Barriers and Enablers to Health and Social Care Access for Homeless Hostel Residents from the Perspectives of Community-based Staff: A Qualitative Study

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Abstract_ *Homelessness represents a persistent public health issue. Homeless hostel residents (HHR), particularly long-term and episodic residents, experience disproportionately high levels of morbidity, multimorbidity, and premature mortality. There has been little research into HHR in Northern Ireland (NI). This qualitative study explores barriers and enablers to healthcare access for people living in homeless hostels in four rural health trusts in NI, drawing on the perspectives of community-based support staff. Using an exploratory qualitative design informed by social constructivism and underpinned by Levesque et al.'s client-centred framework for access to healthcare, eleven semi-structured interviews were conducted with eleven experienced hostel support workers for HHR. Data were analysed using Braun and Clarke's thematic analysis. Findings highlight intersecting personal, structural and systemic barriers, including stigma and discrimination, fragmented service provision, GP registration difficulties, geographical displacement and workforce pressures. Key enablers included the advocacy role of hostel support workers, access to Homeless Health Nurses, and collaborative in-reach services.*

The study underscores the critical role of community-based staff in mitigating health inequalities among HHR and highlights the need for integrated, trauma-informed and adequately resourced models of care. Policy implications include the expansion of specialist homeless health services, improved inter-agency information sharing, and enhanced recognition of support workers' advocacy *roles. These findings contribute to the evidence base on homelessness and health, with relevance for public health policy and service design across comparable settings.*

Keywords_ *homeless hostels; healthcare access; health inequalities; community-based staff; Northern Ireland; qualitative research.*

Introduction

This study focuses on 'homeless hostel residents' (HHR), defined as individuals residing in temporary accommodation such as hostels or shelters (Simon Community, 2022). This population has grown substantially in the UK, with a 74% increase in people living in temporary accommodation over the past decade (Shelter, 2023). While hostels aim to provide short-term accommodation and support, residents often present with complex health needs, including physical illness, mental health conditions, and substance use, commonly described as trimorbidity (Hewett and Halligan, 2010).

This study focuses on Northern Ireland. NI has a population of approximately 1.9 million people (NISRA, 2025). Currently, it is estimated that approx 88 000 individuals are experiencing housing instability in Northern Ireland (Homeless Connect, 2025). This is an increase of 132% over the last decade (Big Issue, 2025). The leading causes of homelessness in Northern Ireland are accommodation not being reasonable, family breakdown, and loss of rented accommodation. These factors are closely associated with increased exposure to environmental hazards, heightened risk of domestic violence, and financial strain (NISRA, 2025). Table 1 below summarises some background data.

Table 1: Summary of recent data on homeless-related populations in Northern Ireland

Indicator	Statistic	Time Period	Source
Homeless Presentations	15 845 households	Oct 2024– Sep 2025	NISRA
Statutorily Homeless	10 501 households	Oct 2024–Sept 2025	NISRA
Children (0-19 yrs) affected	19 700	Sep 2024	NIHE/PPR
Hidden Homelessness	25 000	March 2026	Homeless Connect

In Northern Ireland, there are five geographical Health Trusts, see Figure 1. Belfast Trust is an urban trust, whereas the other four cover more rural areas: Northern, Southern, South Eastern, and Western Trusts. Some research has been undertaken with women living in homeless hostels in the Belfast Trust area (McNeill et al., 2022). The Belfast Trust also has an extensive homeless MDT, in line with NICE guidance. This study, therefore, focuses on the perspectives of community-based hostel staff working in the four rural health trusts in Northern Ireland, where little research has been undertaken and access to homeless health services is limited to 1 Homeless Health Nurse per trust area.

Figure 1

The Supporting People programme funds approximately 86 homeless hostel facilities across NI, see breakdown below. Thirty of these services are registered within Belfast, with the other 56 dispersed across the rest of Northern Ireland.

Table 2: Number of hostel accommodation places, by category across NI Trusts

Accommodation type	Number of services	Number of places
Homeless family hostels	24	311
Accommodation for women experiencing domestic abuse	14	138
Single homeless (includes those for people with additional needs Mental Health, Alcohol and drug addiction, offenders)	48	1256
Total	86	1705

Aims and Objectives

This qualitative study aimed to explore the perceived barriers and enablers to accessing health and social care services for people living in homeless hostels (HHR) in Northern Ireland, from the perspectives of community-based support staff. The objectives were to: Identify perceived barriers to accessing health and social care services for HHR; and explore factors that enable and facilitate access to services using the Levesque et al. (2013) client-centred conceptual framework to inform data collection and analysis. A supplementary objective was to use these findings to develop recommendations that could enhance healthcare access for HHR.

Methods

Study design

An exploratory qualitative design grounded in social constructivism was employed to capture in-depth insights into healthcare access from the perspectives of frontline hostel staff (Parahoo, 2014). Qualitative methods were selected to enable exploration of complex, context-dependent experiences not readily captured through quantitative approaches (Braun and Clarke, 2006).

The study was theoretically underpinned by Levesque et al.'s (2013) client-centred framework for access to healthcare, which conceptualises access as an interaction between individual abilities (to perceive, seek, reach, pay, and engage) and service characteristics (approachability, acceptability, availability, affordability, and appropriateness). This framework has been widely applied to vulnerable populations, including people experiencing homelessness (Cu et al., 2021).

Sampling and recruitment

Purposive sampling was used to recruit experienced community-based staff working directly with HHR across Northern Ireland. Inclusion criteria required participants to have at least two years' experience supporting HHR. Recruitment was facilitated through independent gatekeepers, including the Enhancing Care of the Homeless (ECHO) group and the Northern Ireland Housing Executive.

Eleven participants were recruited, representing all six counties of Northern Ireland, covering all four health trusts. They were aged 30-62 years old and included six women and five men. Participants collectively contributed 192 years of experience working with HHR.

Data collection

Semi-structured interviews were conducted via Microsoft Teams to accommodate geographical dispersion (Thunberg and Arnell, 2022). Interviews lasted 45–90 minutes and were audio-recorded with consent. An interview guide included eight questions, which were informed by the literature review and mapped to Levesque's framework, whilst allowing flexibility to explore emerging themes (See supplementary file).

The themes and sub-themes are mapped to Levesque's framework in Figure 1.

Figure 1: Themes and Sub-themes discussed linked to Levesque's Framework

Themes	Subthemes	Links to Levesque's framework
Personal Barriers	Stigma/ discrimination Mental health and addiction issues Health Literacy	Individuals' ability to perceive, seek, reach and engage. Service approachability, acceptability and appropriateness
Structural barriers	Geographical constraints Transport links	Individuals' ability to reach. Service availability and accommodation, affordability
Systemic Barriers	GP registration difficulties Fragmented healthcare system Attitudes and behaviours of staff Resource constraints	Individuals' ability to perceive, seek, reach and engage. Service availability approachability, acceptability, affordability and appropriateness
Enablers	Homeless health Nurses Hostel Support workers In-reach services C&V sector collaboration	Individuals' ability to perceive, seek, reach and engage. Service approachability, acceptability, availability, affordability and appropriateness

Data analysis

Data were analysed using Braun and Clarke's (2006) six-phase thematic analysis. Transcripts were read repeatedly to ensure immersion, coded inductively, and organised into themes and sub-themes. Themes were subsequently mapped against Levesque's framework to enhance analytical coherence.

Trustworthiness was ensured through strategies addressing credibility, transferability, dependability, and confirmability (Lincoln and Guba, 1985). Member checking, reflexive journaling, and peer debriefing enhanced rigour.

Ethical approval was granted by Ulster University Research Ethics Committee (Ref: CNUR-24-019), and all participants provided informed consent.

Findings

The thematic analysis identified a complex interplay of personal, structural, and systemic factors influencing access to health and social care for HHR. While barriers were dominant across participants' accounts, important enablers were also identified, which were derived from the advocacy role of hostel staff as they support HHR to access health and social care services. Verbatim quotations are included to preserve participants' voices and to illustrate the depth and nuance of the findings.

Personal Barriers to Accessing Care

Stigma, discrimination, and distrust

Stigma emerged as the most consistently reported personal barrier, discussed by all eleven participants. Community experts described how residents' previous negative experiences with healthcare professionals had resulted in deep-seated mistrust of health and social care services. Participants reported that HHR frequently felt judged, dismissed, or treated as undeserving of care, particularly when presenting with mental health or substance use issues.

One participant reflected:

"A lot of our residents have had terrible experiences in the past; they feel judged or dismissed, which makes them reluctant to seek help again." (P09)

Several participants recounted incidents where residents were denied adequate pain relief or had symptoms minimised due to assumptions related to addiction histories. These experiences were described as contributing to feelings of shame, fear, and reduced self-worth, often resulting in avoidance of services until the crisis point. One particularly distressing account highlighted the impact of dismissive professional behaviour following a suicide attempt:

"The first thing the paramedic said was 'you disturbed my lunch'. What does that say to the guy, when he was in a really bad way?" (P02)

Participants emphasised that repeated exposure to such encounters reinforced a sense of fatalism among residents, reducing their willingness to engage with preventive or ongoing care.

Mental health and substance use

Mental health difficulties and substance use were identified as significant personal barriers, often operating simultaneously. Participants described how services frequently refused to engage with individuals who were intoxicated or actively using substances, even when presenting with urgent health needs. Emergency department waiting times were reported to be particularly problematic for residents experiencing withdrawal symptoms, with limited access to substitution or supportive medication while awaiting assessment.

The absence of integrated dual diagnosis services was repeatedly highlighted. Participants described residents being referred, back and forth between mental health and addiction services (CAD), with neither taking responsibility for care:

"Dual diagnosis is a major issue. People are being sent to different places for mental health and addiction, and they just get tired of running between services." (P09)

This lack of coordinated support was seen to exacerbate disengagement and deteriorating health.

Structural Barriers

Geographical displacement and rurality

Rurality was identified as a major structural barrier to healthcare access. Participants described how residents displaced into hostels outside their original Health Trust areas were often required to re-register with GP practices and re-enter waiting lists for specialist services. This frequently resulted in delays in accessing medications and disrupted continuity of care.

One participant explained:

"We've had GPs refusing to give antipsychotic medication… even though they've been taking it for years. That's a real risk management issue for us." (P07)

Participants stressed that such disruptions posed significant risks, particularly for residents with severe mental illness.

Transport and service availability

Limited public transport infrastructure across rural Northern Ireland further compounded access difficulties. Many participants reported that residents were unable to attend appointments due to distance, cost, and poor transport links. Hostel staff frequently accompanied residents to appointments, sometimes using personal vehicles or funds, but acknowledged this was unsustainable.

Missed appointments due to transport barriers often resulted in residents being discharged from services:

"If they miss one appointment, that's it, they're discharged. There's no flexibility." (P08)

Systemic barriers

GP registration and bureaucratic exclusion

Difficulties registering with GP practices were reported by most participants. Requirements for identification, proof of address, and postcode restrictions were described as persistent barriers, despite national guidance stating these are not mandatory for registration. Several participants recounted GP practices refusing registration upon hearing a hostel address:

"As soon as they heard the address, they would say they were full… then if I rang back and didn't give the address, suddenly there was space." (P02)

Participants working in one area reported fewer difficulties, which they attributed to established relationships with GP practices and the presence of an inclusion health hub, highlighting regional inequities in access.

Fragmented services and poor communication

Fragmentation across health and social care services was identified by all but one participant. Poor coordination between mental health, addiction, primary care, and hospital services often resulted in inappropriate discharges, lack of follow-up, and residents having to repeatedly recount traumatic histories.

Participants also reported that information sharing was frequently restricted, with GDPR cited as a barrier:

"Clients go from service to service and have to repeat their stories, get frustrated, and leave." (P01)

Attitudes towards hostel support workers

Seven participants reported feeling dismissed or undervalued when advocating for residents. Hostel staff were often excluded from appointments or care planning, despite their detailed knowledge of residents' needs. One participant described being asked to leave a GP appointment, resulting in the resident receiving inadequate care and later being detained under mental health legislation.

"I work for the Trust, you're voluntary, what would you know?" (P05)

This lack of professional recognition was perceived as undermining collaborative care.

Table 3 provides an overview of the identified barriers and enablers as highlighted by the community-based staff. The table illustrates that personal barriers such as stigma and mental health issues were most frequently reported, while structural challenges like transport and systemic issues, including GP registration difficulties, were also prevalent. Conversely, access to Homeless Health Nurses and the advocacy role of hostel staff emerged as key enablers.

Table 3: Perceived Barriers to accessing health and social care for HHR as identified by community experts

Barriers	01	02	03	04	05	06	07	08	09	10	11
Personal Barriers											
Stigma/discrimination/distrust previous bad experiences HHR	x	x	x	x	x	x	x	x	x	x	x
Mental health and addiction issues	x	x	x	x	x	x	x	x		x	
Health literacy/communication/appt. notification		x	x		x	x	x	x			x
Structural Barriers											
Limited resources/ transport/ travel difficulties	x	x	x	x	x	x	x	x			x
Inadequate local services/geographical restrictions			x	x	x	x	x				x
Lack of health services i.e. Dental	x	x		x						x	x
Systemic Barriers											
Access to GP registration/ Services/GP Rota Issues – issues with Identity Documents/ Paperwork	x	x	x	x	x	x	x	x			x
Inadequate GP/out of hours support once registered/ Unable to access medications/ missed medications	x	x	x			x	x	x	x		x
Stigma to homeless health support workers from the health and social care community	x	x			x	x	x	x			
Lack of continuity of care/ inflexible services/ rapid closure after missed appointments	x	x			x	x	x				x
Inadequate Crisis Response/Mental health access/ long wait times/ unable to transfer and having to start at referral again if displaced	x	x	x	x	x	x	x	x			x
Fragmented services (statutory)/inappropriate discharge/ lack of follow up	x	x		x	x	x	x	x		x	x
Lack of response from social services			x								
Lack of dual diagnosis services	x	x			x	x	x	x		x	x
Attitudes of GP/health and social care staff towards homeless health support workers	x	x		x	x	x	x	x			
homeless health support workers staff burnout/ minimal wages/ emotional impact of the job	x	x		x	x	x	x		x	x	x
Poor communication/ coordination information sharing between health and social care services and hostels/Voluntary &Community sector	x	x	x		x	x	x	x		x	x
Emergency Department wait times/Inappropriate care/ lack of withdrawal meds offered to assist with waiting / hospital admissions		x			x	x	x	x	x		x
No access to Homeless Health Nurse											x

Enablers to Accessing Care

Homeless Health Nurses and specialist services

Access to a Homeless Health Nurse (HHN) was consistently identified as the most significant enabler. Participants described HHNs as providing holistic assessments, advocacy, and navigation of complex systems:

"The Homeless Health Nurse has been a real champion for us… she helps us navigate the system." (P09)

However, participants expressed concern about service inequity, as not all hostels had access to HHNs, and coverage was unavailable during absences.

"Our nurse is amazing, but has been off sick for a while and there is no cover, the service has stopped….one nurse for an entire trust area is just not enough" (P02)

Advocacy role of hostel support workers

All participants described spending between 50–70% of their working time addressing residents' unmet health needs. Hostel staff supported GP registration, appointment attendance, medication management, and health literacy. Their long-term relationships with residents enabled early identification of deterioration and crisis prevention.

"We are with the clients 24/7….we build relationships understand triggers and know when things are going to happen" (P01)

The emotional burden of this role was evident, particularly following resident deaths or suicide attempts. Participants described staff trauma, burnout, and difficulties with recruitment and retention, exacerbated by low pay and insecure funding.

Table 4 demonstrates that access to dedicated Homeless Health Nurses and the advocacy role of hostel support workers were the most frequently cited enablers, complemented by collaborative in-reach services, and strong relationships with health teams.

Table 4: Factors that enable community-based staff to support HHR accessing Health and Social Care

Enablers	01	02	03	04	05	06	07	08	09	10	11
Access to dedicated Homeless Health Nurse	x	x		x	x	x	x	x	x	x	
Advocacy role of homeless health support workers with appointments/letters and health literacy	x	x		x	x	x	x	x			x
Access to other in-reach homeless health practitioners/hub	x	x			x		x	x	x	x	x
Collaborative efforts i.e. ECHO, homeless health nurse working alongside Community & Voluntary organisations	x	x		x	x						x
Locally Enhanced Service funding to engage GPs	x										
On site medication management/ collaborative working with pharmacies	x									x	x
Funding for health initiatives	x	x									x
Community & Voluntary organisations i.e. External, Triangle, floating support, religious organisations			x		x	x	x			x	
A good relationship with health and social care teams/ other bodies i.e. Community Addiction Team/ GP					x	x			x	x	x
Harm minimisation services					x	x	x	x		x	

Table 5 highlights recommendations prioritising the expansion of Homeless Health Nurse provision, development of dual-diagnosis services, improved information sharing, and trauma-informed training, alongside systemic reforms such as streamlined GP registration and integrated care teams.

Table 5: Recommendations to improve access to health and social care for HHR as identified by participants

Recommendations	01	02	03	04	05	06	07	08	09	10	11
Increase number of Homeless Health Nurses to deliver more interventions and provide cover	x	x	x	x	x	x	x	x	x	x	x
Dual Diagnosis services specifically for the homeless	x	x	x	x	x	x	x	x		x	x
Improve information sharing/follow up	x	x	x	x	x	x	x	x		x	x
Promote role of homeless health support workers/More funding to Improve facilities/ training and working environment for homeless health support workers to enhance job satisfaction	x	x			x	x	x	x		x	x
Training of health and social care staff – trauma informed care/sensitivity/ increased awareness of ACEs to reduce stigma etc		x		x	x	x	x	x	x	x	
Policy and funding reform	x	x		x	x	x			x	x	
Streamline GP registration/ to make it accessible	x	x	x	x				x	x	x	
More in-reach services/ mobile units	x	x		x	x			x	x		x
Specialist integrated care teams/ homeless health MDT/Hub in each Trust (as per NICE guidance)		x	x		x	x	x	x		x	
Peer support/PPI involvement in design of services for HHR		x			x	x				x	x
Flexible service pathways/strengthen relationships					x		x		x	x	
Better transportation/free public transport					x	x		x			
Support health literacy and admin needs		x						x			x
Coordinated approach with other sectors i.e. PSNI, NIFRS, NIHE etc							x				x

Discussion

This study highlights how intersecting personal, structural, and systemic barriers constrain healthcare access for HHR across Northern Ireland. Findings align with international literature documenting stigma, fragmentation, and bureaucratic exclusion within healthcare systems (O'Carroll and Wainwright, 2019; Carmichael et al., 2023).

The advocacy role of hostel support workers emerged as central to mitigating these barriers, echoing findings from other European contexts (Armstrong et al., 2021). However, reliance on informal advocacy underscores systemic shortcomings and places emotional and professional strain on a workforce that remains under-recognised.

Mapping findings to Levesque's framework illustrates how service redesign, particularly through trauma-informed care, streamlined registration and integrated homeless health teams, could enhance both access and engagement.

Strengths and limitations

A key strength of this study lies in its focus on rural homelessness, an under-researched community. The qualitative design enabled rich, contextualised insights. Limitations include potential selection bias and the exclusion of Belfast-based hostels, which may limit generalisability to more urban settings. This study was also limited in that it did not directly interview HHR or other stakeholder groups, and the findings may therefore represent some biases due to reliance on staff perspectives. Some aspects of the findings may not be generalisable beyond Northern Ireland.

Implications for policy and practice

Findings support the expansion of access to Homeless Health Nurses, access to dedicated dual-diagnosis services, improved information sharing structures between the voluntary and public sectors with client agreement, and trauma-informed training for healthcare professionals.

Conclusion

Barriers to healthcare access for people experiencing homelessness extend beyond urban centres. In rural Northern Ireland, stigma, fragmentation, and service scarcity intersect and demonstrate a missed opportunity to address key health inequalities. Community-based staff and specialist homeless health services play a vital role in bridging gaps, but structural reform is required to achieve equitable access. Addressing homelessness as a public health priority demands integrated, adequately resourced, and person-centred approaches.

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Registration

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