%	1.00%
Black African	638	33	2,556	21	1,764	7,364	2.20%	0.80%	1.40%	0.10%	1.60%	0.60%
Other Black	544	18	2,219	56	1,410	5,802	1.90%	0.50%	1.30%	0.20%	1.30%	0.50%
Chinese	81	8	329	20	272	1,178	0.30%	0.20%	0.20%	0.10%	0.20%	0.10%
Other	352	10	1,686	60	1,154	10,065	1.20%	0.30%	1.00%	0.20%	1.10%	0.90%
Not stated	271	29	12,347	4,337	6,879	295,260	0.90%	0.70%	7.00%	16.90%	6.30%	26.00%
invalid			3,384	1,233	1,112	75,609	0.00%	0.00%	1.90%	4.80%	1.00%	6.70%
Total	29,050	3,963	176,726	25,690	108,858	1,134,742	100	100	100	100	100	100

This publication is available in other formats and languages on request. Please telephone 0845 601 3012.

આ માહિતી વિનંતી કરવાથી અન્ય રૂપે અને ભાષાઓમાં મળી શકે છે.
મહેરબાની કરી ટેલિફોન નંબર 0845 601 3012 પર ફોન કરો.

GUJARATI

ਇਹ ਜਾਣਕਾਰੀ ਬੈਨਤੀ ਕਰਨ 'ਤੇ ਹੋਰਨਾਂ ਰੂਪ 'ਚ ਅਤੇ ਜ਼ਬਾਨਾਂ 'ਚ ਮਿਲ ਸਕਦੀ ਹੈ।
ਕ੍ਰਿਪਾ ਕਰਕੇ ਟੈਲਿਫੋਨ ਨੰਬਰ 0845 601 3012 'ਤੇ ਫੋਨ ਕਰੋ।

PUNJABI

यह जानकारी बिनती करने पर अन्य रूप में और भाषाओं में मिल सकती है।
कृपया टैलिफोन नम्बर 0845 601 3012 पर फ़ोन करें।

HINDI

Akhbaartan waxaa lagu helaa iyadoo
siyaabo iyo luqado kale ku qoran haddii la
codsado. Fadlan soo wac lambarka telefoon
ee ah 0845 601 3012.

SOMALI

Οι παρούσες πληροφορίες διατίθενται και σε
άλλες μορφές ή γλώσσες εάν ζητηθεί.
Τηλεφωνήστε στο 0845 601 3012

GREEK

المعلومات متاحة أيضاً لدى طلبها بعدد من الأشكال واللغات الأخرى.
الرجاء الإتصال بهاتف رقم 0845 601 3012.

ARABIC

یہ معلومات درخواست کرنے پر دوسرے فارمیٹ یعنی شکلوں میں بھی دستیاب کی جاسکتی ہے۔
برائے مہربانی فون کیجئے 0845 601 3012

URDU

如有需要，本信息还有其他格式和语言的版本。
请致电 **0845 601 3012**。

CHINESE-SIMPLIFIED

如有需要，本信息還有其他格式和語言的版本。
請致電 **0845 601 3012**。

CHINESE-TRADITIONAL

অনুরোধ করলে এই তথ্যগুলি অন্য ভাষা ও আকৃতিতে পাওয়া যাবে।
অনুগ্রহ করে এই নম্বারে ফোন করুন 0845 601 3012

BENGALI

Arzu edildiği takdirde bu bilgi değişik
formatlarda ve dillerde verilebilir.
Lütfen 0845 601 3012 numaralı
telefonu arayınız.

TURKISH

Tin tức này có bằng những hình thức và ngôn
ngữ khác theo yêu cầu.
Hãy gọi phôn số 0845 601 3012

VIETNAMESE

È possibile richiedere le presenti informazioni
su altri supporti o in altre lingue. A tal fine,
telefonare allo 0845 6013012.

ITALIAN

Informacje te są dostępne na życzenie w
innych formatach i językach.
Prosimy zadzwonić pod numer 0845 601 3012

POLISH

Healthcare Commission

Finsbury Tower
103-105 Bunhill Row
London
EC1Y 8TG

Tel 020 7448 9200
Fax 020 7448 9222
Helpline 0845 601 3012
Email feedback@healthcarecommission.org.uk
Website www.healthcarecommission.org.uk

Mental Health Act Commission

Maid Marian House
56 Hounds Gate
Nottingham
NG1 6BG

Tel 0115 9437100
Fax 0115 9437101
Email enquiries@mhac.org.uk
Website www.mhac.org.uk

Care Services Improvement Partnership

Room 8E
44 Quarry House
Quarry Hill
Leeds
LS2 7UE

Tel 0113 25 45127
Fax 0113 25 45596
Email ask@csip.org.uk
Website www.csip.org.uk

National Institute for Mental Health in England

West Midlands Development Centre
The Uffculme Centre
Queensbridge Road
Moseley
Birmingham
B13 8QY

Tel 0121 678 4854
Fax 0121 678 4852
Email westmidlands@csip.org.uk
Website www.csip.org.uk

