HRB Statistics Series 1

High support community residences census 2006

Donna Tedstone Doherty, Dermot Walsh, Ros Moran, Fiona Bannon

Mental Health Research Unit
Health Research Board

Improving people's health through research and information

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About the HRB

The Health Research Board (HRB) is the lead agency supporting and funding health research in Ireland. We also have a core role in maintaining health information systems and conducting research linked to national health priorities. Our aim is to improve people's health, build health research capacity, underpin developments in service delivery and make a significant contribution to Ireland's knowledge economy.

Our information systems

The HRB is responsible for managing five national information systems. These systems ensure that valid and reliable data are available for analysis, dissemination and service planning. Data from these systems are used to inform policy and practice in the areas of alcohol and drug use, disability and mental health.

Our research activity

The main subjects of HRB in-house research are alcohol and drug use, child health, disability and mental health. The research that we do provides evidence for changes in the approach to service delivery. It also identifies additional resources required to support people who need services for problem alcohol and drug use, mental health conditions and intellectual, physical and sensory disabilities.

The **Mental Health Research Unit** gathers data on patient admissions, treatment and discharges from psychiatric hospitals and units throughout Ireland. The data collected have been reported in the Activities of Irish Psychiatric Services since 1965 and continue to play a central role in the planning of service delivery. The unit is extending its service to include information about activity in community care settings in order to reflect the changing patterns of care for patients with a mental illness. Multi-disciplinary experts in the unit carry out national and international research and disseminate findings on mental health and mental illness in Ireland. These findings inform national policy, health service management, clinical practice and international academic research.

The **HRB Research series** reports original research material on problem alcohol and drug use, child health, disability and mental health.

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Acknowledgements

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Summary

A census of high support community residences in Ireland was carried out on the night of the 31 March 2006. The purpose of the census was to gather information on resident in high support community residences provided by the mental health services on the night of the census. The 2006 census, the second in the series, has expanded the scope of the previous census by gathering information on diagnosis and daytime activities such as employment, attendance at day centres, and training. All residences operating under the provisions of the Mental Health Act (2001) were reviewed. Residences catering exclusively for patients with intellectual disabilities or learning disabilities were excluded; this enabled comparisons to be made with the findings of the previous HRB high support hostel census which was carried out in 2001. Forms specifically designed for the 2006 census were forwarded to the directors of nursing in each catchment area, who in turn forwarded them to the appropriate nursing staff in the residences. Completed forms were returned to the HRB. The list of residences was verified by the directors of nursing prior to the analysis of census data by the HRB. There were 1,412 people resident in 113 residences i.e. a rate of 46.6 per 100,000 population aged 16 years and over. There were slightly more male residents than female residents; the majority of male residents were diagnosed with schizophrenia. Approximately half of the residents were aged between 45 and 65 years. Just over one third of the residents were aged 65 years or over; only 18% were under 45. Less than 17% of the residents had lived in their current accommodation for under a year, with almost half (45%) having been resident in the high support facilities for five years or more. Few residents were employed, either in sheltered or mainstream employment; the majority were attending day centres. The results showed that there were few differences in the profile (e.g. age and gender) of residents in high support facilities between the HSE Administrative Areas. However, there was wide variation in the rate of residents per 100,000 population aged 16 years and over. The highest rate was in HSE West at 66.2, followed by HSE South at 48.2. This compares to HSE Dublin North-East with 46.0 residents per 100,000 population and HSE Dublin Mid-Leinster with only 29.8 residents per 100,000 population. Furthermore there was wide variation in the rates of residents per 100,000 population aged 16 years and over between the counties ranging from 8 per 100,000 population to 171 per 100,000 population. The reasons for these discrepancies between HSE Administrative Areas and county areas will require further investigation in order to ensure that the provision of services is needs based. In addition, it is recommended that both the support and the purpose of community residential facilities are defined i.e. whether the facilities have a rehabilitative function or one of continuing care. If residences are to have a rehabilitative role, then there is a need to encourage residents to engage in activities and employment in the community.

Introduction

Over the past 20 years, delivery of mental health services has changed, with a move from institutional-based care to care in the community (Department of Health and Children, 1984; Department of Health and Children, 2006). This has resulted in a decline in patients in large psychiatric hospitals (Daly *et al.*, 2006) and an increase in residential care in the community (Tedstone Doherty *et al.*, 2007). Residential care in the community offers three levels of support ranging from high support to low support. The high support community residences offer 24-hour nursed care, while the low-support residences have frequent visits from nursing staff, with no staff resident on a daily basis. While there is no standardised definition of medium support in Ireland, the most common form offers night-time supervision from non-nursing staff; these are often referred to as supervisors (Tedstone Doherty *et al.*, 2007).

The original policy was that these facilities would act as an interim placement, so that those who were able could move from higher levels of support to lower levels of support and, if possible, to independent living (Department of Health and Children, 1984). Thus, the facilities were supposed to provide rehabilitation interventions that would help people who had been relocated from hospital to integrate into the community into which they were moved. However, a recent study showed that the move to independent living was achieved by relatively few residents. Furthermore, notwithstanding the policies that were in place at the time, the perception of both staff and potential residents at the time of deinstitutionalisation was that these residences were to become a home for the majority of the residents who had been moved there (Tedstone Doherty *et al.*, 2007).

The first census on high support residences was carried out on 31 March 2001 (Daly and Walsh, 2002) and reviewed high support residences provided by the mental health services. Up until the publication of this report, there was little information available about high support residences, or the residents who lived in them. This first census showed that there were a total of 1,104 people resident in 86 high support facilities in Ireland in 2001. Over half of the residents were male and over the age of 55. A significant number of them had lived in the residence where they were enumerated for more than one year; 40% had lived there for one to five years and an additional 40% had lived there for more than five years. The report also showed variation in resident rates across health board areas, with those in the Dublin area showing the lowest rates per 100,000 population aged 16 years and over.

The 2006 census, the second in the series, has expanded the scope of the previous census by gathering information on diagnosis and daytime activities such as employment, attendance at day centres, and training. In line with current health service structure, the report concentrates on comparisons with an HSE Administrative Area, as opposed to a health board area, which was the main analysis used in the previous report. The report also provides a map of rates of residents per county and the location of community residences, psychiatric hospitals, psychiatric units and private hospitals.

Method

A census of high support residences provided by mental health services in Ireland was carried out on the night of 31 March 2006. Residences operating under the provisions of the Mental Health Act 2001 were reviewed; those catering exclusively for people with intellectual disabilities or learning disabilities were excluded.

Prior to the census date, all directors of nursing were sent a letter advising them about the upcoming census; they were also sent census packs for residences in their catchment area. The packs included census forms (see Appendix 1), instructions for completion (see Appendix 2) and return envelopes. The directors of nursing circulated the packs to the appropriate residences; staff returned completed forms to the Health Research Board (HRB). Reminders were forwarded to residences which had not responded at the beginning of May 2006. All residences were verified by directors of nursing prior to analysis of data by the HRB. In order to create as complete a set of data as possible for each individual, incomplete forms were followed up for missing information. Despite taking this measure, however, not all information was retrievable; omissions are noted in the results section.

Rates were calculated based on the 2001 census and are reported per 100,000 population aged 16 years and over (Central Statistics Office; CSO, 2003). At the time of writing this report preliminary results were available from the CSO for the 2006 census for the whole population, but were not available by age, thus making it impossible to calculate rates for those aged 16 years and over (CSO, 2006). The publication of this report was delayed due to the reorganisation of in-house publications. Prior to going to print figures for age and gender became available for the 2006 Census (CSO, 2006). Thus high support community residence rates (per 100,000 population aged 16 years and over) based on these figures were calculated and for comparisons purposes are presented in Appendix 3.

Results

There were a total of 1,412 residents in 113 residences in Ireland on 31 March 2006; this represents a rate of 46.6 per 100,000 population[1]. The total number of beds in these residences was 1,613, based on an occupancy rate of 87% (1,412/1,613). Information was missing for the following variables; gender n = 30; age n = 6; length of stay n = 36; diagnosis n = 11; daily activity n = 653. Of concern was the high number of individuals for whom information regarding their daily activity was not completed. The possible reasons for this will be discussed later.

Gender and age: Over half the residents were male (57%; 794/1,382). The mean age of the residents was 57.9 (SD 14.2; range 18.6–93.7) years with females (mean 58.7 years) slightly older than males (mean 57.3 years). Figure 1 shows the age profile of the residents. All residents were aged over 18, with the oldest aged approximately 94 years. The largest proportion of residents was between the ages of 55 and 64 years (27%), with 21% between the ages 45–54 years, and 24% between the ages 65–74 years. A very small proportion of residents were aged between 18 and 19 (0.2%) and 10% were aged 75 years and over. Rates were higher for males in all age groups (Table 1).

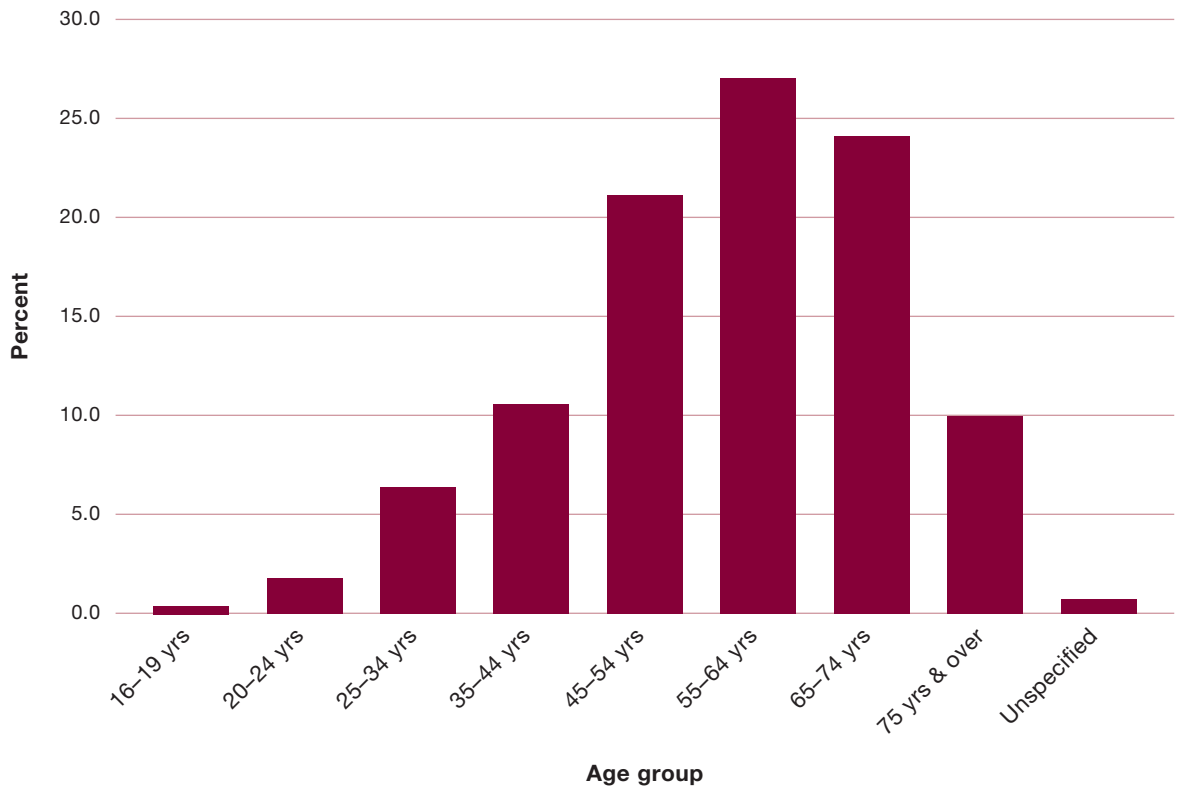


Figure 1 Proportion of residents in high support residences in each of the age groupings

1. Rate for total population for census 2006 was 42.6 per 100,000 aged 16 years and over as above.

Table 1 Number and rates of high support residents per 100,000 population aged 16 years and over for age group by gender[2]

	Numbers			Rates		
	Male	**Female**	**Total**	**Male**	**Female**	**Total**
Under 16 yrs	0	0	0	0	0	0
16–19 yrs	2	1	3	1.5	0.8	1.2
20–24 yrs	15	4	19	9.1	2.5	5.8
25–34 yrs	54	32	86	17.5	10.4	13.9
35–44 yrs	81	60	141	28.9	21.2	25.0
45–54 yrs	170	119	289	70.4	49.8	60.2
55–64 yrs	203	163	366	114.4	93.6	104.1
65–74 yrs	191	143	334	163.2	111.2	136.0
75 yrs and over	73	66	139	101.2	55.8	73.0
Unspecified	5	0	5			
Total	**794**	**588**	**1,382**	**53.3**	**38.2**	**45.6**

Diagnosis: Staff in the residences were instructed to circle the primary diagnosis of the resident from a selected list (see Appendix 1 and Appendix 2). Diagnosis was missing for a total of 11 residents. Of those with a diagnosis (see Figure 2), the majority were diagnosed with schizophrenia 66% (929/1,401). The next highest proportion of residents fell into the depressive disorders classification (13%; 181/1,401). Approximately 6% (79/1,401) of the residents had a diagnosis of intellectual disability, while organic disorders accounted for 2.6% (37/1,401). A very small percentage of the residents had an alcohol or drug disorder (2.1%; 30/1,401).

A second diagnosis was given for 7% (104/1,401) of the residents. Of these, a total of 1.7% (23/104) had a second diagnosis of alcohol or drug dependence, while 3% (42/104) had a diagnosis of intellectual disability. This resulted in 8.6% of the total sample having a diagnosis of intellectual disability and 3.8% of the sample having a diagnosis of drug or alcohol abuse.

2. See Appendix 3 for rates calculated based on the 2006 Census figures (CSO, 2006).

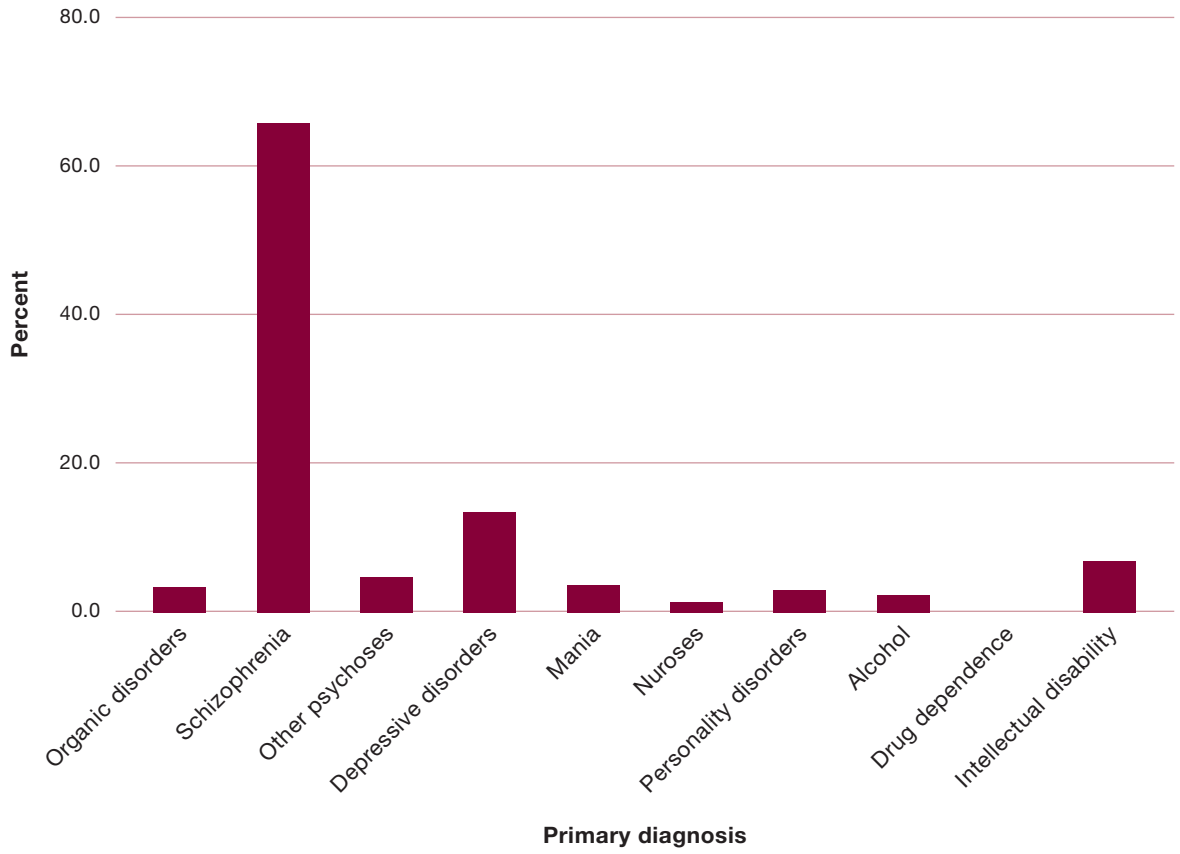


Figure 2 Proportion of residents in high support residences census in diagnosis categories

Daily activities: As noted above, the information collected by the previous census in 2001 was extended to include exploration of the percentage of residents who were in mainstream employment or, if not, were in training or were attending a day centre (see Appendix 1). A total of 46% (653/1,412) of the data was not provided for the daily activity section of the high support residences questionnaire. The incomplete nature of this data for almost half of the residents limits its validity; possible reasons for the low response rate will be addressed in the discussion. The questionnaire enquired as to whether the residents were in sheltered employment or supported employment; were in training, or were attending a day centre (see Appendix 1). Results are presented in Figure 3. Valid percentages are given in the results (i.e. the percentage of the completed data n = 759). The majority of the residents attended a day centre (55.7%; 423/759). One fifth of the residents (19.9%; 151/759) were in training; only 10.5% (80/759) were in sheltered employment; 2.8% (21/759) were in supported employment, and 1.6% (12/759) were in paid employment. The nursing officers reported that 9.5% (72/759) of the residents were unemployed or unoccupied during the day.

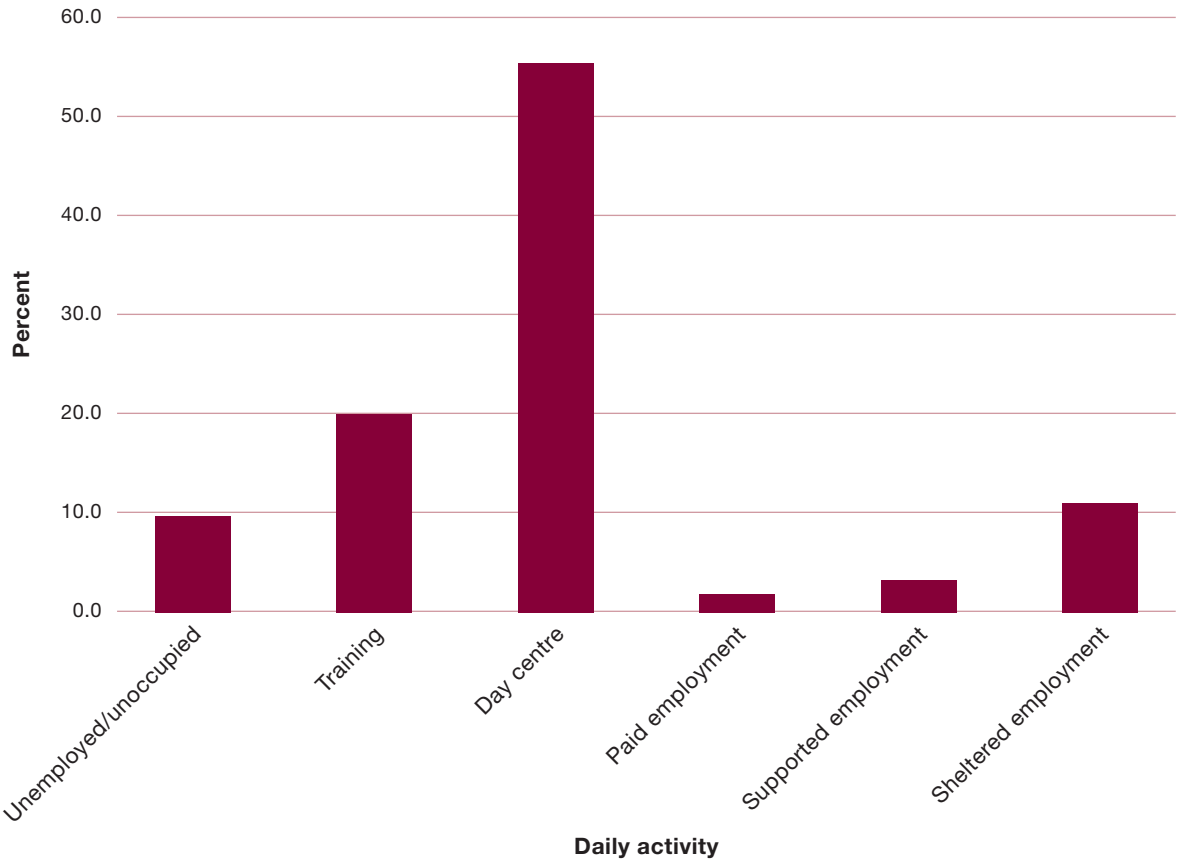


Figure 3 Percentage of residents in high support residences in the daily activity categories

Length of occupancy: The mean length of occupancy was 6.4 (median 6.0; SD 1.4) years. Figure 4 shows the proportion of residents in each of the length-of-occupancy categories. Over one-third (39%; 536/1,376) of the residents were resident for one to five years, while almost one quarter (24.2; 333/1,376) were there for five to ten years. Few of the residents had a length of occupancy of less than three months (6.2%; 84/1,376); just 16.4% (225/1,376) had a length of occupancy less than one year. Likewise, few of the residents had a length of occupancy of 25 years or over (2.1%; 29/1,376).

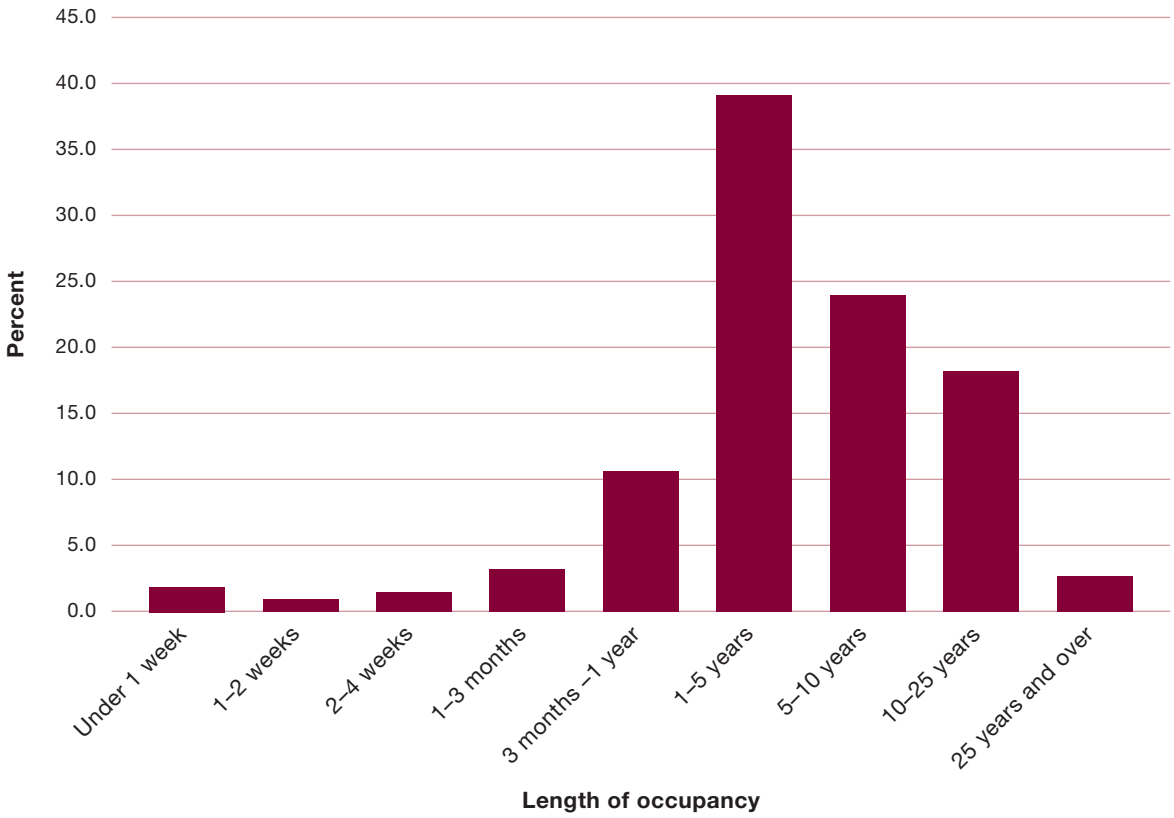


Figure 4 Percentage of residents in high support residences in the length-of-occupancy categories

HSE Area comparisons: Each of the residences was classified according to Health Service Executive Regional Area (HSE Area). Of the 113 residences, 32% (36/113) were in HSE West; 29% (33/113) were in HSE South; 21% (24/113) were in HSE Dublin North-East, and the lowest proportion of the residences was in HSE Dublin Mid-Leinster (18%; 20/113). Table 2 presents the number, percentage and rate of residents per 100,000 population within each of the HSE Administrative Areas. HSE West had the highest percentage of residents and the highest rate of residents per 100,000 population. This was followed by HSE South which showed a rate of 48.2 per 100,000. HSE Dublin North-East was next with a rate of 46 residents per 100,000 population; the lowest rate was in HSE Dublin Mid-Leinster at 29.8 per 100,000 population. Figure 5 shows the rate for gender per 100,000 population by HSE Area. In all areas males exhibited a higher rate than females.

Table 2 Number of residents, percentage and rates per 100,000 population for high support residences in HSE Administrative Areas

Area	Number	Percentage	Rate/100,000
HSE Dublin Mid-Leinster	245	17.4	29.8
HSE Dublin North–East	296	21.0	46.0
HSE South	392	27.8	48.2
HSE West	479	33.9	66.2
Total	**1,412**	**100**	**46.6**

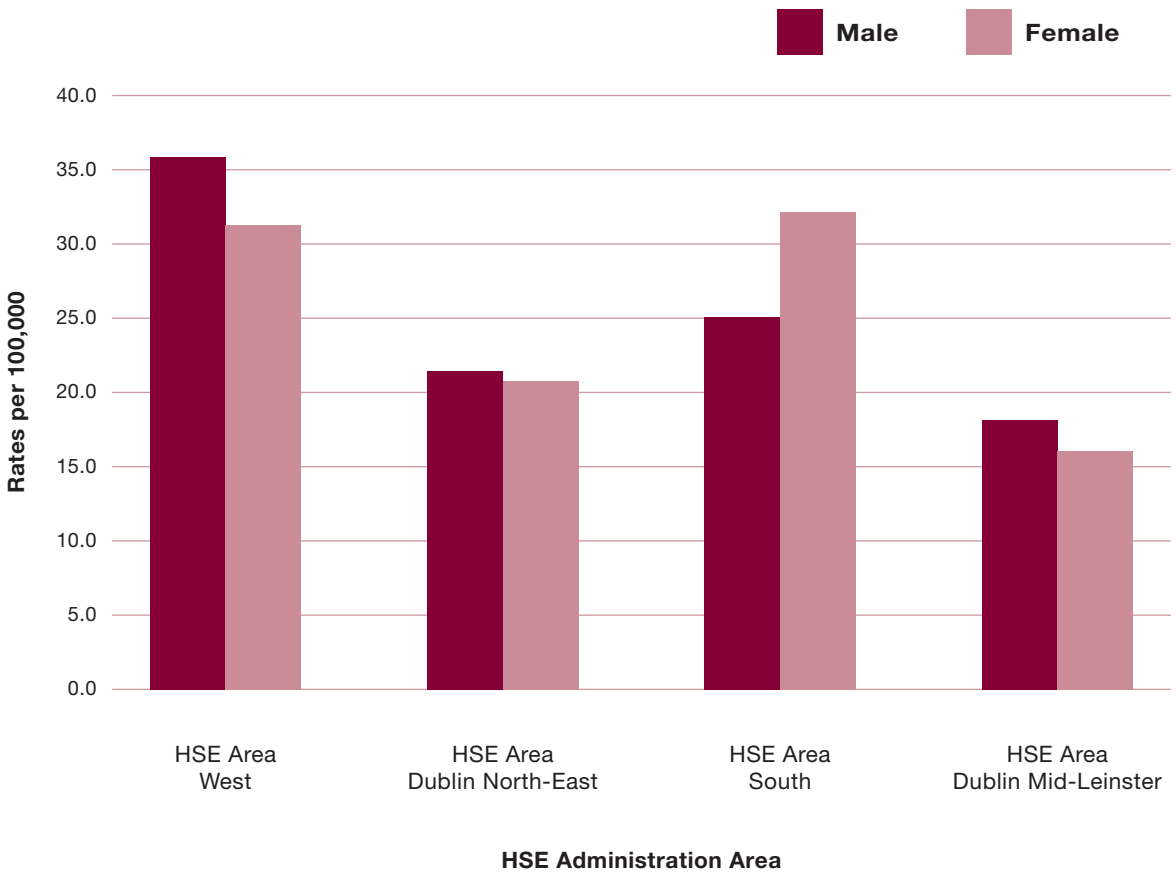


Figure 5 Rate of residents in high support residences in the four HSE Administrative Areas by gender

Table 3 shows the diagnosis of residents by HSE Administrative Area. There was little difference in the diagnosis of the residents across the areas. As was the case with the national level findings, the majority of all residents were diagnosed with schizophrenia.

Table 3 Number and percentage of residents in high support residences by diagnosis by HSE Administrative Area

	Health Service Executive Area							
	HSE West		HSE Dublin North-East		HSE South		HSE Dublin Mid-Leinster	
	Number	%	Number	%	Number	%	Number	%
Organic disorders	13	2.7	8	2.7	3	0.8	13	5.3
Schizophrenia	302	63.7	204	69.4	251	64.4	172	70.8
Other psychoses	21	4.4	7	2.4	18	4.6	11	4.5
Depressive disorders	60	12.7	39	13.3	59	15.1	23	9.5
Mania	17	3.6	9	3.1	10	2.6	9	3.7
Neuroses	5	1.1	3	1.0	2	0.5	3	1.2
Personality disorders	9	1.9	4	1.4	12	3.1	5	2.1
Alcohol	11	2.3	5	1.7	8	2.1	4	1.6
Drug dependence	0	0	1	0.3	1	0.3	0	0.0
Intellectual disability	36	7.6	14	4.8	26	6.7	3	1.2
Total	**474**	**100.0**	**294**	**100.0**	**390**	**100.0**	**243**	**100.0**

Table 4 shows the number and percentage of residents in each length-of-occupancy category for the four HSE Administrative Areas. HSE South had the longest median length of occupancy at 5.9 years, followed by HSE West at 4 years, HSE Dublin Mid-Leinster at 4.5 years and HSE Dublin North-East at 3.5 years (Kruskal Wallis 36.92, df 3, $p = 0.000$). In all Areas the greatest proportion of residents had been accommodated in the residence for one year or more. One third or more of the residents had been in the accommodation where they were enumerated for a period of one to five years. Over half (55%) of the residents in HSE South had a length of occupancy of five years or more; this compared with 69% of residents in HSE Dublin Mid-Leinster, and 38% of residents in HSE West and HSE Dublin North East.

Table 4 Number and percentage of residents in high support residences in each length-of-occupancy category by HSE Administrative Area

	Health Service Executive Area							
	HSE Dublin Mid-Leinster		HSE Dublin North-East		HSE South		HSE West	
	Number	%	Number	%	Number	%	Number	%
Under 1 week	2	0.8	4	1.5	7	1.8	7	1.5
1–2 weeks	2	0.8	1	0.4	5	1.3	4	0.8
2–4 weeks	3	1.2	1	0.4	1	0.3	10	2.1
1–3 months	9	3.7	5	1.8	3	0.8	20	4.2
3 months–1 year	26	10.7	43	15.7	30	7.9	42	8.8
1–5 years	82	33.7	117	42.7	125	32.7	212	44.4
5–10 years	75	30.9	59	21.5	98	25.7	101	21.2
10–25 years	41	16.9	39	14.2	97	25.4	6	15.9
25 years and over	3	1.2	5	1.8	16	4.2	5	1.0
Total	**243**	**100.0**	**274**	**100.0**	**382**	**100.0**	**477**	**100.0**

Table 5 shows the percentage of residents in employment, training or attending a day centre. Given the small numbers within each cell (i.e. six cells had expected counts of less than 5) statistical analysis was unable to be preformed on the data. The findings suggest however that there was higher proportion of residents unemployed in the Dublin North-East than the other areas and this area also had a higher proportion of those in sheltered employment. It is important to note again that these results need to be interpreted with caution given the low response rate to the question. Furthermore Dublin North-East also had the lowest response rate to the question (47%) compared to the other three areas which had above 50%. The highest proportion of residents was attending day centres, with few residents having paid part-time or full-time work, or supported employment.

Table 5 Percentage of residents in high support residences engaged in daily activities captured by HSE Administrative Area

	Health Service Executive Administrative Area							
	HSE Dublin Mid-Leinster		HSE Dublin North-East		HSE South		HSE West	
	Number	%	Number	%	Number	%	Number	%
Unemployed/unoccupied	21	13.5	7	5.0	13	6.0	31	12.5
Training	25	16.0	35	25.2	34	15.7	57	23.0
Day centre	88	56.4	65	46.8	132	61.1	138	55.6
Paid employment	4	2.6	3	2.2	4	1.9	1	0.4
Supported employment	8	5.1	2	1.4	7	3.2	4	1.6
Sheltered employment	10	6.4	27	19.4	26	12.0	17	6.9
Total	**156**	**100.0**	**139**	**100.0**	**216**	**100.0**	**248**	**100.0**

Comparisons with inpatient census and residence census - HSE Administrative Area: The previous census report (Daly and Walsh, 2002) contrary to expectation found no significant correlation between the rates of inpatient stay and residency rates in the high support facilities. Therefore the areas with the lowest inpatient rates do not necessarily have the highest residency rates. Scrutiny of the data in the current census also showed that there was no significant correlation between inpatient rates and residency rates (see Figure 8). HSE West had the highest residency rate and HSE South had the highest inpatient census rate. The lowest inpatient census rate was in HSE West and the lowest residency rate was in HSE Dublin Mid-Leinster. Figure 8 shows the HSE Administrative Areas and rates for inpatient census and residence census per 100,000 population aged 16 years and over.

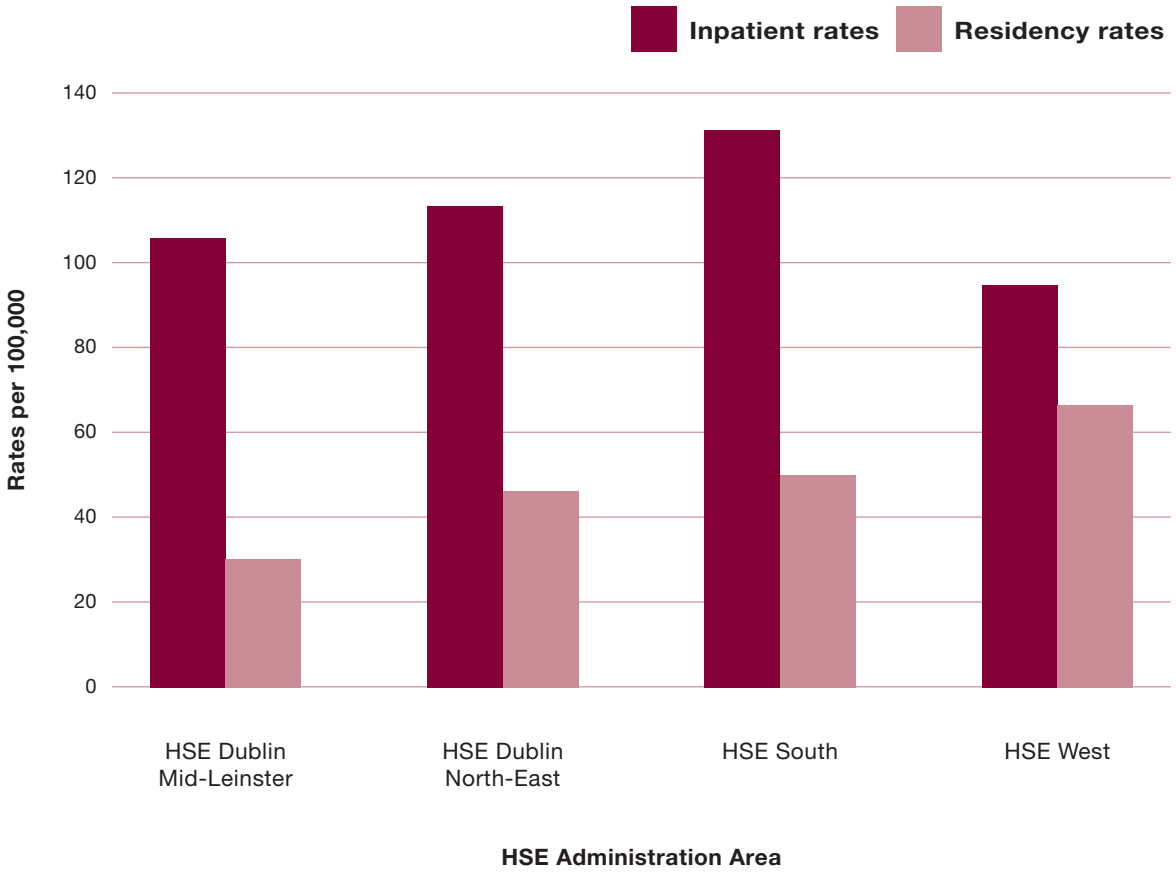


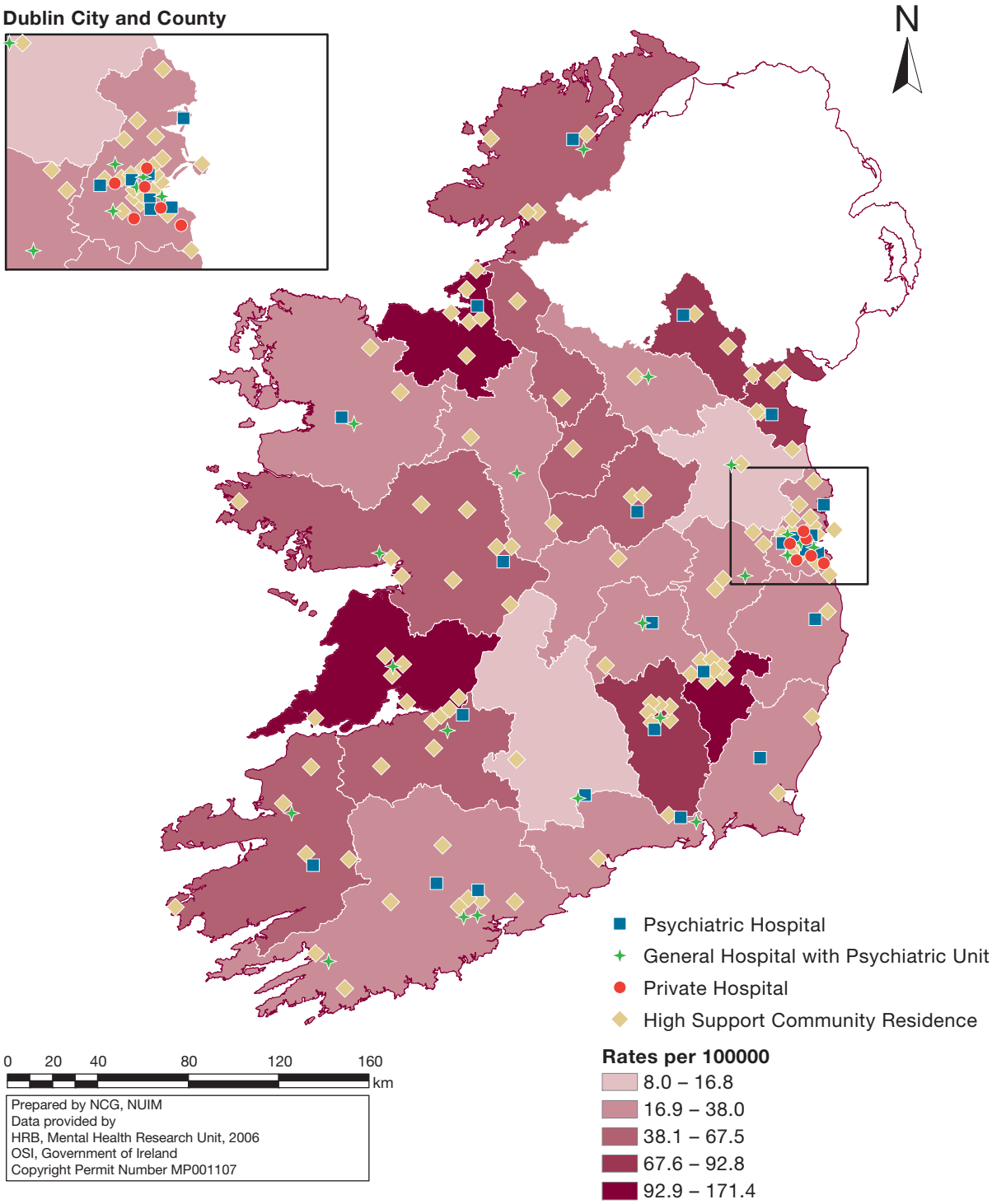
Figure 6 Inpatient census rates for psychiatric hospitals and units and residency census rates for high support residences per 100,000 population by HSE Administrative Areas

County level data: The map shows the rate of residents per 100,000 population aged 16 years and over per county[3]. There was a wide variation in rates at county level ranging from 8.0 residents per 100,000 population to 166.1 residents per 100,000 population. The lowest rate of residents was in County Meath, with County Clare showing the highest rate of residents per 100,000 population. The map also shows the location of the high support residences, psychiatric hospitals, psychiatric units in general hospitals and private hospitals within each county.

3. See Appendix 3 for county rates based on 2006 census data.

Rates of Residents per County in High Support Community Residences, 2006

And Locatio of Psychiatric Hospitals, Psychiatric Units and High Support Community Residences



Discussion

On 31 March 2006 there were a total of 113 community-based mental health residential settings providing 24-hour nursed care for 1,412 residents. This census excluded settings catering exclusively for those with intellectual disabilities or learning disabilities. There was an occupancy rate of 87% at the time of the census; however the census did not address the purpose of the beds. Previous literature has highlighted that some residences have beds allocated for respite and crisis care which increased the occupancy rate to almost full capacity (Tedstone Doherty *et al.*, 2007; Mental Health Commission, 2006). Therefore although there is not full capacity on the night of the census, some of the beds may be designated for other uses. In addition, there may have been residents absent on the night of the census which were not included in the census.

Just over half the residents were male and the majority were aged between 45 and 74 years. The majority of residents were diagnosed with schizophrenia, with the next highest category being depressive disorders. Almost 9% had a diagnosis of intellectual disability; almost 4% had a diagnosis of alcohol or drug abuse, and 3% had a diagnosis of organic disorders. Combined, these groups account for almost 15% of the residents included in the census. This raises questions as to the appropriateness of the placements of these individuals; it also raises questions as to whether the mental health services can meet their needs. It is likely that these individuals will need additional support other than that provided by the psychiatric services – a measure which would require multidisciplinary input. Given the lack of multidisciplinary rehabilitation teams within the psychiatric services (Tedstone Doherty *et al.*, 2007) it is questionable whether the needs of these groups are actually being met. Previous research identified the requirement for further training of professionals who work with people who have particular needs including dual diagnosis (Mental Health Commission, 2005a). This issue requires further investigation in terms of identifying the unmet needs of particular subgroups of service users.

The majority of the residents enumerated had been living in their current setting for some time. Research would suggest that many of these individuals had previously been resident in large psychiatric hospitals but, following the change in mental health services policy in the 1980s, had been relocated to their current community-based settings (Tedstone Doherty *et al.*, 2007).

As highlighted above, the 2006 census endeavoured to collect information on the level of mainstream employment and the daily activities of residents such as their attendance at day centres. Information on the daytime activities of residents was provided in only 54% of cases thus caution must be exercised in the interpretation of these results.

The reasons for the low response rate to questions about daytime activities remain unknown. One can speculate that those for whom information is missing do not attend formal daytime activities (or at least not those specified on the census form). However, they may indeed attend other activities not described on the census form. Previous reports highlight the apparent lack of activity and rehabilitation in many of the residences thus suggesting that many residents do not have meaningful activities to participate in during the day (Mental Health Commission, 2005b; Department of Health and Children, 2006; Tedstone Doherty *et al.*, 2007). In relation to residents for whom the relevant questionnaire data was provided, the majority were shown to be attending day centres. One fifth of the residents for whom responses were available were reported to be in training. Few residents were in sheltered employment (10%) and even fewer (4.4%) were in mainstream employment (either through supported employment or through open employment). The lack of employment, training and other activities may result in individuals being socially excluded from the communities in which they live. Daytime activities can provide a sense of belonging and purpose and can be used to build and develop social contacts and support. The data returned for this question suggested that individuals in community residences participated in few activities outside the facilities. The importance of employment for social inclusion has been highlighted by the National Economic and Social Forum (NESF, 2006). In addition, previous research has shown that many individuals within mental health services (Rankin, 2005) and within Irish community residential facilities in particular would like to work, and are hoping to do so in the future (Tedstone Doherty *et al.*, 2007). There is a need for the mental health services to encourage and facilitate those individuals who wish to obtain and maintain open employment in the community. It has been recommended that the mental health services should evaluate the 'place and train' model of employment within the Irish context (Department of Health and Children, 2006). This model proposed that individuals be placed in appropriate and suitable competitive employment in the community and trained in the necessary skills. Components of this model should also include elements of career planning such as goal setting and assistance with identifying and securing employment.

The number of high support residences recorded in the 2006 census was 113; this compares to 86 high support residences recorded in the 2001 census i.e. an increase of 31%. The findings showed that the total number of residents in high support facilities had increased during the previous five years by 28% (308 residents). This increase was in part due to the continuation of the deinstitutionalisation programme which was firmly postulated in the 1984 policy document (*Planning for the Future*), coupled with the continued strive towards a community-based mental health service. When compared with the previous census, the age range of the clients was similar, with a slight increase in the proportion of those aged over 75 years (i.e. up from 7% to 10%). This was most likely a consequence of the increase in the proportion of residents who

had lived in their current residence for between 10 and 25 years (up from 10% to 18%); an increase in the proportion of residents who had lived there for 25 years and over (up from 0.8% to 2.1%), and a reduction in the shorter-length-of-stay groups. It is clear from the 'age' and 'length of stay' responses reported in the 2006 census that these residences have become a 'home for life' for many of the residents.

As mentioned above, it is evident from the data that few people have employment outside their residence and that the majority attend day centres. In the main, the centres are run by the mental health services and cater exclusively for people with mental health problems. Apart from increasing the isolation of these people from the community in which they live, non-integrated programmes and activities may also serve to increase stigma.

It would reflect a more genuine community-based care service – and more importantly it would benefit clients – if activities outside the mental health services were encouraged and supported. Previous reports have made recommendations regarding the way forward for community residential facilities (Tedstone Doherty *et al.*, 2007; Department of Health and Children, 2006) and it may now be appropriate to redesign programmes and activities that create a more inclusive society for mental health service users and also meet the rehabilitation and recovery needs of the patients living in those residences. For example, some residences may be explicitly used for continuing care while others may be aimed at rehabilitation and recovery. The future development of these residential facilities needs to take this into consideration.

In relation to differences between the HSE Administrative Areas, there were no differences in the profile of residents in the residences, but the rates per 100,000 population aged 16 years and over did differ between HSE regions. The West had the highest residency rate; this was followed by the South. Dublin Mid-Leinster had by far the lowest residency rate. These differences in residency rates between HSE regions were not associated with the inpatient rates in psychiatric hospitals and units. High support community residential facilities therefore do not appear to be compensating for inpatient care in the mental health services. The reasons for these differences are unclear and further research is needed in order to investigate whether it reflects the true need for community residential places of the local area, or whether differences have arisen due to historical or financial factors. The discrepancy in the rates of residents was also reflected at county level, where the lowest rate of residents occurred in County Meath and the highest rate of residents in County Clare.

This census is the second in the series carried out by the Health Research Board and is the only census to be carried out on high support residences on a national level in Ireland. It added to the previous census by providing information on diagnosis and daytime activities. The purpose of the census is to provide information on a national level of the residents who live in high support facilities. Census information will be used to monitor changes over time, especially important in this time of change within the mental health services. One of the limitations of the study was the lack of returned information for the daily activities of residents which is highlighted above. One possible explanation for this was the lack of clarity of the question such as the interpretation of sheltered employment, supported employment and training. There in a need to readdress this question in the next census and possibly to provide explanations of alternative answers.

Finally, as noted above, it is important that community residential services are designed to reflect the needs of the service users and the needs of local areas. A recent report discusses the possible options for the development of these facilities into the future (Tedstone Doherty *et al*., 2007). Following the publication of the policy document, *A Vision for Change* (Department of Health and Children, 2006), it is envisaged that the community residential services will change. It will be essential therefore to ensure that the facilities themselves, and the profile of the people who live in them, continue to be monitored according as changes occur. This will apply not only to high support facilities providing 24-hour nursed care, but also to medium and low-support facilities which provide lower levels of care.

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Appendix 1

HIGH SUPPORT COMMUNITY RESIDENCE CENSUS
31 MARCH 2006

Please complete a form for each patient in your care at midnight 31 March 2006.

Name of residence

Health Board Area

Resident Number

Date of admission / /

Date of birth / / Gender Male Female

Employment

Is the resident employed? **NO** **YES**

If the answer is **NO**
Is the resident in training? Yes / No

and/or

Attending a day centre Yes / No

If the answer is **YES**

Is the resident employed in:
(please tick one of the following)

Full-time/part-time paid employment

Supported employment

Full-time/part-time sheltered employment

Diagnosis

Please circle the primary diagnosis of the resident

Organic category	**1**	Mania	**5**	Drug dependence	**9**
Schizophrenia	**2**	Neurosis	**6**	Mental handicap	**10**
Other psychoses	**3**	Personality disorder	**7**		
Depressive disorders	**4**	Alcohol disorders	**8**		

Appendix 2

Health Research Board
Mental Health Research Division

Instructions for completing National Psychiatric High Support Community Residences Census midnight 31 March 2006

What is the Census

The National Psychiatric Census 2006 will record all patients on the books of all psychiatric hospitals and units and high support community residences at MIDNIGHT on 31 March 2006. National census information is very important for planning and service delivery purposes as it provides a snapshot of the number and characteristics of persons in care on a specified night.

How to complete details on your community residence file:

1 Name of residence	Please enter the full name of residence
2 Address	Please enter the full address of the residence, including postal code if applicable
3 Contact person	Please enter the name of the person filling out the information on the census forms
4 Telephone number	Please enter the telephone number of the contact person
5 Total number of beds	Please enter the total number of beds in the residence
6 Number of beds in use	Please enter the total number of beds in use at midnight on 31 March 2006.

How to complete the Resident Form for each individual resident:

Detailed instructions for each piece of information required are provided in the table below.

1 Name of residence	Please include full name of residence
2 HSE/Health Board Area	Please enter the health board area that your residence services
3 Resident number	Please enter resident number if applicable
4 Date of admission	Please enter date that the patient was admitted as a resident
5 Date of birth	Please enter the patient's date of birth
6 Gender	Please tick either male or female box
7 Employment	If the patient is currently unemployed, please identify whether the patient is in training and/or attending day care. If the patient is currently employed, please identify whether the employment is full/part-time paid employment, supported employment or sheltered employment.
8 Diagnosis	Please circle (from the select list) the diagnoses of the resident

Deadline for return of data to the HRB

We ask you to return all information to the Health Research Board by Tuesday 14 April 2006.

Procedure for acknowledgement, verification of data

On receipt of this information we will issue you with an acknowledgement either by post or email.

Once we have checked and coded the data, a report will be sent to you of what we received, number of inpatients in your care, diagnosis etc. and we will ask you to verify this report. If there are any discrepancies, we would ask you to contact us as soon as possible so that we can sort this out. If we don't hear back from you within ten days of sending you the verification report, we will assume that you require no adjustments to be made to the data and that you are happy to have the information received from you published by us.

Contacts for further information

If you have any queries at all please do not hesitate to contact myself Fiona Bannon or Yvonne Dunne at 01 676 1176 ext 148 or 145 or you can email census2006@hrb.ie

Thank you for your contribution to the collection of National Health Statistics

Appendix 3

Table 6 Rates per 100,000 population aged 16 years and over based on the 2006 census for age by gender (CSO, 2006)

	Rates per 100,000 population aged 16 years and over		
	Males	**Females**	**Total**
16–19	1.7	0.9	1.3
20–24	8.7	2.4	5.5
25–34	14.7	9.0	11.9
35–44	25.7	19.5	22.6
45–54	64.8	45.9	55.4
55–64	98.8	80.9	89.9
65–74	149.9	105.8	127.2
75 and over	91.6	52.5	67.7
Total 16+	**48.2**	**35.2**	**41.7**

Source CSO 2006

Table 7 Rates per 100,000 population aged 16 years and over based on the 2006 census for county (CSO, 2006)

	Rates per 100,000 population aged 16 years and over		
County	**Rate per 100,000**	**County**	**Rate per 100,000**
Carlow	133.1	Louth	70.5
Cavan	26.7	Mayo	28.0
Clare	158.1	Meath	6.5
Cork	34.9	Monaghan	85.5
Donegal	53.8	Offaly	24.1
Dublin	33.0	Roscommon	28.3
Galway	42.7	Sligo	156.0
Kerry	63.3	Tipperary	15.6
Kildare	23.4	Waterford	30.9
Kilkenny	80.2	Westmeath	46.3
Laois	31.4	Wexford	20.9
Leitrim	57.4	Wicklow	24.7
Limerick	53.6		
Longford	49.2		

Source CSO 2006

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