The Institutional Circuit: Single Homelessness in Ireland

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Abstract_*Routinely collected administrative data can help to provide an overview of those adults experiencing homelessness within the Irish population and to identify specific health and social care needs. This research note examines admissions for the last ten years for those recorded as of no fixed abode (NFA) on the National Psychiatric In-Patient Reporting System (NPIRS) to explore if this group is consistent with cohorts of the homeless population in Ireland as recorded on the national data collection system, the Pathway Accommodation and Support System (PASS), in particular, the single 'chronically homeless' people documented in the literature. Only a minority of those who experience homelessness, in the absence of a resolution to their residential instability, make extensive use of a range of expensive emergency services. The paper concludes that more efforts are required to address the needs of this distinctive group so that they can break the institutional circuits and residential instability that they experience, including admission and re-admission to psychiatric in-patient facilities and other emergency and temporary living arrangements.*

Keywords_ *Single people experiencing homelessness, psychiatric in-patient admissions, mental health, institutional circuit, Ireland*

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Introduction

With the introduction of a national data collection system PASS (Pathway Accommodation and Support System) in 2014 for people utilising central and local government funded accommodation services, a reasonably accurate estimate of the extent and characteristics of people experiencing homelessness in Ireland is now possible.[1] Prior to the introduction of PASS, data on the extent of homelessness nationally, and the characteristics of people experiencing homelessness came from periodic assessments of housing need conducted by local authorities, and cross-sectional survey data, primarily carried out by NGOs (see O'Sullivan, 2008 for an overview of this literature). Routinely collected administrative data such as PASS can help to generate a picture of those who are experiencing homelessness, their routes into homelessness and sources of exits. A further source of routinely collected data on those who are experiencing homelessness is the National Psychiatric In-Patient Reporting System (NPIRS) which gathers data on admissions to and discharges from psychiatric hospitals and units and includes data on those, somewhat archaically termed, of no fixed abode (NFA). While not a dataset of people experiencing homelessness *per se*, the NPIRS system can provide some insight into the use of psychiatric in-patient services for those recorded as NFA.[2] This research note utilises these two sets of data to offer support for the 'institutional circuit' thesis offered by Hopper *et al.* (1997) some 20 years ago, which argued that homeless shelters and allied forms of temporary accommodation do little to arrest residential instability, rather they perversely perpetuate and maintain people in an endless loop of expensive unstable short-term residences in a variety of institutional settings.

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1 These data are generated by the PASS (Pathway Accommodation & Support System), a national bed management system for homelessness services, and allow for a monthly report on the number of households in designated homeless accommodation, starting in April 2014 and broken down by gender, age, and nature of accommodation. These data provide information only on households in specific state homelessness accommodation. Accommodation for those persons escaping domestic violence—a total of 21 residential services with a bed capacity of approximately 250— have been transferred from Housing Authorities to a separate Child and Family Agency, and have therefore not been enumerated in the monthly data, since January 1, 2015. Thus, the data on homelessness provided by the PASS system underestimate the extent of family homelessness.

2 The NPIRS collects data on admissions to and discharges from psychiatric in-patient facilities both public and private. These data have been collected and reported on since 1963. The NPIRS system records the address from which the individual is admitted i.e. the address at which the individual was residing at the time of admission to hospital. No fixed abode (NFA) is recorded if the individual does not have an address. Those admissions that had NFA recorded as their living arrangement were extracted for the years under investigation. The data were analysed using SPSS.

Single Homelessness and the 'Institutional Circuit'

Starting with the pioneering work of Kuhn and Culhane (1998), researchers have applied cluster analyses to time series data on shelter admissions in welfare contexts as diverse as the United States, Canada, Denmark and Ireland (Kuhn and Culhane, 2008; Aubry *et al.*, 2013; Benjaminsen and Andrade, 2015; Rabinovitch *et al.*, 2016; O'Donoghue Hynes *et al.,* 2018). Their results showed a clear and consistent pattern whereby approximately 80 percent of emergency shelter users were transitional users, in that they used shelters for very short periods of time or a single episode, and did not return to homelessness (Brown *et al.,* 2017). A further 10 percent were episodic users of shelters, in that they used emergency shelters on a regular basis, but for short periods of time, and the remaining 10 percent were termed chronic or long-term users of emergency shelter services. Although a small percentage of those experiencing homelessness, chronic or long-term users can use up to 50 percent of emergency homelessness beds.

For example, in the case of Dublin, cluster analysis of PASS data shows that 853 single adults were long stay or chronic shelter users, comprising 9 percent of all users, but used 47 percent of all bed nights between 2012 and 2016, staying for an average of 809 nights. Episodic users, comprising of 1,176 adults accounted for 12 percent of shelter users, but consumed 18 percent of shelter bed nights, staying an average of 231 nights. Thus, 21 percent of shelter users, the chronic and episodic, accounted for 65 percent of all bed nights during the five years between 2012 and 2016 (O'Donoghue Hynes *et al.,* 2018). On the other hand, 7,520 single adults or 79 percent of all shelter users used the shelter system on a short-term temporary basis, staying for an average of 68 days and consuming 35 percent of all bed nights.

Research evidence also suggests that long-term single shelter users and people rough sleeping, also tend to be heavy users of criminal justice services, drug and alcohol services and health care including mental health services, leading Pleace and Culhane to conclude that 'long-term/repeated homelessness is economically expensive' (2016, p.15). Recent research in Ireland (O' Farrell, *et al.*, 2016) showed that the number of emergency hospitalisations among those experiencing homelessness has increased significantly in the last ten years and that the majority of these (57%) had a mental or behavioural diagnosis. Males outnumbered females by a ratio of 5: 1 and the mean age was 40.6 years. In a study of presentations to hospital emergency departments for self-harm acts between 2010 and 2014 across Ireland, Barrett *et al.* (2018) found that homeless people accounted for 3.9 percent of all admissions and were predominantly male and living in Dublin. A further cross-sectional study in a large Dublin hospital (Ni Cheallaigh *et al*., 2017) identified a similar pattern, with males representing nearly 80 percent of homeless emergency department attenders, and

a mean age of 39 years for all homeless emergency department attenders. The profile of those using emergency department services suggests that they are in the main, chronically or episodically homeless, a relatively small proportion of the overall homeless population, but heavy users of various costly services.

For those single persons experiencing long-term and episodic homelessness, Hopper *et al.* (1997) note how they traverse through a range of different residential institutions, from emergency accommodation to prisons and psychiatric hospitals, in an endless loop through an 'institutional circuit' of congregate facilities ostensibly with distinct functions such as correcting, rehabilitating, or resocialising, but actually all serving similar functions in maintaining single marginal men and women in a perpetual state of residential instability. Based on qualitative interviews with 36 single adults (26 males and 10 females) with severe mental health problems, they identified a number of functions of the 'homeless shelter'. For some, these shelters were sites of discharge from custodial and medical institutions, and in many cases regular bridges between these institutions and community. For others, shelters were temporary short-term sites that maintained the residential instability of the users rather than resolving it, as they simply were one of a number of temporary sites periodically utilised in the absence of secure accommodation. In particular, they argue that homeless shelters, rather than alleviating homelessness, 'may have the perverse institutional effect of perpetuating rather than arresting the "residential instability" that is the underlying dynamic of recurring literal homelessness and that so often harries the lives of persons with severe mental illness' (1997, p.660). Metraux *et al.* (2010) in a study of first-time shelter users in New York in the late 1990s found that 28 percent had been discharged from institutional care (medical and custodial) within 90 stays of their shelter entry. The services offered to those on the 'institutional circuit' often do not match their needs, leading to refusal of services, which can reinforce a perception amongst service providers that such individuals are service resistant or irrational (Luhrmann, 2008). In the case of single women in Dublin, Mayock *et al.* (2015) highlight they are 'marked by a reliance on individuals and institutions to provide housing and by the ongoing instability arising from highly disruptive and often abusive episodes' (2015, p.894).

'A Vision for Change' the current policy document on mental health services in Ireland also notes this phenomenon, identifying a drift between 'institutional circuits' (Department of Health and Children, 2006: 143) that include mental hospitals, shelters and the street. Gaps in provision include lack of access to appropriate services and the catchment-based nature of mental health services. Indeed, the deinstitutionalisation of patients from psychiatric hospitals from the 1960s was often cited as a contributor to the emergence of the 'new homelessness' from the early 1980s (Shlay

and Rossi, 1992; Lee, *et al.*, 2010). However, more rigorous analyses demonstrate that 'making empirical connections between deinstitutionalisation and homelessness' is difficult to demonstrate (Montgomery *et al.*, 2013: 61).

In the case of Ireland, the number of patients in psychiatric hospitals has declined, more or less, continuously since the early 1960s from 19,422 in 1960 to 2,408 in 2016 (Walsh, 2015; Daly and Craig, 2016). A number of Irish studies have suggested that homeless people exhibit relatively high levels of mental health difficulties; Keogh, *et al.* (2015, p.3) state that up to 70 percent 'had received a formal diagnosis of a mental health condition' (2015, p.3). On the other hand, some commentators have argued that the research on homelessness has inflated the link between such pathologies and homelessness (e.g. Snow *et al.*, 1994). Indeed, Montgomery *et al.* (2013, p.68) concluded that 'the research supports there being nothing inherent to serious mental illness that leads to homelessness, rather this link is mitigated by the economic difficulties that often accompany living with mental illness in the community'.

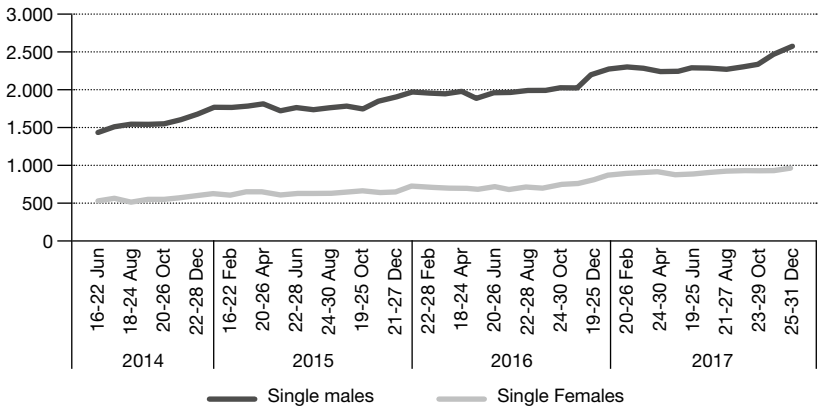
Adults Utilising Homeless Accommodation Services and Irish Psychiatric Units and Hospitals

PASS

The PASS data show a 122 percent increase nationally in the number of adults in emergency accommodation services between April 2014 and December 2017, from 2,477 to 5,508. In terms of household composition, 64 percent were single without accompanying child dependents, 20 percent were couples with accompanying dependent children, and the remaining 16 percent were single adults with accompanying dependent children. Over 90 percent of the single adult households with accompanying dependent children were female headed. Just over 3,000 accompanying child dependents were in various types of emergency accommodation in December 2017. Between mid-2014 and the end of 2017, approximately two-thirds of all homeless adult households in Ireland were in emergency accommodation in Dublin. Forty-two percent of homeless adults in emergency accommodation in Dublin were with accompanied dependent children, in comparison with just over 22 percent outside of Dublin.

In percentage terms, nationally, the number of single people experiencing homelessness has declined from 82 percent of those utilising homeless accommodation to 64 percent (but down to 58 percent in Dublin from 78 percent in April 2014), reflecting the dramatic increase in family homelessness in Ireland in recent years (see O'Sullivan 2017). In real terms, there were 3,544 single people in emergency accommodation services in Ireland in December 2017, up from just under 2,000 in April 2014 (see Figure 1).

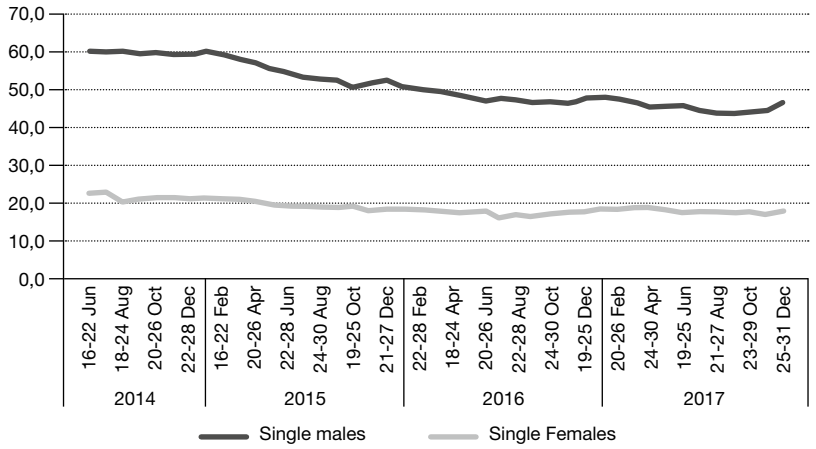
Figure 1: Single Persons Experiencing Homelessness in Ireland, April 2014-December 2017



Source: Department of Housing, Planning and Local Government (2017) Homelessness Reports. http:a//www.housing.gov.ie/housing/homelessness/other/homelessness-data

Roughly three-quarters of these are male – a figure that has remained stable since the PASS data collection system commenced. Of note is that the rate of increase of homelessness amongst singles is roughly the same for single males as it is for single females, despite divergent starting points. While the growth in family homelessness, (particularly in Dublin, where in December 2017 there were 1,121 families with 2,385 dependents residing in a variety of hotels, family hubs, and other emergency accommodation) has generated considerable policy and media attention, it remains the case that the majority of those utilising homeless services are single, and single males account for 47 percent of all adults who are in emergency accommodation in Ireland (see Figure 2).

Figure 2: Single People Experiencing Homelessness in Ireland as a Percentage of all Homeless Adults(%)



Source: Department of Housing, Planning and Local Government (2017) Homelessness Reports. http: // www.housing.gov.ie/housing/homelessness/other/homelessness-data

Despite the relatively short time frame – mid-2014 to December 2017, a growing feminization of homelessness is evident, particularly in Dublin, where by the end of 2017, nearly 45 percent of all adults in emergency accommodation were female, compared to 37 percent in mid-2014. This is largely driven by the increase in adults with accompanying child dependents as noted above. In December 2017 there were 395 single adult females in emergency accommodation outside of Dublin and 574 in Dublin, a total of 967, an increase of over 60 percent from the figure in April 2014.

The number of people sleeping rough in Dublin (data on rough sleeping is not routinely collected outside of Dublin), based on point-in-time counts conducted twice a year since 2007, averaged 108 over the past decade, are predominantly single, male and a high proportion are non-Irish nationals. Contacts with outreach services suggest that between 350 to 450 people sleep rough per quarter over the past 4 years. The majority of people sleeping rough also used emergency shelters, with only 20 percent not accessing emergency shelter services over the period 2012-2016.

By the beginning of 2018, some 2,200 shelter beds were provided for adults in Dublin, up from approximately 1,000 beds in the mid-1980s, with the majority of these beds allocated to single adult males. In Dublin alone, an additional 243 mainly temporary shelter beds were opened in December 2017 – January 2018, operated

by NGO providers. Over the past 4 years, an additional 900 shelter beds were opened, and the annual statutory funding to emergency shelters in Dublin doubled from just under €19m in 2004 to €38m in 2017.

In addition to the increase in emergency shelter beds funded by the State, but provided by NGOs, there was also a rapid growth in the number of adults experiencing homelessness, particularly adults with accompanying child dependents, being placed in hotels and B&B type private accommodation, initially on an emergency basis, but gradually becoming long-term in many cases. Nationally the number of adults in such accommodation increased from just over 800 in mid-2014 to nearly 2,300 by December 2017, accounting for over 40 percent of all emergency bed placements nationally. In Dublin, there was an average of 1,500 adults with 2,300 accompanying child dependents in hotels and B&B type accommodation each month during 2017, at a cost of €61m. To reduce the number of households with children being placed in hotels and B&Bs, during 2017, 437 beds were opened in Dublin and 50 outside Dublin in what were termed 'Family Hubs' – essentially congregate transitional accommodation. In Dublin, just under 200 of the beds in these Hubs were in new facilities operated by NGOs, the remaining were existing commercial hostels and B&Bs that were reconfigured and redesignated as Family Hubs with refurbishment costs estimated at in excess of €60m.

NPIRS

There were 2,176 admissions recorded on NPIRS between 2007 and 2016 (Table 1) that had NFA recorded as their accommodation status. This figure rose from 188 in 2007 to 271 in 2016, an increase of 44% in that period. Numbers rose steadily each year with the exception of a small decline in 2010-11.

The data show much larger proportions of males than females for all years. This is consistent with the PASS data for the last three years for the chronically homeless. Half of admissions were in Dublin (1,089: 50%). Most of the cohort was single (1,643: 75.5%). With regard to the age profile of those admissions with NFA, over one third (763: 35.1%) were in the younger 25-34 years age category and one quarter (568: 26.1%) were in the 35-44 years age category and 370 (17%) were aged 45-54 years on admission. Almost half (49.1%) of the admissions with NFA recorded in the period 2007-2016 were less than 35 years of age and over 90% (92.2%) were less than 55 years of age. Findings on employment status show that not surprisingly, the majority of those within the NFA cohort are unemployed (1,640: 75.4%). The demographic profile of the admissions examined is consistent with the chronically homeless population referred to earlier.

Table 1 Characteristics of 2,176 admissions with NFA as accommodation status to psychiatric hospitals and units, 2007-2016

	No.	%
Total	2,176	100
Gender		
Male	1,598	73.4
Female	578	26.6
Age		
Under 25 years	305	14.0
25 -34 years	763	35.1
35-44 years	568	26.1
45-54 years	370	17.0
55 years +	170	7.8
Marital status		
Single	1,643	75.5
Married	85	3.9
Divorced/widowed	94	4.4
Other	208	9.5
Unknown	146	6.7
Employment status		
Employed	175	8.0
Unemployed	1,640	75.4
Student	49	2.3
House duties	24	1.2
Retired	48	2.2
Unknown	240	11.0
Year of admission		
2007	188	8.6
2008	179	8.2
2009	223	10.2
2010	202	9.3
2011	159	7.3
2012	174	8.0
2013	246	11.3
2014	253	11.6
2015	281	12.9
2016	271	12.5

Source: NPIRS data 2007-2016

In NPIRS, diagnosis is recorded for cases on admission. Table 2 shows the main diagnostic categories for the NFA cohort. For the 10-year period, the key diagnoses recorded are schizophrenia (621, 28.5%), other drug disorders (333, 15.3%) and alcoholic disorders (257, 11.8%). This differs from the national profile of admissions where depressive disorders was the most common diagnostic

category in 2016 at 27% of all admissions that year followed by schizophrenia at 19.8%. In 2016, the year for which most up-to-date data are available, the proportion of admissions for other drug disorders and alcoholic disorders were 5.5% and 7.3% respectively, which are substantially lower than those for the cohort with NFA recorded (Daly and Craig, 2017).

Table 2 Treatment characteristics of 2,176 admissions with NFA as accommodation status in psychiatric hospitals and units 2007-2016

	No.	%
Total	2,176	100
Legal status		
Voluntary	1,824	83.8
Non-voluntary	352	16.2
Previous admission		
First admission	735	33.8
Re-admission	1,441	66.2
Diagnosis on admission		
Organic Mental Disorders	9	0.4
Alcoholic Disorders	257	11.8
Other Drug Disorders	333	15.3
Schizophrenia, Schizotypal and Delusional Disorders	621	28.5
Depressive Disorders	258	11.9
Mania	149	6.8
Neuroses	97	4.5
Personality/Behavioural Disorders	212	9.7
Other and Unspecified	239	11.0
Location		
Inside Dublin	1,089	50.0
Outside Dublin	1,087	50.0
Length of stay		
Under 1 week	955	47.2
(of which 1 day or less)	(318)	(33.3)
1 week – 1 month	683	32.4
1-3 months	329	15.6
3 months +	81	3.8
Hospital type		
General hospital psychiatric unit	1519	69.8
Psychiatric hospital	640	29.4
Private hospital	17	0.8

Source: NPIRS data 2007-2016

The NFA cohort therefore differs from the national profile of admissions to psychiatric hospitals and units. NPIRS records the legal status of each individual on admission and whether an admission is voluntary or involuntary. The majority of admissions for the NFA cohort were voluntary (84.4%).

As well as recording all admissions, NPIRS also records whether admissions were first admissions or re-admissions. This is relevant when considering the range of options that exist for the treatment of mental health issues in the cohort with NFA. Table 2 shows that almost two-thirds (1,441, 66.2%) of admissions in the period 2007-2016 were re-admissions which suggests that the NFA cohort are availing of in-patient psychiatric services on a more than once-off basis. However, without a unique identifier it is not possible to establish the frequency of re-admissions per person.

Length of stay was examined for the NFA group to assess the time spent by this cohort in an in-patient setting. The findings show that a large proportion of the NFA group (955, 47.2%) remained for less than one week and of that number, about a third stayed for a day or less.

When the year on year data are examined, the findings are similar to looking at the cohort overall. The majority of admissions with NFA are male and that this trend has not altered in the last ten years. Similarly, the marital status of those admitted to psychiatric hospitals and units are mainly single. With regard to the legal status of admissions for this group, most are voluntary admissions although there has been an increase in the number of involuntary admissions among this grouping since 2013. Similarly, there is an increasing number of re-admissions recorded on NPIRS for those with NFA since 2014, suggesting that the institutional circuits frequented by this cohort of the homeless population may indeed include psychiatric in-patient facilities.

Conclusion

The NPIRS data show that the number of admissions with NFA recorded has increased over the last decade, but that their characteristics are largely unchanged. Most of those with NFA were younger males, single and admitted for short periods of time, largely on a voluntary basis with diagnoses of schizophrenia or disorders related to alcohol and drug misuse. Their profile varies from the national picture of psychiatric in-patient admissions. The ratio of males to females admitted is broadly similar to singles data from PASS, with females accounting for approximately one in four single persons on PASS and NPIRS. Notwithstanding the limitations of the NPIRS that it is based on admissions rather than individuals, and that there is not currently a unique identifier, the research highlights the value of collecting routine administrative data over longer periods to help identify groups within the homeless population with specific health care or other needs.

Both the PASS and NPIRS data suggests support for the 'institutional circuit thesis' outlined by Hopper, *et al.* (1997), with a distinctive cohort of largely single unemployed males between the ages of 25 and 55 entering and re-entering psychiatric facilities on a voluntary basis for short periods of time, and an increasing number of single males entering shelters designated for people experiencing homelessness.[3] This is certainly suggestive of a cohort making use of a larger range of facilities that offer emergency or short-term congregate accommodation, endlessly or episodically moving around an institutional circuit of homeless, mental health and criminal justice services, without ever resolving what is in essence their inability to acquire secure permanent accommodation with the supports required to maintain residential stability. The data suggests that they fit the episodic profile identified by Culhane and others. Within this cohort, variations in patterns are likely to be observed between males and females, and older and younger users, and more detailed research utilising linked administrative data (Culhane, 2016) and qualitative research (Mayock *et al.*, 2015) will be required to tease out these variations.

Understanding homelessness as residential and economic instability should encourage policy makers to devise responses that makes housing with supports available to those who otherwise will continue to traverse, temporary but extraordinarily expensive responses to this instability. The overwhelmingly positive outcomes in a range of jurisdictions that have housed people, who had experience of entrenched homelessness, through Housing First programmes, (Cherner, *et al.*, 2017; Padgett *et al.*, 2016), demonstrates that there are viable alternatives to the

[3] The number of single females utilising these facilities is significantly less than the number of males, but this is consistent with the under-representation of females in such administrative data (Pleace, 2016), with females utilising a range of informal sites and thus 'hidden' from datasets such as used in the research note.

current practice of maintaining this particular group of people experiencing homelessness in costly institutional sites. Our knowledge of the costs of maintaining people in homelessness, via the provision of congregate emergency and temporary accommodation demonstrates that it is both fiscally responsible and ethically justifiable to provide evidence-based housing responses to people experiencing long-term homelessness, with supports where necessary (Parsell, *et al.*, 2017). A Housing First demonstration project was established in Dublin in 2011, and following a positive evaluation (Greenwood, 2015), a Dublin Housing First Service was launched in 2014 with a target of 100 tenancies for those experiencing chronic homelessness. This was expanded in 2016 to a target of 300 tenancies for Dublin and 100 in Cork, Galway and Limerick, and in 2018 to a national target of over 700 tenancies by 2021. The high retention rate in the existing Housing First tenancies in Dublin, consistent with evaluations of Housing First in other jurisdictions, suggests that the provision of permanent supported housing (Rog *et al.*, 2014) can successfully break the institutional circuit.

Finally, the potential of administrative data to understand patterns of homelessness, to identify specific sub-groups and to respond rapidly to emerging issues is gaining increasing traction. While gold standard methodologies such as Randomised Control Trials have been highly influential in understanding the success of Housing First, they tend to be expensive and can take up to a minimum of two years from project inception before robust results are available. There is an emerging view that 'research that harnesses linked administrative data can assist in guiding and evaluating the impact of more integrated solutions to ending homelessness' (Wood *et al.*, 2017, p.45). In addition, understanding transitions, both developmentally and through institutions and services, is crucial in understanding homeless pathways, and administrative data has the potential to contribute to leading-edge research and to evaluate the impact of research on policy and practice.

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