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An Exploration of the Scale and Impact of Physical Disability in People Experiencing Homelessness in Ireland

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Executive Summary

Researchers from Trinity College Dublin conducted a series of studies, funded by the National Disability Authority to explore the scale and impact of physical disability in people experiencing homelessness in Ireland. The research addressed each of the following research questions:

- What is the international literature pertaining to the magnitude and scope of physical disability in adults experiencing homelessness?
- What are the rates of physical disability among residents of homeless hostels in Ireland?
- How does homeless accommodation in Dublin and Cork city centres correspond to the mobility needs of individuals accessing homeless hostels?
- What is the impact of having a physical disability for people who are homeless?
- What are some solutions to address the issues faced by people who are homeless who have a physical disability?

The rationale for this research is based on the need to understand the scale and impact of physical disability among people who are homeless, so findings can be used to drive policy and practice in this area. It is acknowledged that there are many forms of disability. This report focuses on physical disability that is disability resulting from physical impairments, such as physical functioning and mobility limitations.

People experiencing homelessness live with a high burden of poor health. A multitude of physical health conditions can lead to progressive disability. In some cases, there can be progressive disability on top of acquired disability. Due to the intersectionality of homelessness, diagnostic overshadowing is common, as the disability itself may be masked by a complex presentation of some or all of the following: mental health difficulties, physical health conditions and addiction.

Anecdotally, the rate of physical disability is thought to be high in people experiencing homelessness, but this is not well quantified or understood. Research is necessary to better understand the scale and impact of physical disability in people who are homeless so better supports, housing and preventative strategies can be initiated.

The current research was conducted in three phases. Phase I consisted of a scoping review of the literature evaluating the international literature on the topic of physical disability in people experiencing homelessness. In Phase II, a cross-sectional mapping study evaluated the prevalence of physical disability among users of homeless accommodation in Dublin and Cork, linked to the accessibility of their accommodation. In Phase III, people experiencing homelessness and stakeholders who were working in any capacity with people who are homeless, were interviewed about the impact of physical disability and potential solutions. Ethical approval was sought from the Faculty of Health Sciences in Trinity College Dublin prior to the commencement of this work.

Main Findings

Phase I

A scoping review was performed to provide a comprehensive overview of the published literature pertaining to physical disability among adults experiencing homelessness in various countries and contexts. The search strategy used in this study was broad, aiming to gather evidence from diverse sources using a variety of study designs. Twelve studies were included in this review.

Results indicated that despite variations in study measures and the reporting of outcomes, findings show clearly that there is a higher prevalence of physical disability among people experiencing homelessness compared to the general population.

The findings synthesised from included studies within this review revealed that a relatively high proportion of people experiencing homelessness had musculoskeletal conditions and/or mobility impairments, necessitating the use of mobility devices in 32-80% of people experiencing homelessness.

Phase II

A study was performed among homeless hostels in Dublin and Cork city centres documenting the mobility status of residents, and mapping accessibility of their accommodation to their mobility status.

The findings of our study show that a nearly a quarter [22.7% (n=127)] of our sample of 547 people accessing homeless accommodation on a given night during the summer of 2024 had some kind of mobility limitation. Among residents with some kind of mobility limitation, 49.6% (n=63) were sleeping in a room on the first, second or third floor despite their limited mobility. Of the total sample of 547 people included in the study, 58.9% (n=322) were accessing a bathroom that had no accessibility features. Within the groups with restricted mobility (people with some restriction or difficulty with walking or movement) and impacted mobility (people who are fully mobile but have symptoms that limit activities), 52% (n=66) slept in a room with an ensuite toilet. Therefore, almost one quarter of our sample had some kind of mobility limitation, and in this group almost half were not on ground floor accommodation and half did not have access to an ensuite bathroom.

Phase III

This qualitative study conducted interviews with 24 participants (people experiencing homelessness group, n=18, stakeholder group, n=6). Three main themes were developed from the data: (1) the personal impact of experiencing homelessness with a physical disability, (2) accommodation considerations and staff constraints (3) exiting homelessness.

This study showed that physical disability magnified the vulnerability, stigma and shame associated with the homeless state and can lead to helplessness, hopelessness and isolation, compounding the challenges of lacking a stable home. Some participants with a physical disability were afraid or unable to go out, magnifying their experience of exclusion. Physical disability may have contributed to entrenched homelessness and dependence on hostel accommodation. The built environment within hostel accommodation was generally not sufficient to meet the complex needs of this group, but satisfaction with staff was high, and despite the complex challenges, many were hopeful about their future.

Conclusion

Clearly, physical disability is prevalent in people experiencing homelessness. This came through in the international literature within the scoping review and in the mapping study. In the mapping study, almost a quarter of users of homeless accommodation had some type of physical limitation, and in this group almost half were not on ground floor accommodation/did not have access to an ensuite bathroom.

The qualitative study highlighted the high personal toll of living with a physical disability when homeless, and how it can negatively affect quality of life and may contribute to entrenched homelessness.

Recommendations

- For Homeless Hostel Services
 - Integrate basic screening of mobility into the bed allocation process.
 - Prioritise accessible rooms and bathrooms, lower bunks and shorter corridors to reach services for people with mobility challenges.
 - Train staff to understand and assist with disability needs, including collaboration with health care and other services where applicable.
- For Government:
 - Ensure at least 25% of accommodation, including hostel and 'own door' accommodation is accessible and ground-level.
 - Retrofit existing hostels to improve bedroom and bathroom accessibility.
 - For new accommodation, employ the principles of universal design, so accessibility requirements apply to all accommodation.
 - Plan for long-term care needs for people who are homeless with complex needs which are outside the nursing home model due to pre-geriatric disability.
 - Include and prioritise accessibility as part of inspections (such as the Homeless Accommodation Inspection Service) and quality standards (such as the National Quality Standards Framework for Homeless Services in Ireland).

- Employ a solutions-based approach to act on inadequate accessibility provision.
 - Ensure the needs of people who are homeless with a disability are considered in national homeless strategies.
- For Disabled Persons' Organisations and other representative and advocacy groups:
 - Amplify voices of people who are homeless with disabilities.
 - Promote inclusion of people who are homeless with disabilities in policy-making, public forums, and media.
- For Health Care Systems:
 - Offer early rehabilitation and multi-disciplinary input including physiotherapists and occupational therapists.
 - Ensure access to a General Practitioner, for long term support and referrals to appropriate services.
 - When discharging from acute services to hostel accommodation, communicate mobility needs in advance where applicable to ensure suitable bed allocation.
- For Funders – prioritise research in the following areas;
 - Optimum mobility screening methods within hostel services.
 - Staff training needs with regards to managing physical disability in residents.
 - Observational research to profile physical disability and appropriateness of mobility aid provision.
 - Longitudinal research to track disability over time.
 - Intervention studies on effective physical rehabilitation strategies.
 - Accessibility audits of homeless hostel accommodation.

Introduction

Homelessness is a pertinent social issue. The latest figures from April 2025 show 15,580 people utilising State-funded emergency homeless accommodation in Ireland, which includes 4665 children.¹ While there is no universally accepted definition of homelessness, FEANTSA, the European Federation of National Organisations Working with the Homeless, identifies 4 main categories of living situation; rooflessness, houselessness, insecure housing and inadequate housing to comprehensively encompass the range of living situations that contribute to homelessness.²

People who experience homelessness often have a high burden of poor health. Common health problems among homeless individuals include previous head injuries and falls, early fragility, high blood pressure, epilepsy, HIV, TB, and chronic liver, lung, and stomach problems.³⁻⁶ Linked to poor health and a complex interaction of other factors, including mental health conditions and concurrent substance use issues,⁷ physical functioning limitations and the earlier onset of premature geriatric conditions such as frailty and falls are common and may occur twenty years earlier than the general population.⁸⁻¹¹

Multi-morbidity and geriatric conditions can be associated with disability.^{12 13} The biopsychosocial model of disability proposes that disability is an interaction of health conditions, including impairments, and contextual factors such as environmental factors, that shape how disability is experienced by the individual.¹⁴

Data suggests that disabled individuals represent up to 27%¹⁵ and 34%¹⁶ of the homeless population in Ireland and the UK, respectively, although these figures relate to the breadth of disability, not specifically physical disability. Disability can be a contributory factor to becoming homeless,¹⁶ and can pre-exist in up to 75% of cases,¹⁷ and/or the homeless state can be associated with developing an impairment or condition that leads to disability. In people who experience homelessness with a disability, accessibility to supported housing and recovery services can be limited, potentially perpetuating a cycle of entrenched homelessness by hindering the transition to independent housing.^{16 18} Census data shows that people with disabilities in Ireland are also 3.3 times more likely than people without a disability to experience housing discrimination.¹⁹

Physical disability, which is a limitation of one's physical functioning or mobility, can be progressive, and in some cases, progressive disability may occur on top of acquired disability. There appears to be a bi-directional relationship between physical disability and homelessness. Physical disability appears to be a risk factor for homelessness, and it is common among people experiencing homelessness and can be precipitated and exacerbated by the homeless state.⁸

Insufficient research exists which examines the intersectionality of physical disability and homelessness, specifically the impact of disability, which is essential for guiding data informed practice and policy. To address this knowledge gap, the aim of this study was to investigate the impact of physical disability among people experiencing homelessness.

Research Questions

- What is the international literature pertaining to the magnitude and scope of physical disability in adults experiencing homelessness
- What is the prevalence of physical disability in a sample of people experiencing homelessness?
- What is the impact of physical disability on the daily lives of people experiencing homelessness?
- What are some solutions to improve the situation of people experiencing homelessness who have a physical disability?

The methodology adopted to address these research questions is set out in the next chapter.

Summary of Methodology

A detailed description of the methodology employed within each phase is outlined in the following chapters. A summary of the study methodology used to answer the research questions is outlined in the points below:

- Phase I: A scoping review was conducted in accordance with the Joanna Briggs Institute's methodology for scoping reviews.²⁰ Literature searches using MEDLINE/PubMed, EMBASE, PEDro, AMED, CINAHL, PsychINFO and SCOPUS were undertaken using keywords. A grey literature search was also conducted. The definition of physical disability utilised in this scoping review was any condition of the body which creates difficulties in carrying out activities of daily living and increases restrictions interacting with the world around them.
- Phase II: A survey was devised to document physical disability among people experiencing homelessness who used long-term hostel accommodation in Dublin and Cork city centres on a given night. Details of the accessibility of their accommodation were also collected, and physical disability was mapped to accommodation accessibility. The survey was completed by an employee of each participating hostel.
- Phase III: A qualitative study was conducted which consisted of interviews with people experiencing homelessness who self-declared they had a physical disability and relevant stakeholders. Interviews were recorded, transcribed and then analysed employing Braun and Clarke's reflective thematic analysis.
- Ethical approval was obtained from the Trinity College Dublin Faculty of Health Sciences Research Ethics Committee. Phase II was a fully anonymous study and Phase III was a pseudo-anonymised study. Prior to participation in

Phase III, all participants were given a participant information leaflet and signed a consent form.

- A study advisory group, consisting of stakeholders and people with lived experience of homelessness fed into the design and wording of the survey, the development of the interview questions for the qualitative study, and the discussion section.

Phase I: A Scoping Review of the Scale and Impact of Physical Disability in people Experiencing Homelessness

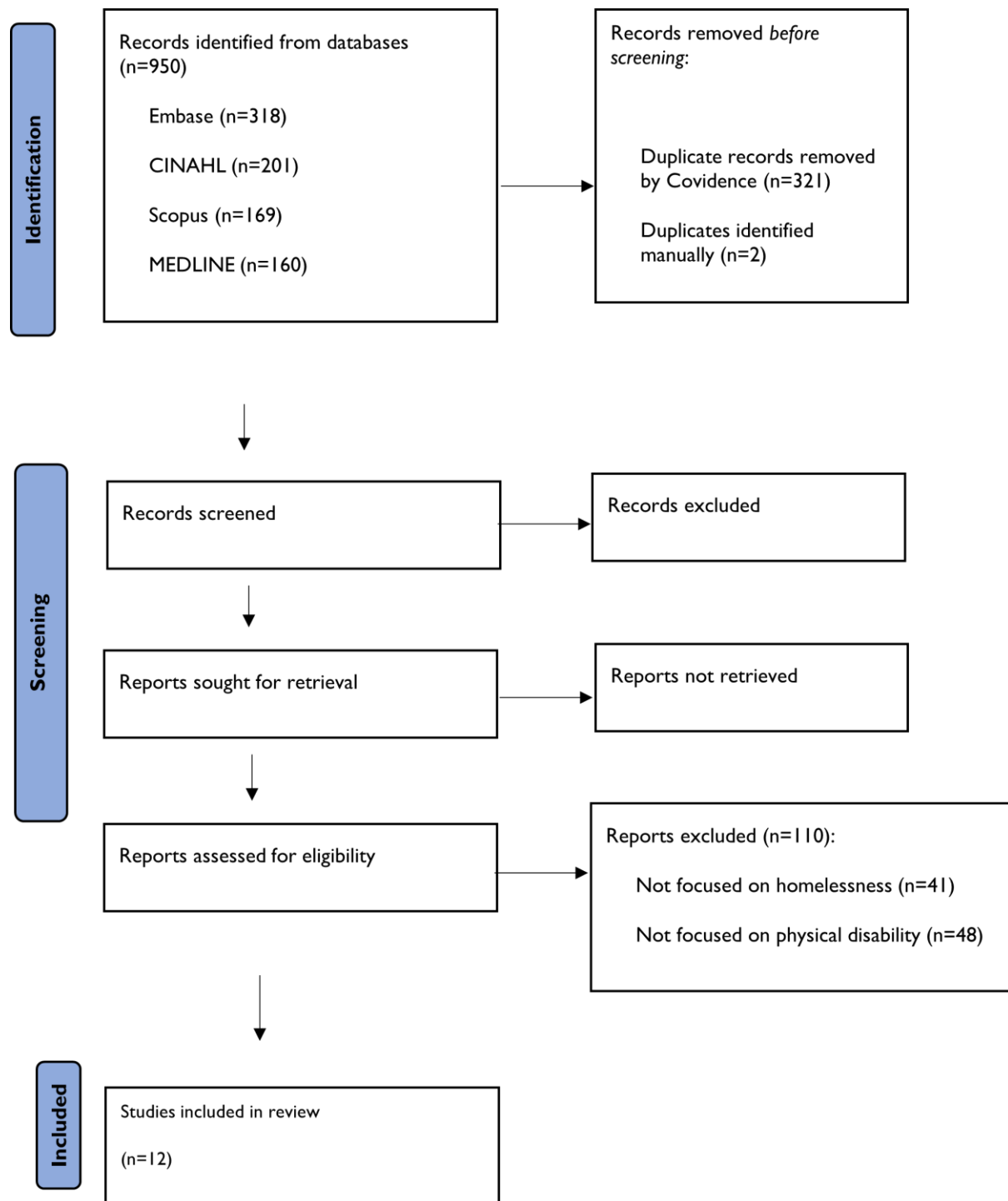
A scoping review was conducted to synthesise the international literature pertaining to the magnitude and scope of physical disability in adults experiencing homelessness.

Method

This review adhered to the Joanna Briggs Institute's (JBI) methodology for scoping reviews²¹ and followed the original framework of Arksey O' Malley²² and the enhancements proposed by Levac et al.²³ It was evaluated against the Preferred Reporting Items for Systematic Reviews and Meta-Analysis (PRISMA) extension for Scoping Reviews Checklist.²⁴ Arksey and O'Malley's five-stage framework was utilised in structuring this scoping review.²²

Stage one involved identifying the research question: the magnitude and scope of physical disabilities in adults experiencing homelessness. Stage two involved identifying studies that were relevant to this scoping review. A comprehensive search (Appendix A) was conducted on the following electronic databases: MEDLINE/PubMed, EMBASE, PEDro, AMED, CINAHL, PsycINFO and SCOPUS up to March 20th, 2024. Grey literature was searched via Lenus.ie, Core.ac.uk, the ProQuest dissertations and theses portal, and through google searches. Stage three involved selecting studies for use in this review. Only studies in English were included. All study designs were included and there were no restrictions placed on publication dates of the studies included. Studies reporting primary data on physical impairments and disabilities in adults experiencing homelessness were included.

Results of database searches were imported into Covidence where deduplication took place followed by title and abstract screening. Stage four involved charting the data. Five reviewers (AP, CH, DS, GK and RS) retrieved relevant data pertaining to physical disabilities in people experiencing homelessness. The data extraction tool compiled the following information concerning the included studies: authorship, title, publication year, study aims/objectives, research design, participants' living arrangements and location, inclusion/exclusion criteria, method of data collection, participant count, mean and standard deviation of age, biological sex distribution, specifics of reported physical health conditions, and comparison of physical health conditions within the background population. Stage five involved collating and reporting the summarised findings. Descriptive analysis was conducted on all demographic data, which was then categorised based on the evaluated outcomes. Qualitative data was organised meaningfully based on the source materials.

Figure 1. PRISMA flow diagram summarising search

Phase I Results

The process of identifying relevant articles is outlined in the PRISMA flowchart in Figure 1. Initially, 950 studies were retrieved from the formal electronic database search and 365 from the grey literature search. Among these, 323 duplicates were removed. Subsequently, 992 unique studies were screened, resulting in the exclusions of 863 studies. The remaining 129 studies were sought for retrieval and 122 underwent detailed eligibility assessment, focusing on their relevance to both homelessness and physical disability. One hundred and nine studies were excluded, meaning 12 met the inclusion criteria for the final review.

The characteristics of the 12 included studies are detailed in Appendix B. Out of these studies, six were conducted in the United States, two in Canada, and one study based in each of the following countries: Ireland, India, Scotland and Spain. Most included studies employed a cross-sectional study design (n=8). Other study designs comprised mixed methods, pretest-post-test and qualitative studies.

As shown in Appendix C, the most common physical impairments were described as (n=6) as a difficulty in performing specific physical functions such as walking, carrying groceries, or walking up a flight of stairs because of a health issue.^{8 17 25-27} Other common definitions considered the patients' need to use assistive equipment for their mobility.^{28 29} Based on the reported data, the prevalence of musculoskeletal conditions varied significantly, ranging from 38% (lowest²⁵) to 52.2% (highest³⁴). Moreover, the utilisation of mobility devices among individuals spanned from 32% (lowest⁸) to 80% (highest²⁸).

The nature of the physical disabilities included in this review were predominantly mobility impairments caused by spinal cord injuries, musculoskeletal conditions (such as arthritis, back problems and problems with walking, lost limb, and orthopaedic disorders. In four of the included studies participants were reported as using a walking stick or 'mobility device' to assist with their disability.^{8 28 29 33}

The various barriers to healthcare faced by individuals (Appendix D) included but were not limited to: a lack of transportation to medical appointments or the pharmacy,^{25 29 33 34} stigma and discrimination,^{17 25 34} excessive waiting time for essential mobility equipment,^{30 34} a lack of services for people who are actively using substances,²⁵ lack of geriatric services for people with premature ageing,²⁸ a lack of multi-disciplinary, coordinated, and integrated services to manage complex health problems,^{32 33} and poor quality of care both in hostels and in hospital settings.^{28 33}

Studies also noted the negative impact that living environments had on the overall health of study participants. These include poor accessibility of accommodation,^{28 29 32 33} a lack of privacy in homeless hostels,^{32 33} and poor sanitation in homeless accommodation.^{26 27 32 33}

Summary of Findings

This scoping review presents a comprehensive overview of the published literature concerning physical disability among adults experiencing homelessness in various countries and contexts. The search strategy used in this study was broad, aiming to gather evidence from diverse sources using a variety of study designs.

The findings synthesised from this review reveal that a significant portion of individuals experiencing homelessness have musculoskeletal conditions and/or mobility impairments, necessitating the use of assistive equipment, such as wheelchairs or walking sticks.

Phase II: Scale of physical disability in people experiencing homelessness in Dublin and Cork: A mapping study

A mapping exercise among 23 homeless hostels in Dublin and Cork city centres documenting the mobility status of residents, and mapping accessibility of their bed to their mobility status was conducted.

The research sought to answer the following question: How does homeless accommodation in Dublin and Cork city centres correspond to the mobility needs of individuals accessing homeless hostels?

Method

Participants and Setting

This cross-sectional mapping survey took place between April and September 2024. A survey was devised to evaluate both the accessibility of hostel beds and other facilities, and the physical mobility of individual staying in the hostel on a given night. It was piloted in two Dublin hostels prior to roll-out to ensure that the language used was understandable and unambiguous, and to uncover any technical issues. One technical problem was detected and small changes in formatting and wording were made as a result of the piloting process.

Data were collected via an anonymous online survey utilising Microsoft Forms, where hostel staff entered the information about residents on the data collection night. The following data were collected for each resident: an estimation of their mobility status (full mobility, impacted mobility, restricted mobility). Here full mobility refers to people with no restrictions or difficulty; impacted mobility refers to people who are fully mobile but have symptoms (e.g. pain, shortness of breath) that limit activities; and restricted mobility refers to people with some restriction or difficulty with walking or movement.

The specific corresponding bed for each resident was also recorded (e.g. single room/shared room and single bed/bunk bed). Further data regarding the access to other facilities was also collected (e.g. ensuite bathroom or distance to bathroom if

not ensuite, whether the room is serviced by a lift, if stairs how many steps, and length of corridor to access room and facilities).

The survey was completed by hostel staff, who filled out a separate set of questions for everyone staying in the hostel on the chosen night to complete the survey. The survey had a total of 24 questions (Appendix E) and took between 3-5 minutes to fill out per resident. All data was collected between April and September 2024, but the night chosen to complete the survey varied, as not all hostels joined the study at the same time. The target recruitment sites were all homeless accommodation hostels run by non-governmental organisations, located between the canals in Dublin city centre including parts of Dublin 1, 2, 7 and 8, and in Cork city centre (radius within 2km of the centre).

The survey was based on staff observation. This was the chosen approach to be able to collect the data in a manner that was minimally disruptive and invasive to hostel users, and which would place a relatively low burden on staff carrying out the data collection. Physical disability was assessed by visible signs of activity and participation limitations in hostel users such as the use of mobility aids and the need for help with daily tasks. Engagement with an advisory group of stakeholders revealed a stability in attendance of many hostel users, so staff had generally made these observations over time.

Because the project relied on homeless hostel staff for the data collection, the research team initiated the project by building a strong rapport with management and staff across the partner organisations. At the outset, the PI (JB) and lead researcher (RS) contacted each organisation's management to arrange their participation. RS then delivered presentations to management in housing organisations in Dublin and Cork and later met with staff at individual hostels or during online staff meetings. This ensured staff had a thorough understanding of the goals and methods of the research.

Phase II Results

Demographics

The full sample comprised 547 people accessing homeless accommodation in Dublin and Cork city centres during the months of June-August 2024. While participating hostels were asked that all residents be counted on their given night, the actual coverage of those counted was not collected. The sex break down (Fig 1) was as follows: 26.3% (n=144) women and 73.7% (n=403) men.

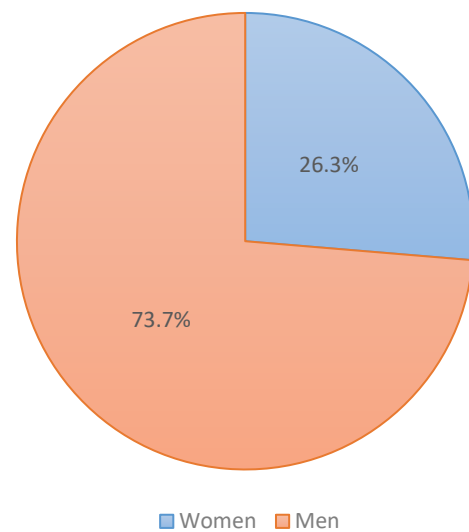


Figure 1: Sex distribution of participants

The age distribution (Fig 2) among the sample was: 42.6% (n=233) under the age of 40, 47.9% (n=262) ages 40-60, and 9.5% (n=52) over the age of 60.

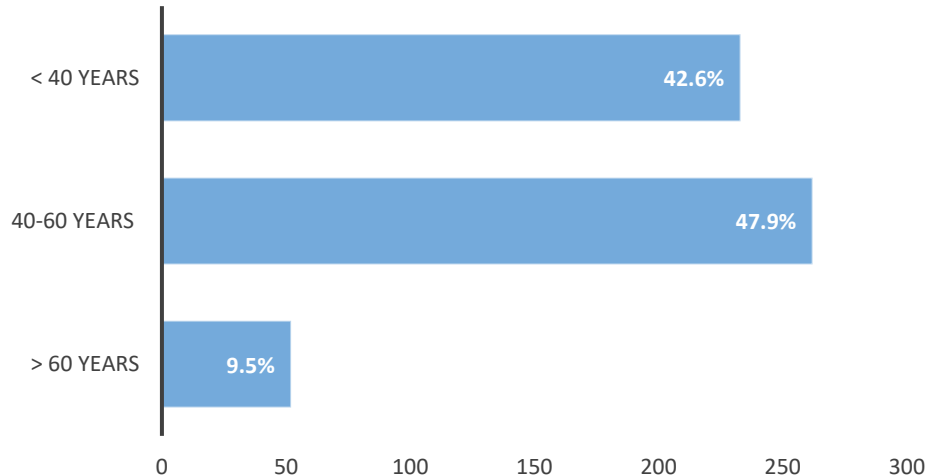


Figure 2: Age distribution of participants

Mobility status

Of the full sample, 76.8% (n=420) were reported as fully mobile meaning that the person could walk and move with no restriction or difficulty; 12.8% (n=70) had impacted mobility meaning that while the person was fully mobile they had symptoms (e.g. pain, shortness of breath) that limited their activities; and 10.4% (n=57) had restricted mobility meaning that the person experienced some restriction or difficulty with their walking or movement. See Fig 3.

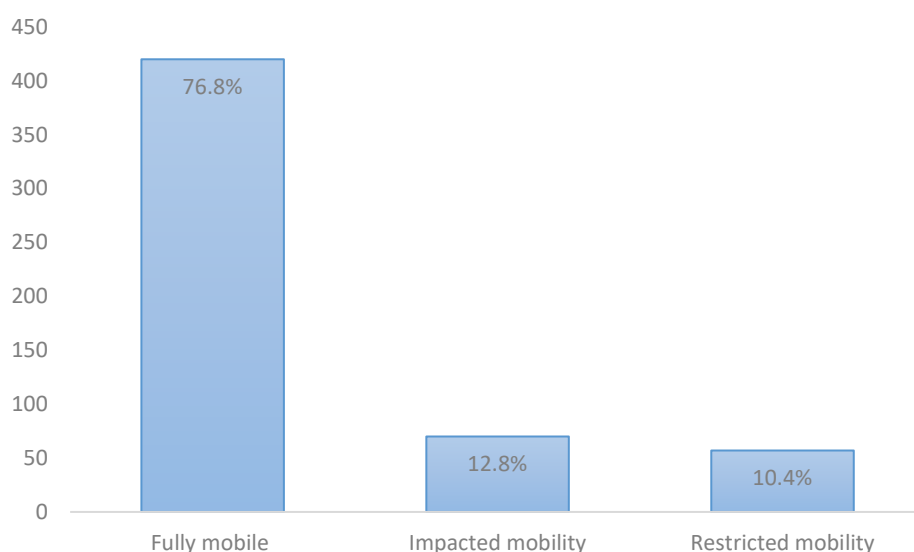


Figure 3: Mobility status

Of the 70 people with 'impacted mobility', 87.1% (n=61) experienced long-term (more than three months) symptoms which limited their activities, while for 12.9% (n=9) they were temporary (less than three months). Meanwhile, of the people identified as having restricted mobility, 80.7% (n=46) used mobility aids while 19.3% (n=11) did not use an aid even though they were having difficulties with mobility. The types of aids used included crutches, sticks, walking frames and wheelchairs.

Age and mobility status

The break -down of age and mobility status is shown in Table I below. There was an over representation of people from the older age groups among those identified to have impacted mobility and restricted mobility compared with those with full mobility. For example, among those classified as having impacted mobility, 61.4% were between the ages of 40 and 60 while 31.6% were over the age of 60. Similarly, for people with restricted mobility, 55.7% were between the ages of 40 and 60 and 18.6% were over the age of 60. However, just over a quarter, 25.7%, of those with restricted mobility were under the age of 40.

Age range	Full mobility	Impacted mobility	Restricted mobility
Younger than 40 years	50.2% (n=211)	7.0% (n=4)	25.7% (n=18)
40-60 years	44.8% (n=188)	16.4% (n=35)	55.7% (n=39)
Older than 60 years	5% (n=21)	31.6% (n=18)	18.6% (n=13)

Table 1: Mobility by age

Room locations

The survey recorded the location of rooms where study participants slept within the hostel on the night when the data were collected. Among the people with impacted mobility and restricted mobility (n=127), 49.6% (n=63) were sleeping in a room not on the ground floor despite their limited mobility, as shown in Table 2. Of these, 22.1% had to travel up one flight of stairs, 17.3% up two flights, and 10.2% up three flights. Plus, while a minority, five individuals with mobility issues were sleeping on a top bunk of a bunk bed.

Room features	Impacted and restricted mobility
<i>Up 1 flight of stairs</i>	22.1% (n=28)
Bunk bed (bottom bunk)	1.6% (n=2)
Single bed	20.5% (n=26)
<i>Up 2 flights of stairs</i>	17.3% (n=22)
Bunk bed (bottom bunk)	2.4% (n=3)
Bunk bed (top bunk)	2.4% (n=3)
Single bed	12.6% (n=16)
<i>Up 3 flights of stairs</i>	10.2% (n=13)
Bunk bed (bottom bunk)	0.8% (n=1)
Single bed	9.5% (n=12)

Room features	Impacted and restricted mobility
On ground floor	50.4% (n=64)
Bunk bed (bottom bunk)	1.6% (n=2)
Bunk bed (top bunk)	1.6% (n=2)
Double bed	0.8% (n=1)
Single bed	46.5% (n=59)

Table 2: Room location by mobility status

Of the people with impacted and restricted mobility who were not sleeping in a room on the ground floor, 44.4% (n=28) were staying in a hostel which did not have a lift.

Bathroom location

Of the total sample of 547 people, 39.3% (n=215) slept in a room with an ensuite toilet. Of the rest of the sample, three people's bathroom location was unspecified, while for the remaining 60.1% (n=329), their room did not have a toilet.

Within the group of people with restricted mobility, 30% (n=21) did not have an ensuite toilet in their room. Among those with impacted mobility, 70.2 % (n=40) slept in a room without an ensuite toilet. Among these, the distances to the bathroom are detailed below in Table 3.

Distance to bathroom	Impacted mobility	Restricted mobility
Over 20 metres	2.4% (n=3)	3.9% (n=5)
10-20 metres	0.8% (n=1)	4.7% (n=6)
5-10 metres	8.7% (n=11)	8.7% (n=11)
Less than 5 metres	4.7% (n=6)	14.2% (n=18)

Table 3: Bathroom location by mobility status

Bathroom features

The survey also asked about various mobility features of the bathrooms in the homeless hostels in the sample. We asked if bathrooms were wheelchair accessible and whether they had emergency button or chord or grab rails. Of the total sample

of 547 people included in the study, 58.9% (n=322) were accessing a bathroom that had no accessibility features. The other 41.1% (n=225) were accessing bathrooms with one (19.7%, n=108), two (10.4%, n=57) or three (10.4%, n=57) of the accessibility features described in Table 4.

Bathroom features	
Emergency button or chord only	7.7% (n=42)
Wheelchair accessible only	4.9% (n=27)
Grab rails only	7.1% (n=39)
Emergency button or chord and Grab rails	3.5% (n=19)
Emergency button or chord; Grab rails; and Wheelchair accessible	10.4% (n=57)
An emergency button or chord; and Wheelchair accessible	0.6% (n=3)
Grab rails; and Wheelchair accessible	6.4% (n=35)
None of the above	58.9% (n= 322)
Unspecified	0.6% (n=3)

Table 4: Bathroom features

Amongst those with with restricted mobility, 11.4% (n=8) used a toilet without any accessibility features. Among those with impacted mobility, 57.9% (n=33) used a toilet with no accessibility features.

Summary of Findings

While there have been anecdotal reports of significant physical mobility challenges among people accessing homeless accommodation in Ireland, we believe this is the first study to attempt to quantify the extent of it, within a sample of homeless accommodation services. The findings of our study show that a nearly a quarter [22.7% (n=127)] of our sample of 547 people accessing homeless accommodation on a given night during the summer of 2024 in Dublin and Cork cities had either impacted mobility or restricted mobility. Additionally, we found that among participants with either restricted mobility or impacted mobility – who clearly had a mobility limitation, 49.6% (n=63) were sleeping in a room on the first, second or third floor despite their limited mobility. Meanwhile, 60.1% (n=329) had to navigate to a shared bathroom, and 58.9% (n=322) were accessing a bathroom that had no accessibility features.

The lack of available rooms which were suitable to the mobility needs present, mirror the wider situation in Ireland for people with disabilities who face increased difficulties compared to the wider population in accessing suitable accommodation.

According to the 2022 census, across the general Irish population 7% experience difficulty with basic physical activities while 9% experience difficulty with pain, breathing or any other chronic illness.¹⁹ Comparing our sample with the general population, the people accessing homeless accommodation in our sample experienced more than twice to three times the amount of physical disability of the general population whether due to pain or due to difficulty with basic physical activities.

Phase III: The impact of Physical Disability on People Experiencing Homelessness

Phase III explored the impact of having a physical disability from the perspective of people who were homeless who self-declared they had a physical disability, and stakeholders who were employed in any capacity in the homelessness sector.

Method

This qualitative study followed a topic guide (Appendix F) and employed a narrative approach combined with semi-structured interview techniques to explore the experience and impact of homelessness and having a disability. The interview consisted of four phases (1) an introduction and explanations about the research, (2) the narrative, (3) the questioning phase, (4) conclusion. This study was reported following the Standards for Reporting in Qualitative Research (SRQR) checklist³⁵ to ensure rigour in study reporting.

Information about the interviews was disseminated to potential participants from gatekeepers within homeless accommodation services in Dublin city centre, for pragmatic reasons, as these were all conducted in-person where researchers were located. Those who expressed an interest were provided with a participant information leaflet (Appendices G and H) and verbal explanation of the study if requested and were given the opportunity to ask questions related to the study. Following this, written, informed consent was obtained.

The study had two groups of interviewees. The main group were people experiencing homelessness who had a disability. To gain a broader understanding, a small stakeholder group also participated, consisting of people who worked within homelessness services. The main study group included people residing in homeless hostel accommodation with congregated living spaces, who self-declared they had some level of physical disability, such as difficulty walking, completing daily physical tasks, or problems with stamina or coordination. The stakeholder group consisted of people who worked or provided services in any capacity (volunteering or paid

capacity) with people experiencing homelessness. Exclusion criteria were (i) people experiencing homelessness who did not have a physical disability, (ii) people who did not have any experience working or providing services to people experiencing homelessness.

The interviews were conducted by a research physiotherapist, MM who had experience working with people experiencing homelessness on previous research projects and had training in qualitative methods. Interviews were conducted in day rooms of homeless hostels and shelters, where the participants resided, at a convenient time and location for them. For the stakeholder group, interviews took place in a location convenient to participants or online (via Microsoft Teams). Prior to recording, the interviewer engaged in informal conversation to build trust and ease participants into the interview process. MM used the interview topic guide (Appendix F) and encouraged participants to elaborate on the personal impact of their physical disability and paraphrased verbal responses back to the interviewee or requested further clarification of certain points. A trauma sensitive approach was employed by the interviewer, given the likely history of trauma experienced by participants. This meant the interviewer took extra time to ease participants into the interview, they were gentle in their approach to sensitive topics and were alert to any potential triggering topics.

The semi-structured interview topic guide was based on reviewing the relevant literature and checking with the study team, and questions were based around the impact of living with a physical disability when homeless. Interviews were conducted until data saturation was reached. The interviews were audio recorded using a Phillips digital voice recorder (DVT2050), and were pseudonymised and transcribed verbatim, by the researcher. Field notes were taken during the interview process if there was any relevant detail not captured in the interview process. Participants from the main study group were given a €50 voucher as a token of recognition for their time.

Data Analysis

All interview data were stored on a secure SharePoint system. All interviews were coded and initial themes and subthemes were developed independently by MM and RK, who then met several times to agree themes and subthemes, which were then discussed and defined with JB. Braun and Clarke's 6 step thematic analysis was conducted: (1) data familiarisation; (2) systematic data coding; (3) generating initial themes from coded and collated data; (4) developing and reviewing themes; (5) refining, defining and naming themes; and (6) writing the report. Considerable time was devoted to familiarisation with the data and coding process by the researcher (MM) and an independent validator³⁶ (Step 1-2), and when consensus was reached candidate themes and subthemes were generated, reviewed and defined (Steps 3-5).

Public and Patient Involvement

Public and patient involvement (PPI) was an important element of this study. A PPI group consisting of people working in the homelessness sector and people with lived experience of homelessness and disability were included. This group engaged in a collaborative and advisory capacity. Meetings took place throughout the project to advise on project recruitment and aid interpretation of the data when it became available.³⁷

Phase III Results

A total of 25 participants were interviewed, including 19 people experiencing homelessness and 6 stakeholders. The data for one participant was lost due to an error with the recording device, resulting in interviews generated for 18 people experiencing homelessness and 6 stakeholders. No participants withdrew.

The participants experiencing homelessness were aged between 40 and 72 years with a mean ($\pm$ SD) age of 53 ($\pm$ 5.3) years. In this group, all were Caucasian, one participant was of mainland European origin, while two participants were members of the Irish Traveller community, the remaining participants were white Irish. Most participants were men ($n=19$) with 5 women. Stakeholders included a peer-support worker, a hostel manager, a project worker, an advanced nurse practitioner and two occupational therapists. The age range of the stakeholder group was 27 – 52 years with a mean age of 39.8 ($\pm$ 13.4) years.

Three overarching themes were generated from the interview data; 1-personal impact of being homeless with a physical disability, 2-accommodation considerations and staff constraints, 3-exiting homelessness.

Theme 1: Personal impact of experiencing homelessness with a physical disability

This theme was prominent, as participants experiencing homelessness illuminated many ways in which living with a physical disability in homeless accommodation affected their lives. The impacts included a loss of independence, difficulty in daily functioning, the strain of managing the complexity of their medical needs, and managing mental health challenges as well as addiction, whilst experiencing stigma and shame.

Physical disability limiting function and independence

Most participants felt that their disability significantly restricted their independence. Many struggled with tasks that were once routine. This loss of independence affected not only their physical well-being but also their emotional and psychological health, as they became increasingly reliant on others for support with daily activities.

“Even walking now I'm afraid to walk to the shops on my own, in case I fall. I ask somebody to walk to the shops with me, even though it's only two minutes around the corner... coming back up that hill, then takes a strain on my legs.” P13

For some, it was isolating:

“I was very active... it's restricted me to stay in a lot more, it's hard to go out and walk... I don't really leave the building. I'm kinda confined to the building now, you know what I mean?” P19

A number of participants reported a need for assistance with physical tasks in some areas of their lives, which appeared to be largely unmet.

“If I feel I want to do a bit of shopping in Dunnes stores, I can't do it like.... maybe if I'd some someone along to help me, it would do me.” P15

“At least, I know I'd have that person to reach out to, because when you have a disability.... you have to rely on people, you know?” P20

Several others alluded to the toll of living with a disability.

“It just takes a toll on your body. And when you, like, when you wake up in pain, and you're in pain all day, and you're going to bed in pain, it's just, it does wipes the life outta ya like, you know.” P20

Complexity of medical co-morbidities

The physical difficulties described above were often compounded by co-morbidities, requiring participants to manage co-existing health conditions simultaneously. Notably, a number of participants reported living with epilepsy, adding another layer of complexity to their daily challenges and further impacting their overall well-being.

“I've osteoporosis, I've emphysema, I've high blood pressure, I've serious medical conditions. I've vertigo. I've a broken arm. I broke me hip a couple of years ago. I'll show you me medical condition. The amount of medication I've to take is a joke.” P10

“I feel weak and... because of the false hip and that like I do be afraid... to walk too much you know? And with me epilepsy as well, I never know when a seizure is gonna happen you know?” P06

Compounding effect of mental health and substance difficulties

Almost all participants mentioned the additional burden of a dual diagnosis of mental health and substance use disorder, which significantly impacted their ability to manage their health and daily lives. These issues often exacerbated the challenges of

dealing with physical disabilities, creating a more complex and difficult self-management process.

“When you suffer from a mental health as well. It's, it just takes a toll on you. And your physical, your physical being is, does be non-existent sometimes, cause you just want to lie in the bed...” P20

Stakeholders agreed that the participants usually had complex needs, owing to the prevalence of tri-morbidity (physical and mental ill health, coupled with addiction) and accelerated ageing.

“We're seeing a lot of frailty combined with mental health difficulties... and you got addiction difficulties and they all kind of compound each other really.” P24

Social impact and stigma

This subtheme explored the social impact on the lives of people who were experiencing homelessness and living with a disability and their beliefs about how others perceived them. Several participants found it challenging to navigate their environments, which restricted their ability to engage socially.

“I'd like to be able to get around, go visit my family.... me sister... I just went up to her house a while ago there, and I couldn't get up the steps into the house. I had to be pulled up into the house. I sat down into a chair. I couldn't get out of the chair.” P03

Several others were limited in their social interactions due to feelings of vulnerability or shame.

Well for me, I'm talkative anyway but like you don't want anyone to see you with your stick you know? You feel vulnerable anyway with the stick or if you're talkin to people in a pub or anything. If you've a walker it's impossible to get around when you've a walker” P11

Others felt stigmatized because of their disability.

“People do look at you different... some people make comments, so it's very hard. It's very hard to be seen sometimes. You're afraid to go out sometimes” P03

In contrast, some individuals felt they had strong social lives within the hostels and believed that their social capital and social interactions had improved while living there.

“I haven't found it as hard since I moved since I moved into the accommodation here.” P03

“I'll be honest with you, I made a couple of good friends here.” P05

Theme 2: Accommodation considerations and staff constraints

Many complex structural factors hindered people's ability to overcome the immense challenge of living with a disability in a homeless environment, including the accessibility of accommodation, staffing constraints as well as policy and service constraints.

Accommodation accessibility

Issues around lack of accessibility in accommodation were prominent. The consensus across both groups was that most homeless accommodation was not adequately accessible, hindering residents' ability to live comfortably and creating potential hazards in case of emergencies. People experiencing homelessness described the challenges they faced in navigating their accommodation and how the in-room facilities were insufficient for their needs. This issue was further exacerbated by the accommodation shortage, as hostels had a limited number of accessible rooms which were often already occupied.

“ they said “You're, you're third floor”, I says “I can't do stairs” and I had to go up on me arse basically on some of the steps to get up and eh I fell, I fell.... they had me on a top bunk as well and I fell out of the top bunk ” P11

“I'd vertigo at the time. I said I can't climb up them, on a bunk bed....and I got up the first step and I slipped. Oh man, pain in that was horrendous” P10

“Some services are ok... especially ones with ground floor only, which there's not many... like we've a lift here in this building. But even we've some (with)... no lift and ... no choice” P23

Stakeholders concurred with this sentiment.

“We've got people with crutches like even just one crutch going four flights of stairs, and sometimes there's just no other room for them. it's quite a lot on the person and especially if they're only new to the homeless environment and new to this hostel.” P23

Despite a right to suitable accommodation, several participants expressed gratitude and acknowledged that staff made efforts to accommodate their needs.

“I'm actually on the ground floor. I was upstairs, in a room upstairs, but when I came back from the hospital, they moved me over here, which is very great. A great help.” P15

Staffing constraints

Both people experiencing homelessness and stakeholders recognised that staff in homeless accommodations were overburdened. Despite this, again, participants expressed deep appreciation for the staff and the care they received.

“The staff worry about me a lot. They look after me.” P03

Participants expressed the need for staff to be trained to meet their specific needs—a sentiment also shared by stakeholders.

“The staff aren't trained either like to help people with disabilities... like they have the understandability, like they feel compassion towards you, but they're not trained to help us with disabilities...they're overworked as well, you know?” P11

Again, stakeholders' views aligned with service users'.

“I think there's a lot of demands and expectations placed on staff with very mixed backgrounds in terms of working with people, understanding people with their complex health needs,” P25

“I think there's probably a lot of frustration and burnout and exhaustion by not being able to meet the needs of this population... there's a lot more care.... a lot more being put on the hostel staff.” P22

Policy and service constraints

Most participants felt that the current range of services were poorly designed to meet the needs of service users. On one hand, there are hostels—some of which were originally private and were repurposed as emergency homeless accommodations—where accessibility is a major concern. On the other hand, nursing homes (designed for older adults) are often the only alternative for those whose needs cannot be met in a hostel. This was not viewed as a solution;

“They said they didn't have the staff to be able to look after me when I was falling. So they wanted me to go a nursing home and I said “not happening, I'm going back on the street I'm not going into a nursing home” P01

Again, stakeholders concurred.

“There's a big gap that we could fill with appropriate services, but they're just not there. So people.... they basically age out of homeless services and have to go into a nursing home in their 40s, early 50s.” P22

Mixed views were expressed regarding access to healthcare services. Some hostels had visiting doctors and nurses and were located near hospitals, leading to an appreciation of accessible healthcare. However, others found access to healthcare

extremely challenging, citing waiting lists and transportation as significant barriers. Both groups also highlighted an absence of primary or community care within the hostels and difficulty in accessing equipment and supports when required.

“They've handrails in there, but they're not really positioned. They're not in the shower either. So going into the shower, I have nothing to hang into. I'm pressed up against the wall. That's not down to staff. They have to...they can't put this stuff in unless the OT (occupational therapist), you know what I mean, clears it. We tried several things to get the OT down here. I went to me local TD (Teachta Dala, member of the Irish parliament).” P03

“The difference, I suppose, is, is that primary care physio might not see someone who's in active alcohol use, so I'll advocate for that person to be seen and I have really successfully got physios out to review people.” P24

Some of the people experiencing homelessness perceived themselves as disadvantaged due to unfair systems of accommodation placement.

“The government has a bad way of dealing with (it) I think.” P01

“I haven't really seen any social housing being built in a long time. The only things that I see being built are student accommodation and hotels. Like that's all I've seen.” P22

Theme 3: Exiting Homelessness

The challenges of exiting homelessness were highlighted, as finding accessible permanent accommodation was especially challenging. Despite the challenges, resilience and hope featured, as well as an acceptance of their current situation and the need for ongoing support.

Resilience

Despite the challenges to self-determination and independence faced by people experiencing homelessness with disabilities, many showed remarkable resilience and desire for independence. People persevered despite their struggle and indicated a longing for the privacy and self-determination associated with independence. Moreover, despite their current circumstances, they were actively striving to achieve independence where possible.

“I like my own place, my own privacy, my own key of me own front door. I, I'm waiting for that last... I don't know how long I'm waiting for that.” P18

“I do everything myself. I like to be independent as much as I can. So even though it mightn't go the way want it to go, still I did it myself.” P01

Acceptance of the status quo

In contrast to those who expressed a strong desire for independence, a minority lacked confidence and appeared to doubt their ability to live on their own. Some were content with their current housing situation, while others expressed fear at the prospect of living independently due to chronic illnesses and disabilities which require support.

“As I said before, I’m quite happy where I am. The staff understand me.” P05

“I do be fearful of actually walking on my own.” P06

“I’d be fearful of ..moving into a place on my own... not the false hip or anything but mainly because of the epilepsy.” P06

Stakeholders observed that prolonged reliance on services could lead to a loss of independence, as service users might gradually lose the skills needed to live autonomously.

“They don't know how to cook for themselves anymore because they haven't had to....they can definitely manage the shopping and the cleaning and all that stuff. But maybe just not all at the same time, so that like phased support.” P22

Hope

Notwithstanding the immense challenges, tones of hope resonated through many interviews. People experiencing homelessness expressed optimism about recovery, gaining employment, and improving their overall quality of life. Perspectives on the path to improvement varied among participants—some acknowledged that progress would be slow and challenging, while others believed that their problems could be relieved through medical treatment.

“I’m hoping that if I get the operation then I won't need my scooter, I won't need my walker, I'll be able to....just walk, like normal.” P01

“Well, I always say, like, things might get better ... never give up.” P15

“I'm not easily employed.... so I really hope I'm going to get better in time to do some improvement in my life... I could go out more, go volunteer somewhere, you know, get some interaction with people. That's how you get a job. ” P21

Ongoing support

To enable people to transition out of homelessness, remain housed, and achieve a meaningful quality of life, both groups emphasised the need for ongoing community

support. People experiencing homelessness felt they may be vulnerable and struggle to manage physically.

"Me memory isn't good, if I was to live say in a ...council house or something like that. I'm good at keeping the place up, keeping it clean and stuff like that... but I'm not good at remembering appointments and things like that." P01

"You need the likes of a keyworker or a housing representative from the council or whatever. Someone who's going to come in and watch you and make sure you're okay someone to come into your block or your apartment or whatever and check up on you." P14

"If you actually get a place, if you get your own home, how are you gonna manage? Like with your physical disabilities. Like, you're going to need to have a carer coming in or... Do you get me?" P20

Stakeholders identified supported living or phased support including financial guidance as important considerations.

"To facilitate them to let's make your lunch today... let's do your shopping together because those are the things that people find hard to do when they move out of homelessness. They find it hard to budget their accommodation because now they have to buy food where they didn't have to before. Now they have to pay rent and then maybe didn't have to before. So there's a transition um where people are trying to learn again how to live independently on very little. And it could be really challenging for people. So, so much that they're like "Ah feck it, I'll just go back to the hostels." P22

"They normally will have a number of medical appointments, but with that, you're bringing in addiction and mental health with it. So it's not just one solution. It'll never be one size fits all. ' P09

Summary of Findings

This study which consisted of interviews with 24 participants (18 people who were homeless and 6 stakeholders.) The following main themes were developed from the data: (1) the personal impact of experiencing homelessness with a physical disability, (2) accommodation considerations and staff- specific constraints (3) exiting homelessness. Our research showed that physical disability magnified the vulnerability, stigma and shame associated with the homeless state and can lead to helplessness, hopelessness and isolation, compounding the challenges of lacking a stable home. Some participants with a physical disability were afraid or unable to go out, magnifying their experience of exclusion. Physical disability may have contributed to entrenched homelessness and dependence on hostel accommodation. Some participants also expressed a desire for more independence and autonomy, but support would be required to enable transitioning to more independent forms of housing. The built environment within hostel accommodation was generally not

sufficient to meet the complex needs of this group, but satisfaction with staff was high, and despite the pressures of the system a tone of hope was evident. More research should focus on how best to meet the current and future needs of this doubly burdened group.

Discussion

Research Challenges and Limitations

A limitation of Phase I was that we conducted a scoping review, rather than a full systematic review. While this review type was suitable to capture the breadth of this field, as is the convention in scoping reviews, quality assessment did not take place, so we could not comment on the quality of included studies.

A limitation of Phase II was the availability of homeless hostels who were able to participate in the study. While we had consistent and dedicated engagement from many homeless accommodation organisations, others were not able to participate, so the generalisability of results is not known, although we feel the sample of 547 people who use homeless accommodation in Dublin and Cork is robust and compares favourably with research in the area.

In addition, in Phase II, the presence of and degree of physical disability was categorised by hostel employees who completed the surveys. This methodology was chosen due to pragmatic reasons, mainly to reduce the burden on hostel residents. 'Hidden disability' refers to a disability that interferes with an individual's daily functioning yet is not noticeable to others.³⁸ As disability is socially constructed some may not declare or self-identify it, perceive it or wish to be associated with disability,³⁹ especially as we have shown it can be linked to vulnerability in people who are homeless. In Phase II, as staff of homeless hostels completed the survey, hidden disability could not be captured. In addition, hostel staff were subjectively assessing disability, without objective measures, which could lead to inaccuracies in reporting. In Phase III, our participants were presumably comfortable to self-declare they had a physical disability in order to participate in this study, but it is likely that others were not willing to disclose their disability status and chose not to participate.

In Phases II and III, we did not explore the complexity of disability, as participants were not questioned about the nature or cause or extent of their physical disability.

It is possible that people with more severe impairments who needed nursing care for instance, may have already accessed more suitable forms of accommodation, and were therefore not captured in Phase II or III of this study.

The focus of this study was specifically physical disability. Other disabilities such as visual, hearing, intellectual and autism are pertinent to consider but were beyond the scope of the present study.

In Phases II and III, as the research was situated in homeless hostels, rough sleepers were not included, the scale and impact of physical disability in this cohort should be investigated in future studies. In addition, no private homeless hostels were included, therefore the applicability of findings to this setting is not fully known.

Overall Key Findings and Implications

A major strength of this study is that it is the first of its kind to attempt to examine the access needs of people who are homeless in conjunction with the accessibility of the homeless hostels where they were currently residing. In doing so, we have shown that just under half of the people with impacted or restricted mobility were sleeping in rooms up at least one set of stairs and just under half of these were staying in a hostel without a lift. As well as the physical impact on residents, there are serious fire safety implications of these arrangements. One third of those with impacted or restricted mobility did not have access to an accessible bathroom. Another strength is the size of the sample. Thanks to the persistent efforts among our study partners, we were able to collect data on 547 individuals. By collecting information on this sizable cohort, this study contributes to the literature about what is already known about the scale of physical disability in people experiencing homelessness.

Our interview-based study is one of the first to explore the qualitative experience of homelessness while managing a physical disability. It has demonstrated the high toll and personal impact of experiencing homelessness whilst living with a physical disability, with potentially co-existing mental health and addiction challenges. A high physical burden was reported in this study, which mirrors findings in a Spanish study of people experiencing homelessness who also had a disability.¹⁷ The impact on mental health reported in this study, is unsurprising as people with physical disabilities are at an elevated risk for depressive symptoms and major depressive disorder.⁴⁰

A further strength of the study was that the research was conducted by an entirely independent research team, from Trinity College Dublin, rather than directly from the homelessness setting, which should add a degree of impartiality to findings. A further strength was the inter-personal skills of the study researcher (MM) who, employing a trauma-informed approach and, was skilled in establishing a rapport and trust early in the interview process, and actively listened throughout.⁴¹ Disability as a contributing identity to intersectionality is becoming more recognised.⁴² This study uniquely captured the intersectionality⁴³ of homelessness and physical disability.

It is possible that due to the pressurised, under-resourced system, some people remained in unsuitable and inaccessible accommodation, with serious consequences such as reported falling (from bunk bed and down stairs) and injuries. This inaccessible environment was potentially further disabling. For some, it limited daily life activities such as going to the shops, and restricted one participant from leaving their accommodation, compounding their exclusion and isolation and creating additional barriers to accessing services and achieving life goals, such as independence and autonomy. For some participants, the physical environment failed to meet their needs, lacking reasonable adjustments and accommodations to participate on par with others. This is unsurprising as much of homeless accommodation in Dublin and Cork is based in older housing stock which lack accessibility, although it is

acknowledged that the reasons for not leaving accommodation are likely to be complex and not just related to an inaccessible environment. This could also be related to other reasons such as the lack of assistive technology or other supports, which should be explored in future studies.

Despite the challenges identified within the built environment, an overarching theme of satisfaction and positive relations with staff was observed. This demonstrates meaningful relationships and is testament to the care and compassion of staff, despite the pressures of the system. The need for targeted training for staff to understand and manage disabilities was evident, as many staff may not have had preparatory training to deal with physical health care needs and disability. Some good practices were reported such as joined up thinking and integration between the local hospital and hostel.

The need for more independent housing was highlighted but this was nuanced. On the one hand, contentment and acceptance of the status quo was expressed by some and a need for continued support, limiting their ability to move to more independent forms of housing. This is likely due to the social support and care from staff, and potentially an element of institutionalisation may have been present. Social networks and connectedness in hostels were important – likely valued due to the often fragmented social capital of people experiencing homelessness.⁴⁴ It has been shown previously that people experiencing homelessness with a disability are likely to have been homeless for longer compared to those without a disability.⁴⁵ On the other hand, some expressed a desire to move to more independent, accessible forms of housing, which if suitable, may reduce the impact of disability, because health and homelessness has been shown to improve among residents of housing first projects.⁴⁶ Accessing suitable accommodation with a disability is more challenging, however. This aligns with a Spanish study which showed that not having a disability was one of the factors that closely correlated with gaining access to improved accommodation.⁴⁵

This study demonstrated that the dual burden of homelessness and physical disability intensified stigma, shame and unwanted attention, which exacerbated the experience of exclusion, labelling and othering, which mirrors other work.¹⁷ When services were sufficient and needs were met, a sense of gratitude was expressed, even though a health equity perspective would attest to the right to a fair and just opportunity for everyone to attain their full potential.⁴⁷

Recommendations

- For Homeless Hostel Services
 - Integrate basic screening of mobility into the bed allocation process.
 - Prioritise accessible rooms and bathrooms, lower bunks and shorter corridors to reach services for people with mobility challenges.
 - Train staff to understand and assist with disability needs, including collaboration with health care and other services where applicable.

- For Government:
 - Ensure at least 25% of accommodation, including hostel and ‘own door’ accommodation is accessible and ground-level.
 - Retrofit existing hostels to improve bedroom and bathroom accessibility.
 - For new accommodation, employ the principles of universal design, so accessibility requirements apply to all accommodation.
 - Plan for long-term care needs for people who are homeless with complex needs which are outside the nursing home model due to pre-geriatric disability.
 - Include and prioritise accessibility as part of inspections (such as the Homeless Accommodation Inspection Service) and quality standards (such as the National Quality Standards Framework for Homeless Services in Ireland).
 - Employ a solutions-based approach to act on inadequate accessibility provision.
 - Ensure the needs of people who are homeless with a disability are considered in national homeless strategies.
- For Disabled Persons’ Organisations and other representative and advocacy groups:
 - Amplify voices of people who are homeless with disabilities.
 - Promote inclusion of people who are homeless with disabilities in policy-making, public forums, and media.
- For Health Care Systems:
 - Offer early rehabilitation and multi-disciplinary input including physiotherapists and occupational therapists.
 - Ensure access to a General Practitioner, for long term support and referrals to appropriate services.
 - When discharging from acute services to hostel accommodation, communicate mobility needs in advance where applicable to ensure suitable bed allocation.
- For Funders – prioritise research in the following areas;
 - Optimum mobility screening methods within hostel services.
 - Staff training needs with regards to managing physical disability in residents.
 - Observational research to profile physical disability and appropriateness of mobility aid provision.
 - Longitudinal research to track disability over time.
 - Intervention studies on effective physical rehabilitation strategies.
 - Accessibility audits of homeless hostel accommodation.

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Appendices

Appendix A Search strategy scoping review EMBASE

'homelessness'/exp OR 'homeless person'/exp

homeless*:ti,ab,kw

(Rough NEAR/3 sleep*):ti,ab,kw

((Insecur* OR inadequate OR precarious OR instability) NEAR/3 (housing OR accommodation)):ti,ab,kw

#1 OR #2 OR #3 OR #4

'physical disability'/exp

(Physical* NEAR/3 (disabled OR disabilit* OR disabled OR incapacit* OR deficienc* OR handicap*)):ti,ab,kw

'wheelchair'/exp

(Wheelchair* OR crutch* OR prostheses OR Amputee* OR 'disabled person' OR 'disabled people'):ti,ab,kw

'motor dysfunction'/exp

((Motor OR movement) NEAR/3 (disabilit* OR disfunction OR disorder* OR impair* OR dysfunction OR limitation*)):ti,ab,kw

((Ambulation OR walking OR mobility) NEAR/3 (difficult* OR dependent OR disabilit* OR limitation* OR issues)):ti,ab,kw

#6 OR #7 OR #8 OR #9 OR #10 OR #11 OR #12

#5 AND #13

Medline

exp Homeless Persons/

homeless*.tw.

(Rough adj3 sleep*).tw.

((Insecur* OR inadequate OR precarious OR instability) adj3 (housing OR accommodation)).tw.

1 OR 2 OR 3 OR 4

Disabled Persons/ OR Amputees/

(Physical* adj3 (disabled OR disabilit* OR disabled OR incapacit* OR deficienc* OR handicap*)).tw.

Wheelchairs/

(Wheelchair* OR crutch* OR prostheses OR Amputee* OR disabled person OR disabled people).tw.

((Motor OR movement) adj3 (disabilit* OR disfunction OR disorder* OR impair* OR dysfunction OR limitation*)).tw.

((Ambulation OR walking OR mobility) adj3 (difficult* OR dependent OR disabilit* OR limitation* OR issues)).tw.

6 OR 7 OR 8 OR 9 OR 10 OR 11

5 AND 12

CINAHL

(MH "Homeless Persons") OR (MH "Homelessness")

TI (homeless*) OR AB (homeless*)

TI (Rough N3 sleep*) OR AB (Rough adj3 sleep*)

TI ((Insecur* OR inadequate OR precarious OR instability) N3 (housing OR accommodation)) OR AB ((Insecur* OR inadequate OR precarious OR instability) N3 (housing OR accommodation))

S1 OR S2 OR S3 OR S4

(MH "Persons with Disabilities") OR (MH "Amputees")

TI (Physical* N3 (disabled OR disabilit* OR disabled OR incapacit* OR deficienc* OR handicap*)) OR AB (Physical* N3 (disabled OR disabilit* OR disabled OR incapacit* OR deficienc* OR handicap*))

MH "Wheelchairs"

TI (Wheelchair* OR crutch* OR prostheses OR Amputee* OR "disabled people" OR "disabled person") OR AB (Wheelchair* OR crutch* OR prostheses OR Amputee* OR "disabled people" OR "disabled person")

TI ((Motor OR movement) N3 (disabilit* OR disfunction OR disorder* OR impair* OR dysfunction OR limitation*)) OR AB ((Motor OR movement) N3 (disabilit* OR disfunction OR disorder* OR impair* OR dysfunction OR limitation*))

TI ((Ambulation OR walking OR mobility) N3 (difficult* OR dependent OR disabilit* OR limitation* OR issues)) OR AB ((Ambulation OR walking OR mobility) N3 (difficult* OR dependent OR disabilit* OR limitation* OR issues))

S6 OR S7 OR S8 OR S9 OR S10 OR S11

S5 AND S12

Google Scholar

Homeless|homelessness|"rough sleeper|sleepers" "Physical|physically AROUND(3) disability|disabled|incapacitated|deficiencies|handicap|impediment"

"Insecure|insecurity|insecurities|inadequate|precarious|instability AROUND(3) housing|accommodation" "Physical|physically AROUND(3) disability|disabled|incapacitated|deficiencies|handicap|impediment"

Web of Science

homeless* OR (Rough NEAR/3 sleep*) OR ((Insecur* OR inadequate OR precarious OR instability) NEAR/3 (housing OR accommodation))

(Physical* NEAR/3 (disabled OR disabilit* OR disabled OR incapacit* OR deficienc* OR handicap*)) OR Wheelchair* OR crutch* OR prostheses OR Amputee* OR ((Motor OR movement) NEAR/3 (disabilit* OR disfunction OR disorder* OR impair* OR dysfunction OR limitation*)) OR ((Ambulation OR walking OR mobility OR "disabled people" OR "disabled person") NEAR/3 (difficult* OR dependent OR disabilit* OR limitation* OR issues))

#1 AND #2

SCOPUS

TITLE-ABS-KEY(homeless* OR (Rough W/3 sleep*) OR ((Insecur* OR inadequate OR precarious OR instability) W/3 (housing OR accommodation))) AND TITLE-ABS-KEY((Physical* W/3 (disabilit* OR disabled OR incapacit* OR deficienc* OR handicap*)) OR Wheelchair* OR crutch* OR prostheses OR Amputee* OR ((Motor OR movement) W/3 (disabilit* OR disfunction OR disorder* OR impair* OR dysfunction OR limitation*)) OR ((Ambulation OR walking OR mobility) W/3 (difficult* OR dependent OR disabilit* OR limitation* OR issues)))

Appendix B Table I. Characteristics of Included Studies

Authors (year)	Study Title	Study Design	Methods	Location of Study
Cimino et al. (2015)	"The Course of Functional Impairment in Older Homeless Adults: Disabled on the Street"	Prospective, cross-sectional	Baseline interviews conducted with 250 homeless adults (>50 years) recruited from 8 homeless shelters, follow-up interview conducted after 12 months. Information obtained included socio-demographic characteristics and health status.	United States
Cohen et al. (1988)	"The physical well-being of old homeless men"	Cross-sectional	Interviews conducted on 281 older men, 86 of whom were homeless using the Comprehensive Assessment and Referral Evaluation (CARE) and the Network Analysis Profile (NAP) instrument.	United States
Gibson et al. (2023)	"Health care in supportive housing facilities"	Mixed-methods case study	Interviews conducted with tenants (n=42) and staff (n=23) at supportive housing sites regarding health needs and related support.	Canada
Guillén et al. (2021)	"Disability, Health, and Quality of Life Among Homeless Women: A Follow-up Study"	Prospective, cross-sectional	Interviews conducted with women who lived on the street and in homeless shelters, follow-up interview conducted after 12 months. Information obtained included socio-demographic characteristics, homelessness characteristics and prevalence of disability.	Spain

Gutman et al. (2018)	"Assessing Environmental Safety Modifications in the Chronically Ill Sheltered Homeless Population: A Pilot Study"	Pretest-posttest	Data collected one year before and after a falls-prevention intervention, which included safety modification such as grab rails and safety training to 10 participants living in homeless hostel accommodation.	United States
Harris et al (2006)	"Disability and homelessness in Central and Northern Scotland"	Qualitative, interview-based study	Interviews conducted with people experiencing homelessness and disability.	Scotland
Ho et al. (2007)	"Health and housing among low-income adults with physical disabilities"	Qualitative	Conducted focus groups of participants with physical disabilities living in one of the three housing types: nursing home, homeless shelter and inaccessible home	United States
Kehn et al. (2013)	"Identifying the health service needs of homeless adults with physical disabilities"	Cross-sectional	Semi-structured interviews with 83 homeless individuals from 13 adult homeless shelters conducted to gather data related to the health and function of adults with mobility impairments who are living in homeless shelters.	United States

Kiernan et al. (2021)	“Markedly poor physical functioning status of people experiencing homelessness admitted to an acute hospital setting”	Cross-sectional	A comprehensive ward-based test battery evaluated physical functioning in 65 in-patients registered as homeless with an age range of 23–80 years.	Ireland
Nikoo et al. (2015)	“Chronic Physical Health Conditions among Homeless”	Cross-sectional	Modified version of the ‘National Survey of Homeless Assistance Providers and Clients (NSHAPC)’ used to investigate the prevalence rates of self-reported chronic physical health conditions among 500 people experiencing homelessness.	Canada
Shinn et al. (2007)	“Predictors of homelessness among older adults in New York City: Disability, economic, human, and social capital and stressful events”	Comparative cross-sectional	Interviews conducted with 61 housed and 79 homeless adults aged 55 and older. Homeless participants were recruited from a drop-in centre for older people who are homeless in New York.	United States
Sivabalan (2016)	“Health Status and Perceived Needs of Homeless People – A Mixed Method Research”	Mixed method, sequential research design	Semi-structured interviews with 30 people who were homeless, focussing on health and life satisfaction.	India

Appendix C Table 2. Details of physical disability in included studies

Author s	Participan t count	Physical Disability Definition	Homelessness Definition	Biologica l Sex	Mean Age $\pm$ SD	% People with Physical Disability and Nature/Impact of Disability	Other Reported Disabilities/Relate d Conditions
Cimino et al. 2015	N=204	Difficulty performing basic self-care activities that are considered essential for independence such as bathing and dressing.	Not specified	Female = 18.1% F: 37	56.0 $\pm$ 5.5 years	Mobility impairment n=87 (42.6%)	Visual impairment (n = 61, 29.9%), hearing impairment (n = 65, 31.9%), alcohol use problem (n = 36, 17.6%), drug use problem (n = 35, 17.2%), cognitive impairment (n = 52, 25.5%), depression (n = 79, 38.7%), urinary incontinence (n = 99, 48.5%)
Cohen et al. 1988	N=281	Persons with congenital and acquired (through accidents, illness,	Currently living in a homeless hostel or	Male: 100% M: 251, F:0	61.51 $\pm$ 6.24	Trembling in past month: 37%	Chest pain in past month: 20%, Swollen ankles: 27%, Palpitations in past month 34%,

		substance use, and age) disabilities.	sleeping on the street			Dizziness/ weakness in past month: 45 % Arthritis or rheumatism 39% Difficulty ambulating 35% Fracture aftereffects 14%	Trembling in past month 37%, Fainting or weakness in past month 11%, Breathlessness in past month 50%, Persistent cough 31%, Fever or persistent chills 21%, Nausea/ vomiting 5%, Persistent pain in abdomen 7%, Seizures in past 2 years 12%
Gibson et al. 2023	N=42	Problems with mobility. Physical needs such as falls or incontinence.	Tenants at three supportive housing sites	Not specified Total sample n=42	Not specified	Musculoskeletal disease: 38% (n=16) Mobility issues: 31% (n=13)	Chronic disease: 93% Psychiatric and mental health: 71% Substance use disorder: 50%

							Dental conditions: 43% Nutritional deficiency and obesity: 26% Neurological conditions: 21% Alcohol use disorder: 19% Communicable disease: 16% Developmental disability: 7% Neoplastic disease: 5% Conditions caused by poor hygiene: 5%
Guillén et al. 2021	N=136	Self-report and using a functional disability scale assessing difficulty in: - feeding oneself, - getting in and out of bed	European Typology on Homelessness and Housing Exclusion (ETHOS) criteria	Female only = 100% M: 0 F: 136	45.5 $\pm$ 11.37 years	31 women (22.8%) reported having a physical disability at baseline. Functional disability resulted	Mental health disability: 14% (n=19)

		- dressing and undressing - using the toilet - bathing/showering				in issues with basic activities of daily living (ADL) such as - getting in and out of a bed or chair (17.8% at baseline and 20% at follow-up), - dressing and undressing (14.1% at baseline and 22.4% at follow-up), - bathing or showering (14.1% at baseline	
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						and 20% at follow-up).	
Gutman et al. 2018	N=10	Focus on safety risk resulting in falls, near falls (loss of balance without falling), and emergency department visits	Chronic homelessness	Male = 60% Female = 40% M: 6 F:4	60.7 $\pm$ 6.97 years	8 (80%) of 10 participants used mobility devices, including a: - straight cane (n = 5, 50%), - rollator (n = 2, 20%), and - wheeled walker (n = 1, 10%)	Cardiopulmonary Disease (n = 4, 40%), diabetes (n= 4, 40%), hypertension (n = 4, 40%), schizophrenia spectrum disorder (n = 5, 50%) and anxiety disorder (n = 5, 50%).
Harris et al 2006	N=14,880	Self-reported long-standing disability in Scottish Household Survey	Self-reported experience of homelessness in Scottish Household Survey	Sex not specified	Not specified	Within the group of people reporting “disability”, 7.6% (n=274) said they had experienced homelessness	

						compared with 4.5% (n=434) in the non-disabled group. .	
Ho et al. 2007	N=28	People who require the use of assistive equipment such as a cane, walker, wheelchair, or scooter	People living in a homeless hostel	Male = 85% M: 11	43.2 ± 8.9 years	Spinal cord injury (n=6, 46%), amputation (n = 1, 8%), fractured leg or hip (n = 1, 8%), arthritis in hip or ankle (n=2, 15%), in need of assistance with self-care, shopping, daily activities (n=2, 15%),	Stroke (n=1, 8%), unspecified (n=2, 15%)
Kehn et al. 2013	N=83	A mobility impairment requiring the use a mobility device eg wheelchair or cane	Lacking a fixed, regular and adequate nighttime residence	Male: 76% M: 63	18 – 64 years	N=53, 65% used a cane for ambulation. N=39, 47% reported limitations in	On average respondents reported five chronic conditions in addition to mobility impairments. Five

						seven of 10 daily living activities, such as travelling outside the hostel (n=76, 92%), getting around inside the hostel (n=71, 86%), bathing (n=56, 68%), and toileting (n=54, 65%)	most commonly reported conditions were: high blood pressure (n = 58, 70%), arthritis (n = 55, 66%), depression (n = 41, 50%), high cholesterol (n = 30, 36%), and diabetes (n = 23, 28%)
Kienan et al (2021)	N=65	Having functional limitation eg poor strength and mobility, and high risk of falls	Lacking stable housing eg rough sleeping, sofa-surfing, living in long-term or short-term homeless accommodation .	Male: 67.7% (n=44) Female: 33.3 % (n=21)	Median age: 45	32% (n = 21) used a mobility aid (a stick (n = 6), crutches (n = 12) and a frame (n= 3)). Eight participants used a wheelchair on a long-term basis. 83% (n = 58) had one or more mobility limitations. 56.0% (n = 20) were at	Chronic medical conditions most commonly reported were: hepatitis C (n = 27), liver disease (alcohol related) (n= 13), epilepsy/seizure disorders (n= 11) and mental health conditions (n = 17)

						risk of falling. 30.0% (n=20) of participants could attempt climbing one flight of stairs. 70.0% were either pre-frail (vulnerable) or frail.	
Nikoo et al. 2015	N=500	Musculoskeletal conditions	A living situation without physical accommodation where often sleep outdoors, in emergency shelters or at other places not meant for human habitation	Male: 59.8% Female: 40% Missing: 0.2% M:299 F: 200	37.9 ± 11.0 years	Musculoskeletal conditions (n=261, 52.2%), including: - Arthritis (n=142, 28.4%) - Back problems (n=194, 38.8%) - Problems in walking, lost limb, physical	Neurologic disease (n = 363, 72.6%), infectious disease (n = 205, 41%), respiratory disease (n = 159, 31.8%), gastrointestinal disease (n = 109, 21.8%), cardiovascular disease (n = 97, 19.4%), sensory problems (n = 92, 18.4%), long-term conditions (n = 114, 22.8%)

						handicap(s) (n=119, 23.8%) - Other (n=35, 7%)	
Shinn et al. 2007	N=79	Health problems which affected the ability to carry out any of five tasks (e.g. engage in moderate physical activity such as carrying groceries or climbing stairs), or hospitalisation for a medical problem	Currently living on the street and visiting a drop-in centre for various needs	Male= 81% Female: 19% M: 64 F: 15	63.6 $\pm$ 7.6 years	42% are reported to have an unspecified physical disability	24% had mental disability
Sivabalan 2016	N=30	Not specified	People who lack housing because they cannot afford, or otherwise unable to maintain a regular, safe,	Male: 77% Female: 23% M: 23 F: 7	Median age 51.25 years	40% had a physical disability, 26% experienced physical injuries	20% had diabetes and visual impairments (20%), 10% had respiratory issues and epilepsy, 33% had severe illnesses, and 50% had additional health issues

			and adequate shelter.				
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Appendix D Table 3. Relevant data from qualitative studies

Authors:	Identified Themes	Qualitative Results & Comments from Participants
Ho et al. 2007	Barriers to health care	- Lack of needed and accessible transportation to doctor's office - Extended waiting time for essential mobility equipment - "I had to stay in bed for like three months because I was waiting for my wheelchair to come to my place...I just stayed in my apartment until the rent got too high and I couldn't afford it and I got put out." - Poor quality of care - "... have to sign these papers before you go in and you wait and you wait and you wait." - Inadequate care or service coordination from shelter staff members - "I didn't know any places to go for health-wise...and I got more information out of the women who live here than I did from the staff." - Lack of access to dental care
	Impact of living environment on health	- Poor accessibility, particularly for wheelchair users - "I haven't taken a shower in three months. I'm bathing in a little tub..."

		- Safety concerns - “...people [have] robbed me. They looked at me in my chair... like real easy prey to them” - Lack of privacy - Poor sanitation - “This whole shelter is crammed. Every so often, a viral infection will start running through the whole establishment.”
Gibson et al. 2023	Lack of awareness about services	- “I don’t know what the resources are, I don’t know what my options are or accessibility or anything like that. I feel like I’ve been housed and that was it.”
	Barriers to maintaining health care appointments	- “The one thing I have been asking for years now is help, to get me from home to the doctor’s when my back is hurting, and I can’t walk to the bus stop.”
Harris et al 2026	Service providers having a lack of expertise and resources	People with complex chronic conditions and disabilities being placed inappropriately in short-term homeless accommodation: - ‘People with chronic conditions should not be here but they are dumped on us’.

		- 'All the people here are mainly chronic alcoholics which leads to chronic physical and mental health problems... [we also have] people with physical disabilities due to amputations from addiction'.
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Appendix E Survey Phase II

Scale of physical disability in people experiencing homelessness in Dublin and Cork:

A mapping study

Appendix 1

Full survey

Please fill out part one regarding the hostel

Part 1

Type of hostel accommodation (eg long term/emergency etc) provide by the hostel

--

where you work

What clientele does the hostel accommodate (eg males/wet hostel etc)

--

Please fill out Part 2 and Part 3 for each individual.

Part 2 *This relates to the current physical status of the individual.*

Age of individual	
<40 years	☐
40-60 years	☐
>60 years	☐
Gender	
Male	☐
Female	☐
Non-binary	

What is the mobility status of this individual	
Full mobility (this means they can walk and move with no restriction or difficulty)	☐
Impacted mobility – Whilst fully mobile, does this individual have symptoms (eg pain, shortness of breath) that limit their activities	☐
Restricted mobility (this means there is some restriction or difficulty with their walking or movement)	☐
Unsure	☐
If mobility is restricted does the individual	
Walk with a significant limp but does not use a mobility aid	☐
Use 1 crutch on a temporary basis (less than 3 months)	☐
Use 1 crutch/walking stick on a long-term basis (more than 3 months)	☐
Use 2 crutches on a temporary basis (less than 3 months)	☐
Use 2 crutches on a long-term basis (more than 3 months)	☐
Use a walking frame on a temporary basis (less than 3 months)	☐

Use a walking frame on a long term basis (more than 3 months)	☐
Are they wheelchair Dependent (outdoors only) on a temporary basis (less than 3 months)	☐
Are they Wheelchair Dependent (outdoors only) on a long term basis (more than 3 months)	☐
Are they Wheelchair dependent (indoors and outdoors) on a temporary basis (less than 3 months)	☐
Are they Wheelchair dependent (indoors and outdoors) on a long term basis (more than 3 months)	☐
If mobility is impacted – Whilst fully independent, does this individual have symptoms (eg pain, shortness of breath) that limit their activities	
Are symptoms temporary (<3 months)	☐
Are symptoms long-term (>3 months)	☐
What level of assistance do they need with their daily self-care activities (washing, dressing, toileting)	
Independent	☐
Needs assistance on a long term basis (more than 3 months)	☐
Needs assistance on a temporary basis (less than 3 months)	☐

Part 3 This relates to the accommodation details of the individual on the night of the census

What was the location of this individual's	On the ground floor Up or down	☐
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accommodation in the hostel	1 flight 2 flights 3 or more flights If yes to up or down at least 1 flight of stairs; Is there a lift Is this functioning at the moment Have there been times when this lift is non- functioning in the past 12 months	☐ ☐ ☐ ☐ ☐ ☐
Bed details	Is this a Single bed Bunk bed If bunk bed Top bunk Bottom bunk Other _____	☐ ☐ ☐ ☐ ☐
Room occupancy	Is this a Single room Shared room If shared how many people is it shared with	☐ ☐ Fill in

Location of room in hostel	Distance from main entrance to bedroom <20m 20-50m >50m	☐ ☐ ☐
Toilet	Is this room en suite If no Approximate distance from toilet to bedroom Is the bathroom up/down another level	☐ Fill in
Toilet details	At the toilet are there? Grab rails (yes/no) Is there a raised toilet seat (yes/no) Is there an emergency button or chord in the toilet (yes/no) Is it wheelchair accessible (yes/no)	☐ ☐ ☐ ☐ ☐
Shower	Is there a shower en suite If no Approximate distance from shower to bedroom Grab rails (yes/no)	☐ Fill in ☐ ☐

	Is there an emergency button or chord in the toilet (yes/no) Is it wheelchair accessible (yes/no)	☐
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Appendix F Interview Guide Phase III

Part A Interview Guide for People Experiencing Homelessness Group

Initially -participant is welcomed and ice – breaker question to start with (eg how are you getting on today)

Main questions

‘Tell us about your physical disability’ (prompts - do you have diagnosis, how long have you had this disability, were you born with it or did it develop over time, if so how did you develop it, was it one event or a combination of different reasons,

‘Does it impact your daily activities and your ability to do what you want to do (eg leisure, work, do you need help with some of your daily activities’ eg assistance with washing/dressing).

‘How does it affect your ability to access facilities in the hostel (eg getting to meals) and accessing services outside the hostel (eg medical appointments).

‘How does your physical disability affect your ability to connect or mix with others’

‘What does it stop you doing or do you have to do things a different way’ (does it stop you doing anything that you liked to do before, have you had offers of accommodation that weren’t suitable)

‘How do you feel about your physical status at the moment (how has your physical disability affected your life, and at what point in your life did it become a big issue for you, how has your disability changed, Is there anything about your life that you miss before your physical disability developed’)

‘Do you feel you are treated differently due to your physical disability’ (in a positive or negative way)

‘How do you see your disability progressing and affecting your life in the future, (eg do you see it continuing to impact what you do, what would to be able to do, what support would you need to be able to do what you would like to do, what do think could help you manage your disability better)

‘Has your disability affected your ability to move out of homelessness’

‘What matters to you most at the moment’

Any other comments you would like to make or do you feel we missed out on

Part B Interview Guide Stakeholders

Initially -participant is welcomed and ice – breaker question to start with (eg how are you getting on today)

Main questions

‘In what capacity have you worked or volunteered with people experiencing homelessness’

‘Have you noticed many people who are homeless with a physical disability’

(can you tell us about what you have observed, what kind of issues have you seen)

‘Do you feel hostel accommodation services for people who are homeless who have a disability are adequate’

(If yes or no, can you tell us more about this)

‘Do you think people experiencing homelessness are treated differently’

(in a positive or negative way)

‘Do you think physical disability prevents people from moving out of homelessness’

(how so, can you expand on this)

‘What possible solutions do you think would work to improve hostel accommodation for people who are homeless with a physical disability’

‘Any other comments you would like to make or do you feel we missed out on’



Appendix G Participant Information Leaflet and Consent Phase III

People Experiencing Homeless Group

Participant Information Leaflet

Study Title	'The impact of physical disability in people experiencing long term homelessness – an Interview based study with people experiencing homelessness and stakeholders'
Research Site	Hostels which accommodate people experiencing homelessness
Principal Investigator(s) and Co-Investigator(s) (Study Team)	Principal Investigator: Dr. Julie Broderick Co-investigators: - Prof. Cliona Ní Cheallaigh, Associate Professor and Consultant in Infectious Diseases, School of Medicine Trinity College - Ms Jess Sears, Inclusion Health Clinical Nurse Specialist, St James's Hospital - Ms Sara Quinn, Assistant Professor, Discipline of Occupational Therapy, School of Medicine
Study Organiser/ Sponsor	National Disability Authority
Data Controller	Trinity College Dublin (research data)
Data Protection Officer (Research Data)	Data Protection Officer Secretary's Office Trinity College Dublin Dublin 2

We would like to invite you to take part in a research study that is being carried out by Dr. Julie Broderick and her research team at Trinity College Dublin.

Before you decide whether or not you wish to take part, please take time to read this information leaflet carefully and discuss it with your family, friends or GP if you wish.

If there is anything which is not clear, or if you would like more information, please ask the researchers. You should understand the benefits and any risks of taking part in this study so that you can make a decision that is right for you.

Do I have to take part?

No, you don't have to take part in this study. It is entirely voluntary and up to you. If you decide not to take part, it won't affect any current or future services you receive. Don't feel rushed or under pressure to take part or to make a quick decision. You can change your mind and opt out even if the study has started.

This leaflet has six parts:

Part 1 - The Study

Part 2 - Data Protection

Part 3 - Approval, Organising and Funding

Part 4 - Future Research

Part 5 - Further Information

Part 6 – Next steps

Part 1 - The Study

Why have I been invited to take part?

You have been invited to take part as you have indicated that you have some form of physical disability. This means you find it harder to move or walk or physically function in your environment, or you have a problem with your coordination or fitness which affects your ability to undertake normal physical activities.

Why is this study being done?

We know that people who are homeless often experience poor health and it likely that there is a higher rate of physical disability among this group. We are interested to understand how physical disability affects people who are homeless, which is the topic of this research.

What does taking part involve?

This would involve participating in a once-off interview which is expected to take about 20-30 minutes. This study is expected to commence in March 2024 and will take place over 6 months. If you decide to take part, a member of the research team will discuss this information leaflet and the consent form with you. You will be given a copy of your signed consent form and this leaflet to keep.

The study will take place in a safe, secure location sourced by staff in hostels which accommodate people experiencing homelessness, which is convenient for you.

Following consent you will take part in an interview with the study researcher. If further information, for the purposes of this study, is required, the research physiotherapist may clarify information with staff in the hostel where you are staying.

During the interview you will be asked questions about your views on your own physical disability and how this impacts your life. With your permission, the interviews will be audio recorded. We will transcribe (write out) the interview and offer you an opportunity to check the transcript afterwards.

What are the possible benefits of taking part?

There may be no direct benefit to you from participating in this interview. In the future, findings from this study may help us design better services for people who are homeless who also have a physical disability. By participating, you are helping to advance science and medicine/education for future generations.

Are there any possible disadvantages or risks from taking part?

- At all times, the well-being of participants takes priority over research activities.
- In the event of the interview triggering an emotional event, the interviewer will stop the session and we will link you in with an appropriate staff member.
- There is also a possibility that a connection to your identity could be made. However, we take many measures to ensure the confidentiality of all data and the risk to you of a breach of confidentiality is considered very low your data will be coded so this is unlikely and data from all participants will be analysed together, so the possibility of a connection to your identity is very unlikely.
- If you are harmed in any way, the researchers on this study are covered by insurance through Trinity College Dublin. This insurance will cover you in the highly unlikely event that you injured or harmed as a result of taking part in this study. This is highly unlikely as this study involves participation in a once-off interview.

What will happen to the results of the study?

The results of the study will be reported in medical/scientific/educational journals and disclosed at medical/scientific conferences. No information which reveals your identity will be disclosed. Some quotations from the interviews may be used in reports. However, no information which reveals your identity will be disclosed.

You will not be told the outcome of this study, but if you have questions about physical disability in general, the physiotherapist will be able to answer those questions.

Part 2 - Data Protection

What information about me (personal data) will be used for this study

Personal information such including your age, gender, race and ethnicity will be collected, and we will use the information you provide in the audio recording, that is your views about your physical disability to try to understand physical disability better in people who are homeless.

To protect your identity, any information will be labelled with a code instead of your name prior to sharing for this research project. This code will be stored separately from the other research information in a locked filing cabinet in the Trinity Centre, St. James's.

Only the information which we need about you for this study will be collected and nothing extra.

Who will access my personal data?

Only the principal researcher, Dr. Julie Broderick and the study physiotherapist will be able to identify you. They will keep the master file which links your identity to the research data (your health data and your interview transcript).

The study physiotherapist will replace your name with a code on all research data.

How is the information kept confidential and secure?

Your privacy is important to us. We take many steps to make sure that we protect your confidentiality and keep your data safe. Here are some examples of how we do this:

- We will code the research data and the key to identify participants will be kept confidential and separate to the research data.
- **Data security arrangements** are in place. Only TCD provided secure systems will be used.
- **A Data Protection Impact Assessment** has been carried out.
- No **presentation or publication** in relation to the study could identify you as all results will be analysed together.
- The research team having access to the personal data are **bound by a professional code of secrecy**.
- **Training in data protection law** and practice has been provided to the research team.

How long will my personal data be needed?

The research data (data concerning health and physical function and the coded transcripts) will be retained until the study report and all related publications have been released. At that point, the link between you and your personal data will be securely deleted.

The audio recording of the interview will be retained until it has been transcribed and the content verified after which it will be securely deleted.

Your consent form will be retained until the study report and all related publications have been released.

What is the lawful (legal) basis to use my personal data?

We will only use your personal data for this research project, which we hope will improve the health of people experiencing homelessness and addiction. We will also ask for your consent as a requirement of Irish law (Health Research Regulations), but we do not rely on this as our legal basis under GDPR¹.

¹ The European General Data Protection Regulation (GDPR)

¹ Article 9(2) (j)

¹ (Article 6(1)(e)

What are my rights under Data Protection law?

You are entitled to:

- The right to access to your data and receive a copy of it.
- The right to restrict or object to processing of your data.
- The right to object to any further processing of the information we hold about you.
- The right to have inaccurate information about you corrected or deleted.
- The right to receive your data in a portable format and to have it transferred to another data controller.
- The right to request deletion of your data.

By law you can exercise the following rights in relation to your personal data, unless the request would make it impossible or very difficult to conduct the research. You can exercise these rights by contacting your study Doctor [INSERT CONTACT DETAILS] or the Trinity College Data Protection Officer, Secretary's Office, Trinity College Dublin, Dublin 2, Ireland. Email: dataprotection@tcd.ie. Website: www.tcd.ie/privacy.

Part 3 - Approval, Organising and Funding

Has this study been approved by a research ethics committee?

Yes, this study has been approved by the Faculty of Health Sciences Research Committee in Trinity College Dublin. Approval was granted on [INSERT DATE].

Who is organising and funding this study?

This study is being undertaken by Dr. Julie Broderick as Study PI. This study is being funded by The National Disability Authority (NDA). The NDA will be provided with an anonymous report. They will not access any personal data.

Will I be paid for taking part?

No, there is no payment for taking part in the study, but you will be offered a €30 voucher as a token of appreciation for your time.

Will my personal data be used in future studies?

Your data will not be used for any future studies. You have only given permission for your data to be used in this study.

Part 4 - Future Research

Will my personal data be used in future studies?

Your data will not be used for any future studies. You have only given permission for your data to be used in this study.

Part 5 - Further Information

What happens if I change my mind?

Your participation in this study is voluntary and you can change your mind even if the study has started.

You do not have to give a reason for changing your mind. This will not affect the services you receive in any way.

If you would like to withdraw from the study, please contact Dr. Julie Broderick at (01) 8962110, who can organise this for you. She will discuss with you if you are happy for us to continue to use information about you (personal data) which has already been collected. If you do not consent to your personal data being retained for this study, we will delete any information that could identify you.

Please note that we will not be able to remove personal data which has been shared or pooled for use in publication before your request for deletion.

Who should I contact for information or concerns?

If you have any concerns or questions, you can contact:

- Principal Investigator: Dr. Julie Broderick (01) 8962110

If you have any questions in relation to your rights under data protection law, you can contact the Data Protection Officer, Trinity College Dublin: Data Protection Officer, Secretary's Office, Trinity College Dublin, Dublin 2, Ireland. Email: dataprotection@tcd.ie. Website: www.dataprotection.ie.

Under GDPR, if you are not satisfied with how your data is being processed, you have the right to raise a concern with the Office of the Data Protection Commission, 21 Fitzwilliam Square South, Dublin 2, Ireland. Website: www.dataprotection.ie

Part 6 - Next Steps

Will I be contacted again?

If you would like to take part in this study, you will be asked to sign the Consent Form on the next page. You will be given a copy of this Leaflet and the signed Consent Form to keep. Please retain these in case they are needed for future reference.

After the study you will not be contacted again by the study team.

Thanks

Thank you for taking the time to read this Participant Information Leaflet.



CONSENT FORM

STUDY: 'The impact of physical disability in people experiencing long term homelessness – an Interview based study with people experiencing homelessness and stakeholders'

Recruitment Site: Hostels which accommodate people experiencing homelessness

There are **two sections** in this form.

Section 1 contains statements of understanding and asks you to tick each if you understand. Please ask any questions you may have when reading each of the statements.

Section 2 asks for your informed consent. Please select either 'yes' or 'no' to indicate your choice.

Thank you for participating.

The end of this form is for the researchers to complete.

1. General Understanding	Tick
I confirm that I have read and understood the Information Leaflet for the above study. The information has been fully explained to me and I have been able to ask questions, all of which have been answered to my satisfaction.	
I understand that taking part in this study is entirely voluntary . I understand that not taking part will have no negative impact on me.	
I understand that I can leave this study at any time without giving a reason . I understand that leaving this study will not affect access to any services now or in the future.	
I understand that I will not be paid for taking part in this study .	
I know how to contact the research team if I need to.	
By ticking each box above and choosing my options below <u>and</u> signing this document I agree to participate in 'X' study as described in the Participant Information Leaflet.	
2. Consent	

I agree to take part in this research study, having been fully informed of the risks and benefits in the participant information leaflet provided to me.	Yes No ☐ ☐
I agree to the use of information about me (personal data) including my age, gender, race and ethnic origin, and recording of my perceptions about my physical disability being used by the research team for this research study as described in the participant information leaflet.	Yes No ☐ ☐

Participant Name (Block Capitals)
Date

Participant Signature

Witness Name (Block Capitals)
Date

Witness Signature

To be completed by the Principal Investigator or nominee.

I, the undersigned, have taken the time to fully explain to the above participant the nature and purpose of this study in a way that they could understand.

I have explained the risks and possible benefits involved. I have invited them to ask questions on any aspect of the study that concerned them.

I have given a copy of the participant information leaflet and consent form to the participant with contact details of the study team.

Researcher name

Title and qualifications

Signature

Date

Copies to be created and retained: 1 for Participant, 1 for PI



Trinity College Dublin
Coláiste na Tríonóide, Baile Átha Cliath
The University of Dublin



Appendix H Participant Information Leaflet and Consent Phase III Stakeholder Group

Participant Information Leaflet

Study Title	‘The impact of physical disability in people experiencing long term homelessness – an Interview based study with people experiencing homelessness and stakeholders’
Research Site	Hostels which accommodate people experiencing homelessness
Principal Investigator(s) and Co-Investigator(s) (Study Team)	Principal Investigator: Dr. Julie Broderick Co-investigators: - Prof. Cliona Ní Cheallaigh, Associate Professor and Consultant in Infectious Diseases, School of Medicine Trinity College - Ms Jess Sears, Inclusion Health Clinical Nurse Specialist, St James’s Hospital - Ms Sara Quinn, Assistant Professor, Discipline of Occupational Therapy, School of Medicine
Study Organiser/ Sponsor	National Disability Authority
Data Controller	Trinity College Dublin (research data)
Data Protection Officer (Research Data)	Data Protection Officer Secretary’s Office Trinity College Dublin Dublin 2

We would like to invite you to take part in a research study that is being carried out by Dr. Julie Broderick and her research team at Trinity College Dublin.

Before you decide whether or not you wish to take part, please take time to read this information leaflet carefully and discuss it with your family or friends if you wish.

If there is anything which is not clear, or if you would like more information, please ask the researchers. You should understand the benefits and any risks of taking part in this study so that you can make a decision that is right for you.

Do I have to take part?

No, you don't have to take part in this study. It is entirely voluntary and up to you. Don't feel rushed or under pressure to take part or to make a quick decision. You can change your mind and opt out even if the study has started.

This leaflet has six parts:

Part 1 - The Study

Part 2 - Data Protection

Part 3 - Approval, Organising and Funding

Part 4 - Future Research

Part 5 - Further Information

Part 6 – Next steps

Part 1 – The Study

Why have I been invited to take part?

You have been invited to take part as you work or provide services, in a paid or voluntary capacity to people experiencing homelessness.

Why is this study being done?

We know that people who are homeless often experience poor health and it is likely that there is a higher rate of physical disability among this group. We are interested to understand how physical disability affects people who are homeless, which is the topic of this research.

What does this involve?

This would involve participating in a once-off interview which is expected to take about 20-30 minutes. This study is expected to commence in March 2024 and will take place over 6 months. If you decide to take part, a member of the research team will discuss this information leaflet and the consent form with you. You will be given a copy of your signed consent form and this leaflet to keep.

The study will take place in a safe, secure location sourced by staff in hostels which accommodate people experiencing homelessness, which is convenient for you.

Should you wish to take part, following consent, you will take part in an interview with the study researcher.

During the interview you will be asked questions about how you feel physical disability affects people experiencing homelessness who avail of long-term homeless accommodation, and possible solutions. We will transcribe (write out) the interview and offer you an opportunity to check the transcript afterwards.

What are the possible benefits of taking part?

There may be no direct benefit to you from participating in this interview. In the future, findings from this study may help us design better services for people who are homeless who also have a physical disability. By participating, you are helping to advance science and medicine/education for future generations.

Are there any possible disadvantages or risks from taking part?

- At all times, the well-being of participants takes priority over research activities.
- .
- There is a possibility that a connection to your identity could be made. However, we take many measures to ensure the confidentiality of all data and the risk to you of a breach of confidentiality is considered very low as

your data will be coded so this is unlikely and data from all participants will be analysed together, so the possibility of a connection to your identity is very unlikely.

- If you are harmed in any way, the researchers on this study are covered by insurance through Trinity College Dublin. This insurance will cover you in the highly unlikely event that you injured or harmed as a result of taking part in this study. This is highly unlikely as this study involves participation in a once-off interview.

What will happen to the results of the study?

The results of the study will be reported in medical/scientific/educational journals and disclosed at medical/scientific conferences. No information which reveals your identity will be disclosed. Some quotations from the interviews may be used in reports. However, no information which reveals your identity will be disclosed.

Part 2 – Data Protection

What information about me (personal data) will be used for this study

The only personal information collected about you will be your age, gender and the context in which you have worked or volunteered with people experiencing homelessness and we will use the information you provide in the audio recording, that is your perspectives about how physical disability people who are homeless and possible solutions.

To protect your identity, any information will be labelled with a code instead of your name prior to sharing for this research project. This code will be stored separately from the other research information in a locked filing cabinet in the Trinity Centre, St. James's.

Only the information which we need about you for this study will be collected and nothing extra.

Who will access my personal data?

Only the principal researcher, Dr. Julie Broderick and the study physiotherapist will be able to identify you. They will keep the master file which links your identity to the research data (your health data and your interview transcript).

The study physiotherapist will replace your name with a code on all research data.

Your privacy is important to us. We take many steps to make sure that we protect your confidentiality and keep your data safe. Here are some examples of how we do this:

- We will code the research data and the key to identify participants will be kept confidential and separate to the research data.
- **Data security arrangements** are in place. Only TCD provided secure systems will be used.
- **A Data Protection Impact Assessment** has been carried out.
- No **presentation or publication** in relation to the study could identify you as all results will be analysed together.
- The research team having access to the personal data are **bound by a professional code of secrecy**.
- **Training in data protection law** and practice has been provided to the research team.

How long will my personal data be needed?

The research data will be retained until the study report and all related publications have been released. At that point, the link between you and your personal data will be securely deleted.

The audio recording of the interview will be retained until it has been transcribed and the content verified after which it will be securely deleted.

Your consent form will be retained until the study report and all related publications have been released.

What is the lawful (legal) basis to use my personal data?

We will only use your personal data for this research project, which we hope will improve the health of people experiencing homelessness and addiction. We will also ask for your consent as a requirement of Irish law (Health Research Regulations), but we do not rely on this as our legal basis under GDPR¹.

¹ The European General Data Protection Regulation (GDPR)

¹ Article 9(2) (j))

¹ (Article 6(1)(e

What are my rights under Data Protection law?

You are entitled to:

- The right to access to your data and receive a copy of it.
- The right to restrict or object to processing of your data.
- The right to object to any further processing of the information we hold about you.
- The right to have inaccurate information about you corrected or deleted.
- The right to receive your data in a portable format and to have it transferred to another data controller.
- The right to request deletion of your data.

By law you can exercise the following rights in relation to your personal data, unless the request would make it impossible or very difficult to conduct the research. You can exercise these rights by contacting your study Doctor [INSERT CONTACT DETAILS] or the Trinity College Data Protection Officer, Secretary's

Office, Trinity College Dublin, Dublin 2, Ireland. Email: dataprotection@tcd.ie.
Website: www.tcd.ie/privacy.

Part 3 – Approval, Organising and Funding

Has this study been approved by a research ethics committee?

Yes, this study has been approved by the Faculty of Health Sciences Research Committee in Trinity College Dublin. Approval was granted on [INSERT DATE].

Who is organising and funding this study?

This study is being undertaken by Dr. Julie Broderick as Study PI. This study is being funded by The National Disability Authority (NDA). The NDA will be provided with an anonymous report. They will not access any personal data.

Will I be paid for taking part?

No, there is no payment for taking part in the study.

Will my personal data be used in future studies?

Your data will not be used for any future studies. You have only given permission for your data to be used in this study.

Part 4 - Future Research

Will my personal data be used in future studies?

Your data will not be used for any future studies. You have only given permission for your data to be used in this study.

Part 5 – Further Information

What happens if I change my mind?

Your participation in this study is voluntary and you can change your mind even if the study has started.

You do not have to give a reason for changing your mind. This will not affect the services you receive in any way.

If you would like to withdraw from the study, please contact Dr. Julie Broderick at (01) 8962110, who can organise this for you. She will discuss with you if you are happy for us to continue to use information about you (personal data) which has already been collected. If you do not consent to your personal data being retained for this study, we will delete any information that could identify you.

Please note that we will not be able to remove personal data which has been shared or pooled for use in publication before your request for deletion.

Who should I contact for information or concerns?

If you have any concerns or questions, you can contact:

- Principal Investigator: Dr. Julie Broderick (01) 8962110

If you have any questions in relation to your rights under data protection law, you can contact the Data Protection Officer, Trinity College Dublin: Data Protection Officer, Secretary's Office, Trinity College Dublin, Dublin 2, Ireland. Email: dataprotection@tcd.ie. Website: www.dataprotection.ie.

Under GDPR, if you are not satisfied with how your data is being processed, you have the right to raise a concern with the Office of the Data Protection Commission, 21 Fitzwilliam Square South, Dublin 2, Ireland. Website: www.dataprotection.ie

Part 6 – Next Steps

Will my personal data be used in future studies?

Your data will not be used for any future studies. You have only given permission for your data to be used in this study.

Will I be contacted again?

If you would like to take part in this study, you will be asked to sign the Consent Form on the next page. You will be given a copy of this Leaflet and the signed Consent Form to keep. Please retain these in case they are needed for future reference.

After the study you will not be contacted again by the study team.

Thanks

Thank you for taking the time to read this Participant Information Leaflet.



CONSENT FORM

STUDY: 'The impact of physical disability in people experiencing long term homelessness – an Interview based study with people experiencing homelessness and stakeholders'

Recruitment Site: Hostels which accommodate people experiencing homelessness

There are **two sections** in this form.

Section 1 contains statements of understanding and asks you to tick each if you understand. Please ask any questions you may have when reading each of the statements.

Section 2 asks for your informed consent. Please select either 'yes' or 'no' to indicate your choice.

Thank you for participating.

The end of this form is for the researchers to complete.

1. General Understanding	Tick
I confirm that I have read and understood the Information Leaflet for the above study. The information has been fully explained to me and I have been able to ask questions, all of which have been answered to my satisfaction.	
I understand that taking part in this study is entirely voluntary . I understand that not taking part will have no negative impact on me.	
I understand that I can leave this study at any time without giving a reason . I understand that leaving this study will not affect access to any services now or in the future.	
I understand that I will not be paid for taking part in this study .	
I know how to contact the research team if I need to.	
By ticking each box above and choosing my options below <u>and</u> signing this document I agree to participate in 'X' study as described in the Participant Information Leaflet.	
2. Consent	

I agree to take part in this research study, having been fully informed of the risks and benefits in the participant information leaflet provided to me.	<table border="1"> <tr> <td data-bbox="1158 210 1273 241">Yes</td> <td data-bbox="1273 210 1372 241">No</td> </tr> <tr> <td data-bbox="1158 264 1273 318"></td> <td data-bbox="1273 264 1372 318"></td> </tr> </table>	Yes	No		
Yes	No				
I agree to the use of information about me (personal data) including my age, gender and context in which I volunteered or worked with people experiencing homelessness, and recording of my perceptions about how physical disability affects people who are homeless and possible solutions.					

Participant Name (Block Capitals)
Date

Participant Signature

Witness Name (Block Capitals)
Date

Witness Signature

To be completed by the Principal Investigator or nominee.

I, the undersigned, have taken the time to fully explain to the above participant the nature and purpose of this study in a way that they could understand.

I have explained the risks and possible benefits involved. I have invited them to ask questions on any aspect of the study that concerned them.

I have given a copy of the participant information leaflet and consent form to the participant with contact details of the study team.

Researcher name

Title and qualifications

Signature

Date
