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Life-course and structural determinants of positive health and ageing

for older adult Travellers and older people who have experienced homelessness

A briefing paper based on the Older Traveller and Older Homeless (OTOH) study.

Institute for Lifecourse and Society

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Why is this topic important?

Research evidence indicates that older adult Irish Travellers and older adults who have experienced homelessness are particularly susceptible to *unequal ageing* (Cush *et al.* 2020). These populations are more likely to exhibit poor health outcomes, higher rates of comorbidity, lower life-expectancies, and patterns of advanced biological ageing (Walsh, 2013; Abdalla, 2010). They are also more likely to have experienced an accumulation of social exclusion and disadvantage across the life course. This includes deficiencies in accessing structural supports, for example those related to employment, housing and education (Reynolds *et al.* 2016; Coates *et al.* 2015), and an exposure to challenging life experiences, for example ill-health, addiction, relationship breakdown or insecure housing tenure (Watson *et al.* 2017; Crane and Warnes, 2010). In light of this heightened marginalisation, and the growing interest in securing policy goals related to positive health and ageing – as reflected in the Decade of Healthy Ageing (2020-2030) (WHO, 2020) – consideration of factors that contribute to more equitable later-life experiences for older Travellers and older people who have experienced homelessness is necessary. However, how these two populations achieve positive health and ageing outcomes has rarely been considered in research and policy (Cush *et al.* 2020). This reflects a general lack of recognition that members of both communities are a part of our ageing population, and a consequent failure to consider their circumstances within related policy and practice strategy development.

The limited research evidence that is available indicates that people's ability to harness their life experiences, and the informal and formal resources available to them, can help ameliorate risks, and possibly health inequalities (Grenier *et al.* 2016; Van Cleemput *et al.* 2007). This draws attention to how life-course and structural factors more generally might shape, and can be drawn upon, by members of these two groups to benefit their health and well-being. Failing to adequately investigate these sorts of pathways side-lines the relevance of positive health and ageing goals for these populations, and means that policy and practice interventions for these groups are likely to remain deficit-based and narrowly focused. It is also likely to mean that older Travellers and older people who have experienced homelessness risk becoming further removed from equitable and healthy later life experiences.

What is the purpose of this Briefing Report?

This Briefing Report investigates the life-course and structural determinants of positive health and ageing for older adult Travellers and people who have experienced homelessness. In this manner it provides insight into the sorts of factors that must be considered if members of these communities are to be supported to achieve positive health and ageing. The Briefing Report draws on findings of the Older Traveller and Older Homeless (OTOH) study to present the views and perspectives of these sections of the older Irish population. First, a short overview of the methodology used to collect and analyse the data will be outlined, including a summary of the backgrounds and demographics of the study participants. Second, findings related to the life-course and structural determinants of positive health and ageing for these two groups are presented. Third, conclusions are drawn from these findings, and key policy recommendations are presented.

This is the second Briefing Report from the OTOH Briefing Report Series. For more information on the series and the OTOH study, please go to **https://icsg.ie/our-projects/otoh/**.

About the Older Traveller and Older Homeless (OTOH) Study

The aim of this study is to investigate life-course and structural determinants of positive subjective health amongst older Travellers and older people who have experienced homelessness, with a view to centralising the voice of these groups in effective, ethical and rights-based models of home care delivery. This programme of work has five objectives:

1. Review international knowledge on determinants of positive health, in community contexts, for vulnerable groups of the older population;
2. Explore social and primary care provision for older Travellers and older individuals who have experienced homelessness in Ireland, identifying individual- and structural-level risk factors for health inequities, informal practices for addressing such disparities, and on-the-ground knowledge deficits;
3. Capture the lived experiences, expectations and needs of a diverse group of older Travellers and older individuals who have experienced homelessness, unpacking the role of individuals' life events, and societal and institutional practices in the construction of positive health biographies;
4. Facilitate and advance the voice of older Travellers and older individuals who have experienced homelessness to highlight 'insider' perspectives on meanings of home and successful strategies for securing positive health biographies;
5. Harnessing learning from older Travellers and older individuals who have experienced homelessness, develop policy recommendations to inform the development and implementation of relevant and impactful older adult home care structures.

What did we do and who was involved?

The data presented in this Briefing Report was collected using a qualitative, 'voice-led' methodology, which was participatory in approach and designed to place the voice of older Travellers and older people who have experienced homelessness at the heart of this study.

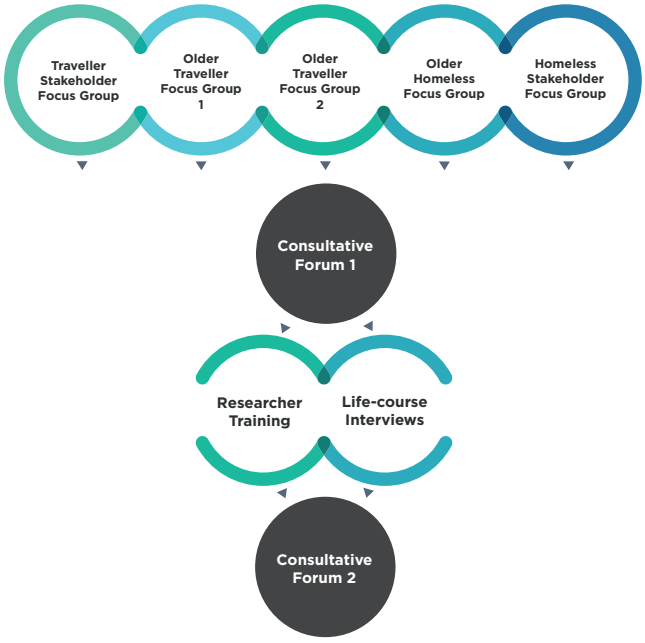

Figure 1: Primary data collection strands

With reference to Figure 1, the study involved five data collection strands. First, to investigate the challenges, opportunities and inequities encountered by the two groups, five focus group discussions were conducted separately with: older homeless people (n=5); older adult Travellers (two groups; n=11 overall); and statutory and third-sector stakeholders working with and representing older homeless adults (n=7), and older adult Travellers (n=7). These stakeholders included representatives from public and third sector social care providers, primary and community health care organisations, and national advocacy and civil society groups. Second, a Consultative Forum (n=9), which drew together a sample of participants from each focus group was conducted to confirm the focus group findings, and to agree the priority research questions to be investigated in subsequent strands. Third, in-depth life-course interviews were conducted with 22 older adult Travellers (8 male; 14 female) and 27 older homeless people (22 male; 5 female) (n=49 overall). Interviews lasted approximately one hour and consisted of three parts: an open narrative portion which focused on a single question about health experiences; an in-depth, semi-structured portion based on questions/topics agreed in the Consultative Forum (for example meanings and behaviours related to positive health and ageing; community and societal belonging; utilisation, needs and preferences for community-based health and social care services); and two life-path exercises where participants worked with the researcher to map out (1) their health biography of positive and negative experiences (Figure 2), and (2) their residential history over their lives (Figure 3). The interviews were audio-recorded and transcribed before being

analysed with the aid of *NVivo* qualitative analysis software. Fourth, five older individuals (either Travellers or those who had experienced homelessness) were trained as participant researchers, and conducted their own research projects (in the areas of identity and belonging, and health and social care environments and service delivery) with the support of the OTOH study team. Fifth, the Consultative Forum was reconvened for the purpose of reviewing the overall findings from the study, and agreeing priorities and recommendations for policy and practice (n=9).

All interview participants were either older ethnic Irish Travellers or older adults who are currently, or who have recently experienced homelessness. Reflecting the faster pace of biological ageing that both groups face, 'older' was defined in this study as those aged over 50 years. Consideration in recruitment was also given to age, gender, housing and accommodation status, urban or rural location, health status, ethnicity, and for older homeless participants, duration of homelessness (for more details on interviewee demographics, see Tables 1 and 2). Reflecting the diversity of participants, the social care needs of the study sample ranged from those who did not need any form of assistance (with some individuals even serving as informal carers for others) to those who possessed complex and multifaceted care needs. The majority of the field research took place in 2019 and early 2020, in sites on the East and West coast of Ireland (primarily Dublin, and Galway cities and counties). The second Consultative Forum was conducted online in December 2020, due to the COVID-19 pandemic.

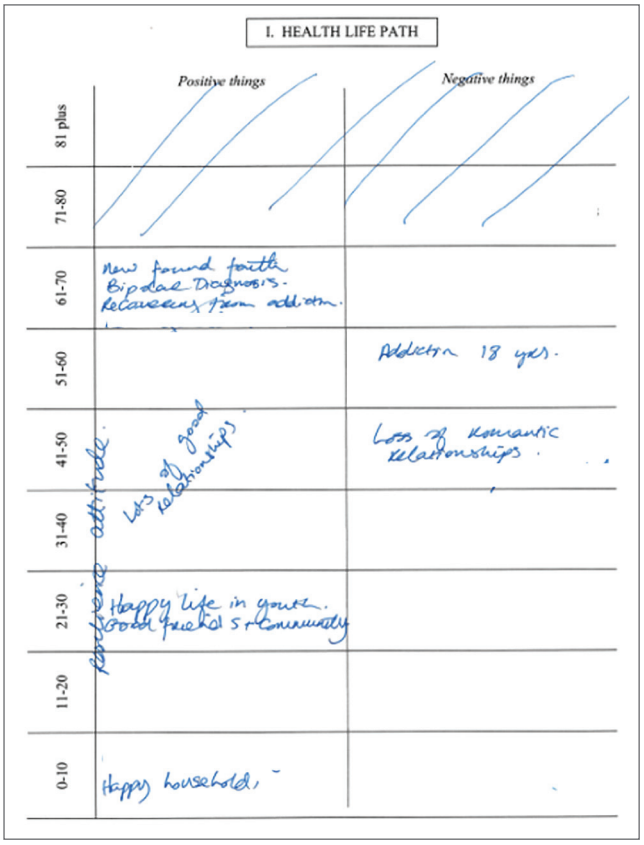

Figure 2: Sample of completed health life path

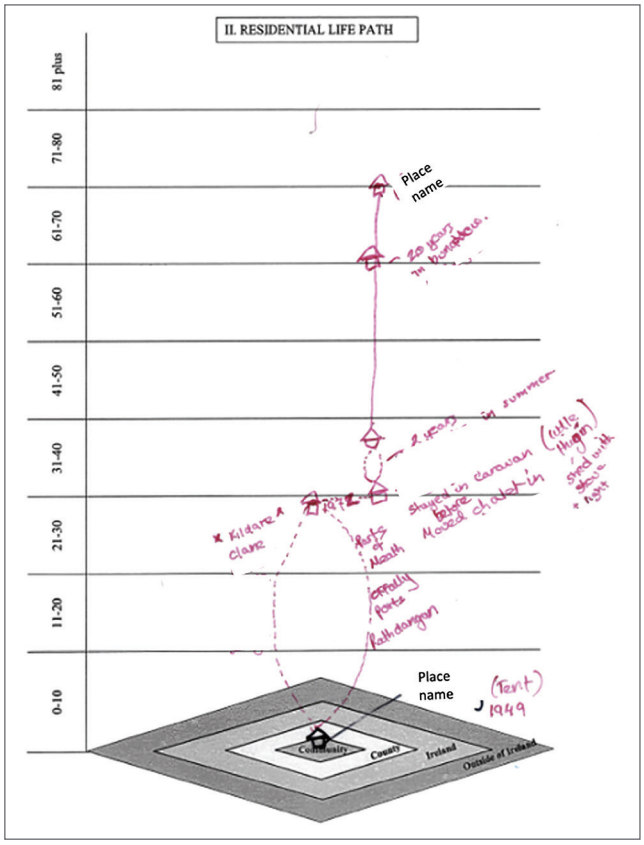

Figure 3: Sample of completed residential life path

Gender	Male	Female
	8	14

Age	50-54	55-59	60-64	65-69	70-74	75-80	No data
	9	1	4	5	2	0	1

Marital status	Married or partner	Separated/divorced	Single	Widowed	No data
	16	2	1	2	1

Accommodation type (Traveller)	Group housing or halting site	Local authority housing	Private rented accommodation	Unauthorised temporary location	Home owner	No data
	12	7	0	0	2	1

Main employment class	Professional	Managerial or technical	Non-manual	Skilled-manual	Semi-skilled	Unskilled	No data
	0	0	6	4	2	9	1

Level of educational attainment	No education	Incomplete primary	Completed primary	Completed group, inter or junior cert	Completed leaving cert or equivalent	Post leaving cert diploma	Third level degree or higher	No data
	2	6	9	2	1	1	0	1

Table 1: Older Traveller interviewees' demographic information

Gender	Male	Female
	22	5

Age	50-54	55-59	60-64	65-69	70-74	75-80
	3	11	5	6	2	0

Marital status	Married or partner	Separated/divorced	Single	Widowed
	3	13	9	2

Accommodation type[1]	Sleeping rough (roofless)	Houseless (temporary accommodation)	Insecure accommodation	Inadequate accommodation	Secure accommodation
	0	24[2]	0	0	3[3]

Temporary accommodation type (n=24)	Emergency accommodation	Long term accommodation	Supported accommodation	Supported community housing
	8	5	9	2

Main employment class	Professional	Managerial or technical	Non-manual	Skilled-manual	Semi-skilled	Unskilled
	5	1	2	8	6	5

Level of educational attainment	No education	Incomplete primary	Completed primary	Completed group, inter or junior cert	Completed leaving cert or equivalent	Post leaving cert diploma	Third level degree or higher
	2	1	8	2	7	2	5

Table 2: Older homeless interviewees' demographic information

[1] ETHOS classification

[2] See next two rows for further breakdown

[3] Homeless charity facilitated independent housing (n=2); Private rented accommodation (n=1)

Although all strands of work have informed the conclusions of this study, it is the data from the in-depth interviews with older adult Travellers and older homeless people that are presented in this Brief. The conclusions and recommendations presented in the Brief also draw directly on and reflect the discussion of the second Consultative Forum.

How is Positive Health Described in Research?

Positive subjective health can be understood as a complex cognitive process, which incorporates physical health and functional ability, subjective bodily feelings, internal (coping mechanisms and resilience) and external resources and mental and psychological well-being (Benyamini, 2011; Idler and Benyamini, 1997; Ryff and Singer, 1998).

What did we find?

Four determinants of positive health and ageing were identified: (1) social relations; (2) material and accommodation circumstances; (3) formal supports and systems; (4) critical transitions and resilience. The determinants could incorporate once-off events, or longer-term situations. But their influence on positive health and ageing for these participants often spanned large-portions of people's lives, and were sometimes life-long. Across these determinants, participants generally identified experiences and turning-points that positively impacted on, or which they drew upon for, their health and well-being. However, negative experiences were sometimes linked to these positive factors, and will be described where appropriate.

Social relations

Social relations was the most prominent determinant of positive health and ageing to emerge from interviews. This influence was sometimes explicitly expressed by participants, but was often implicit within their experiences of health and well-being. Several interviewees from both groups had experienced unstable personal relationships, with accounts of early life disruption (for example: abuse; parental mental ill-health; neglect), mid-life conflict (for example: marital breakdown; domestic abuse) and later-life relational stress (for example: continued estrangement). For some participants, these experiences were associated with life-long impacts in the form of substance addiction, mental health issues, or the inability to form and maintain personal relationships. Nonetheless, the majority of participants could pin-point at least one set of positive social relations that were instrumental in their lives. Descriptions pointed to a range of important ways that relationships had a positive impact, including affirming emotional stability, enabling positive behaviours and the mobilisation of social support. For many, early-life relationships, typically familial, contributed constructively to their personal development, and attitudes towards life:

> *My parents tried everything they could to bring us up as good as they could and we were as happy as they could make us...My father was awful pleasant… my father was the soft one, really soft.* (BCTD19: Traveller participant, female, 53)

In adulthood, and into older age, relational networks and close personal contacts were frequently cited by participants with regard to positive experiences of well-being. Examples were given of how social relations helped to generally bolster a sense of personal stability and self-esteem. The supply of social and emotional support during periods of adversity and personal crises was especially valued, and in some cases helped to facilitate positive turning points in people's lives. While descriptions of networks indicated a diversity of important supporting relationships for participants, familial support was most common amongst Traveller interviewees:

> *But what strikes me from working in this job is people's connectedness to their family [that is]… what is very positive in the Travelling community.* (Traveller stakeholder focus group participant)

As homeless participants were more likely to be single, and/or more likely to have experienced relationship breakdown, family relations were perhaps not as strong. Homeless participants were more likely to describe receiving relational support from contacts who had formal roles within homeless services. These participants, particularly those with weaker social and familial

networks, lauded both volunteers and professionals within these services on the empathy and care they show:

I suffer from depression… and you know the girls that staff the place… [homeless charity service]… they might make me a cup of tea… and I find… when I'm talking to somebody… it becomes more manageable and I function an awful lot better.
(Homeless service-user focus group participant)

Material and accommodation circumstances

Material and accommodation circumstances emerged as an important influence in participants' descriptions of their health and well-being across their lives. There were shared experiences of material insecurity amongst all participants, across both groups, and an entrenched form of poverty and deprivation evident within the accounts of older Travellers. For that reason, positive aspects of material and accommodation circumstances were often based on relative changes in conditions.

At a very general level, interviewees noted the rise in standards of living which enabled more positive health behaviours. Participants, particularly older Travellers, spoke about the additional employment opportunities through state sponsored schemes and access to improved welfare supports. While extended periods of unemployment was certainly a feature of some participants' lives, and job or income loss sometimes a prominent aspect of homelessness pathways, the old-age pension was credited with giving a sense of financial stability in later life for those who met the age criteria.

In terms of accommodation, experiences of poor and inadequate housing were common across both groups, and often entailed profound forms of housing deprivation. For Traveller participants, the vast majority reported having lived at some point in very poor conditions where accommodation was cold, damp, lacking electricity or running water, and often involved temporary shelters or caravans. In contrast, the transition to 'settled' housing was seen by some participants as providing gradual but important improvements in accommodation over time:

Well we travelled down around the country 'til I was four and then...we moved here to Finglas… So, we got a house then, kind of a shed house. It was very poorly, but… every couple of year the Corporation would make our house a bit better.
(BCTD8: Traveller participant, female, 51)

Case Study 1:

Life and structural impacts on well-being in homelessness

Gary's story

Gary, aged 59, has faced much adversity in his life, starting with being institutionalised in a children's home for the first seven years of his life. He suffers from alcoholism and has been homeless for over 25 years. For these reasons he has not been able to maintain a relationship with his children, who are now grown. Because of this he draws on and highly values the relationships he has with other family members, not only in terms of being sources of emotional and instrumental support, but as an opportunity to build reciprocal and intimate connections with others. Gary works hard to nurture these relationships in the absence of being able to play a paternal role with his own children:

I was talking to my nephew yesterday… and I know I have an effect on him and I know I'm making a difference… and I feel good about that, you know?...And while I can't do it for my children, I do it for my nephews and nieces. They replaced what I lost and they're a good replacement. The only replacement I could have had at the time when I lost my children…

In spite of the challenges he has faced, Gary exhibits significant resilience and attempts to frame negative or challenging life events more positively, as opportunities for growth. Connected to this, he demonstrates an understanding of his own capacity to make changes in his life. Notwithstanding the significant structural factors that some older homeless adults face, Gary speaks about the need to be resilient against challenges, not give in to them, and to recognise one's own ability to alter personal circumstances:

…... it's all down to acceptance and if you stop and you say to yourself 'I'm not accepting this anymore' then you must do something about it and that's what I done. I just [said] 'Not this, there has to be something better than this.'

For older homeless adults, experiences of poor accommodation were less linear. Although some had lived in unstable housing environments, or even in institutional or temporary foster accommodation in their youth, others had not. Instead, they encountered these challenges, often as major traumas, in adulthood or later life. It was again relative improvements that were emphasised: *'I have arthritis in my shoulders but that's from the concrete on the streets',* (SKHD07: homeless participant, male, 59). The severity of earlier experiences meant some participants inferred a feeling of security from their current and often very basic accommodation, which was usually temporary in nature. This betrayed a very low-level of expectation with regard to housing, as one stakeholder suggested: *'So like what is a positive outcome for them is that they feel comfortable in the homes that they live in…',* (Homeless stakeholder focus group participant). Nonetheless, many homeless individuals highlighted the importance of a more permanent, private dwelling:

> *You have to have your own place where you can bring in your own friends, rather than being in… a hostel...but until such time as you regain privacy, my own place...you're lost, that's my feeling.*
> (Homeless service-user focus group participant)

Formal supports and systems

The influence of formal supports and systems was clearly evident from participant interviews and was for many a strong determinant of positive health and ageing experiences in later life.

First, while half of the participants reported negative experiences in education, a number of participants experiencing homelessness spoke positively of educational experiences (mainly post-primary but also third-level). Individuals cited benefits for health literacy, self-esteem and for personal confidence as they entered adulthood. For Traveller participants expectations around a 'good education' were significantly lower, reflecting barriers experienced by successive generations of the community, and were focused on basic literacy.

Second, although over a quarter of interviewees reported negative experiences with the formal health system, the majority of participants highlighted one or more positive interactions with health supports in their lives. These accounts sometimes praised the accessibility of services, the quality of provision (continuity, specialist care) and the personal nature of the treatment they received. Stakeholders working with both homeless individuals and Travellers noted the positive impact certain primary care initiatives had had across these communities (for example: Safety-net Primary Care for older homeless adults; Primary Health Care for Travellers Projects for older Travellers), particularly in their ability to reach these (traditionally) difficult to access groups of people:

> *A couple of years ago we had a meningitis breakout and… [the Primary Health Care for Travellers Projects]… worked very closely with the HSE in setting up certain clinics in certain areas for certain extended families, so the whole extended family could be treated…*
> (Traveller stakeholder focus group participant)

Many participants viewed these positive experiences as being pivotal for their health and well-being. This was particularly evident where interactions with the health systems had improved their quality of life through more regular or effective treatment procedures. Participants from both groups also noted how these experiences had fostered positive relationships with primary and specialist care providers (for example: general practitioners; public health nurses; allied health professionals), which enhanced trust in the health system and encouraged more proactive health behaviours.

Finally, two-thirds of respondents discussed receiving supports at critical points in their lives from other formal, usually social care, sources. Older Travellers commented on the support they received from social workers and Traveller representative bodies, in relation to facilitating and brokering service access and the assertion of rights. Homeless participants discussed addiction supports and especially homeless support organisations and the multifaceted nature of their service provision (for example temporary accommodation; counselling; addiction services). Some participants described these interactions as positive transitions in their lives, with lasting impacts:

> *If you had seen me when I came here first, oh my God...I had no weight at all. But they* [a homeless charity organisation] *turned my life around. You can have your shower and things like that but. But it's not just that. It's bigger than that. If I didn't meet people from…* [the organisation]*… , I'd be dead… They gave me a chance in life, they gave me hope...It was the best welcome I ever got… this woman, one of the staff put her arm around me, 'We're going to look after you now'. I'll never forget it.*
> (BCHG21: homeless participant, female, 59)

Critical transitions and resilience

Given the marginalised status of the older homeless and Traveller communities, and the tumultuous circumstances of some individual lives, the majority of participants unsurprisingly encountered negative, and sometimes traumatic, life events and transitions. For some older Travellers, this could include having to leave behind a nomadic lifestyle, whereas for older homeless people it included the transition into homelessness itself. As this stakeholder describes for older homelessness adults, there can be an accumulation of traumas for some individuals:

I think any homeless person who is over the age of 40 who is long-term homeless … they have had huge volumes of loss in terms of death of family members, death of friends… Especially for females, they… [may have]… had numerous rapes… Separated from parents as well, or children. (Homeless stakeholder focus group participant)

While these experiences had negative effects for positive health and ageing, interview data suggest that they were in some circumstances linked with more favourable outcomes, for some individuals. First, participants conveyed a sense of being buoyed by having gotten through the hardest times of their lives. This bolstered feelings of personal efficacy and, over time, contributed to the development of a sense of personal strength, and resilience. For a number of participants, and in a somewhat problematic form, this constructed a relative appreciation for improved, although often still marginalised, conditions.

In other cases, negative experiences could serve as turning points in people's lives eventually leading to positive outcomes, which may never have come about, except for these catalysing events. A small number of participants for example highlighted that low points in their health either forced them to seek support from formal or informal sources, or effectively mobilized this support within their social and familial relationships. An older Traveller man speaks about this in the context of mental health issues, his attempts to take his own life, and how support from his wife enabled him to seek help:

If I was separated at the time...or she [his wife] wasn't there, I'd be dead now. Because I would have went through with it [taking his own life] that night...She said, listen, what's on your mind? What are you thinking about right now? And I explained to her...opened up more and more and more and then the help came in then. Straight to the doctor the next morning and it was great...
(KWSKTD3: Traveller participant, male, 52)

Case Study 2:

Health and relationships as an older Traveller woman

Gillian's story

Gillian, a Traveller woman aged 53 years, has lived a life with much positivity, beginning early with a loving and secure home in rural Ireland, filled with a large immediate and extended family. She married young and had seven children before returning to education in her 30s to complete her Junior and Leaving Certificate exams (having left school at 12), leading her to her current job. Although she had a serious health scare in her early 40s, she considers herself now to be largely healthy. Her well-being is further bolstered by strong relationships she maintains with her family.

Gillian perceives her lifelong material and accommodation circumstances, while not abundant, as having been sufficient for her needs, never having 'gone without':

> ***[In childhood]…we lived in a house. A standard bungalow. Three bedroom house…We used to sow our own vegetables….Daddy had an acre of land, so he used to sow his own potatoes and onions and stuff like that…we were always well fed.***

Furthermore, when she has had occasion to engage with the formal health care system (which she has much experience of as someone who tries to proactively maintain her health), she has had largely positive experiences:

> ***My life basically health-wise, I'm never really a person that's really sick. I had two scares – breast scares for cancer. Very prompt. Seen to straight away. No issues…I had an operation for one of them, so yeah. Very nice. Very welcoming. Very prompt. I can't really say enough about them. The nurses and the doctors were actually lovely. Gave a lot of information. The second time, I went to [hospital name], and they're the same out there. They're very nice. Very welcoming.***

Finally, experiences of stigma and discrimination, which were common amongst both groups, lead to an attitude of defiance and motivated action to seek out advocacy support and to become empowered through learning, whether this learning related to a fundamental skill, such as literacy, or becoming more aware of their own civil rights:

> *People… [said]… you can't read or write Bridgie… and I do say to them well anything I'm saying I'm saying it from my heart, it's the truth and they can't contradict me… let it be the Local Authority, say let it be the Minister for Health…*
> (Focus group: Traveller participant, female)

What are our conclusions?

The research findings illustrate the key determinants of positive health and ageing for older adult Travellers and older people who have experienced homelessness, highlighting the importance of personal life experiences and structural supports. The findings also demonstrate the capacity of individual members of both of these populations to negotiate significant challenges, and harness limited resources, to create positive opportunities. This testifies to the resilience of individuals and their personal agency. It also illustrates what others have argued for these populations, that there is a fundamental need to move from a deficit-based to an asset-based approach, recognising the potential for positive health and ageing for older Travellers and older homeless adults (Miranda *et al.* 2019; Heterington and Hamlet, 2017; Brough *et al.* 2004). The fact that formal supports and systems were referenced by participants in this research as supporting positive health and ageing also indicates that there are many things working well for the groups across Traveller, homeless and older people's services. Interviewees were sincere in their appraisal of the commitment displayed by many organisations and individual representatives to their welfare and well-being.

However, there are a number of problematic elements that must be acknowledged with respect to this topic for the two groups. First, framing the experiences of older Travellers and older homeless adults as determinants of positive health and ageing runs the risk of masking the entrenched disadvantage, and in many cases the violation of human rights (across civil, economic, social and cultural spheres), that can be encountered at a group level, and the traumatic events that have occurred within the lives of some individuals. Second, and given the depth of deprivation experienced at earlier points in their lives, it was evident that for a number of participants that low expectations were likely to have shaped more favourable assessments of current circumstances. Third, the tentative link between adverse events in people's lives and positive outcomes that has been presented in this Briefing Report has to be interpreted with caution. The margins between being able to harness such circumstances in constructive ways, and not being able to do so, were often small. These instances were typically the exception, rather than the rule.

Across the four determinants, we can also draw out a number of specific challenges that are inferred by the findings, despite the positive focus. These relate to: the narrowness of social and relational supports (primarily only family support for Traveller participants; only homeless service social support for older homeless adults); the depth of material and accommodation deprivation that people have experienced; and the breakdown in trust and the weak or ruptured ties between individuals and wider society. Older adult members of both communities were often only linked to one of the core social spheres or systems (family and friend networks; community and voluntary system; state systems; private systems). This meant their connections to key societal safety nets were often tentative, and the potential for exclusion from these social systems was significant (Philip and Shucksmith, 2003).

This points to broader concerns with respect to the integrity and safeguarding of the rights and freedoms that should be afforded to older Travellers and older adults experiencing homelessness under our Constitution (for example equality of treatment), and European and international conventions on human rights. More active scrutiny in this regard for the two populations is required and along with a more detailed analysis of the consequences of violations for positive health and ageing. 'Public Sector Duty' as presented in section 42 of the Irish Human Rights and Equality Commission Act 2014 offers another lens through which to examine the circumstances of both groups. Requiring all public bodies to assess relevant human rights and equality issues, address and report on related developments and achievements, the Duty certainly places a firm focus on the accommodation situation of older Travellers and older adults who have experienced homelessness. The sort of housing deprivation

frequently evident within older Traveller's interviews, and the complete absence of housing tenure and security amongst those currently experiencing homelessness, needs immediate action by relevant State agencies and local authorities.

Other considerations with respect to the sample of participants in this research are also necessary, but either have only been touched upon or have not been discussed in the presentation of findings. They include intersectional social categorisations with respect to disability, migration (inward and return) and ethnicity, sexuality, marital status, and specific traumas such as institutional abuse, imprisonment and accumulated bereavements. Gender was also a factor. While older women were generally considered to fare better in both communities, differences and implications with respect to gender norms and roles were clear. All of these biodemographic and life-course variables require more consideration than the space they have been given here.

In presenting an analysis for older Traveller and older homeless adults together, there is a danger, in a short report such as this, that the circumstances of these groups would be homogenised. The experiences of these sections of the older population are not the same. The mechanisms of disadvantage and the drivers of exclusion that they face are often different, and the solutions required will in many instances need to be targeted specifically for each group. Indeed, for both older Travellers and older adults who have experienced homelessness, there is very clear diversity evident even within each population (for example cohort differences for ageing Traveller adults; differences in timing and causes of homelessness for older homeless adults). Nonetheless, the research illustrates the need for a broader life-course approach – not tied to defined age thresholds – that would enable enhanced risk and need assessment, better decision making regarding the timing of interventions, and the appropriate allocation of resources to secure positive health and ageing for these groups. Without such an approach, favourable outcomes for these populations will only be evident for the minority, and meaningful gains in healthy life expectancy and positive ageing unlikely.

Recommendations

Based on the findings of the research, we make the following recommendations in relation to supporting the capacity of older adult Travellers and people who have experienced homelessness for positive health and ageing:

1. Public bodies, private organisations and community and voluntary organisations working with and on behalf of these groups must adopt an assets-based approach to supporting positive health and ageing for older adult Travellers and older people who have experienced homelessness. Thereby, focusing on the possibilities, potential and heterogeneity of these groups, and shifting away from more deficit-based framings.

2. The role of structural-level as well as individual-level influences in creating disadvantages and risk (intensifying disenfranchisement and social displacement in later life), and advantages and opportunities (supporting positive health and ageing outcomes), must be considered by those charged with the development of policy and practice relevant to these groups.

3. Government departments, the Health Service Executive (HSE) and local authorities must work to support the agency and resilience of older Travellers and homeless older people, embracing the achievement of older age for these groups and recognising that their 'expert' voices needs to be integrated into policy and practice development relevant to their situations.

4. Multifaceted structured inclusion programmes, developed and implemented by local authorities and civil society organisations, are required to build and enhance the links between members of these groups (and other marginalised sections of the older population) and wider society, as they age. This will create essential bonds between individuals and each of the key social systems (family and friend networks; community and voluntary system; state systems; private systems).

5. Those working with older Travellers and older adults experiencing homelessness, across public, private, and community and voluntary sectors, must embed the building of trust as a core principle of positive health and ageing interventions for these populations, creating the basis for more sustained and positive exchanges across social, health, service and civil spheres.

6. Social care actors, and relevant bodies and representative organisations, must support older Traveller adults and older individuals who have experienced homelessness to broaden and deepen their social supports, diversifying and expanding what can often be a narrow and limited set of informal support networks.

7. In recognition of the important role strong family relationships can play in promoting positive health and ageing for older Travellers, the HSE and other State organisations must facilitate these relationships. This should be done through the development, expansion and funding of intergenerational programmes that support the well-being of Travellers across generations, particularly those targeting education and health literacy.

8. Additional statutory funding needs to be provided to community and voluntary organisations delivering homelessness services to develop specialised and additional social care supports for the ageing homeless population. This funding could target areas such as environmental/residential modifications and mobility aides, combatting loneliness and social isolation, counselling, and others forms of personal support.

9. Led by local authorities and the Department of Housing, Local Government and Heritage, secure, accessible and quality accommodation for older Travellers and older people experiencing homelessness must be provided, recognising the profound and life-long influence of housing for the health and well-being of members of both groups.

10. To secure meaningful positive health and ageing outcomes for these populations, it is essential that statutory resource allocation, needs assessment and intervention development must adopt a life-course approach that considers the accumulation of risk, and the ageing process beyond a narrow life-stage view.

11. Expand the preventative and enabling role of community-based health and social care for these two populations, strengthening the capacity of the sector to respond to individual level crises, and wider public health risks (such as the outbreak of COVID-19) that may disproportionately impact the groups.

About the Older Traveller and Older Homeless Populations

In this study, older adult Travellers refer to those aged 50 years and over *'...who are identified…[by themselves and others]…as people with a shared history, culture and traditions including, historically, a nomadic way of life'* (Equal Status Act Ireland, 2000, Sec 2 (1)). While the majority of Irish Travellers live in private dwellings, only 20% own their own homes (versus 67.6% of the general population) and 3.2% live in caravans or other mobile or temporary structures (CSO, 2016). A series of restrictions on camping and mobility introduced in the early to mid-1960s greatly limited the travelling lifestyle, but while the majority of the population are no longer nomadic, nomadism continues to be a vital part of Traveller culture (Joyce, 2018). The Traveller population are also considered to have experienced systemic societal discrimination and long-standing marginalisation from mainstream societal institutions (education; health services; labour market). Currently, there are 2,639 older Travellers resident in Ireland (and a further 10,374 resident in England and Wales). The age structure of the Traveller community is significantly younger than the general population (aged 65 or older: Travellers, 2.5%; wider population, 13%). However, in line with increasing life-expectancy and reflecting international patterns for other indigenous populations, the older adult section of this community is growing (CSO, 2016).

Adopting the European Typology of Homelessness and Housing Exclusion (ETHOS), older adult homelessness in this research is considered to involve those aged 50 years and over who are currently or who have recently experienced rooflessness, houselessness, or who currently or have recently had inadequate or insecure accommodation (Amore *et al.* 2011; Edgar *et al.* 2003). There are 1,069 older homeless adults in Ireland with people aged 50 or older representing 15% of the total homeless population (CSO, 2016). However, due to difficulties in collecting accurate data, this is likely to be an under-estimation of the number of people experiencing later life homelessness. In line with demographic ageing patterns nationally, the older homeless population is expected to increase in size in the coming years, as it has in other nations. Internationally, the impact of economic uncertainty, the restricted supply of affordable housing, and ageing demographic structures have led to a marked increase in ageing homeless populations, with some jurisdictions – for example USA and Canada – reporting that up to half of the homeless group are aged 50 years and over (Grenier *et al.* 2016; Woolrych *et al.* 2015).

Older Travellers and older adults experiencing homelessness are more likely to experience poor health outcomes, a greater prevalence of co-morbidities, substantially lower healthy-life expectancies, and in some instances premature biological ageing (O'Donnell *et al.* 2016).

COVID-19 and Older Travellers and Older Homeless Adults

The Covid-19 pandemic has brought new challenges for the health of these two groups. The HSE Social Inclusion office anticipated this as a particular challenge for Travellers and developed supplementary guidance for this group as well as identifying priorities for their care during the pandemic (HSE Social Inclusion, 2020b). This is reflective of Travellers, and indeed homeless people being identified as two (of six) populations which are vulnerable to Covid-19 outbreaks. While homeless populations have represented less than 2% of all vulnerable group outbreaks, Travellers have accounted for almost 73% of vulnerable population Covid-19 outbreaks (HSE-HPSE, 2020).

While not focusing specifically on older members of the two groups, the National Social Inclusion Office reports on homeless and Traveller service user experiences during the pandemic illustrate that a significant minority (20%-34%) felt that their physical and mental health, as well as their quality of life was worse than at the same time the previous year. However, it is important to note that some of those homeless participants who had been cocooning or self-isolating reported a positive change in their health and well-being due to improvements in their living situation (for example having their own room) which were catalysed by the circumstances of the pandemic. These participants described positive changes around feelings of safety, mental health, drug use and relationships (HSE Social Inclusion, 2020a). In addition, some Traveller respondents reported accessing new health supports since the start of the outbreak including those for Covid-19 but also beyond (HSE Social Inclusion, 2020b).

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