Positive health and ageing policies for older Irish travellers and older people who have experienced homelessness in Ireland: Life-course meanings and determinants

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Positive health and ageing policies for older Irish travellers and older people who have experienced homelessness in Ireland: Life-course meanings and determinants

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ABSTRACT

Marginalised groups of older people remain neglected in positive health and ageing (PHA) agendas, whether they concern healthy or active ageing concepts. Questions exist around the meaning of such constructs and the factors that enable disadvantaged populations to achieve equitable later-life experiences. Focusing on two such groups in Ireland, this study investigates the constituent dimensions of PHA for older Irish Travellers and older people who have experienced homelessness and the role of life-course and structural determinants in constructing PHA trajectories for these groups. The study involves a qualitative, participatory voice-led methodology, with analysis based on 49 in-depth life-course interviews with people aged 50 years and over from the two populations. Five interconnected dimensions of PHA are identified and presented. Four determinants related to life-course experiences and structural factors are identified as contributing to these dimensions: social relations, material and accommodation circumstances, formal supports and systems, and critical transitions and resilience. While illustrating the validity of PHA agendas for these groups when understood through their lived experiences, the findings highlight the significant deprivations and risks to rights that must be accounted for to secure meaningful gains in PHA for the groups.

1. Introduction

The life-course risks that characterise the circumstances of some marginalised older adult groups can challenge international policy goals related to positive health and ageing (PHA) (Boudiny, 2013; Foster and Walker, 2021). In Ireland, older Irish Travellers (OT), who are an Indigenous ethnic minority, and older people who have experienced homelessness (OH) are two such groups. In this article, PHA is used as a general term and a pragmatic approach to encapsulate the range of ageing-related policy constructs in international public policy that target more positive outcomes for later life. This includes both *healthy ageing* – 'developing and maintaining the functional ability that enables well-being in older age' (WHO, 2015) - and *active ageing* – 'optimizing opportunities for health, participation and security in order to enhance the quality of life as people age' (WHO, 2002: 12).

With OT and OH populations exhibiting pronounced inequalities and lower life expectancies, these groups are more susceptible to patterns of unequal ageing (Abdalla et al., 2010; OECD, 2017). Their circumstances are indicative of rising insecurity, that can be evident within heterogeneous ageing societies (Grenier et al., 2020). Despite this, there has been limited study of the meaning of PHA policy agendas for the lived experiences of these groups, and few investigations of the factors that construct or can be mobilised by such groups to achieve equitable later-life experiences (Waldbrook, 2015). Notwithstanding research growth on marginalised older adults (Oetzel et al., 2019), there has been a failure to elaborate an assets-based assessment of life-course factors – such as transitions and trajectories, and structures and institutions – which could serve as determinants of favourable later life outcomes (Cush et al., 2020). This reflects a wider research paucity on the lived experience of marginalised populations and PHA policies embedded in

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European and developed societies (Dizon et al., 2019).

Responding to these deficits and concentrating on lived experience insights, this article investigates PHA constituent dimensions for OT and OH and the role of life-course determinants in constructing PHA trajectories for these populations. Failing to investigate such pathways sidelines the relevance of PHA goals for these groups and ensures targeted interventions remain deficit-based. Older Travellers are those aged 50 years or more 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, 2000, Sec 2 (1)). Older people who experience homelessness are those aged 50 years or older, who are currently or who recently experienced rooflessness, houselessness, or inadequate/insecure accommodation (based on the European Typology of Homelessness and Housing Exclusion homeless classification - Edgar et al., 2007). This article employs a qualitative exploratory approach, which focuses on capturing in-depth lived experience insights from specific samples of OT and OH adults in Ireland and not on identifying generalisable or representative patterns of findings.

As a nation that has embraced PHA frameworks at all government levels, Ireland presents a valuable study context. In addition to committing to the Madrid International Plan of Action on Ageing, Ireland launched its National Positive Ageing Strategy in 2013, grounding its goals in international development related to healthy and active ageing (Department of Health, 2013). As a member of the Global Network for Age-Friendly Cities and Communities (GNAFCC), Ireland became the first age-friendly country globally (McDonald et al., 2023), with all its local authorities committing to pursue age-friendly programmes and their active ageing objectives. Within this policy landscape, the Irish Traveller community and those experiencing homelessness are identified as priority populations in health and social-protection agendas (Smyth et al., 2017). The severity of a national housing crisis, for homeless adults, and a long-fought battle for recognition of Irish Traveller ethnic identity, has highlighted the extent of systemic barriers facing both groups (Authors, 2020). Nevertheless, there have been few attempts to examine PHA for these populations (c.f. Cush et al., 2020), or the agency of individuals in potentially mediating accumulated life disadvantages. The complete absence of both groups from policy spheres crystallises their positions as principal examples of the marginalisation that can impact Irish older populations. Thus, although mechanisms differ, the groups experience similar patterns of inequality, posing PHA challenges of similar magnitude.

1.1. PHA and life-course marginalisation

PHA constructs have been credited with promoting positive aspects of later life based on increased longevity. As such they mark a departure from theories and policies that emphasise the decline and disengagement of older people (Foster and Walker, 2021; Urtamo et al., 2019). These constructs are considered to have reframed ageing politically, supporting more comprehensive approaches to older people's societal participation. Such attributes may in themselves add value to how we support marginalised groups in later life. However, a sustained critique of PHA frameworks has also emerged. Researchers have drawn attention to how these constructs support narrow homogenised interpretations of health and normative views of what a useful contribution to society is (Foster and Walker, 2015; Stephens, 2017). Critical perspectives highlight how PHA constructs can be used by policymakers to underpin neo-liberal agendas. This places the responsibility for older adult well-being on individuals themselves to avoid the projected impact of ageing on welfare system sustainability (Rubinstein and de Medeiros, 2015).

In effect, questions remain about how these constructs may marginalise older adult groups who do not fit the resource and capability parameters of a homogenised 'healthy' and 'active' population. PHA-ascribed meanings can lack cultural relevance for populations whose understandings are distinct from Western individualist views of achievement – such as the collectivist values of older adult Aboriginals (Ranzijn, 2010). PHA goals can also be starkly juxtaposed with the lived realities of older marginalised groups, neglecting their needs and diversity (Bryant et al., 2001; van Dyk, 2014). Others have gone further noting that these concepts may intensify stigmatisation by framing a lifetime of disadvantage as a failure to age healthily or actively (Foster and Walker, 2021). Therefore, individual-level risks (e.g., disrupted employment, relationship breakdown, substance use, ill-health, and deprivation) and structural deficiencies (in education, employment, services, housing, and stigmatisation) encountered by OT and OH adults may challenge the validity of PHA constructs (Crane and Warnes, 2010).

However, previous research has indicated the capacity of these groups to harness experiences and available resources to ameliorate inequalities and secure positive outcomes (Grenier et al., 2016). This draws attention to how life-course factors, more generally, might shape and can be drawn upon to enhance well-being. As has been argued within more flexible, capability orientated PHA conceptualisations (Sadana et al., 2016), resilience and personal agency are often integral within this dynamic (Waldbrook, 2015). But so too are other factors (see Author, 2020). For OT, and reflecting other older Indigenous minorities (e.g., older Māori - Oetzel et al., 2019), these factors include supporting appropriate care, material circumstances, family relationships, and religious faith (Coates et al., 2015). For OH, they include recognition, accessible services, and secure accommodation (Milaney et al., 2020; Montgomery et al., 2016). Therefore, while achieving aspects of PHA may be possible for such groups, the number of studies in this area is low (Author, 2020), with few researchers having focused directly on what constitutes and constructs PHA for these populations (c.f. Waldbrook, 2015).

1.2. Older Travellers and older adults in homelessness

In 2016, there were 3439 Travellers aged 50 years and older, and 30,987 overall, living in Ireland. Reflecting the level of structural disadvantage facing the general Traveller community, 80 percent of Travellers were unemployed, 56 percent had completed primary education, 3 percent lived in caravans/temporary structures, and just 20 percent owned their homes (versus 68 percent generally) (CSO, 2016). Traditionally nomadic, the population is primarily settled (with no data available on the number of nomadic OT) after restrictions on camping/temporary dwellings which were introduced in the 1960s limited Traveller culture (Joyce, 2018). In 2010 (most recent data), life expectancy was 71 years for Traveller women and 62 years for men, with just 3 percent of the community aged 65 years and over. But in recent years, this population has increased in line with national demographic patterns. In 2016, there were 1069 OH adults in Ireland aged 50 years and over, representing 15 percent of those homeless (CSO, 2016). While available data is limited for this group, the population is projected to grow, mirroring homelessness profiles internationally, where OH can constitute between a third and a half of the population. Housing crises, rapid urban development, economic uncertainty and macro-financial shocks have all contributed to these patterns globally (Grenier et al., 2016).

2. Methodology

2.1. Conceptual framework

Two interconnected literatures form a conceptual frame for this article. As an overarching view of PHA production, the analysis is first situated within Solar and Irwin's (2007) social determinants of health framework, and its later adaptation by Sadana et al. (2016) for healthy ageing equity. This framework illuminates four intermeshing blocks: (1) Root causes (physical-socio-economic-political environments) or overall context; (2) structural determinants (genetic inheritance and socioeconomic position); (3) intermediatory determinants (both those that

reflect social stratification and health-promoting/damaging behaviours), and (4) healthy ageing outcomes. Consideration here is given to a social system's structural aspects within block 1, which might establish the stratification of opportunities for the two groups; the social hierarchy within block 2, where the groups' socially constructed position may drive unequal power and resources; vulnerabilities and exposures, the care system, and the environment within block 3, which are likely to shape PHA processes; and individuals' capacity for PHA within block 4. Second, our analysis is also located within a life-course paradigm (Elder, 1985) to further elaborate the socially constructed distribution of risks and inequities across people's lives (Dannefer, 2003). Emphasis is placed on how PHA trajectories may be derived from early-life experiences, transitions and events and the normative/institutional positioning of these groups as social locations (Alwin, 2012). Within this, timing, socio-historical context, and linked lives are considered (Elder, 1985), with recognition given to how the agency of these groups and cohort expectations can mediate risk accumulation and PHA subjective assessments.

2.2. Design, data collection, and analysis

Data comes from 49 in-depth life-course interviews conducted with OT and OH adults. The interviews were part of a larger study which employed an explorative qualitative, participatory methodology to capture the 'insideness' of the groups' perspectives and those of key stakeholders. These perspectives were channelled into a decision-making structure shaping the research. The methodology adopts principles of a participant-voice framework for including marginalised populations in research (Fitzgerald et al., 2016), which promotes different forms of expertise, ethical engagement, lived experience, and social context.

The interviews were conducted as a part of a larger study that involved a range of data collection strands (see Walsh et al., 2022), and that either informed broad interview topics or helped validate findings. This overall structure will first be briefly outlined. To identify themes important to each population, five focus groups were first conducted with OH (n = 5), OT (two groups, n = 11), and statutory and third-sector stakeholders working with Traveller (n = 7) and homeless (n = 7) populations. Second, a Consultative Forum (n = 9) drew together a sample of participants from each focus group to finalise themes based on common concerns. The life-course interviews explored these and related themes in-depth (see below). Finally, the Consultative Forum (n = 9) was reconvened to validate interpretations and agree on recommendations. Field research took place in 2019 and early 2020, prior to the COVID-19 pandemic (the second Consultative Forum was conducted online in December 2020).

2.3. Life-course interviews

The interviews consisted of four parts. First, open participant narration, adapted from the Biographic-Narrative Interpretative Method (Wengraf, 2001), was used to elicit participants' narratives of ageing and health. Participants were invited to think about their entire lives and to speak about their health and well-being for up to 20 min without interruption. Second, a life-path exercise (Hägerstrand, 1970; Rowles, 2008) was used as a visual aid to stimulate discussion and to probe on participants' health and ageing biographies. On a preprepared timeline, interviewees and researchers together marked down positive and negative factors (particularly major health changes) that influenced people's well-being from birth to present. Third, a semi-structured guide explored the agreed Consultative Forum themes, including questions relating to (1) life-course meanings of PHA, (2) health and risk behaviours related to PHA, (3) societal belonging and exclusion, (4) support and coping strategies, and (5) care service utilisation. A second life-path exercise explored the residential life-course history and was used to discuss integration levels and spatial transitions, for example, the shift from Traveller nomadism to permanent settlements and transitions in-and-out of homelessness. The life-path exercises helped to establish the sequence of major life-turning points. Fourth, a short profile questionnaire collected bio-demographic data. Interviews lasted, on average, 70 min (ranging from 40 min to 120 min).

2.3.1. Inclusion criteria and recruitment

Recruitment protocols were developed with five project collaborators. Collaborators comprised of representatives from national health service and social inclusion organisations, an ageing advocacy organisation, and national groups working with the two populations. The protocol first specified participant inclusion criteria (including age, accommodation, and representative bio-demographic details). Mirroring age categorisations within the literature (Grenier et al., 2016), recruitment focused on OT and OH aged 50 years and over, with different age groups (50–59, 60–69, etc.) targeted. Accommodation types considered for OT included: group housing schemes (culturally appropriate accommodation typically involving a number of houses where extended families can live together) and halting sites (purpose-built accommodation involving multiple halting bay sites where caravans/mobile homes can be stationed and have access to basic facilities); local authority housing; private and private-rental housing; and unauthorised temporary sites. For OH adults, this included (based on ETHOS homelessness classifications-Edgar et al., 2007): roofless (emergency shelter accommodation; living rough – meaning living in the streets or public spaces without a shelter); houseless (short-term temporary accommodation (less than one year, including hostels and transitional supported accommodation); long-term temporary accommodation (more than one year); insecure accommodation (not usual residence; no legal tenancy); and inadequate housing (sub-standard; makeshift or semi-permeant structure). Supported housing in the community (long-term accommodation with homeless support services) and general secure accommodation (mainstream accommodation in the community where those formerly homeless may reside) were also considered. Recruitment also considered gender, disability, marital status and, for homeless populations, ethnic/migrant background, and timing of homelessness. Second, the protocol helped establish ethical recruitment pathways, where collaborators identified suitable grass-roots organisations (for example, advocacy groups and service providers) to assist with recruitment and acquisition of informed consent. Reflecting population concentrations, recruitment focused on two cities and surrounding regions on the east and west coasts of Ireland. OT were primarily recruited through two Traveller civil society organisations (the national representative body and regional charity) and their service/programme networks, encompassing eight recruitment sites overall. The OH sample was recruited primarily through five homeless charity organisations (two on the west coast and three on the east coast) and their various service and accommodation programmes, encompassing approximately nine sites overall. See Table 1 for a breakdown of accommodation types for OH.

Nomadic OT could not be recruited for this study. This was because only two people fitting this criterion were identified across the two regions during the recruitment phase, and these individuals declined to participate. While OH adults living in roofless circumstances are represented in the OH sample, this is only in terms of those living in emergency accommodation. Individuals living rough could not be recruited. This was despite targeted efforts to recruit those living rough through day/meal services and shelters working with this group. Researchers did not have access to potential participants directly, where service professionals who were initially approaching participants reported that some individuals declined participation, while others were not in a position to participate based on health grounds. The two participant groups did include individuals with past/recent experiences of these circumstances (nomadism for OT; living rough for OH), but essentially the interview samples represent OT who were settled and OH individuals who were living in some form of accommodation at the time of the study.

Table 1
Traveller Interviewees' Demographic Information (proportion in parentheses).[a, b, c and d]

Gender	*Male*	*Female*		
	8 (36%[a])[b]	14 (64%)		
Age[c]	*50–59*	*60–69*	*70–79*	*80+*
	10 (48%)[d]	9 (43%)	2 (10%)	0
Marital status	*Married/ partner*	*Separated/ divorced*	*Single*	*Widowed*
	16 (76%)	2 (10%)	1 (5%)	2 (10%)
Accommodation type	*Group housing or halting site*	*Local authority housing*	*Private rented accommodation*	*Home-owner*
	12 (57%)	7 (33%)	0	2 (10%)
Main employment class	*Semi-skilled or unskilled*	*Skilled: manual*	*Non-manual*	*Professional, managerial or technical*
	11 (52%)	4 (19%)	6 (29%)	0
Level of educational attainment	*None or incomplete primary*	*Primary*	*Intermediate or final post-primary*	*Third level or higher*
	8 (38%)	9 (43%)	3 (14%)	1 (5%)

Notes:
[a] All percentages have been rounded to the closest whole number.
[b] The male/female split among the wider older Traveller population in Ireland is 49% men to 51% women (CSO, 2016).
[c] Hereafter, the numbers total 21 to reflect the absence of data for one interviewee.
[d] These proportions compare to the age spread among the wider older Traveller population in Ireland of: 50–59: 50%; 60–69: 30%; 70–79: 12%; 80+: 4%.

2.3.2. Participants

With reference to Tables 1 and 2, 22 OT (8 male; 14 female) and 27 OH people (22 male; 5 female) with similar age ranges (OT: mean age = 59 years; OH: mean age = 61 years) were interviewed. These samples equate to 0.6% and 2.5% of the OT and OH populations, respectively. All OT participants were of Irish Traveller ethnicity, while three homeless participants were from migrant or minority ethnic backgrounds. There were marked differences between the groups in terms of gender, marital status, and education levels. The higher representation of OT women may, in part, reflect higher female life expectancy (CSO, 2016), but it is more likely to be as a result of the established difficulty in engaging Traveller men in health-related research (Hodgins and Fox, 2012). This gender imbalance is, nonetheless, recognised as a sample limitation. The higher representation of OH men is likely to reflect the higher proportion of men within this population and, potentially, the hesitancy of older women to self-identify as homeless (Petersen, 2015). Differences in marital status are likely to reflect associations between homelessness and marital breakdown and single living, and the higher marriage rate and lower divorce rates within the Traveller community. Differences in education levels reflect the acknowledged structural barriers facing successive Traveller generations. All OH participants had experienced long-term homelessness (at least one year), with three having recently left homelessness. Eight individuals became homeless for the first time in later life.

2.3.3. Data analysis

Three team members conducted the interviews. Two of the interviewers (first and second authors) had conducted research with OT and OH populations previously. Another author had research experience with Traveller and homeless populations, and all authors had extensive experience working with excluded groups. The authors were not members of the Traveller community and did not have direct lived experience of homelessness. The interviews were audio-recorded, transcribed verbatim, and analysed using an inductive, semantic thematic approach (Braun and Clarke, 2006). First, a provisional coding framework was developed from an initial reading of four interview transcripts. This framework was then agreed upon amongst the team members. Second, each transcript was analysed by the first author in an iterative process that sought to merge key units of meaning into descriptive codes. This process was continued until major inductive themes were identified in each transcript. Third, these themes were used to refine the provisional framework into main themes and sub-themes. The framework served as a basis for identifying cross-cutting themes and the similarities and differences between the two groups. The study team met regularly to discuss emerging themes and, later, to agree on descriptions of major themes. To aid this process, descriptive outlines with illustrative quotes were first drafted and discussed for each theme. *NVivo 12* qualitative analysis software was used to organise the data. Where appropriate, participant life-paths and exemplar case illustrations were also used to elaborate these themes. Prior to finalising the analysis, preliminary thematic findings were presented to the Consultative Forum to help validate the findings and to illicit any further contextual insights to aid further interpretation.

3. Findings

Participants' understandings of PHA dimensions are first outlined. Life-course determinants of PHA trajectories, which are framed by these understandings, are then described. Due to their prevalence, and the complexity with which they could unfold, more attention is given to describing these determinants. The findings presented are largely relevant to both groups, but it is highlighted where this is not the case. Quotations are attributed by an interview code based on interview number, group membership (OT – 'T'; OH – 'H'), gender (male – 'M'; female – 'F') and age. Any names included in the quotations are pseudonyms.

3.1. PHA dimensions

Five interconnected dimensions [bolded, italicised text] were

Table 2
Homeless Interviewees' Demographic Information (proportion in parentheses).

Gender	*Male*	*Female*			
	22 (81%)	5 (19%)			
Age	*50–59*	*60–69*	*70–79*	*80+*	
	14 (52%)	11 (41%)	2 (7%)	0	
Marital status	*Married/partner*	*Separated/divorced*	*Single*	*Widowed*	
	3 (11%)	13 (48%)	9 (33%)	2 (7%)	
Accommodation type	*Emergency accommodation (temporary)*	*Medium-long term supported accommodation (temporary)*	*Long term accommodation (unsupported and temporary)*	*Supported community housing*	*Secure accommodation*
	8 (30%)	9 (33%)	5 (19%)	2 (7%)	3 (11%)
Main employment class	*Semi-skilled or unskilled*	*Skilled: manual*	*Non-manual*	*Professional, managerial or technical*	
	11 (41%)	8 (30%)	2 (7%)	6 (22%)	
Level of educational attainment	*None or incomplete primary*	*Primary*	*Intermediate or final post-primary*	*Third level or higher*	
	3 (11%)	8 (30%)	9 (33%)	7 (26%)	

Note: Disaggregated data by age is unavailable for the older homeless population.

identified. These were contextualised within the circumstances of participants' lives, and their experiences as older members of the two communities. The dimensions represent PHA states that characterised daily lives, desired outcomes, and/or participants' recognition of their PHA agency.

First, interviewees felt maintaining ***physical independence*** was a necessity for ageing well and autonomy. This emphasis appeared greater due to the advanced ageing effects that some participants believed impacted their lives and those of their peers. Being able to complete everyday activities (e.g., self-care tasks) was especially highlighted and as succinctly expressed by this OT man, was considered essential for personal dignity:

> Getting in my bath, [that's the problem] … I wouldn't let my daughter into the bathroom … I'd be ashamed of my life! (BC12-T-M-69)

Participants in both groups noted how crucial walking and mobility were for independence. For OT, this related to life-course cultural practices, such as hunting and keeping animals, and for older cohorts, nomadic lifestyles. For OH participants, particularly those in longer-term homelessness, this related to how walking was an essential coping strategy, being an affordable way to get places, something to do when feeling low, and a source of pride where some participants described themselves as 'expert' walkers. Some men emphasised their desire to maintain their physical conditioning, reinforcing their expression of 'tough guy' or 'sportsman' masculine identities:

> Physically I love to be strong, I love to be fast. I love to be the strongest and fastest. I really surprise people because of my weight, they think I'm not going to be the strongest, but believe me, I am! (SK4-H-M-69)

Second, most participants talked about ***relational connectedness*** as a hallmark of PHA. Interviewees specified the importance of striving for good relationships with family or people they loved. This was especially evident for longer-term homeless adults who had experienced estrangement from family, as this person describes:

> My own family … were all there yesterday and said: 'You'll never want for nothing. You just come in and live near us, we'll be delighted'. So, that kind of set-up [family reengagement] is kind of coming back and … [the possibility of living] the remainder of my life out there where they are. And I want that. (SK7-H-M-59)

Some participants mentioned that broader networks were important during times of difficulty. Irrespective of birth cohorts, OT focused on the wider Traveller community. For OH, the emphasis was on relationships they had with support workers, and/or within their localities. One longer-term homeless man highlighted how his decision to engage locally made him feel like he was '*starting to become [a] part of society*' (BC14-H-M-59). Participants emphasised that having access to both emotional and instrumental support was fundamental for PHA:

> Someone there to keep [an older person] happy and [give] love and attention [is important] … I have a little friend here now and she's very caring and a lovely woman. And you know, she always makes sure you eat and always phones and that's what you call a genuine friend … (BC-H-F-59)

Third, ***material security*** was central to PHA and linked to a range of health benefits. While several interviewees emphasised the importance of financial stability, the focus was mostly on secure accommodation (adequacy and tenure). Having an adequate, warm home was linked to dignity, a sense of self and, as this OT woman describes, morbidity and mortality outcomes:

> My uncles died when they were in their late 30's – one from pneumonia, one from TB – from poor living conditions … Whereas if we had proper living accommodation … a good warm house, of course you'll live longer, and your health will be better … (BC18-T-F-62)

OH interviewees spoke about security of tenure and how it was critical for a sense of stability. It was clear that many OH, regardless of the length of homelessness, viewed housing security as a priority goal due to their advancing age and their experiences of precarious living conditions:

> My goal was to have my own place by the time I was 60, because of the winters hitting in and I said 'Gary, you won't be able for it' … It's not so much the winters that I'm not able for. It's the loss and the constant living in that frame of mind. (SK7-H-M-59)

Fourth, many interview participants conveyed the importance of ***personal identity expression***. While the other dimensions supported this dimension, cultural activities and interests, religious faith and work were also significant. OT noted how much they valued Traveller cultural practices such as traditional music and, for older age groups, tinsmithing and nomadism. Participants from both groups cited hobbies which helped keep their minds occupied, and work, which bolstered their self-esteem. As this quote illustrates, such activities, even if in the past, provided a source of pride despite the losses that could challenge identity:

> I was a great guitarist in my time … I was a musician at one point in a band. I spent years teaching guitar … and I was very good at that. Like I turned out loads of guitarists. (KW1-H-M-61)

Spirituality and faith were closely connected to identity for a number of individuals in this study. Religion was described by some as a source of practical and cognitive support at times of ill-health and emotional difficulty. Some OT, especially those in older age groups, equated religion with a shared identity that extended beyond the Traveller community where general integration was otherwise challenging. Similarly, one OH participant noted that he always found community through his religion despite his transience.

> [Because of my religion, I have friends] … All over Ireland, yeah, all over Ireland and England. I go to any village, any town, and there's people there that loves me and waiting for me … just by my religion. (SK4-H-M-69)

Finally, ***proactive capacity*** was considered by participants to be essential for well-being and reflected their own agency in achieving PHA. Interviewees spoke about a positive attitude as critical in times of adversity, or when symptoms of pre-existing depression re-emerged. This emphasis was evident for both groups but was strongest amongst OH and the younger Traveller interviewees who were more aware of mental health challenges amongst their cohort:

> But I think it's good for your mind to … think of happy things because it's very good, especially if you're sick and down mouthed. You know, it's good for your body. (BC17-T-M-67).

Participants also emphasised the need to actively engage with health services through health checks and adhering to treatments. For OT, health-service engagement was something which they felt had traditionally been a problem in their community. Participants from the two groups asserted the importance of facing any illnesses head-on, with many stating that being proactive was about acknowledging their own role in securing better health for themselves.

> I mean you're your own gatekeeper really aren't you … If I noticed something [health problem], I wouldn't just ignore it … I'd go and talk to somebody [health professional] about it. I wouldn't just put it onto the back burner. (BC14-H-M-55)

3.2. Life-course and structural determinants

Four life-course determinants of PHA impacted participants' capacity to age positively, and largely correspond to the PHA dimensions. But where PHA dimensions were generally more outcome-orientated, determinants covered a range of time periods from early-to later-life experiences, and from one-off transformational events to life-long states. Across the determinants, participants identified experiences and turning points that positively impacted on, or which they drew upon for, their health and well-being. Given their causal and temporal links, negative life-course experiences are difficult to overlook when discussing determinants, and their influence will be referenced where appropriate.

3.2.1. Social relations

Social relations was the most prominent life-course PHA determinant to emerge from interviews, and was not just a driver of *relational connectedness* but also other PHA dimensions (e.g., identity expression). Interviewees from both groups experienced unstable relationships with early-life disruption (such as parental ill-health, neglect, and foster/institutional care), mid-life conflict (e.g., marital breakdown and domestic abuse) and later-life stress (such as, continued estrangement). For some, these experiences were associated with life-long impacts, including an inability to maintain close relationships. However, most participants emphasised that at least one set of positive relations had been critical in their lives.

Reflecting on early life, participants conveyed how relationships (typically familial) were fundamental to well-being, positively impacting their personal development. Many reported growing up in secure, loving families. For some OT, the emotional security they felt as part of a large family unit contrasted with experiences of impoverished conditions:

> 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. Because my father every Christmas … there were biscuits in the shops and we'd only see them through the window and … he'd put a biscuit, a sweet and maybe an orange into a cloth and he'd tie it … and he'd give one each to my sisters and myself … My father was awful pleasant … (BC19-T-F-53)

In adulthood and into older age, participants described the mobilisation of networks as a force for positive well-being during crises and offered examples of the social and emotional support that sometimes helped to facilitate positive change in their lives. Interviewees also spoke about the benefits of harnessing relational connections when dealing with complex mental health challenges:

> Without the grandkids, I don't think I'd be where I am today to be honest … The medication is working and maybe I feel a little bit better in myself but it's just the kids … Being able to pick them up in the morning, take them down to my house, spend the day with them, and that's great. That's half the battle. (KW3-T-M-52).

Participants' descriptions of networks pointed to a diversity of important relationships. That said, familial relations were strongest amongst OT, with few links between individuals and the settled community. As OH were more likely to have experienced relationship breakdown, family relations were not as strong. Nonetheless, reconciled relationships with children and siblings were noted by some as facilitating positive life changes. More prominently, OH described relational support from workers in homeless services and lauded how these individuals' empathy helped support their own agency for achieving wellbeing:

> I suffer from depression … and you know the girls that staff [name of homeless charity], they might make me a cup of tea or something. It's not that I couldn't make it myself. It's just I might be in the depths of depression and it's just nice to have a cup of tea and I find conversation lifts me totally … The pain eases, it becomes more manageable, and I function an awful lot better. (KW-H-M).

3.2.2. Material and accommodation circumstances

Material and accommodation circumstances emerged as an important determining factor of PHA. Almost all participants described experiences of material insecurity, with entrenched poverty evident within OTs' accounts. Thus, positive mechanisms in this theme comprised relative changes in conditions.

Generally, interviewees noted the rise in living standards, which enabled positive behaviours. Participants, particularly Travellers of a younger cohort (50–60 years), mentioned additional employment opportunities through state-sponsored schemes and improved welfare supports. While long-term unemployment was a feature of some participants' lives, and job loss was prominent in homelessness pathways, the state pension was credited by both groups with providing stability for those who met the age criteria.

Inadequate housing and accommodation displacement were common across both groups, although the timing and trajectories often diverged. The majority of OT reported having lived at some point – usually in childhood – in poor, sometimes temporary accommodation with no electricity or running water. Despite a sense of loss expressed for nomadic lifestyles by some older aged participants, the transition to 'settled' accommodation was welcomed, particularly with accommodation improving (albeit gradually) over time:

> … we travelled down around the country 'til I was four, and then … because you couldn't be let camp or stay in the place … So, we got a house then, kind of a shed house. It was very poorly, but it was warm, and we had a toilet and electricity … Every couple of year the Corporation would make our house a bit better, and better and better. (BC8-T-F-51).

Accommodation experiences of OH were less linear. Although some had lived in difficult environments or institutional or foster accommodation in their youth (approximately 6 participants), others had not. Instead, they encountered these challenges in adulthood or later life after first becoming homeless. It was again relative improvements in conditions that were emphasised and were compared with previous more precarious living circumstances: '*I've had to live within a tough life, out on the roads, extremely dangerous …* ' (SK7-H-M-59). These dislocating experiences meant that some participants spoke about the security of current accommodation circumstances, even when this involved living in emergency or in supported housing. As this OH woman describes, such accounts emphasised relative improvements in circumstances, and low expectations:

> Living here [supported accommodation] has been great, a sense of independence … It's fantastic here, I can't tell you enough about the place, how good it is, it's been unbelievable … I was just couch-surfing, I was everywhere and nowhere. It was awful. I don't know how I went through it to be honest. (BC22-H-F-60s).

Despite this, and irrespective of timing of homelessness, many participants highlighted the enabling nature of a permanent, private dwelling of their own for wellbeing and self-identity. An older man who experienced homelessness for the first time in later life expresses this:

> You have to have your own place where you can bring in your own friends, rather than being in, we'll say something like a hostel … but until such time as you regain privacy, my own place … you're lost, that's my feeling. (KW-H-M)

3.2.3. Formal supports and systems

Formal supports and systems were pervasive in participant PHA biographies. First, while many participants reported negative experiences with education, all interviewees emphasised its importance for longer-

term well-being outcomes. A small number of individuals, mainly OH, spoke positively of their educational experiences and cited benefits for health awareness and self-worth. Reflecting structural barriers to Traveller education, OT who highlighted positive impacts were typically younger in age and emphasised basic literacy. Education was a catalyst for these individuals, particularly in terms of health agency and literacy:

> If I get an [health] appointment tomorrow morning out in the post, I can read it. I can understand it. If a person gets a letter and they can't read it and they can't understand it … You have to go to try to find someone to read it to you … But I've often got people there ringing into my mother's house there, "I'll read it for you and I'll explain it …" That's the great thing about education. (KW3-T-M-52).

Second, although a quarter of interviewees reported negative experiences with the health system, most highlighted one or more important interaction with health supports in their lives. Participants from both groups noted how these experiences had enhanced trust in services. Descriptions praised service accessibility (especially in more recent years), and the high quality and personalised provision. Participants viewed these interactions as helping them to achieve good health in their lives, and/or to improve their quality of life through better treatment:

> [My] boss there was a total control freak. And he was giving me a really hard time there. It just dragged me down. I couldn't stand up for myself. So eventually I went to a doctor … and he prescribed antidepressants that took about two months to work and suddenly I felt on top of the world. (KW1-H-M-61).

Finally, two-thirds of respondents discussed the importance of supports from formal social care services. Despite accommodation difficulties, both groups praised representatives of public agencies or charities who helped to secure their housing supports. OT mentioned representative bodies in relation to supporting their rights, and support from social workers in dealing with complex situations, such as domestic violence. OH primarily talked about homeless support organisations, highlighting their multifaceted services (such as, accommodation and counselling), and how such support marked significant turning points. This was particularly emphasised by those who experienced homelessness for the first time in older age:

> If you had seen me when I came here first, oh my God … I had no weight at all. But they [homeless charity] 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. The people care about you, do you know what I'm saying? If I didn't come [here] or if I didn't meet people from [here], 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'. (BC21-H-F-59).

3.2.4. *Critical transitions and resilience*

Given the tumultuous circumstances of some individual's lives, unsurprisingly many participants had encountered traumatic life events. While such trajectories resulted in deleterious effects on well-being, and compounded challenges with respect to achieving PHA, interviews also suggest that these trajectories could indirectly lead to more favourable outcomes. This was especially the case where participants themselves were able to harness or frame experiences in positive ways.

Some participants conveyed a sense of being buoyed by having gotten through the hardest of times. Overcoming these challenges enhanced feelings of self-efficacy and, over time, contributed to a sense of resilience:

> How could somebody survive thirty fucking years of a street. Lost his children. Lost his home. Lost his love, lost everything he ever loved … and then come to a conclusion that I've done enough, that I've given enough of my life to the road … So I said 'What'll I do with what I have left?' Continue to give is what I will do. But in a different manner. (SK7-H-M-59).

For several participants, and somewhat problematically, previous harsh experiences constructed a relative appreciation for improved, but often still marginalised, conditions. For example, an OH man who had spent much of his adult life in prison described how long-term incarceration meant he viewed his situation in different terms:

> I'll always get out [of the accommodation], because I know what it's like to be having to fucking stay in – them four walls in prison and all that, done me the world of good. Now that I'm out, I appreciate what I see. (BC5-H-M-63).

In other cases, negative experiences served as catalysing events. A small number of participants highlighted low points in their lives that either forced them to seek formal support or effectively mobilised this support within their own networks. An OT man referred to such an example 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 that night [taking his own life] … 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 … (KW3-T-M-52).

Finally, experiences of discrimination, which were common amongst both groups, could lead to an attitude of defiance. In some cases, it motivated people to become advocates or to be empowered through learning – whether related to a fundamental skill, such as literacy, or becoming more aware of their rights. This was particularly strong for some OT participants:

> 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 … (KW-T-F).

4. Discussion

This article identified the core dimensions and key determinants of PHA for older Irish Travellers and older people experiencing homelessness, in the context of personal life experiences and social structures. There are three primary limitations to this analysis. First, the analysis did not involve OH currently living rough, or nomadic OT – although included those with experiences of both. This means the interview samples only represent currently settled OT and sheltered OH adults, restricting the sub-section representativeness of the sample. As such, the absence of these sub-groups reflects a sample bias and a sampling strategy failing that may mean the findings cannot be considered to represent those OT who are nomadic or those OH who are living rough. Second, and furthermore, the small sample size means these findings cannot be considered representative of the general experiences of these populations in Ireland or elsewhere. It is argued that the exploratory qualitative nature of the research, and the participatory elements of the overall design, hold particular value in capturing in-depth insights into participant experiences and life-course trajectories. Nevertheless, and although the themes are generally reflective of those documented in the international literature for these groups (Coates et al., 2015; Grenier et al., 2016; Oetzel et al., 2019; Waldbrook, 2015), the findings and conclusions presented in this article must be contextualised and interpreted within this limitation and cannot be generalised beyond this study. Third, in presenting the analysis for these two groups together there is a danger of homogenizing the circumstances of the two populations. The drivers of exclusion were often different (e.g.,

discrimination for OT; family breakdown for OH), with significant diversity also evident within each group. However, this article aimed to illuminate the neglected positions of older members of two social inclusion priority populations in Ireland (Smyth et al., 2017) which challenge PHA frameworks, within a country that has fully embraced these agendas. It is argued that exploring these inter-group perspectives provides for a more comprehensive assessment of the applicability of PHA constructs to diverse ageing populations (Stephens, 2017; van Dyk, 2014). In this regard, the analysis offers important insights for PHA policy for both groups.

The study indicates that participants' understandings of PHA dimensions incorporate the physical, social, psychological, and material aspects of life that have been noted for mainstream populations (Ryff and Singer, 1998) and for older homeless adults and those from indigenous ethnic minorities (Oetzel et al., 2019; Waldbrook, 2015). However, these dimensions were contextualised within participants' life experiences and their circumstances as members of marginalised older communities. Significantly, and as documented previously (Ranzijn, 2010), the findings illustrate the potential relevance of these concepts to participants' lives when they are interpreted from the perspectives of OT and OH themselves (Oetzel et al., 2019). It is evident across these dimensions that establishing stability and security, facilitating control and autonomy, and supporting personal and group identity all matter for these groups. This is reflective of the exclusions that individuals have had to contend with in their lives (Crane and Warnes, 2010; Watson et al., 2017) and the emphasis that some participants placed on their own agency in achieving PHA.

Similar patterns are borne out in relation to PHA determinants. The importance of each of these factors throughout the life course for these groups has been documented in the general wellbeing literature (Coates et al., 2015; Montgomery et al., 2016). Therefore, their prominence in this study is not unexpected and mirrors flexible, capability orientated conceptualisations of PHA, including Sadana's et al. (2016) four intermeshing blocks. While some pathways through which determinants influenced PHA were independent of individuals (e.g., state supports), others were not and implicated participants' actions at different points in their lives (e.g., mobilising networks), even if this was just availing of assistance when most in need. The tentative link between serious adverse events and positive outcomes must be interpreted with caution, where the margins between capitalising on such circumstances constructively and suffering their deleterious effects were often small and positive outcomes were the exception rather than the rule. Nonetheless, determinant factors were often integrated within coping strategies, for example, an OT participant reporting utilising particular relationships to bolster mental well-being, and an OH man reporting strategically accessing accident and emergency services on a Friday evening, knowing he would be allowed to stay over the weekend, and be able to avail of meals and accommodation. The findings, thus, demonstrate participants' capacity to negotiate challenges and harness limited resources to create positive PHA opportunities. Directing future policy to account for these PHA dimensions and to support these determinants will enhance the relevance of PHA agendas to the circumstances of both groups.

The potential for a gendered-influenced perspective within the findings must be acknowledged – although the sample imbalances may be somewhat wider population profiles (CSO, 2016). Amongst OT, gender norms around caregiving influenced life trajectories and the nature of events impacting wellbeing (e.g., reproductive health). Amongst OH, female domestic abuse and male institutional abuse were evident for some, and increased risks of homelessness. Masculine norms also appeared to shape the emphasis that older men placed on physical independence. These elements created gendered nuances (Hodgins et al., 2006), albeit the robustness of the dimensions and determinants remained for men and women. Variations in cohort perspectives were also apparent. For OT, nomadism and relative appreciation for improved circumstances were evident for those 65 plus, while concerns for mental health were strongest amongst younger individuals. Birth-cohort distinctions were less obvious for OH (notwithstanding historic macroeconomic factors like economic recessions), and instead timing of homelessness was key. As noted by Waldbrook (2015), participants who became homeless in later life were more likely to cite financial or housing issues as triggers. While these participants often had less accumulated trauma, these individuals were less familiar with how to negotiate support systems. Additionally, participants' intersectional positionalities could influence PHA capacities. This includes the greater level of accumulated exclusion due to life-long exposure to risk for many individuals. Intersectional considerations also include how complex health challenges could be exacerbated by age-related health declines. Although this increased need, with some participants placing a greater emphasis on health aspects of PHA, anecdotal evidence suggested that some older participants may have been prioritised (on a discretionary basis) within systems – partially explaining positive assessments of formal supports. Ultimately, however, future work regarding PHA will need to consider and further elaborate the influence of each of these factors beyond what is possible within this article's scope.

The findings do illustrate problematic elements for research and policy with respect to PHA for these groups. This pertains to how low expectations, because of deprivation experienced earlier in life, appeared to sometimes shape favourable descriptions of current circumstances and goals for inclusion. Previous studies (e.g., Grenier et al., 2016) have noted that there can be an effective ceiling on wellbeing ambitions for such populations. Moreover, framing these populations' experiences as determinants of PHA runs the risk of masking the entrenched disadvantage and, in many cases, the violation of rights (across civil, economic, and socio-cultural spheres) that can be encountered at group level and the traumatic events that characterise some individual trajectories. The findings infer a few specific challenges that must be accounted for within PHA approaches that aim to be meaningful for these groups (Milaney et al., 2020; Watson et al., 2017). These relate to the narrowness of supports (for example, family for OT and service-based support for OH), the depth of material deprivation, and the rupture in trust between individuals and society. As shown for similar populations (Coates et al., 2015; Milaney et al., 2020), participants were often only linked to one of the core social systems (family and friend, community and voluntary, state and private). This meant their ties to societal safety nets were often tentative and the potential for exclusion from such systems was high (Philip and Shucksmith, 2003). These challenges point to broader concerns with respect to safeguarding the rights and freedoms that should be afforded to the two groups under European and international conventions on human rights. For example, the sort of housing deprivation evident within OT interviews and the complete absence of housing security amongst OH is an area that needs immediate action by state authorities, particularly given the critical enablement role that housing can play in PHA trajectories evident within this and previous studies (Bates et al., 2020). More active scrutiny in this regard is required, along with a more detailed analysis of the consequences of violations for PHA.

But the positions of OT and OH also hold wider relevance outside of an Irish context. This is with respect to complementary insights relevant to growing populations of OH (c.f. Woolrych et al., 2015) and ageing indigenous ethnic minority groups (c.f. Oetzel et al., 2019). But it is also with respect to the ways in which the circumstances of these two groups illuminate life-course processes of interlocking marginalisation, especially those related to societal displacement, that need to be countered in the pursuit of PHA outcomes (Sadana et al., 2016). In this regard, this work has highlighted what others have identified as an increasing prevalence of insecure conditions in older age and the extension and impact of precarious life-course trajectories into later life (Grenier et al., 2020).

5. Conclusion

There is a fundamental need to move from a deficit-based to an asset-based approach, recognising the potential for PHA for the groups, and the legitimacy of setting policy goals on this basis. The circumstances of older Travellers and older homeless adults must be more actively considered within the development of PHA policy and practice. This is whether it is framed as "healthy ageing" or "active ageing." As problematic as some of these concepts may be, focusing on developing PHA initiatives in conjunction with these groups is likely to help achieve more equitable outcomes in ageing societies. Interventions will, in many instances, need to be targeted for each group. Nonetheless, a broader life-course approach – not tied to age-stage thresholds – is critical to enabling enhanced risk assessment, better decision-making regarding intervention timing, and the appropriate allocation of resources to secure PHA. 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.

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Brídín Carroll: Formal analysis, contributed to field work and of the data for this article. was the lead author, and co-wrote the paper with. **Kieran Walsh:** Formal analysis, Writing – original draft, contributed to field work and, of the data for this article. who contributed directly to writing and editing the text. **Thomas Scharf:** Formal analysis, contributed to the original study design, the of findings, and commented on and edited the text. **Diarmuid O'Donovan:** Formal analysis, contributed to the original study design, the of findings, and commented on and edited the text. **Sinead Keogh:** Formal analysis, contributed to field work and of the data for this article.

Data availability

The authors do not have permission to share data.

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