Care Services Improvement Partnership CSIP

COMMISSIONING FOR EQUITY SERIES

EQUAL ACCESS, EQUAL CARE?

Can London Deliver the Race Equality Action Plan for Mental Health?

REVISED JUNE 2007

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March 2007

Acknowledgements

The authors would like to thank the Healthcare Commission for supplying the London data from the ***"Count Me in census"*** and for additional analysis that was undertaken for this revised report. We are particularly grateful to Giovanna Polato, Veena Raleigh and David Hussey.

We would also like to thank Melba Wilson, Ali Davies and the London Development Centre (Care Services Improvement Partnership) for commissioning and supporting this work, which forms part of their ongoing work to support implementation of the Delivering Race Equality Action Plan.

Finally the authors are grateful for all the comments received from Mental Health Trusts, Focus Implementation Sites, and other colleagues and stakeholders working to deliver this agenda.

About the London Development Centre

The London Development Centre is part of the Care Services Improvement Partnership (CSIP) and one of eight regional development centres in England. We aim to support service improvement of care services in London and help ensure better outcomes for children and families, adults and older people, including those with mental health needs, physical disability or learning disabilities and people in the criminal justice system. For further information on us and our work programmes, please visit our website www.londondevelopmentcentre.org.

About the London Health Observatory

The London Health Observatory provides information, data, and intelligence on Londoners' health and health care for practitioners, policy makers and the public. We are one of nine regional Public Health Observatories in England set up in 2001 by the Department of Health. The LHO takes the national lead role in monitoring health inequalities, ethnicity and health, and tobacco. For further information on our work programme please visit our website www.lho.org.uk.

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1 Executive summary

1.1 Introduction

This report has been produced by the London Health Observatory (LHO) for the London Development Centre to provide a London baseline for monitoring specific actions in the Delivering Race Equality (DRE) action plan[1]. The report summarises the findings of an analysis of the information collected from all of London's nine Mental Health NHS providers, and 22 independent providers for the national census of inpatients in mental health hospitals and facilities in England and Wales on 31 March 2005[2].

In this report, the term ethnic minority groups includes all groups except the White British group, and therefore includes White Irish and Other White groups.

1.2 Key Findings

- There is strong evidence that Black groups represent a higher proportion of inpatients in London's mental health services than expected, given the local population size, and Asian and Chinese groups a much lower proportion of the inpatient population.
- In all ethnic minority groups there were higher proportions who were compulsorily detained under the Mental Health Act (1983)[3] compared to the White British group, with considerably higher proportions in the Black group. There were also higher proportions of Black and Mixed groups who had been physical restrained by nursing staff compared to the White British group. However in both cases differences were only statistically significant for the Black group. The London findings confirm what has been previously found across the UK.
- The very wide variation in the use of compulsory detention, physical restraint and seclusion (supervised confinement away from other patients) between London's Mental Health Trusts warrants detailed audit and explanation. Sharing knowledge and peer-led learning between Mental Health Trusts might help to reduce some of these variations.
- Analysis of the source of referral showed that in all ethnic minority groups there were greater proportions experiencing coercive care pathways (such as via the police and courts) into inpatient services than the White British group. Such coercive care-pathways are associated with the use of compulsory detention.
- London had a higher proportion of inpatients who were on the Care Programme Approach (CPA) than England overall. However a significant proportion of patients in some mental health trusts were under neither the CPA nor the Single Assessment Process (SAP, a similar process to the CPA for older adults) despite recommendations that all users of specialist mental health services be cared for under the CPA[4].

See Box 1 (page 7) for detailed findings.

1.3 Implications

General implications

- The national census findings alone are a continuing cause for concern, but do not provide sufficient evidence to explain the causes of ethnic differences in admission rates and care practices between London's trusts and between London and England. Multiple factors including differences in need, case severity and racial inequalities and discrimination need also to be taken into account.
- The origins of higher levels of compulsory detention and coercive care pathways for some ethnic minority patients need to be better understood in terms of the wider care pathways for patients with mental illness, in particular the limited involvement of London's primary care services in the referral process compared with England, and the relationship with the local Criminal Justice System.
- Initiatives targeted at reducing admission and detention rates in ethnic minority groups should begin upstream focusing both on prevention and early intervention. Cross-agency working is vital to achieve this.

Implications for commissioners and providers

- Now that overall ethnicity monitoring in inpatient mental health services has reached 97 per cent in the capital[5], there is scope for London's Mental HealthTrust Boards to agree a system of a small basket of indicators of coercive admission/treatment to monitor across London with audit of the outliers. Public debate of these findings could help to ensure that such treatment is only used and justified as a last resort.
- NHS patients in private facilities should not be considered outside the scope of the DRE action plan. In the report we have provided an overview of patients in private facilities, however our detailed trust analysis excludes these patients as we were not able to link patients to their commissioning Mental Health Trust or Primary Care Trust (PCT). Mental Health Trusts who commission these facilities have a responsibility to ensure that their service users receive both culturally and clinically appropriate treatment in any facility in which they are placed.
- All patients in specialist mental health services should be identified within the CPA or SAP framework.
- Information on the ethnicity of staff as well as the take-up of training on cultural awareness is essential to understand the cultural climate in which treatments and care are provided and should already be part of trusts' Race Equality Schemes.

Implications for future National Censuses

- The ability of the national inpatient census to serve the objectives of the DRE would be enhanced if the following information items were included or improved in the future:
    - country of birth and number of years resident in England
    - improved collection and analysis of postcode of residence and commissioning PCT
    - registration and use of GP and Criminal Justice System services
    - alignment with items in the new Mental Health Minimum Dataset (MHMDS) in order to provide opportunities for ongoing and more regular monitoring of ethnic disparities in the full breadth of specialist mental health services.

1.4 Explaining trust and ethnic variations

Whilst the aim of the census was to help assess the factors underlying ethnic differentials in inpatient care, helping to identify potentially discriminatory practices, some of the basic factors which could explain the variation such as case mix, case severity and socio-demographic factors were not recorded in this census, and could not thus be taken into account. The types of services provided by trusts will affect many of the indicators on coercive treatment, specifically where trusts provide secure services for its own and other catchment populations. Moreover, as information was not available on full postcode of residence, which was only collected from the second census onwards, and commissioning PCT, which was collected but not provided for this analysis, it was not possible to compare resident London populations in a meaningful way.

1.5 Conclusions

Our report demonstrates the need for a more sophisticated use of ethnicity information in mental health services. The census findings thus need to be seen as a *starting point* for Mental Health Trusts, working with primary care, police and partner agencies to audit and explain outlying positions, and to demonstrate to their Boards, users and local communities that their practices continue to be clinically and culturally appropriate. The data should not be used in isolation, but should be reviewed alongside local and routinely collected information (such as the Hospital Episode Statistics data) and evidence available on prevalence and morbidity.

Box 1: Detailed findings

Overall admission rates

- There were considerably higher than average ratios of admissions for all Black groups but lower ratios for Indian, Pakistani and Chinese groups. This concurs with previous research evidence and the findings of the national census ***"Count Me In"***.

Compulsory detentions

- London has significantly higher ratios of detention on admission than England as a whole.
- All ethnic minority groups in London had higher ratios of detention under the Mental Health Act (1983) than the White British group, although statistically significant differences were only found for the Black group.
- About two thirds of Black groups in London NHS mental health services were detained under the Mental Health Act compared to just over one third of the White British group.
- A higher proportion of the Mixed group were detained on the day of the census (i.e. after their admission) than on the day of their admission. This is different to all other ethnic groups for whom there were little difference in their legal status between the day of admission and the day of the census.
- Inpatients from the Black ethnic group were more likely to be in some form of secure unit (24 per cent of the Black group) compared to the White British group (12 per cent).
- There were wide variations across London NHS trusts in the ethnic profile of patients and the proportion who were compulsorily detained; in West London Mental Health Trust 74 per cent of patients were compulsorily admitted compared to a London average of 45 per cent. This finding is likely to reflect the provision of Medium and High Secure services, with West London Mental Health Trust being the only provider of High Secure services in London.

Referral sources

- London has significantly lower ratios of referrals from GPs but significantly higher ratios of referrals from social services and courts than England overall.
- There are clear differences in the way in which patients from different ethnic groups access and are referred to inpatient services. All ethnic groups were less likely to be referred by GPs, but were more likely to be referred by the police, courts and probation services and social services. Further, Black groups were three times less likely to be referred by a GP to the mental health service and twice as likely to be referred by Police, Courts or Probation services than the White British group.
- Overall, ethnic minority groups represented 58 per cent or more of referrals from Police, Courts and Probation Services, and High or Medium Secure Units, compared to only 26 per cent of referrals from GPs.

Use of the Care Programme Approach (CPA) and Single Assessment Process (SAP)

- London had a higher proportion of inpatients who were on CPA (92 per cent compared to 83 per cent in England).
- However, 19 per cent of inpatients in Camden and Islington Mental Health Trust and Barnet, Enfield and Haringey Mental Health Trust were on neither CPA nor SAP (compared to a

London average of 7 per cent).

- At least three quarters of Asian inpatients (75 per cent) and Black inpatients (77 per cent) were on enhanced CPA compared to 59 per cent of the White British group.

Seclusion and control and restraint

- Overall, four per cent of London NHS inpatients had experienced seclusion in the last three months, and seven per cent had experienced control and restraint. London had similar ratios of seclusion than England, but statistically significant lower ratios of control and restraint.
- All ethnic minority groups in London were proportionally more likely to have experienced seclusion and control and restraint in the last three months than the White British, with particular differences noted in the use of control and restraint. However standardising for age shows that the Mixed group had lower ratios of seclusion than the White British group. Statistically significant differences were only found for control and restraint, where the Black group were the only group that had significantly higher ratios of restraint than the White British group.
- Black inpatients were twice as likely to have been placed in seclusion in the last three months of their inpatient care than White British inpatients.
- Ten and 11 per cent of Mixed and Black groups had experienced control and restraint compared to six per cent of the White British group.
- The treatment received by patients varied considerably across London. In West London Mental Health Trust 11 per cent of patients had been secluded in the last 3 months (compared to the London average of 4 per cent) and in Camden and Islington 14 per cent of patients had experienced physical restraint in the last 3 months (compared to 7 per cent across London).

Injuries

- London had a lower percentage of patients reporting an injury than England overall: 9 per cent compared to 11 per cent. However the proportion of patients reporting injuries was as high as 20 per cent in one London trust.
- Inpatients from Mixed and Black groups were half as likely to report an injury compared to the White British group. This might be a reflection of smaller ethnic populations in the older populations in which the majority of injuries are reported. However this anecdotal evidence needs to be formally validated.

2 Introduction

2.1 Introduction

The London Development Centre, as part of its ongoing work to support the implementation of the Delivering Race Equality (DRE) action plan, commissioned the London Health Observatory (LHO) to undertake a London analysis of the data collected in the 31 March 2005 *Count Me In* psychiatric inpatient survey.

This work was undertaken as part of the London Mental Health Intelligence Programme which is jointly funded between the London Development Centre and the LHO.

Whilst the DRE Action Plan forms the framework for this analysis, not all aspects of the action plan can be measured using the *Count Me In* survey. Therefore this report focuses specifically on those aspects relating to admission, detention and use of restraint and seclusion which can be monitored through the mental health census.

2.2 Aims and objectives

The aims of this report are:

- to provide a London-specific baseline analysis for monitoring the reduction in admission rates and the use of compulsory detention and seclusion in ethnic minority groups, as specified in the Delivery Race Equality action plan
- to support the implementation of the DRE action plan in relation to the work of the Focus Implementation Sites (these are explained in 2.4.1)
- to analyse and explain as far as possible, differences found between trusts within London.

2.3 Terminology

The Government's DRE report uses the term Black and Minority Ethnic (BME) groups to refer to all ethnic minority groups except the White British group, including White Irish and Other White groups. Except for where the DRE report has been quoted, we have used the term *'ethnic minority group'* throughout the report to refer to BME groups.

2.4 Background

2.4.1 Delivering Race Equality

In January 2005 the Government published *Delivering race equality in mental health care (DRE)*[6]. The aim of this five-year action plan was to improve mental health services for ethnic minority groups by providing equitable services for all and tackle discrimination in mental health services. DRE is based on three core 'building blocks' which are:

1. *More appropriate and responsive services - achieved through action to improve mental health care for BME patients, developing a more culturally capable workforce, and finding new pathways to care and recovery.*
2. *Community engagement - achieved by engaging communities in planning services, and supported by 500 new community development workers and the expertise of independent sector BME service providers.*
3. *Better information - from improved monitoring of ethnicity, better dissemination of information and good practice, and by improving knowledge about effective services. This includes the new regular census of mental health patients covering their ethnicity, faith, legal status and more*[i]*.*

Although there are few targets associated with the plan there are clear goals to achieve, including a reduction in the rate of admissions of people from minority ethnic communities to psychiatric inpatient units and a reduction in the disproportionate rates of compulsory detention (see Box 2 for a full list of goals).

Box 2 The vision for Delivering Race Equality in Mental Health Care

By 2010 mental health services will be characterised by:

- *less fear of mental health services among BME communities and service users;*
- *increased satisfaction with services;*
- *a reduction in the rate of admission of people from BME communities to psychiatric inpatient units;*
- *a reduction in the disproportionate rates of compulsory detention of BME service users in inpatient units;*
- *fewer violent incidents that are secondary to inadequate treatment of mental illness;*
- *a reduction in the use of seclusion in BME groups;*
- *the prevention of deaths in mental health services following physical intervention;*
- *more BME service users reaching self-reported states of recovery;*
- *a reduction in the ethnic disparities found in prison populations;*
- *a more balanced range of effective therapies, such as peer support services and psychotherapeutic and counselling treatments, as well as pharmacological interventions that are culturally appropriate and effective;*
- *a more active role for BME communities and BME service users in the training of professionals, in the development of mental health policy, and in the planning and provision of services; and*
- *a workforce and organisation capable of delivering appropriate and responsive mental health services to BME communities.*

Taken from the Department of Health website.

Focused Implementation Sites (FIS) have been selected across the country to demonstrate how a whole-systems approach can improve mental health services for BME groups through a range of collaborative initiatives, leadership and strategic partnerships, and building capacity and intelligence. Further, in addition to a national evaluation, implementation sites are encouraged to generate information and evidence on effectiveness to increase the knowledge base.

Better ethnic monitoring is essential to delivering this policy, and the national census of inpatients in mental health hospitals and facilities in England and Wales was identified as being key in delivering this. The first annual "Count Me In" census, conducted on 31 March 2005, provided a baseline of the ethnicity of inpatients at this time which can be used to measure changes and improvements in mental health care[7]. It was organised by the Healthcare Commission, the Mental Health Act Commission, and the National Institute for Mental Health in England (NIMHE) which is part of the Care Services Improvement Partnership (CSIP).

2.4.2 National Results, 2005

To a large extent, the ***"Count Me In"*** census from 2005 confirmed many previous assertions and findings about the disproportionate representation of Black and other Ethnic minority groups in mental health and secure mental health services, and the increased use of coercive treatment for these groups[8].

Specifically they found that, when compared to the England and Wales average:

- Black Caribbean, Black African, Other Black and White / Black Mixed groups had rates of admission that were three or more times higher than average
- Black Caribbean, Black African and Other Black groups were 33 to 44 per cent more likely to be detained under the Mental Health Act (1983) than average
- Men from Black Caribbean, Black African, Other Black and Indian groups were more likely to be placed in seclusion than men from the White British group, and men from the Black Caribbean group had a ratio of control of restraint 29 per cent higher than average
- There were higher proportions of men from Black Caribbean, Other Black, and White / Black Caribbean on medium or high secure wards than average.

2.4.3 London's diversity and mental health need

London has the most ethnically diverse population in the UK. Forty per cent of London residents are from an ethnic minority group (almost 30 per cent of adult Londoners), and over 300 languages are spoken[9]. The Capital has the highest proportion of people born outside the UK (27% compared to the England figure of 9%)[10].

Alongside this diversity there are major social and economic inequalities. London experiences higher unemployment rates compared with the whole of Great Britain, contains some of the most deprived

areas in the country, has high levels of homelessness and mobility and a significant refugee and asylum seeker population[ii].

It is therefore vital that London's health commissioners, mental health service providers and partner agencies - both in the NHS and Independent sector - ensure that the services they provide are equitable and culturally appropriate.

2.4.4 Explaining ethnic differentials in the use of mental health care - The evidence and policy context

Whilst the "***Count Me In***" census of 2005 supported previous findings of the differential use of mental health services, and particularly compulsory psychiatric treatment across the different ethnic groups, it did not attempt to provide any explanation as to the reasons why these difference exist. To date, the body of research evidence on these issues remains contradictory and inconclusive, and has provoked considerable debate amongst healthcare professionals, academics and service-user forums. It is not possible to do justice to the issues and research in this report. This report is therefore only intended to introduce the issues, providing a surface summary with reference to recent or most commonly cited studies / papers. For a more in-depth analysis of the evidence please refer to the academic literature.

Differences in prevalence rates and risks of developing mental health problems

Prevalence studies / surveys on mental health aim to measure the number of people in given populations who have, at any one time, a mental health problem / diagnosis. In England, the EMPRIC study (Ethnic Minority Psychiatric Illness Rates in the Community)[11] found that there were no significant differences in prevalence rates by ethnic groups for common mental health problems[iii], except for Bangladeshi women who had significantly lower prevalence rates compared to White women (once age had been adjusted). Further, whilst annual prevalence rates of psychosis[iv] were twice as high in Black Caribbean populations than White populations, these differences were only statistically significant (i.e. they could not have occurred by chance) for Black Caribbean women, and not the Black Caribbean group overall. However, after adjusting for confounding or mediating factors such as education, social class, marital status, and other factors, researchers found that the Black Caribbean group had significantly higher odds ratio for psychotic symptoms than the White group[12]. Higher rates were also found in the Pakistani group and slightly lower rates in the Bangladeshi group but these were differences were not significant. It is important to note that these are community based surveys and exclude people who were in hospital or other care establishment at the time, including hostels and supported housing, prison establishments etc. They also exclude homeless and transition populations where mental health problems are known to be prevalent.

[ii] Summary of evidence available from the London Health Observatory (www.lho.org.uk).

[iii] In this study, common mental health problems referred to generalised anxiety disorder, mixed anxiety and depressive disorder, depressive episode, phobias, obsessive compulsive disorder, and panic disorder.

[iv] Psychosis referred to schizophrenia, schizotypal and other delusional disorders, manic episodes and bipolar affective disorder, and other affective disorders with psychotic symptoms.

In contrast to the community prevalence estimates, the admission ratios for Black Caribbeans in the *Count Me In* census were 5 times higher than for White British patients. In fact all ethnic groups other than Pakistani, Indian and Chinese had significantly higher ratios of admission than White British (see Table 1). Unfortunately the EMPIRIC survey did not make distinctions between different White ethnic groups which would have been useful for comparison against admission ratios. However the inpatient admission ratios are clearly much higher that the community prevalence estimates suggest.

Table 1 Standardised admission ratios by ethnic group for England and Wales (England and Wales = 100)

Census groups	Census categories	Observed	Standardised Admission Ratio	Lower (95%) confidence interval	Upper (95%) confidence interval	Significance compared to White British
White	British	26,229	90	89	91	
	Irish	707	146	135	157	High ↑
	Other White	1,035	122	114	129	High ↑
Mixed	White / Black Caribbean	254	369	325	417	High ↑
	White / Black African	70	235	183	297	High ↑
	White / Asian	104	149	122	181	High ↑
	Other mixed	165	274	234	319	High ↑
Asian	Indian	431	76	69	84	Low ↓
	Pakistani	324	101	90	112	
	Bangladeshi	151	128	109	150	High ↑
	Other Asian	260	193	170	218	High ↑
Black	Caribbean	1,357	418	396	440	High ↑
	African	640	277	256	299	High ↑
	Other Black	564	1373	1262	1491	High ↑
Other	Chinese	80	63	50	78	Low ↓
	Other	353	296	266	329	High ↑
Total		32,724	100	99	101	High ↑

Source: *Count Me In* 2005. Results table 1 Healthcare Commission.

Other research suggests that certain ethnic minority groups are at more risk of developing certain mental health problems. Results from the AESOP study (Aetiology and Ethnicity in Schizophrenia and

Other Psychosis) found that all ethnic minority groups had higher incidence rates[v] of psychoses (including schizophrenia, other non-affective psychosis and affective psychoses) when compared to the White British population. African Caribbean and Black African populations were 9 and 6 times at more risk of developing these conditions than the White British population[13].

Differences in socio-economic backgrounds

Whilst the reasons for differences in prevalence and incidences rates are not fully understood, societal factors, including the usual determinants of mental health plus experiences of discrimination by ethnic minority groups, are likely to play a part. For example, the EMPIRIC study found that annual prevalence rates of psychosis were over twice higher in economically inactive Black Caribbeans than employed Caribbeans (3% compared to 1.3%), and in economically inactive White compared to employed White (1.5 percent compared to 0.6 percent). However, employment status did not have such large effects on community prevalence of psychosis in other ethnic groups, suggesting that there is an interplay between employment, severe mental illness, and ethnicity which needs further exploration.

The AESOP study also found that there was a 2.5 fold increased risk of developing psychosis if an individual had been separated from one or both parents for more than 1 year resulting from family breakdown before the age of 16. The authors concluded that separation from parents at an early age not only increased the risk of psychosis in adulthood, but also disproportionately affected the African-Caribbean population due to family breakdown being more common in this population, contributing to higher rates of psychosis[14].

Our own previous analyses show that deprivation is closely associated with higher use of mental health inpatient services in London, with particularly high demand in inner London. Statistical analysis has shown that socio-demographic factors can explain 73% of the variation in the number of bed days per year and 60% of the variation in admission rates across London[15]. Our analysis alone does to provide sufficient evidence for a direct causal link, however there is considerable research showing that issues associated with deprivation, poverty and socio-economic inequalities are related to increased risk of developing mental health problems. Therefore the socio-economic backgrounds of groups needs to be considered when attempting to explain variations in service use and prevalence of mental illness.

Differences in access to healthcare

It is almost certainly the case that the causes of increased admission rates in certain ethnic groups are multi-factorial. The way different groups are brought into contact with services may also impact on the level of coercion that they experience within the system. The ***"Count Me In"*** census found that White British patients were more likely to be referred by their GP than the average, whilst referral rates by GP were between 40 and 70 per cent lower for Black Caribbean and Black African groups.

[v] Incidence rates are a measure the number of new cases of an illness, or in this context, the relative risks of individuals and groups of developing mental health problems.

However referrals by the police were almost double in Black Caribbean and Black African groups than the average referral rates, and referrals by the court were double in Black Caribbean groups. Similar results were found in the AESOP study with African-Caribbean and Black African patients being significantly more likely to access services via the police or another criminal justice agency and significantly less likely to access services via a GP.

There are potentially many reasons behind differences in access to mental health service by ethnic groups, including cultural and community behavioural and social norms, beliefs and attitudes towards mental health and stigma, and the availability and culturally appropriateness of local services. The reasons behind these access issues need to be fully explored and understood.

Racism and discrimination

Discrimination may also play a part in differences in care pathways and the use of more coercive treatments for some ethnic groups. The Independent Inquiry into the death of David Bennett[16] recommended that *"there should be a Ministerial acknowledgement of the presence of institutional racism*[vi] *in the mental health services and a commitment to eliminate it"*. The DRE action plan which included the Government's response to the David Bennett inquiry did not include such an acknowledgement. The issue remains controversial amongst the academic community, service providers, black and minority ethnic groups and service user populations. However the recently published Service User Survey which was undertaken as part of the 2005 ***"Count Me In"*** census found differences in satisfaction with the treatment received by inpatients by ethnic groups, with 33 per cent of Black groups reporting being discriminated on the grounds of race (this is in contrast to 15 per cent of the overall sample)[17]. In response, in a letter sent on 4 October 2006 from Rosie Winterton, Minister of State for Health Services, to the Strategic Health Authority Chief Executive's, the government confirmed that the BME programme outlined in the DRE action plan was a priority for mental health services. The letter stated that *"the quality of mental health care for BME communities in England is not acceptable. To be blunt, services are discriminating in a way that is arguably both unethical and unlawful*[18]*".* A later letter, dated 21 February 2007 however stated *that "the reasons for the high numbers of people from some BME backgrounds in mental health services, and the high use of compulsion in care, are complicated"* and that *"many of the factors involved are outside the control of the NHS"*. This did not, however, remove the need for action, which the minister announced was a moral and legal imperative for the NHS[19].

The current situation

Although it remains difficult to provide a simple or single explanation for the variation in use of mental health services by different ethnic groups, the Minister's letter to SHA's demonstrates the need for moving forward on this issue and emphasises the need to ensure that all Mental Health Trusts provide clinically and culturally appropriate and effective services, and continue to make progress in implementing the DRE action plan. Further work is certainly needed to understand access issues to mental health services, and particularly to link this to outcomes and the social inclusion agenda. However emphasis on action and re-addressing current inequalities is now a priority.

[vi] Using the definition set out by Sir William Macpherson in the Stephen Lawrence inquiry (1999)

2.5 Ethnicity coding

Under the Race Relations (Amendment) Act 2000, all Public Authorities are obligated to promote race equality, and monitor the impact of their functions, services, and policies on race equality. The Delivering Race Equality action plan identifies the need to improve ethnicity monitoring in mental health services to support organisations in meeting their duties under this act. It states that *"high-quality data on ethnicity are essential for mental health service providers ... Despite that, there is clear evidence that the quality and comprehensiveness of ethnicity data collected in mental health services is inadequate"*[vii].

Table 2 Ethnic group classification, National Census 2001

5 group classification	16 group classification
White	White British
	White Irish
	White Other
Mixed	Mixed White & Black Caribbean
	Mixed White & Black African
	Mixed White & Asian
	Mixed Other
Asian	Indian
	Pakistani
	Bangladeshi
	Asian Other
Black	Black Caribbean
	Black African
	Black Other
Other ethnic groups	Chinese
	Other ethnic group

NHS trusts currently collect the ethnicity of their inpatient service users using the 2001 Census ethnic group classifications (see Table 2 above). Since 2002/03 there has been slow but steady improvement in the completeness of ethnicity coding in acute / specialist trusts and Mental Health Provider Trusts (see Table 3). For example, in 2002/03 66 percent of finished consultant episodes (FCEs) in Acute and Specialist Trusts in London, and 82% of FCEs in London Mental Health Provider Trusts had a recorded ethnicity using the 2001 census ethnic groups. By 2005/6 this had risen to 84%

[vii] Delivering Race Equality p. 65.

in acute / specialist trusts and 97% in Mental Health Trusts in London (see Appendix One for an ethnic breakdown by Mental Health Trust, 2005). Throughout, Mental Health Trusts have demonstrated greater achievement in collecting ethnic data on their service users.

Table 3 Proportion of valid / stated ethnic codes for London NHS hospital and mental health trusts

	2002/03	2003/04	2004/05	2005/06*
	%	%	%	%
Acute and Specialist Trusts	66	77	80	84
Mental Health Provider Trusts	82	93	95	97

Source: Hospital Episode Statistics (HES), The Information Centre for health and social care. *2005/06 HES data provisional and excludes North East London Mental Health Trust. Analysed by LHO

However, mental health services provide more than just inpatient services. Data collected from London Mental Health Providers Trusts by the LHO and London Development Centre for a benchmarking exercise found that ethnicity on CPA cases was not stated on over a quarter of standard and enhanced CPA records. Whilst this data was not collected specifically to explore ethnic monitoring, it demonstrates that ethnicity is less available on non-inpatient services. More information on community and non-inpatient mental health services is certainly needed, and this is becoming more available through the Mental Health Minimum Data Set[viii]. However an analysis of records in the dataset for England, 2004/05 found that only 60 per cent of records in working age adults had a recorded ethnic group, 34 per cent had ethnic group recorded as 'not stated' and 6 per cent of records had missing or invalid ethnic coding. To date, the completeness of ethnic recording for inpatients has been a priority and has been monitored through the Healthcare Commission's performance reviews. However there appears to be no such obligation for ethnic recording in community mental health services. The use of the Mental Health minimum Data Set should be encouraged to monitor recording of ethnicity across all mental health NHS services and support the commissioning of equitable services.

[viii] The Mental Health Minimum Dataset is a national framework through which all NHS specialist mental health services are required to collate information on their adult and older adult mental health services and submit these to the NHS Wide Clearing Service (NWCS).

3 Data sources and Methods

Data from the census for London mental health services was provided by the Healthcare Commission, in agreement with the Mental Health Act Commission. This data was provided for the purposes of monitoring of the DRE Action Plan in London. The census covered inpatients of all ages.

The data were provided in aggregated form for each Mental Health Trust and facility in London. The same data was made available to each of the previous Strategic Health Authorities in London and each Mental Health Trust. No individual patient data was made available. Regional and 'England and Wales' data are also available on the Healthcare Commission's website[ix]. In both of these cases, the data is an aggregation of all private and NHS facilities in those geographies.

Only part of the postcode of the patient's residence was collected in the first census. Therefore, London patients refers to those people in inpatient services in London. These patients may be from outside London, and some London residents will show up in non-London services. This makes it difficult to calculate accurate admission rates for London. Trusts' own data or Hospital Episode Statistics (HES) data should be used to fill this information gap.

Whilst a distinction between private and NHS facilities has been made in our analysis it is assumed that the majority of, if not all, individuals in private facilities are in fact NHS patients. However it is not possible from the data provided to attribute patients in private facilities to their commissioning Mental Health Trusts or to London boroughs, therefore in order to monitor service change at local level, it has been necessary to focus the majority of the analysis on London's NHS trusts only.

Data disclosure and missing numbers

Given the sensitivity of the information contained within this data source, we have taken care not to publish any figures under 6 (i.e. no category has less than 6 patients assigned to it) which would allow the identification of patients in London NHS trusts. This also includes where we have provided percentages; if from the percentage and the total number of patients it is possible to identify less than 6 patients, we have suppressed the data or merged that category with another.

However we have not suppressed information at a pan-London level as this information (for all inpatients including private and NHS facilities) is available from the Healthcare Commission.

[ix] http://www.healthcarecommission.org.uk/nationalfindings/nationalthemedreports/mentalhealth/mentalhealthreports.cfm/cit_id/445

4 Structure of the results

We have chosen to present the findings as set out below in discussion with the LDC. LHO can be contacted for other analyses if required. The report has been structured as follows:

London's Inpatient Population

The section provides a pan-London overview of the inpatient population on the day of the census, including those in NHS and private facilities. It also assesses how the inpatient population compares to the local population and the number of asylum seekers in facilities at this time.

London NHS baseline and Trust comparisons

This section analyses the London baseline position for NHS mental health services only. The aim here is to support the monitoring and evaluation of the FIS pilots which are NHS-specific. The section has been structured into two broad themes:

- Who are London's NHS inpatients, where are they, and how did they get there?
- How are NHS inpatients treated?

We have compared data for London with England, and showed variations between London's Trusts, where possible and acceptable within the bounds of the Data protection Act. The London NHS trusts are:

- Barnet Enfield and Haringey Mental Health Trust
- Camden and Islington Mental Health and Social Care Trust
- Central North West London Mental Health NHS Trust (which in our analysis, includes inpatients in Hillingdon PCT facilities)
- East London and The City Mental Health NHS Trust
- North East London Mental Health Trust
- Oxleas NHS Foundation Trust
- South London and Maudsley NHS Foundation Trust
- South West London and St George's Mental Health NHS Trust
- West London Mental Health Trust.

In addition there were 22 Independent Providers who contributed data to the census. These have not been identified in this report.

5 London's inpatient population (all NHS and private facilities)

5.1 ***Overview***

On the day of the census, information was collected on 7,099 inpatients. There were only 55 cases where ethnicity was 'not-stated' or 'invalid'.

Table 4 shows the ethnic profile of patients in London and England facilities recorded on the day of the census. In London, the single largest ethnic group was White British, which represented 53 per cent of all inpatients, followed by Black Caribbean which represented 11 per cent of inpatients. This is different to the national picture where 78 per cent of inpatients were White British. Overall in London, almost two thirds of inpatients (63 per cent) were White, and almost a quarter (23 per cent) were Black. Asian patients represented 7 per cent of the inpatient population and Mixed and Other ethnic groups represented 3 per cent each of inpatients.

Men represented 59 per cent of all inpatients, and women 41 per cent. This is slightly different to the national picture, where men represented 55 per cent of inpatients, and women 45 per cent.

Table 4 Ethnicity of all inpatients in NHS and private facilities in London and England

		London						England					
		Male		Female		Total*		Male		Female		Total*	
Ethnic group	Ethnic sub-group	N	%	N	%	N	%	N	%	N	%	N	%
White	British	2,053	49.1	1,688	58.3	3,753	52.9	12,992	74.8	11,766	82.7	24,800	78.3
	Irish	155	3.7	143	4.9	300	4.2	357	2.1	322	2.3	682	2.2
	Other White	212	5.1	209	7.2	422	5.9	522	3.0	490	3.4	1,014	3.2
Mixed	White and Black Caribbean	62	1.5	31	1.1	94	1.3	173	1.0	75	0.5	249	0.8
	White and Black African	21	0.5	15	0.5	36	0.5	43	0.2	24	0.2	68	0.2
	White and Asian	17	0.4	9	0.3	26	0.4	64	0.4	35	0.2	99	0.3
	Other mixed	36	0.9	24	0.8	61	0.9	108	0.6	56	0.4	165	0.5
Asian	Indian	116	2.8	63	2.2	179	2.5	261	1.5	170	1.2	431	1.4
	Pakistani	48	1.1	20	0.7	68	1.0	232	1.3	90	0.6	323	1.0
	Bangladeshi	68	1.6	29	1.0	97	1.4	107	0.6	42	0.3	149	0.5
	Other Asian	94	2.2	54	1.9	150	2.1	168	1.0	93	0.7	263	0.8
Black	Caribbean	514	12.3	248	8.6	764	10.8	943	5.4	417	2.9	1,362	4.3
	African	275	6.6	138	4.8	415	5.8	433	2.5	201	1.4	636	2.0
	Other Black	333	8.0	121	4.2	455	6.4	421	2.4	143	1.0	565	1.8
Other Ethnic Groups	Chinese	19	0.5	17	0.6	37	0.5	38	0.2	40	0.3	79	0.2
	Other	122	2.9	64	2.2	187	2.6	238	1.4	108	0.8	347	1.1
Not stated / Invalid		35	0.8	20	0.7	55	0.8	275	1.6	161	1.1	436	1.4
Total		4,180	100	2,893	100	7,099	100	17,375	100.0	14,233	100.0	31,668	100.0

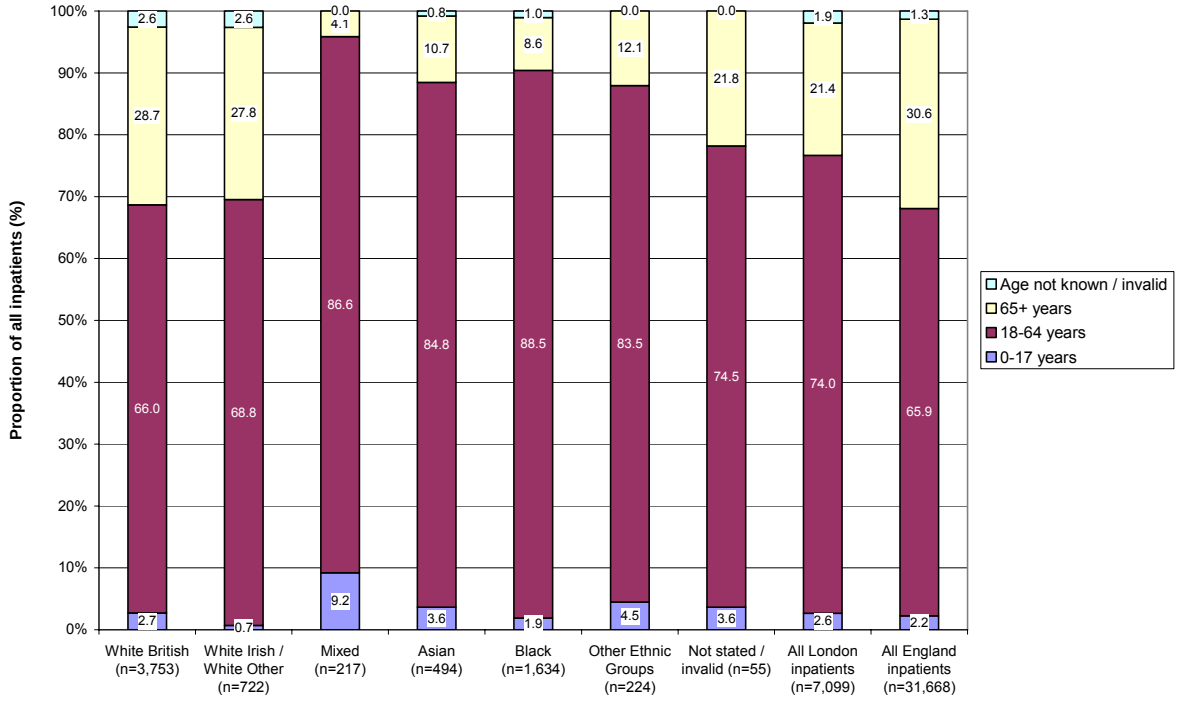
*Totals include where sex is Not known / Not stated.

As inpatient services also covered child and adolescent, working age adult and older adult units there was a large range of ages in the census. Overall, almost three quarters (74 per cent) of inpatients in London were aged 18-64 years, 21 per cent were aged 65 years and over, and only three per cent were aged under 18 years.

The age breakdown by ethnic group varied considerably as can be seen in Figure 1. All ethnic groups other than White groups had a considerably lower proportion of inpatients who were aged 65 years and over compared to the average. However some ethnic groups had higher proportions of patients that were aged under 18, particularly Mixed ethnic groups where 9 per cent were in this age range (three times more than the White British group). These differences may reflect age profiles within the ethnic populations with White groups having older populations than ethnic minority groups; the youngest ethnic minority group in Great Britain at 2001 was Mixed with 50 per cent being under the age of 16 years[x]. However access inequalities and poor recognition of mental health problems in some ages and ethnic groups also need to be considered.

London actually had a lower proportion of inpatients aged 65 years and over than England overall (21 per cent compared to 31 per cent) and a higher proportion or working aged inpatients (74 per cent compared to 66 per cent).

Figure 1 Age of all inpatients in NHS and private facilities in London and England by ethnic group



[x] ONS 2001 Census.

*5.2 **Comparison between NHS and private facilities***

Only 581 inpatients in the census were in private facilities (8 per cent) with the majority being in NHS units. However comparison of the NHS and private data show a differential use of private facilities based on geography and client group. For example, in South West London, 15 per cent of inpatients were in private facilities compared with 5 per cent in North East London (see Table 5).

Table 5 Proportion of inpatients in NHS and private facilities by London sector

	NHS		Private		Total	
	N	%	N	%	N	%
North West	1,833	92.5	149	7.5	1,982	100.0
North Central	1,293	91.8	116	8.2	1,409	100.0
North East	1,240	95.5	58	4.5	1,298	100.0
South East	1,431	91.6	132	8.4	1,563	100.0
South West	721	85.1	126	14.9	847	100.0
London	6,518	**91.8**	581	**8.2**	7,099	**100.0**

Analysis of the data provided by the NHS and the private facilities also found that:

- There was a higher proportion of White British patients in private facilities compared to NHS units (62 per cent compared to 52 per cent). There were lower proportions of all other ethnic groups in private wards compared to NHS units, except for Mixed groups
- 60 per cent of inpatients in private facilities were compulsorily detained under the Mental Health Act (1983) on admission compared to 45 per cent patient in NHS facilities
- 36 per cent of the Child and Adolescent Mental Health Service inpatients were in private facilities, compared to 8 per cent of inpatients in working age adult units and 4 per cent in older adult units
- 29 per cent of patients in low secure units, 14 per cent of inpatients in medium secure units, and 22 per cent of patients in Psychiatric Intensive Care Units (PICUs) were in private facilities. In contrast only 4 per cent of acute ward inpatients were in private facilities.

The data tables for these findings are provided in Appendix Three. These findings are most likely to represent historic spending patterns and the commissioning of specialist services which do not have sufficient demand to warrant providing these in each trust. They may also demonstrate gaps in services or over demand for some service types. Annual information relating to the use of private facilities by NHS Mental Health Trusts would be useful for commissioners of NHS services. These private facilities also need to act according to the Race Relations Act and commissioners and NHS trusts should ensure that private facilities are acting in the spirit of DRE.

For an analysis of spending on NHS, Local Authority and Independent Sector mental health services in London see the report *Commissioning for Equity: An analysis of planned spending on Adult Mental Health Services in London for 2005/06.*[20]

5.3 Asylum seekers

The census identified a small number of asylum seekers on London wards, 103 in total. This represents less than 2 per cent of the total inpatient population on that day; nationally asylum seekers represented less than 1 per cent of the total inpatient population. In London there were another 110 patients who did not have their asylum seeker status known or recorded. Information collected by the London Asylum Seekers Consortium on asylum seekers receiving Local Authority social service or subsistence only support suggests there were about 26,000 asylum seekers in the capital in March 2005. This would represent less than 1 per cent of the total population of London at that time.

Table 6 shows the location of these asylum seekers and their ethnicity. Over 50 per cent of the asylum seekers were in North Central and North West London. Another fifth (22 per cent) were in the South East. The largest proportion of asylum seekers were in the Black or Black British ethnic group.

Table 6 Number of asylum seekers in NHS and private facilities by London area and ethnic group

London sector	Number of asylum seekers	% of all asylum seekers	**Ethnic group**	Number of asylum seekers	% of all asylum seekers
North West	29	28.2	White	19	18.4
North Central	31	30.1	Asian	16	15.5
North East	13	12.6	Black	49	47.6
South East	23	22.3	Mixed and other Ethnic Groups	19	18.4
South West	7	6.8	Total	103	100.0
Total	103	100.0			

Whilst the number of asylum seekers appears small, it must be recognised that the survey would not have identified failed asylum seekers, refugees and other immigrants who might be at risk of mental health problems but who would not fall into the category of asylum seekers.

Information on country of birth and duration in this country would help to identify migrants better. This information would be useful as it is likely that migrants will be more affected by language difficulties as well as requiring input from a range of services.

5.4 Ethnicity of inpatients and comparison to local population

It is difficult to compare the inpatient population with the local population in a meaningful way as data on full post-code of residence was not collected in the first census. Further, the completeness of information on commissioning PCT, and full post-code of residence as collected in subsequent censuses, is thought to be poor. However, place of residence (full post code) and commissioning PCT is available through Hospital Episode Statistics (HES) data submitted to the Department of Health, and should therefore be known for all patients. Trusts should be encouraged to complete, to their best ability, this data in future inpatient censuses.

However, using the information that is available, i.e. the ethnicity of those inpatients in London services on the day of the census, we have calculated admission ratios based on the updated GLA ethnic population projections (see Table 7). As the ethnic profile of London varies according to age i.e. there is a higher proportion of ethnic minority groups amongst the younger age groups, particularly children, we have compared the inpatient population to London residents aged over 18 years as only 3 per cent of all inpatients in London in the census were aged 18 years or under.

Table 7 Ratios per 100,000 of male and female inpatients in NHS and private facilities

	Male	Female	All persons
White	119.6	95.8	107.4
Black Caribbean	448.2	159.1	281.7
Black African	211.6	90.8	146.5
Black Other	1077.3	333.9	657.8
Indian	62.3	33.5	47.8
Pakistani	85.7	38.1	62.6
Bangladeshi	138.9	55.9	96.2
Chinese	52.0	39.3	45.1
Other Asian	139.7	89.4	116.1
Other	219.1	95.7	149.9
Total	148.8	96.2	121.6

Population figures source: Estimated GLA projections for 2005 (18 years and over)

This analysis shows the differences in admission ratios by ethnicity, with considerably lower admission rates in Asian and Chinese groups and higher rates in Black groups. In men, Black Caribbean and Black Other groups had ratios that were over 3 and 9 times higher than White groups respectively. In women, Black Other groups had admission ratios over 3 times higher than White groups, whilst Indian, Pakistani and Chinese groups had admissions ratios over half that of the White group. Overall, admission ratios in Black Caribbean and Black Other were over twice and over 6 times higher than the White group, and Indian and Chinese ratios were over half that of White groups.

This is in line with the national analysis which found that rates of admissions were significantly lower for White British, Indian and Chinese groups, and significantly higher for all other groups except Pakistanis, and particularly high for people from Black Caribbean, Black African and Other Black and White/Black Mixed groups.

Unfortunately, the GLA projections have subsumed mixed groups within the 'other' categories (i.e. White / Asian Mixed groups are combined with the Asian Other group, and White / Black Mixed groups are in the Black Other group). This is a significant limitation to this data source. Also, age profile was not considered in this analysis. Further work is required to assess the extent of the mixed ethnic population in the capital and how the community population reflects the inpatient psychiatric population taking into account age structure.

Information on staff ethnicity was not collected during the census, although such data may exist elsewhere. This would be useful in assessing to what extent inpatient staff's ethnicity reflects both the local population and the inpatient profile. Whilst matching staff and patient ethnicity may not be possible given the ever changing ethnic profiles in London, such information would help to inform training and development.

6 London NHS baseline and Trust comparisons

This section presents an overview of the inpatients in NHS facilities in London on 31 March 2005. It provides a London perspective, highlighting differences to the national picture, and where useful, shows variations across London trusts.

6.1 Who are London's NHS inpatients, where are they, and how did they get there?

6.1.1 NHS inpatients by sex and ethnicity

There were 6,518 patients on NHS inpatient wards on the day of the census. Ethnicity was recorded for 99.2 per cent of people (6,469). Figure 2 shows the breakdown of all NHS inpatients in London where ethnicity was known and recorded. Overall, the largest proportions of patients were White British (52 per cent). The second largest ethnic group was Black (24 per cent), and a further 11 per cent were White Irish / White Other.

Figure 2 Ethnicity of inpatients as a proportion of all London inpatients (NHS facilities)

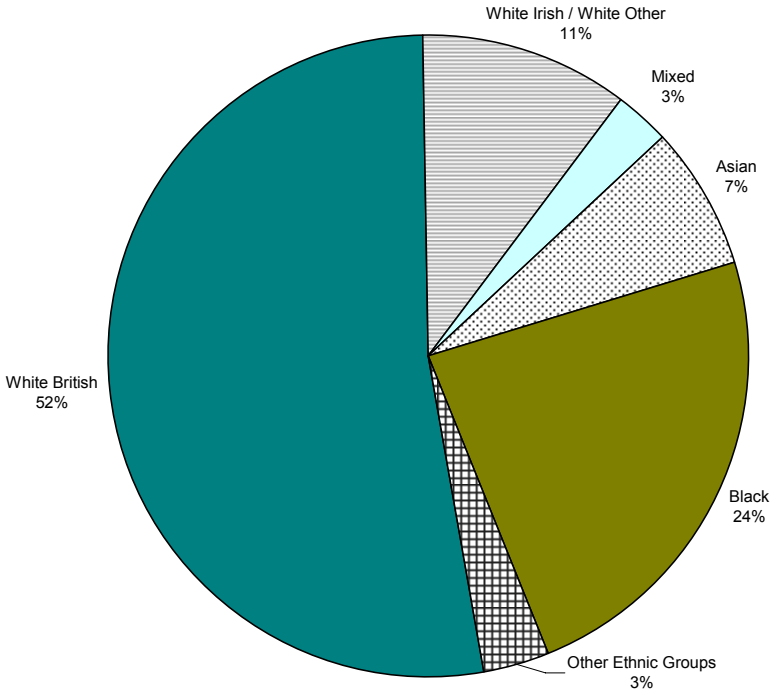


Table 8 shows the ethnicity of inpatients for each trust. The proportion of patients that were White British ranged from 36 per cent in East London and the City to 70 per cent in North East London and Oxleas, whilst the proportion that were Black ranged from 11 per cent in North East London to 35 per cent in East London and the City.

Table 8 Ethnicity of inpatients (NHS facilities) by Mental Health Provider Trust

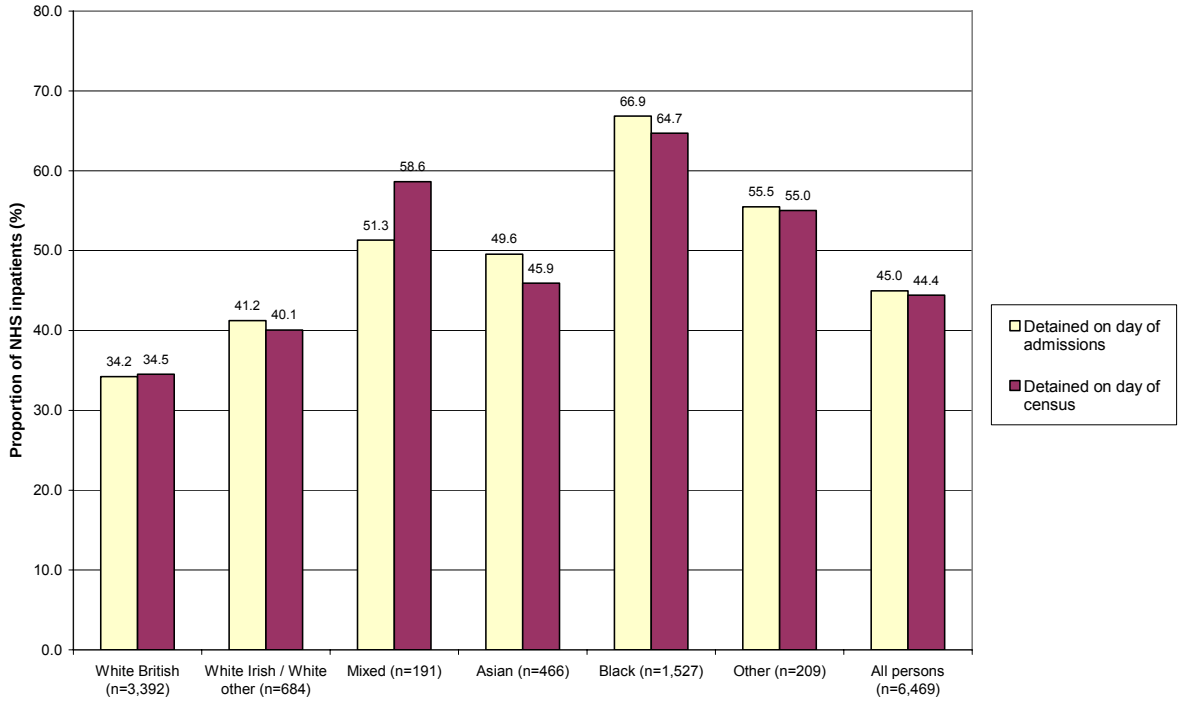
	White British		White Irish / White Other		Mixed		Asian		Black		Other		All persons	
NHS Trust	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Barnet Enfield and Haringey	415	48.7	109	12.8	34	4.0	57	6.7	195	22.9	43	5.0	853	100.0
Camden and Islington	204	47.3	81	18.8	24	5.6	20	4.6	93	21.6	9	2.1	431	100.0
Central North West London	409	47.8	120	14.0	20	2.3	84	9.8	175	20.5	47	5.5	855	100.0
East London and the City	249	36.1	70	10.1	15	2.2	95	13.8	238	34.5	23	3.3	690	100.0
North East London	375	70.2	37	6.9	20	3.7	33	6.2	60	11.2	9	1.7	534	100.0
Oxleas	305	70.0	26	6.0	10	2.3	13	3.0	73	16.7	9	2.1	436	100.0
South London and the Maudsley	476	48.5	99	10.1	22	2.2	35	3.6	326	33.2	24	2.4	982	100.0
South West London and St. George's	478	66.7	55	7.7	15	2.1	42	5.9	115	16.0	12	1.7	717	100.0
West London	481	49.5	87	9.0	31	3.2	87	9.0	252	26.0	33	3.4	971	100.0
All NHS trusts	3,392	52.4	684	10.6	191	3.0	466	7.2	1,527	23.6	209	3.2	6,469	100.0

6.1.2 Compulsory detentions

Overall, 46 per cent of patients in private and NHS facilities in London were compulsorily detained under the Mental Health Act (1983) on admission, compared to 39 per cent in England, which is a significantly higher ratio of detention on admission than the national average[21]. One explanation for this finding is that, on average, patients presenting to London psychiatric inpatient wards are more severely mentally ill than those in psychiatric services across the country. There is some evidence to support this. For example, the inpatient caseload mix in London is different to the rest of England with London having a higher proportion of inpatients with a primary diagnosis of a psychotic disorder[22]. The census also found that London had significantly higher ratios of referrals from courts and the criminal justice system (see section 6.1.3) which are associated with the use of the Mental Health Act (1983).

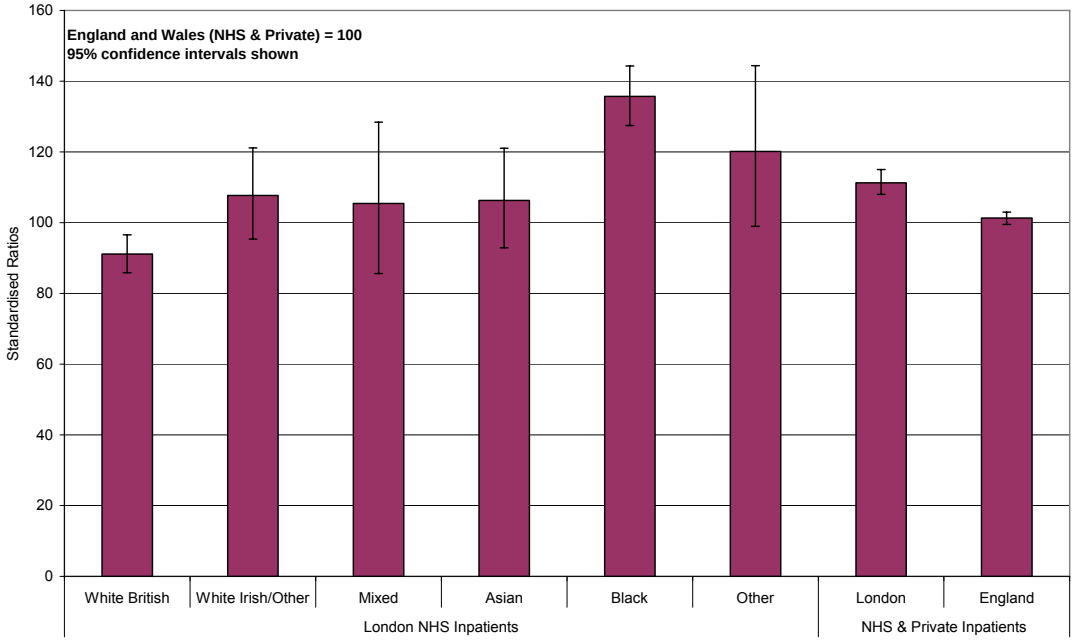
Figure 3 shows the proportion of inpatients in the census who had been a) compulsorily detained on admission, or who were b) compulsory detained on the day of the census, by ethnic group. Generally there were few ethnic differences between the proportion of those detained on the day of census and those who were compulsorily detained on admission, except for Mixed ethnic groups, where 7 percentage points more were detained on the day of the census than on admission. Whilst the difference is not statistically significant, all the other ethnic groups except White had higher proportions detained on admission compared to on the day of the census. This is an interesting finding for which further investigation may be required.

Figure 3 Proportion of inpatients in each ethnic group who were compulsorily detained on the day of the census or on admission (NHS facilities)



The highest ratios of compulsory detention were amongst the Black group, where 65 per cent were detained on the day of the census and 67 per cent compulsorily admitted (detained on admission). The lowest ratios of detention were amongst the White British group where just over a third were detained on the day of admission and on the day of the census. However when age is taken into consideration, ratios of detention are only significantly higher in the Black group. Figure 4 shows the standardised ratios for compulsory detention on admission. This is in line with national findings which found that Black Caribbean, Black African and Other Black groups were more likely to be detained under the Mental Health Act (1983) when compared to the average.

Figure 4 Age standardised ratios of compulsory detention on admission by ethnic group for NHS inpatients, compared to all inpatients in London, England and England and Wales.



Source: Count Me In census (2005) analysed by the Healthcare Commission for the LHO.

Information on primary diagnosis / case-mix would be helpful for understanding these differences. Analysis of Hospital Episode Statistics (HES) data for 2004/05 shows that over twice the proportion of patients from Black groups are admitted with a primary diagnosis of Schizophrenia or another delusional disorder than patients from White groups (56 per cent compared with 22 per cent, see Appendix Two). Therefore it appears that Black groups presenting to inpatient psychiatric services are more likely to have a severe mental illness (SMI) as a primary diagnosis. The reasons for this are complex and numerous, as described in section 2.4, and do not necessary just reflect prevalence or incidence rates, but also access and outcome variables.

The ratios of detention also varied considerably across the trusts. West London had the highest proportion of patients who were detained on admission (74 per cent) and North East London the lowest (24 per cent) (see Table 9).

Table 9 Proportion of inpatients in each ethnic group who were compulsory detained on the day of admission (NHS facilities) by Mental Health Provider Trust

NHS Trust		White British	White Irish / White Other	Mixed	Asian	Black	Other	Total
Barnet Enfield and Haringey	Detained (n)	115	47	20	28	128	25	363
	Detained (%)	27.7	43.1	58.8	49.1	65.6	58.1	42.6
	Total patients	415	109	34	57	195	43	853
Camden and Islington	Detained (n)	81	34	14	*	63	*	207
	Detained (%)	39.7	42	58.3	*	67.7	*	48
	Total patients	204	81	24	20	93	9	431
Central North West London	Detained (n)	121	49	14	32	108	23	347
	Detained (%)	29.6	40.8	70	38.1	61.7	48.9	40.6
	Total patients	409	120	20	84	175	47	855
East London and the City	Detained (n)	84	33	9	54	160	11	351
	Detained (%)	33.7	47.1	60	56.8	67.2	47.8	50.9
	Total patients	249	70	15	95	238	23	690
North East London	Detained (n)	76	6	*	14	28	*	130
	Detained (%)	20.3	16.2	*	42.4	46.7	*	24.3
	Total patients	375	37	20	33	60	9	534
Oxleas	Detained (n)	67	7	*	*	42	*	127
	Detained (%)	22	26.9	*	*	57.5	*	29.1
	Total patients	305	26	10	13	73	9	436
South London and the Maudsley	Detained (n)	140	29	9	15	199	12	404
	Detained (%)	29.4	29.3	40.9	42.9	61	50	41.1
	Total patients	476	99	22	35	326	24	982
South West London & St George's	Detained (n)	137	17	*	12	78	*	259
	Detained (%)	28.7	30.9	*	28.6	67.8	*	36.1
	Total patients	478	55	15	42	115	12	717
West London	Detained (n)	340	60	22	57	215	27	721
	Detained (%)	70.7	69	71	65.5	85.3	81.8	74.3
	Total patients	481	87	31	87	252	33	971

* Small numbers below 6 have been suppressed.

Case-mix and severity of mental illness may explain some of these ethnic variations. In the absence of this data, the type of ward where patients are receiving treatment may be a useful indicator of severity or type of mental illness. The location of secure services will particularly impact on detention rates across trusts. Secure (or forensic) services provide inpatient treatment for patients who have shown challenging behaviour and require physical security that is not available within usual acute inpatient services. Mentally disordered offenders are also treated within these services[xi]. Patients on these units will be detained under the Mental Health Act (1983). Secure services can be broken down into three levels; low secure, medium secure and high secure (see Box 3).

Box 3: Type of wards

Acute Inpatient Unit/Ward* *General acute wards may be on a general hospital site, part of a psychiatric hospital or in a separate purpose built unit. They provide care, including residential care with intensive nursing support for patients in periods of acute psychiatric illness. Patients will usually spend less than six months on an acute inpatient ward, although problems with discharge may mean that this is not achieved in practice.*

Psychiatric Intensive Care Unit* *Psychiatric intensive care is for patients compulsorily detained usually in secure conditions, who are in an acutely disturbed phase of a serious mental disorder. There is an associated loss of capacity for self-control, with a corresponding increase in risk, which does not enable their safe, therapeutic management and treatment in a general open acute ward. Length of stay varies but in London would ordinarily not exceed eight weeks in duration. Psychiatric Intensive Care is delivered by qualified staff according to an agreed philosophy of unit operation underpinned by principles of risk assessment and management.*

Residential Rehabilitation Unit* *Rehabilitation units are non-acute NHS facilities designed to provide continuing care for people with severe and enduring mental illness who are judged to be too chaotic or unwell to tolerate the environment of a residential place in the community. While not designed for permanent residency, a small number of rehabilitation patients may effectively live in the unit for many years. The characteristics of a rehabilitation unit are: a hospital or community base, 24 hour nursing care, the provision of treatment and rehabilitation, regular input from a multi-disciplinary psychiatric team, the patient is under the day to day care of a psychiatric consultant.*

Low secure unit* *These units are geared towards the patient group who require treatment for longer periods of time in a low secure environment, providing a locked door and little more than domestic levels of physical security. Many of these will require help and support for several years. They may cater for some patients presenting less serious threat of harm to others or those who are sufficiently compliant with treatment to be trusted in a lower security building. They will also provide treatment and care for people who have committed serious harm but where the possibility of repetition or the immediacy of the threat has passed and the patient is compliant.*

[xi] *About Mental Health Trusts*. The NHS Confederation:
http://www.nhsconfed.org/mental-health/mental-health-1759.cfm

Box 3: Type of wards cont.

Medium Secure unit** *Medium secure units provide care and treatment for patients who, though not presenting a grave and immediate danger to the public, do still pose a significant risk to others. Hence they require higher levels of security than that afforded in low secure facilities. Medium secure units have moderately high perimeter security and variable levels of internal physical security. Patients detained in these conditions may pose varying levels of risk but risk to others is not generally seen as immediate. Where the patient maybe less co-operative in complying with treatment it is felt they can be contained within the level of security provided.*

High secure unit** *High security units are intended to provide a high secure and safe environment for people regarded as a grave and immediate danger to the public. High security hospitals provide high perimeter and internal physical security. They are for people experiencing mental health problems of a degree requiring hospital treatment, thought to pose imminent serious harm to others and who are unable to co-operate with treatment in a less secure environment.*

* Taken from the Adult Mental Health Mapping, Mental Health Workbook produced by Gyles Glover for North East Public Health Observatory and the University of Durham.

**Taken from the Count Me In 2007 Data Capture Protocol v 2.6. http://www.mhac.org.uk/

On the day of the census there were 272 inpatients in high secure services in London, all of these being in West London Mental Health Trust (Table 10). West London is the only high secure service provider in London (and also provides services for South England). There were also 521 patients in medium secure units in London on the day of the census, with 158 of these (30 per cent) being in West London. As with high secure services, London medium secure services also service non-London populations, highlighting the need for information on patients postcode and commissioning PCT when comparing differences in admissions rates and compulsory detainments by ethnicity and trust.

Overall 15 per cent of inpatients were in some form of secure facility (low, medium or high), ranging from 23 per cent in Oxleas to 53 per cent in West London. Removing inpatients in secure facilities from the analysis could impact considerably on trust based detentions ratios in most London trusts as only North East London and Camden and Islington Trusts do not provide any secure services.

Table 10 Number and proportion of inpatients in secure units / beds (NHS facilities) by Mental Health Provider Trust

	Low secure		Medium secure		High secure		Total	
	N	%	N	%	N	%	N	%
Barnet Enfield and Haringey	0	0.0	99	11.6			99	11.6
Camden and Islington	0	0.0	0	0.0	0	0.0	0	0.0
Central and North West London	11	1.3	0	0.0	0	0.0	11	1.3
East London and the City	36	5.2	70	10.1	0	0.0	106	15.4
North East London	0	0.0	0	0.0	0	0.0	0	0.0
Oxleas	32	7.3	68	15.6	0	0.0	100	22.9
South London and the Maudsley	21	2.1	58	5.9	0	0.0	79	8.0
South West London and St George's	0	0.0	68	9.5	0	0.0	68	9.5
West London	80	8.2	158	16.3	272	28.0	510	52.5
All NHS Trusts	180	2.8	521	8.0	272	4.2	973	15.0

Overall, 55 per cent of all London patients were on an acute inpatient ward (Table 11). Those from mixed ethnic groups were more likely to be on a psychiatric intensive unit (PICU) than the other ethnic groups; 11 per cent of these patients were on a PICU, compared to 5 per cent on average. White British patients were more likely to be on a high dependency or extra care unit compared to the average (8 per cent compared to 6 per cent). However Black groups were much more likely to be on secure units. Almost a quarter (24 per cent) of Black patients were on some form of secure unit, compared to 12 per cent of White British patients (see Table 11). This is similar to the national picture, with men from Black Caribbean, Other Black, and White/Black Caribbean groups being more likely to be on a medium or high secure ward than average.

Table 11 Type of ward by ethnic group (NHS facilities)

	White British		White Irish / White Other		Mixed		Asian		Black		Other		All persons	
Type of ward	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Acute Inpatient	1,808	53.3	420	61.4	101	52.9	285	61.2	794	52.0	125	59.8	3533	54.6
High Dependency/Extra Care Unit	285	8.4	36	5.3	*	*	6	1.3	32	2.1	*	*	370	5.7
Psychiatric Intensive Care Unit (PICU)	107	3.2	26	3.8	20	10.5	25	5.4	97	6.4	16	7.7	291	4.5
Low Secure	58	1.7	10	1.5	*	*	17	3.6	82	5.4	*	*	180	2.8
Medium Secure	169	5.0	40	5.8	24	12.6	38	8.2	226	14.8	23	11.0	520	8.0
High Secure	183	5.4	21	3.1	*	*	6	1.3	52	3.4	*	*	273	4.2
Rehabilitation	434	12.8	77	11.3	19	9.9	69	14.8	198	13.0	20	9.6	817	12.6
Other	348	10.3	54	7.9	9	9.9	20	4.3	46	3.0	8	8.6	485	7.5
All wards	3,392	100.0	684	100.0	191	100.0	466	100.0	1,527	100.0	209	100.0	,6469	100.0

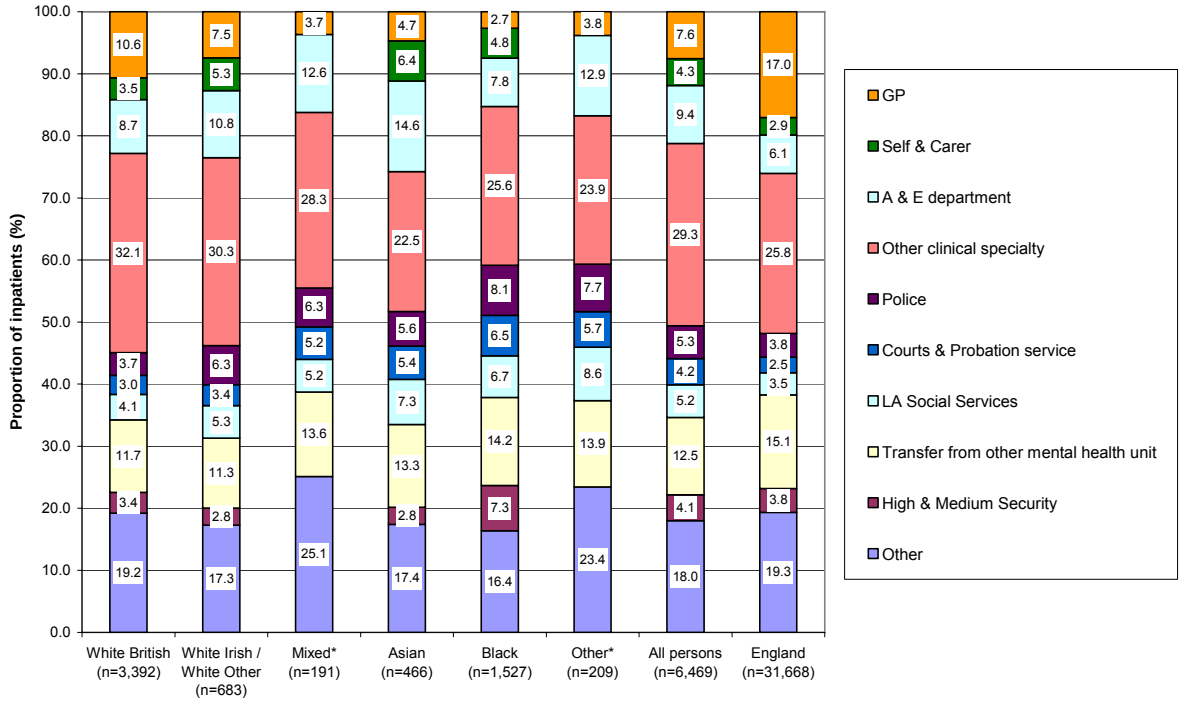
* Small numbers below 6 have been suppressed.

6.1.3 Where do patients come from - Referral sources?

The most common sources of referral for NHS inpatients services in London were clinical specialties other than A&E (29 per cent), transfer from another mental health unit (13 per cent), and A&E department (9 per cent), see Figure 4. London differs considerably from the national picture in terms of how patients were referred to mental health inpatient units, particularly with regard to referrals from General Practitioners (GPs). In England 17 per cent of inpatients were referred by GPs, compared to just 8 per cent in London (see Figure 4). In fact, London has significantly higher ratios of referrals by social services and by courts than England overall, but significantly lower ratios of referrals by GPs. This would corroborate the picture of a higher use of compulsory treatment in London, as found in the census, and greater levels of severe mental illness within the system.

In the capital we found that all ethnic minorities were less likely to have been referred by GPs compared to the White British group, for whom 11 per cent were referred via this route (see Figure 5). Black groups had the lowest proportion who were referred by GPs (3 per cent). However, Black groups were over twice as likely to be referred by police, courts or probation services than the White British group (15 per cent compared to 7 per cent). In each ethnic minority group, 10 per cent or over were referred via police, courts or probation services, which is higher than for the White British group.

Figure 5 Referral source by ethnic group (NHS facilities)



* Due to small numbers, the categories Self & Carer, and High & Medium Security have been included in the Other category for Mixed and Other Ethnic groups.

The London findings reflect the national picture. For example Black Caribbean, Black African and Other Black groups were 40 to 70 per cent less likely to be referred via GPs than the White British group. In England, lower ratios of referral were also found amongst Bangladeshi, White Irish, Other Asian and Other groups when compared to White British. Further in England referrals by police were almost double in the Black Caribbean and Black African groups than the White British group, and referrals from court were also almost double in the black Caribbean group.

Table 12 shows the ethnicity of patients from each referral source. Seventy four per cent of all GP referrals were White British although this group only made up 52 per cent of the London inpatient population. Therefore only 26 per cent of GP referrals were from ethnic minority groups and only 8 per cent were from the Black group, an ethnic group that represented 24 per cent of the inpatient population. In contrast, ethnic minority groups together represented 64 and 62 per cent of referrals from Police, and Courts and Probation Services respectively and Black groups made up 36 and 37 per cent of referrals from Police, and Courts and Probation services respectively.

Table 12 Ethnicity of inpatients by referral source (NHS facilities)

	White British		White Irish / White Other		Mixed		Asian		Black		Other		All persons	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%
GP	361	73.7	51	10.4	7	1.4	22	4.5	41	8.4	8	1.6	490	100.0
Self & Carer	119	42.7	36	12.9	*	*	30	10.8	73	26.2	*	*	279	100.0
LA Social Services	139	41.0	36	10.6	10	2.9	34	10.0	102	30.1	18	5.3	339	100.0
A & E department	294	48.5	74	12.2	24	4.0	68	11.2	119	19.6	27	4.5	606	100.0
Police	124	36.0	43	12.5	12	3.5	26	7.6	123	35.8	16	4.7	344	100.0
Other clinical specialty	1090	57.5	207	10.9	54	2.8	105	5.5	391	20.6	50	2.6	1897	100.0
Courts & Probation service	103	37.7	23	8.4	10	3.7	25	9.2	100	36.6	12	4.4	273	100.0
High & Medium Security	114	42.5	19	7.1	*	*	13	4.9	111	41.4	*	*	268	100.0
Transfer from other mental health unit	397	49.1	77	9.5	26	3.2	62	7.7	217	26.9	29	3.6	808	100.0
Other	651	55.9	118	10.1	35	3.0	81	7.0	250	21.5	30	2.6	1,165	100.0
All referral sources	3,392	52.4	684	10.6	191	3.0	466	7.2	1,527	23.6	209	3.2	6,469	100.0

* Small numbers below 6 have been suppressed.

This analysis suggests real inequalities in terms of access to, and timeliness of mental health and psychological interventions from health and other services, with particular impact on Black groups. Again, the reasons for this are likely to be numerous and do not just affect Black communities. Stigma of mental health problems and the association of mental health services with police and the criminal justice system may be barriers to accessing services. As the implications of lack of timely treatment and care may be increased severity of mental health problems, increased detention rates and greater likelihood of admission to the criminal justice system, the importance of developing trust and understanding between all communities and statutory health and mental health services, and preventing and breaking the cycle of compulsory treatment cannot be underestimated. It is therefore essential that we develop a thorough understanding of the interaction between different communities and health and mental health services, with particular emphasis on Black communities.

In order to reduce high admission and detention rates in the BME groups, initiatives need to begin upstream in community, primary care and other service settings such as social services and the voluntary sectors, and should focus on both prevention, early intervention, and promoting mental wellbeing, de-stigmatising mental illness and improving access to services.

The importance of working with the local criminal justice system, police and safer neighbourhood teams cannot be overemphasised. Building on community engagement through the new Community Development Workers (CDW) will also be key but neither England nor London were on track to meet their target quota of CDWs by the end of 2006. This target has been revised to December 2007, with London needing to meet 50 per cent of its quota of 93 whole time equivalent (WTE) CDWs by March 2007[23]. The London Development Centre's report *Could Do Better* found that during the summer of 2006 there were only 21 WTE CDWs in post which met the Department of Health's definition[24]. This was considerably lower than the 32-40 CDWs reported directly by the previous London Strategic Health Authorities, and by Local Implementation Teams (LITs) in the Adult Mental Health Service Mapping[25]. The Early Intervention Services for Psychosis introduced in the National Service Framework for Mental Health[26] should also be encouraged to see DRE as a core business objective, working closely with the CDWs and statutory and non-statutory services.

6.2 How are NHS inpatients treated?

6.2.1 Use of the Care Programme Approach (CPA) and Single Assessment Process (SAP)

The Care Programme Approach (CPA) is a mandatory framework for co-ordinating and managing the care of people with mental health problems using specialist mental health services. It includes elements of assessment, care planning, and key worker monitoring. It has two tiers;

- **Standard CPA** for patients who with relatively straightforward service needs and who pose little danger to themselves or others.
- **Enhanced CPA** for patients tend to have more complex or multiple care needs requiring more intensive or frequent interventions from several agencies and who may be pose a danger to themselves or others.

According to the Mental Health Act *Code of Practice*, all those receiving specialist mental health care should be on the CPA[27]. The Single Assessment Process (SAP) is a similar process for older adults over 65.

Overall London had a slightly higher proportion of patients on a CPA (28 per cent on Standard and 64 per cent on enhanced) than England (24 per cent and 59 per cent), see Table 13. It also has a lower proportion on neither CPA or SAP, 7 per cent of patients compared to 15 per cent.

In London Asian and Black groups were more likely to be on enhanced CPA than the White British group (75 percent and 77 per cent compared to 59 per cent respectively), and less likely to be on standard CPA (21 and 18 per cent compared to 32 per cent).

Table 13 Use of CPA and SAP by ethnicity (NHS facilities)

	Standard CPA		Enhanced CPA		SAP		Neither CPA nor SAP		Invalid / Not known		Total	
	N	%	N	%	N	%	N	%	N	%	N	%
White British	1,070	31.5	2,003	59.1	59	1.7	260	7.7	0	0	3,392	100.0
White Irish / White Other	238	34.8	387	56.6	7	1.0	52	7.6	0	0	684	100.0
Mixed	47	24.6	128	67.0	0	0.0	16	8.4	0	0	191	100.0
Asian	97	20.8	347	74.5	*	*	*	*	0	0	466	100.0
Black	277	18.1	1,173	76.8	13	0.9	64	4.2	0	0	1,527	100.0
Other	64	30.6	125	59.8	*	*	*	*	0	0	209	100.0
All persons	1,793	27.7	4,163	64.4	88	1.4	425	6.6	0	0	6,469	100.0
England	7,658	24.2	18,715	59.1	598	1.9	4,652	14.7	45	0.1	31,668	100.0

* Small numbers below 6 have been suppressed.

Table 14 shows the large variation in the use of CPA and SAP across London.

- Between 81 and 100 per cent of inpatients were on either standard or enhanced CPA or SAP
- Between 43 per cent and 92 per cent of inpatients were on enhanced CPA, the highest proportion being in West London
- Only 4 trusts reported patients on the Single Assessment Process which accounted for 1-5 per cent of their inpatients at the time
- Whilst two trusts had all their patients on either CPA or SAP, two had 19 per cent of their patients on neither of these care frameworks

Table 14 Use of CPA and SAP (NHS facilities) by Mental Health Provider Trust

	Standard CPA		Enhanced CPA		SAP		Neither CPA nor SAP		Total	
	N	%	N	%	N	%	N	%	N	%
Barnet Enfield and Haringey	211	24.7	438	51.3	41	4.8	163	19.1	853	100.0
Camden and Islington	118	27.4	215	49.9	15	3.5	83	19.3	431	100.0
Central North West London	*	*	446	52.2	*	*	28	3.3	855	100.0
East London and the City	185	26.8	498	72.2	7	1.0	0	0.0	690	100.0
North East London	268	50.2	230	43.1	0	0.0	36	6.7	534	100.0
Oxleas	*	*	246	56.4	*	*	0	0.0	436	100.0
South London and Maudsley	343	34.9	557	56.7	16	1.6	66	6.7	982	100.0
South West London and St George's	68	9.5	637	88.8	0	0.0	12	1.7	717	100.0
West London	38	3.9	896	92.3	0	0.0	37	3.8	971	100.0
London	1,793	27.7	4,163	64.4	88	1.4	425	6.6	6,469	100.0

* Small numbers below 6 have been suppressed.

These variations may represent differences in thresholds and definitions of CPA levels therefore it is difficult to use this information to assess severity of illness and application of CPA. However, given that it is recommended that all patients receiving specialist mental health care should be on a CPA, it is worrying that almost 1 in 5 patients in Camden and Islington, and Barnet Enfield and Haringey are

not on any form of care programme or assessment process (which is higher than the England average of 15 per cent). In order to understand these differences, local audit is needed.

6.2.2 Seclusion

According to the Code of Practice of the Mental Health Act (1983), seclusion is *"the supervised confinement of a patient in a room, which may be locked to protect others from significant harm. Its sole aim is to contain severely disturbed behaviour which is likely to cause harm to others."*

Seclusion should be used for as short a time as possible, and as a last resort, and is not supposed to be used as a punishment or as a form of treatment. Evidence to date suggests black patients are more likely to be secluded than white patients, and females more likely to be secluded than males. The census collected information on any period of seclusion that a patient had experienced within the last three months of their inpatient care. Seclusion here referred to being placed *"any time and for any duration, alone in an area with the door(s) shut so that they could not leave freely"*.

In London 4 per cent of inpatients had been secluded (see Figure 6). The White British group had the lowest proportion of patients who had been secluded, 3 per cent. The Black or Black British group had the highest proportion of patients who had been secluded, 6 per cent in total which was twice that of the White British group. This analysis bears out previous research and the national findings of the census which showed that men from the White British group were less likely to be secluded than men from the Black Caribbean, Black African, and other Black groups. However analysis undertaken by the Healthcare Commission on the London NHS inpatient data found that, once the proportions of seclusion were standardised to take into account age profiles, the Mixed group had the lowest ratios of seclusion, rather than the White British group. However none of these ethnic differences were statistically significant (see Figure 7).

Figure 6 Use of seclusion in the last three months by ethnic group (NHS facilities)

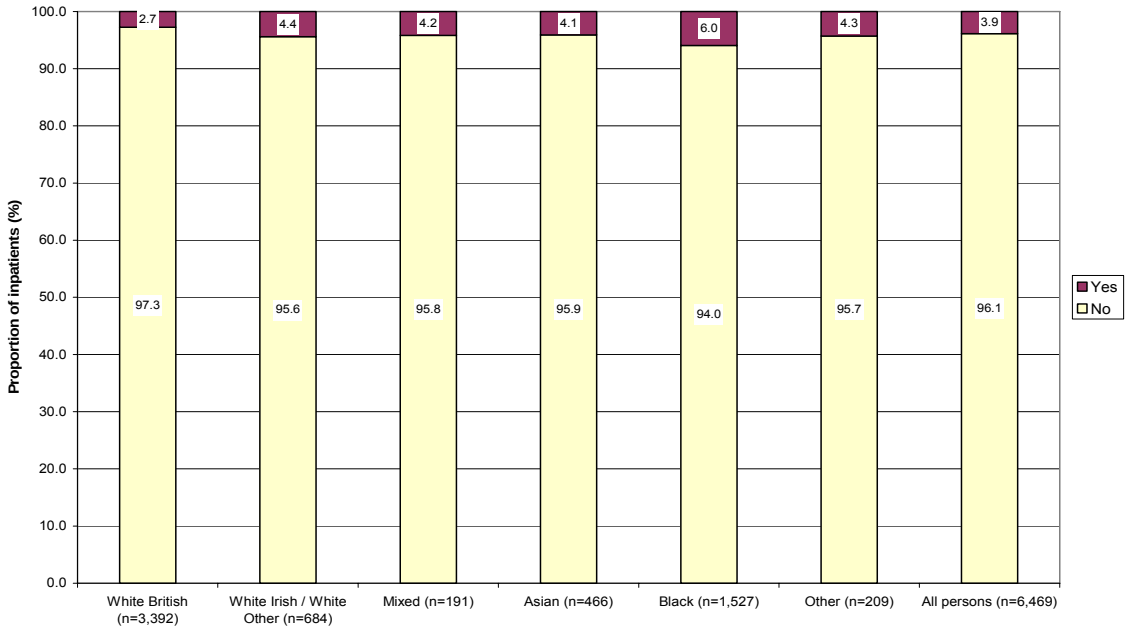
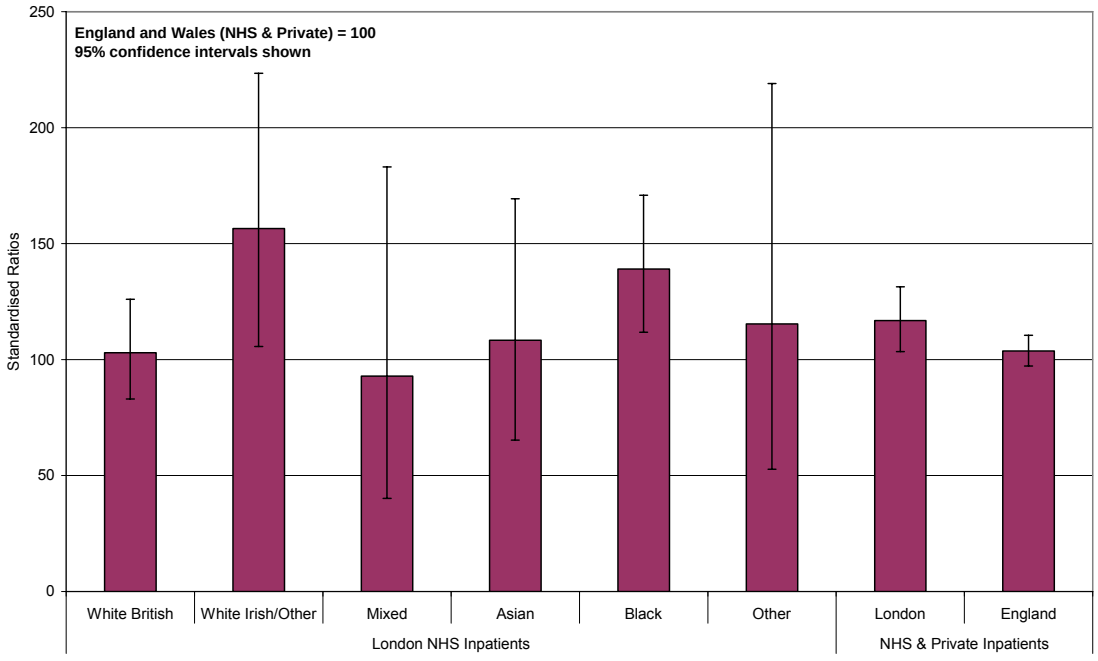


Figure 7 Age standardised ratios of seclusion in the last three months by ethnic group for NHS inpatients, compared to all inpatients in London, England and England and Wales.



Source: Count Me In census (2005) analysed by the Healthcare Commission for the LHO.

The use of seclusion clearly varies across London's NHS trusts. In East London and the City, North East London, and Oxleas Mental Health Trusts, the numbers of inpatients who had been secluded were so small we have not been able to publish these figures. Whilst in West London over 10 per cent of patients had been secluded. West London, as mentioned before, provides London's only high secure units, and has one of the highest proportions of compulsory detention, which would impact on the use of seclusion. Therefore the use of these practices needs to be broken down according to type of ward. Unfortunately this was not available for this analysis. However all trusts should be auditing their use of seclusion to ensure it complies with the code of practice and is not used discriminatorily.

Table 15 Use of seclusion in the last three months (NHS facilities) by Mental Health Provider Trust

	Yes		No		Total	
	N	%	N	%	N	%
Barnet Enfield and Haringey	46	5.4	807	94.6	853	100.0
Camden and Islington	11	2.6	420	97.4	431	100.0
Central North West London	17	2.0	838	98.0	855	100.0
East London & The City	*	*	*	*	690	100.0
North East London	*	*	*	*	534	100.0
Oxleas	*	*	*	*	436	100.0
South London and Maudsley	41	4.2	941	95.8	982	100.0
South West London and St George's	13	1.8	704	98.2	717	100.0
West London	110	11.3	861	88.7	971	100.0
London	250	3.9	6,219	96.1	6,469	100.0
England (NHS and private)	957	3.0	30,711	97.0	31,668	100.0

* Small numbers below 6 have been suppressed.

6.2.3 Control and restraint

Control and restraint is a technique used by nursing staff to physically restrain a patient to prevent harm to self or to others. The Joint Commission on Human Rights states that restraint:

> *"should be a last resort. Staff should therefore be equipped with a range of skills to deal with and de-escalate potentially violent situations, as well as a range of restraint techniques that will allow for use of the minimum level of force possible. Restraint in detention should be a rare event, and should never be used as a matter of routine."*[xii]

[xii] http://www.publications.parliament.uk/pa/jt200405/jtselect/jtrights/15/1511.htm

In these circumstances, seclusion would be preferable to restraint. In 1998 David Bennet, a Black-Caribbean inpatient died after 25 minutes of being restrained in the prone (face-down) position highlighting the risks of harm of such interventions. This evidence presented in this case suggested that control and restraint was used discriminatory more for Black patients[28].

Figure 8 shows the proportion of patients who experienced one or more incidents of control and restraint in the last three months. Overall 7 per cent were restrained with the White British group having the least proportion of patients who had been restrained (6 per cent). Black or Black British and mixed ethnic groups were considerably more likely to have been restrained, 11 and 10 per cent respectively. Further analysis by the Healthcare Commission however found that only the Black group had statistically significantly higher ratios of restraint. None of the other ethnic minority group ratios were significantly different from the White British group (see Figure 9).

Figure 8 Use of control and restraint in the last three months by ethnic group (NHS facilities)

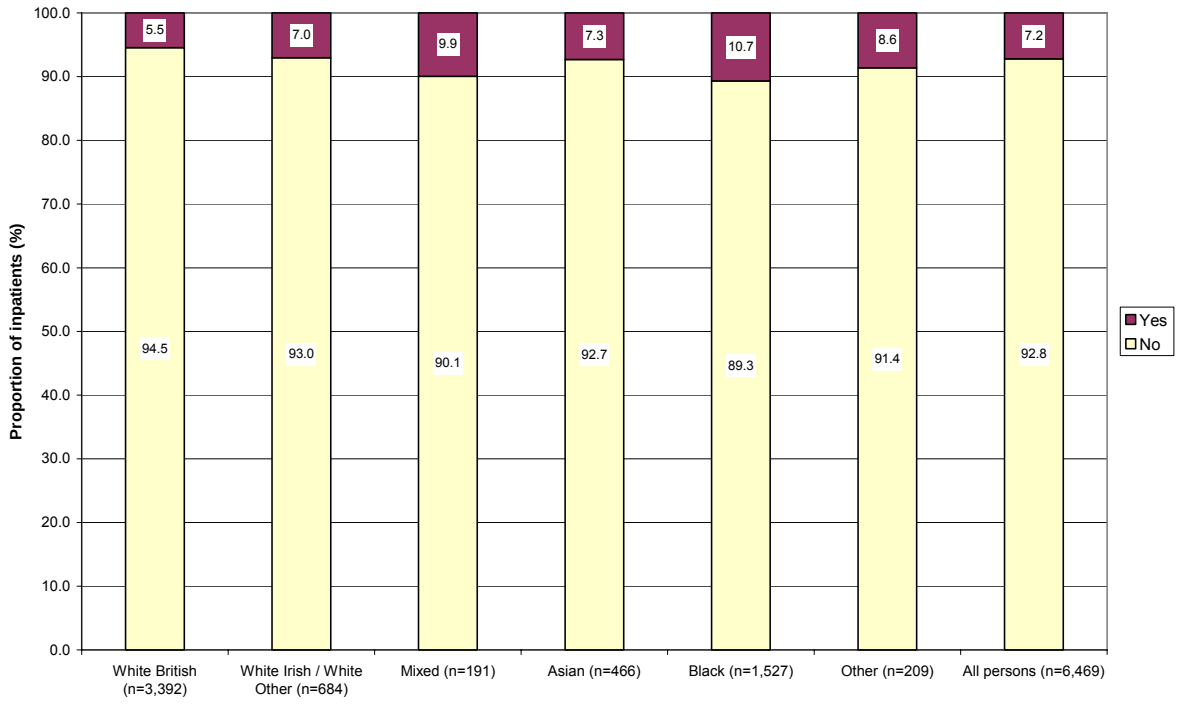
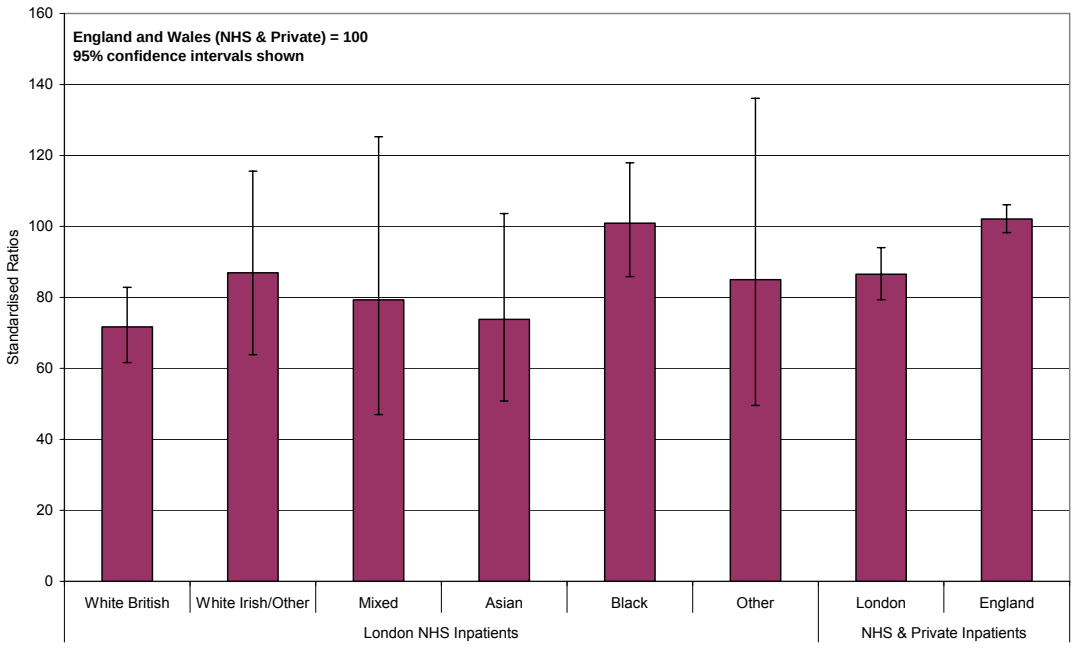


Figure 9 Age standardised ratios of control and restraint in the last three months by ethnic group for NHS inpatients, compared to all inpatients in London, England and England and Wales.



Source: Count Me In census (2005) analysed by the Healthcare Commission for the LHO.

Nationally 8 per cent of inpatients had experienced an incident of control and restraint (see Table 16) and London has a statistically significantly lower ratio of control and restraint than the England average. Therefore there might be lessons that the rest of England could learn from London's mental health providers. Furthermore, men from the Black Caribbean group were 29 per cent more likely to experience such an incident than the average male ratio for inpatients in England and Wales.

As with the use of seclusion, incidences of control and restraint varied considerably across trusts, with only 2 per cent of patients in Oxleas having experienced such an incident but 14 per cent of inpatients in Camden and Islington (see Table 16). All trusts, and specifically those with high ratios of restraint once type of ward is taken into account, should audit their use of this technique to ensure that it is used appropriately, safely, and without discrimination.

Table 16 Use of control and restraint in the last three months (NHS facilities) by Mental Health Provider Trust

	Yes		No		Total	
	N	%	N	%	N	%
Barnet Enfield and Haringey	50	5.9	803	94.1	853	100.0
Camden and Islington	60	13.9	371	86.1	431	100.0
Central North West London	39	4.6	816	95.4	855	100.0
East London & The City	32	4.6	658	95.4	690	100.0
North East London	27	5.1	507	94.9	534	100.0
Oxleas	7	1.6	429	98.4	436	100.0
South London and Maudsley	107	10.9	875	89.1	982	100.0
South West London and St George's	48	6.7	669	93.3	717	100.0
West London	97	10.0	874	90.0	971	100.0
London	467	7.2	6,002	92.8	6,469	100.0
England (NHS and private)	2,627	8.3	29,041	91.7	31,668	100.0

6.2.4 Injury and harm

Table 17 shows the proportion of patients in each ethnic group who had sustained and recorded any injuries during the last three months of their stay (excluding self-harm). Overall, 9 per cent of patients had sustained an injury, the highest proportion being in patients from the White British group where 11 per cent had recorded receiving an injury in the last three months. Patients from Black and Mixed groups were half as likely to have recorded an injury than the White British group. Nationally Black Caribbean and Indian groups had a significantly lower than average proportions reporting injury. Several stakeholders have noted that the most injury and harm reported in inpatient psychiatric services is in the older adult population, and particularly for falls. This population group are more likely to be White British than from another ethnic group, which might explain this finding. However it must also be considered that some ethnic groups might be less likely to report any injuries sustained or that they are less likely to receive such injuries, and this needs to be explored.

Table 17 Proportion of inpatients reporting injuries in the last three months by ethnic group (NHS facilities)

	Yes		No		Not known / invalid		Total	
	N	%	N	%	N	%	N	%
White British	377	11.1	2,908	85.7	107	3.2	3,392	100.0
White Irish / White Other	51	7.5	613	89.6	20	2.9	684	100.0
Mixed	9	4.7	*	*	*	*	191	100.0
Asian	29	6.2	427	91.6	10	2.1	466	100.0
Black	68	4.5	1,397	91.5	62	4.1	1,527	100.0
Other	15	7.2	*	*	*	*	209	100.0
All persons	549	8.5	5,712	88.3	208	3.2	6,469	100.0

* Small numbers below 6 have been suppressed.

Table 18 shows the proportion of patients who recorded an injury in the last three months by trust. Overall the proportion of patients who had sustained injuries in London NHS Mental Health Trusts was lower than the England average, 9 per cent compared to 11 per cent. However the range across London trusts was large, ranging from 5 per cent in Camden and Islington, East London and the City, and Oxleas, to 20 per cent in South West London and St George's. In some trusts there were a large proportion where this information was not available, for example, 10 per cent of patients in Oxleas, which could explain the low percentage of reported injuries. It is not clear why this information was not available, but recording of this needs to be improved in order to ensure equitable care for all patients. Differences in reporting systems between trusts may explain some of this variation.

Table 18 Proportion of inpatients reporting injuries in the last three months (NHS facilities) by Mental Health Provider Trust

	Yes		No		Not known / invalid		Total	
	N	%	N	%	N	%	N	%
Barnet Enfield and Haringey	51	6.0	765	89.7	37	4.3	853	100.0
Camden and Islington	22	5.1	*	*	*	*	431	100.0
Central North West London	62	7.3	766	89.6	27	3.2	855	100.0
East London & The City	37	5.4	653	94.6	0	0.0	690	100.0
North East London	54	10.1	*	*	*	*	534	100.0
Oxleas NHS Trust	20	4.6	374	85.8	42	9.6	436	100.0
South London and Maudsley	80	8.1	823	83.8	79	8.0	982	100.0
South West London and St George's	141	19.7	576	80.3	0	0.0	717	100.0
West London	82	8.4	*	*	*	*	971	100.0
All trusts	549	8.5	5,712	88.3	208	3.2	6,469	100.0
England (NHS and private)	3,570	11.3	26,982	85.2	1116	3.5	31,668	100.0

* Small numbers below 6 have been suppressed.

It is difficult to draw a conclusion from this information. Information needs to be broken down by age of the patient and type of ward for further analysis. Trust's internal records of incidences might be better used for monitoring types of injuries and ethnic breakdowns. Further, information from patient surveys might be able to uncover whether there are ethnic differences in the reporting of injuries.

7 Discussion

Our analysis of the BME census provides a broad picture of differences across the capital in terms of patient profiles and the treatment that different ethnic groups receive.

There are of course, some limitations to the data and how we can interpret these findings. It must be remembered that London overall has high need for mental health services, with much higher detention ratios (as evident from this report) and it is safe to assume that the capital experiences higher levels of serious mental illness, particularly in areas of high deprivation, which are often those areas where there are high proportion of BME groups. The capital also has a higher proportion of its population from ethnic minority groups. This presents a complex picture of need which requires a high level of sophisticated analysis to distinguish appropriate and inappropriate treatment. This is not possible using the current dataset.

Despite these limitations, large differences in the treatment of different ethnic groups in London mental health services were observed in the “Count Me In” census which require explanation at a local level. Local commissioners, clinicians and services users should demand that these differences are further explored. Whilst our report cannot provide these answers, the data provided for this report is useful for monitoring change and delivery at a regional level. Not all of the information in this report may be of use for monitoring DRE, and a more focused analysis and monitoring framework should be considered. In addition, other datasets and information will also be required to see change as a result of the implementation of DRE, such as patient surveys. At a regional level it would be helpful to commission a purposeful and specific monitoring framework for DRE. However evaluation and assessment must also continue at a local level, and the data available at this level has considerably more detail than can be made available to the LHO.

8 Conclusion

The census findings need to be seen as a *starting point* for Mental Health trusts, working with primary care, police and partner agencies to audit and explain outlying positions, and to demonstrate to their Boards, users and local communities that their practices continue to be clinically and culturally appropriate.

It is vital to recognise that the census only provides a high level view of *one part* of the mental health system. If racial equality, equity of access and culturally appropriate care are to be achieved in London, it is important to be able to understand the *whole system* of prevention and care and to take action both outside and inside specialist mental health services where locally needed.

9 Full implications

9.1 General implications

- The national census findings alone are a continuing cause for concern, but do not provide sufficient evidence to explain the causes of ethnic differences in admission rates and care practices between London's Trusts and between London and England. Multiple factors including differences in need, case severity and racial inequalities and discrimination need also to be taken into account.
- The origins of higher levels of compulsory detention and coercive care pathways for some ethnic minority patients need to be better understood in terms of the wider care pathways for patients with mental illness; in particular the limited involvement of London's primary care services in the referral process compared with England, and the relationship with the local Criminal Justice System.
- Initiatives targeted at reducing admission and detention rates in ethnic minority groups should begin upstream focusing both on prevention and early intervention. Cross-agency working is vital to achieve this.

9.2 Implications for commissioning and providers

- The close existing partnership between London's mental Health Trusts and good routine ethnic monitoring data in London, provides an opportunity for an agreed set of London indicators to be monitored regularly drawing from a number of Trust sources including adverse incidents, HES data and other sources. Prompt investigation of outliers could help reassure Boards, users and communities that the DRE Action Plan is being actively monitored.
- However, local clinically led audit and debate in those trusts with high rates of detentions, seclusions and control and restraint could help to explain the census findings and help ensure that these compulsions are being used only when required, and are not being used discriminatorily.
- NHS patients in private facilities should not be considered outside the scope of DRE. Mental health trusts who commission these facilities have responsibility to ensure that their service users receive both culturally and clinically appropriate treatment regardless of race or ethnicity.
- All patients in specialist mental health services, irrespective of ethnic origin, should be identified within the CPA framework.
- Information on the ethnicity of staff as well as the take-up of training on cultural awareness is essential to understand the cultural climate in which treatments and care are provided and should already be part of trusts' Race Equality Schemes.
- NHS patients in private facilities should not be considered outside the scope of DRE action plan. In the report we have provided an overview of patients in private facilities, however our detailed trust analysis excludes these patients as we were not able to link patients to their commissioning Mental Health Trust or Primary Care Trust (PCT). Mental Health Trusts who

commission these facilities have a responsibility to ensure that their service users receive both culturally and clinically appropriate treatment in any facility in which they are placed.

- All patients in specialist mental health services should be identified within the Care Programme Approach (CPA) framework or Single Assessment Process (SAP).

9.3 Implications for future National Censuses

- The ability of the national inpatient census to serve the objectives of the DRE would be enhanced if the following information items were included or improved in the future:
    - country of birth and number of years resident in England
    - measures of mobility (length of time at current address)
    - whether they are registered with a GP and the last time seen by a GP
    - primary diagnosis
    - contacts with the Criminal Justice System
    - improved collection and analysis of postcode of residence and commissioning PCT
    - better recording of refugees and asylum seekers
    - alignment with items in the new Mental Health Minimum Dataset (MHMDS) which would provide opportunities for ongoing and more regular monitoring of ethnic disparities in the full breadth of specialist mental health services, alongside opportunities for exploring long-term inequalities in care, treatment and outcomes for patients from different ethnic groups.

10 Appendix One: Ethnic coding

See next page for table.

Table 19 Summary of ethnic coding in London's main NHS Hospital Trusts, all FCEs, 2002/03 - 2005/06

	Ethnicity stated / valid codes				Not stated / invalid codes			
	2002/03	2003/04	2004/05	2005/06*	2002/03	2003/04	2004/05	2005/06*
Acute and Specialist Trusts Total	**66.1**	**76.5**	**80.1**	**83.9**	**33.9**	**23.5**	**19.9**	**16.1**
Mental Health Provider Trusts								
North East London Mental Health NHS Trust	81.2	91.3	91.7	0	18.8	8.7	8.3	**
West London Mental Health NHS Trust	50.3	90.2	92.9	94.7	49.7	9.8	7.1	5.3
Oxleas NHS Trust	53.6	96.3	96.8	97.2	46.4	3.7	3.2	2.8
South West London & St George's Mental Health NHS Trust	91.6	93.4	96.6	97.8	8.4	6.6	3.4	2.2
Barnet, Enfield & Haringey Mental Health NHS Trust	95.8	97.7	97.1	96.6	4.2	2.3	2.9	3.4
Central & North West London Mental Health NHS Trust	92.3	91.8	98.5	99.7	7.7	8.2	1.5	0.3
South London & Maudsley NHS Trust	86.3	93	93.7	95.8	13.7	7	6.3	4.2
East London & The City Mental Health NHS Trust	80.6	87.7	94.8	98	19.4	12.3	5.2	2
Camden & Islington Mental Health & Social Care Trust	91.4	94.3	93.1	97.9	8.6	5.7	6.9	2.1
Mental Health Provider Trusts Total	**82.1**	**92.7**	**94.8**	**97.3**	**17.9**	**7.3**	**5.2**	**2.7**
All Trusts	**66.3**	**76.7**	**80.4**	**84**	**33.7**	**23.3**	**19.6**	**16**

* provisional data

** North East London Mental Health Trust data excluded due to missing observations in 2005/06 provisional data.

Source: Hospital Episode Statistics (HES), The Information Centre for health & social care. 2005/06 HES data provisional. Analysed by LHO

Table 20 Proportion (%) in each ethnic group in London's NHS Mental Health Trusts, all FCEs 2005/06 (provisional)

	North East London Mental Health NHS Trust **	West London Mental Health NHS Trust	Oxleas NHS Trust	South West London & St George's Mental Health NHS Trust	Barnet, Enfield & Haringey Mental Health NHS Trust	Central & North West London Mental Health NHS Trust	South London & Maudsley NHS Trust	East London & The City Mental Health NHS Trust	Camden & Islington Mental Health & Social Care Trust	All Trusts
White British	**	45.1	70.6	71.6	49.6	36.1	47.8	33	30.9	48.4
White Irish	**	3.5	1.2	2	2.7	6	3.8	3.2	6.2	3.5
Other White	**	6.8	5.3	4.2	12.3	9.6	16.7	11.2	26.4	11
White / Black Caribbean	**	0.5	0.4	1.3	1.1	1	1.5	1.2	1.3	1.1
White / Black African	**	*	0.5	0.4	1	0.9	*	0.7	*	0.5
White / Asian	**	0.4	0.3	0.4	0.2	0.5	0.3	0.6	0.8	0.4
Other Mixed	**	0.9	1.1	0.8	0.7	0.8	0.5	0.6	0.6	0.8
Indian	**	5.3	1.6	1.6	2.8	3.3	1.4	3.1	0.7	2.5
Pakistani	**	2.2	0.6	1.1	0.4	1.2	0.4	1.9	0.3	1.1
Bangladeshi	**	0.4	*	0.4	0.8	1.1	*	7.6	3	1.8
Other Asian	**	5	1	2.5	1.7	3	1.3	1.9	1.5	2.3
Black Caribbean	**	5.9	4.1	5.4	8.2	11.7	6.1	11.6	9	7.9
Black African	**	3.9	6.4	3.2	6.3	8.8	2.5	10.7	9.2	6.4
Other Black	**	10.7	1.1	1.6	3.8	6.5	10.3	7.7	4.4	5.7
Chinese	**	*	*	0.5	0.4	0.6	0.5	0.5	*	0.3
Other	**	3.4	2.6	0.8	4.3	8.5	2.3	2.6	2.8	3.3
Not stated / invalid	**	5.3	2.8	2.2	3.4	0.3	4.2	2	2.1	2.7
Stated / valid	**	94.2	96.7	97.8	96.6	99.7	95.4	98	97.2	97
Total	**	100	100	100	100	100	100	100	100	100
Total (n)	**	2,865	2,283	3,692	2,704	2,687	2,280	3,527	2,360	22,398

* Small numbers suppressed.

** North East London Mental Health Trust data excluded due to missing observations in 2005/06 provisional data.

Source: Hospital Episode Statistics (HES), The Information Centre for health & social care. 2005/06 HES data provisional. Analysed by LHO

11 Appendix Two: Admissions by diagnosis 2004/05

Table 21 Proportion of patients from each ethnic group admitted to London NHS facilities for selected mental health diagnoses, 2004/05.

	Ethnic group						
Diagnosis	White	Mixed	Asian	Black	Other	Not stated	Total
Mental / behavioural disorders • due to use of alcohol	26.0	12.6	14.4	5.9	16.1	44.3	22.4
• due to other psychoactive substance use	7.6	8.6	4.7	5.5	6.4	3.7	6.7
Schizophrenia	15.7	28.0	27.6	39.7	19.3	10.6	20.8
Other delusional disorders	6.0	11.8	10.4	15.8	12.2	7.3	8.6
Bipolar affective disorder	7.3	7.1	8.4	10.8	7.5	3.3	7.7
Depressive disorders	11.9	9.8	12.5	8.1	13.3	8.9	11.1
Neurotic, stress-related & somatoform disorders	5.8	5.8	6.2	3.4	9.0	8.1	5.7
Disorders of adult personality & behaviour	9.1	3.9	3.9	2.9	4.7	3.0	6.8
Unspecified mental disorder	3.8	7.0	3.5	3.2	7.5	4.0	3.9
Other mental health problem	6.8	5.3	8.3	4.7	3.8	6.8	6.4
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0

Source: Hospital Episode Statistics (HES), The Information Centre for health & social care. 2005/06 HES data provisional. Analysed by LHO.

12 Appendix Three: Data tables comparing NHS & Private facilities

Table 22 Ethnicity of inpatients by NHS / Private facility

	NHS		Private		Total	
	N	%	N	%	N	%
White British	3,392	52.0	361	62.1	3,753	52.9
White Irish / White Other	684	10.5	38	6.5	722	10.2
Mixed	191	2.9	26	4.5	217	3.1
Asian	466	7.1	28	4.8	494	7.0
Black	1,527	23.4	107	18.4	1,634	23.0
Other	209	3.2	15	2.6	224	3.2
Not stated / invalid	49	0.8	6	1.0	55	0.8
All persons	6,518	100.0	581	100.0	7,099	100.0

Table 23 Legal status of inpatients on admission by NHS / Private facility

	NHS		Private		Total	
Legal status	N	%	N	%	N	%
Detained	2,937	45.1	347	59.7	3,284	46.3
Informal	3,476	53.3	234	40.3	3,710	52.3
Invalid	105	1.6	0	0.0	105	1.5
Total	6,518	100.0	581	100.0	7,099	100.0

Table 24 Ward age range by NHS / Private facility

	NHS		Private		Total	
Ward age range	N	%	N	%	N	%
CAMHS	139	64.1	78	35.9	217	100
Working age adults	4,924	91.8	440	8.2	5,364	100
Older adults	1,455	95.8	63	4.2	1,518	100
All wards	6,518	91.8	581	8.2	7,099	100

Table 25 Type of ward by NHS / Private facility

	NHS		Private		Total	
	N	%	N	%	N	%
Acute Inpatient	3,559	95.8	155	4.2	3,714	100.0
High Dependency/Extra Care Unit	373	95.6	17	4.4	390	100.0
Psychiatric Intensive Care Unit (PICU)	296	77.9	84	22.1	380	100.0
Low Secure	182	70.8	75	29.2	257	100.0
Medium Secure	525	86.3	83	13.7	608	100.0
High Secure	273	95.1	14	4.9	287	100.0
Rehabilitation	822	92.8	64	7.2	886	100.0
Other	488	84.6	89	15.4	577	100.0
All wards	6,518	91.8	581	8.2	7,099	100.0

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