Older women's perceptions of the impact of homelessness on their health needs and their ability to access healthcare

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Abstract

Objective: This study explored the healthcare needs and barriers to health services in older homeless women in the Perth metropolitan area, Western Australia.

Methods: Twenty-two older women experiencing homelessness completed a questionnaire and semi-structured interview. Data were analysed using descriptive statistics and thematic analysis.

Results: The study highlighted that these women had complex and inter-related issues that affected their health. The nine major themes that emerged from the interview data consisted of: safe accommodation; financial insecurity; experience of trauma and abuse; stigma, embarrassment and fear of being judged; the health impact of not fulfilling their role as family nurturer; mental health; complex interaction of physical and mental health issues; healthcare costs; and the need for ongoing psychosocial and healthcare support once housed.

Conclusion: Provision of safe and secure accommodation is pivotal to women's health, as is the need for greater understanding of the impact of poverty, women's traditional roles, social disconnection and domestic violence, and ongoing access to healthcare and support services.

Implications for public health: A structural and systemic approach based on a social determinants of health framework is required to address the health needs of the increasing numbers of older women becoming homeless in this country.

Key words: older women, homelessness, health, healthcare, social determinants

Australian Bureau of Statistics (ABS) National Census data for 2011 and 2016 shows that the rate of homelessness in Australia increased by 14% across the period. The 2016 Australian Census estimated that more than 9,000 people experience homelessness in WA on any given night, with a consensus in the homelessness sector that it has since increased, both in Perth and regional areas.[1]

Homelessness comes in many forms. The AIHW considers that "a person is homeless if they are living in non-conventional accommodation such as living on the street, sleeping in parks, squatting, staying in cars, living in improvised dwellings; or short-term or emergency accommodation such as refuges, crisis shelters, couch surfing, living temporarily with friends and relatives, insecure accommodation on a short-term basis, emergency accommodation arranged by a specialist homelessness agency".[2]

Older women comprise the fastest emerging group among the homeless population, with rates increasing by 31% between 2011 and 2016.[3] The Specialist Homelessness Services (SHS), which provide support to Australians at risk of homelessness or who are homeless, has reported the number of women accessing their services exceeds the number of men, and there are significant increases in the number of older persons seeking support from their services. This reflects the growing problem of older people, particularly women, who are vulnerable to homelessness.[2,4-6]

It is recognised that statistical counts understate the full extent of the problem of older women experiencing housing crises and homelessness in Australia. Some women do not classify themselves as 'homeless' due to stigma, being in hiding or fearful of assault, or because they use informal networks of support such as 'couch surfing', staying with friends or sleeping in cars.[7,8]

The reasons underpinning this trend in older women involve socially determined, complex and systemic factors that have impacted on them over their lifetime. These include spending considerable time out of the workforce to care for children or older parents, socioeconomic disadvantage, domestic violence, trauma and mental health concerns, a high cost of living that includes unaffordable rent, and reaching retirement or becoming redundant with limited savings and inadequate superannuation.[6,7,9,10]

The World Health Organization (WHO) defines health as "a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity".[11] The social, economic and cultural conditions in which

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people grow, live, work and age contribute to health inequality and form the social determinants of health.[12] Homelessness is also an outcome of underlying structural factors and consequences, particularly social and economic disadvantage.[8,13,14]

Previous research from Australia and internationally has demonstrated that people experiencing homelessness have a high prevalence of a range of physical and mental health conditions that result in high rates of morbidity and mortality.[15-17] The homeless are also known to be less likely to access primary and preventive healthcare services resulting in their health needs being unaddressed until they present as seriously ill with a medical crisis at hospital emergency departments.[13,14,18] This interconnectivity between homelessness and health is well recognised by Stafford and Wood who stated that "we need to view homelessness as a combined medical and social issue. Addressing homelessness is, in itself, an important form of healthcare, not a separate 'non-health' issue".[14]

Despite a growing awareness of the increasing cohort of older women becoming homeless, there are limited data in the research literature about their health needs and how their health is impacted by their homelessness experience. While some earlier studies have examined the underlying causes and impact of homelessness in women,[19,20] very few have focused specifically on older women, despite it being known that they are at special risk. This has led to calls for more research to guide how best to frame government policy to address the intersecting health and homelessness issues facing older women.[8,10,21]

This study aimed to help fill this void by exploring the impact of homelessness on the health and wellbeing of older women who live in Perth, Western Australia. The research uses a mixed methods approach to develop a deeper understanding of the factors impacting on them and any barriers to accessing existing healthcare services.

Methods

Recruitment

A total of 43 organisations were identified, of which forty were listed on the Department of Child Protection and Family Support's public access website as providing services to the homeless in metropolitan Western Australia. On advice from the homeless sector, three non-government (philanthropic-funded) services were also identified. Following review or follow-up of each organisation's mission statement on their website, eight organisations supported only homeless males or the younger population, leaving 35 that provided some level of support to women. Of these, 16 indicated that they were willing to further assist in the research. From these, a sample of seven homeless support services was selected using a maximum variation sampling approach[22] to ensure a distribution of the homelessness service types and potentially the women's own diverse experiences based on a range of criteria that included organisational size, range of services provided and the level of support to access healthcare services.

The selected seven organisations were then asked to approach potential study participants that met the AIHW's definition of homelessness.[2] In a two-stage process, following an initial introduction by a senior staff member, the researcher, who was an older Caucasian woman with considerable experience in women's health nursing, further explained the interview process and clarified any concerns with the women. Time was taken to develop rapport with the women and all indicated a willingness to participate. Of the 22 women identified, all signed consent forms prior to completing a questionnaire and a voice recording of their interview.

Questionnaire and interview design

The development of the questionnaire and interview schedule was based on two previous studies involving homeless populations that incorporated a broad social determinants approach.[23,24] Additionally, local homelessness services, healthcare providers and a clinical psychologist specialising in women's health and domestic violence were consulted. Both tools were pilot tested before use.

The participants completed an initial questionnaire that obtained a range of demographic, social and health information before a semi-structured interview that provided a deeper exploration of their experiences with homelessness, health concerns and ability to access healthcare services. Each woman took between 60 and 90 minutes to complete the process.

All the interviews took place in a private setting within the facilities of the specialist homelessness service through which they were recruited, except for one woman who elected to be interviewed in her temporary (supported) rented apartment where she was living at the time.

Data analysis

Questionnaire data were analysed using descriptive statistics. The digital recordings of the women's interviews were transcribed by an independent person. The accuracy of each file was verified against the recordings by the researcher with a sub-set reviewed by an independent researcher. Interview transcripts and notes were imported into NVivo 11 and coded inductively to an emergent coding framework to facilitate thematic analysis.[25]

The study was granted ethics approval by the Human Research Ethics Committee at The University of Notre Dame (approval number 016100F).

Results

Questionnaire data

At the time of the interview, the average age of the 22 women interviewed was 59.8 years with a range of 48 to 82 years. More than one-third of the women were experiencing homelessness for the first time. Seventeen women (77%) had been homeless for more than 12 months, but this ranged from <3 months (9%) to >10 years (27%). Sixteen women (73%) were born in Australia, including seven (32%) Aboriginal and Torres Strait Islander women. More than 30% of the women were born overseas including two women born in England, two in New Zealand, one from Bosnia and one from Africa. Twelve women (55%) had completed high school education, including nine women who had TAFE or higher education qualifications and one with university qualifications.

Most women (16; 73%) were living in short-term/ transitional housing with four (18%) in emergency accommodation and two (9%) sleeping rough.

A history of domestic violence was reported by 18 (82%) women with their intimate partners being the major source of the abuse. Prior to becoming homeless, 13 women (59%) had required medical attention for injuries inflicted by their partners, with two of these women (9%) requiring hospitalisation and suffering long-term impacts of acquired brain

injury (ABI). Physical abuse after becoming homeless was also reported by seven other women (32%,) with four being assaulted and three raped while living on the streets.

In response to the question: *In general, how would you describe your current health?,* 16 (73%) stated it was fair to very poor. For many (13; 59%), their current health was similar to a year ago, but others (6; 27%) reported it had improved since finding somewhere safe and secure to live. The most common health concerns and issues reported by women (18; 86%) included injury and trauma, upper respiratory tract conditions (17; 82%), depression (16;73%) sleeping disorders (16; 73%), fatigue (16; 73%) and chronic pain (13; 59%).

The women reported accessing a wide range of health services since becoming homeless. The most common were: GP services (including mobile GP services [7; 32%] and hospital emergency services [9; 40%]), although 11 women (50%) reported being admitted to hospital. Many of the women accessed counselling services (psychological [12; 55%], general [12; 55%], sexual assault [6; 27%]) and just over one-third of the women utilised mental health services (8; 36%). Similarly, the women had accessed dental (11; 50%) and seven women (32%) had accessed allied health services.

Interview data

Thematic analysis of the interview data resulted in nine major themes presented below with additional relevant details obtained from the questionnaire. Although outlined separately, elements of the themes overlap and intersect, highlighting the complexity of women's experiences of homelessness and the inter-related nature of their homelessness and healthcare needs. Each theme is detailed in the following sections including illustrative quotes from the women (fictitious names have been used).

Accommodation and safety

When asked, *What does it mean to you to be healthy*? and *What are your main health needs now*? many of the women recognised the multidimensional aspects to the term, with one woman stating:

> *So, that's your physical health. Your emotional health. Your mental health. Your spiritual health. And your financial health as well and having no pain.* (Dawn, 66)

However, almost all of the women linked their health and health needs as being dependent on having safe, affordable accommodation, as illustrated in the response below:

> *Oh, for me being healthy would be a proper home environment. To have a decent home-cooked meal, in you know, in a place where I can sleep, rest and relax. And safe. It's really unsafe out there at night.* (Rose, 52)

In addition to the security element, safe accommodation also enabled storage of food and personal items that were essential to improving health.

> *For me, it's having a home – having a fridge, and an oven and a stove … you know, just the basics that people would take for granted … the most important things because without that I can't control my diabetes for a start, which is not helping my other health issues – my diabetes has gotten worse … because I can't cook and can't keep fresh food …* (Angela, 50)

Accommodation also provided a place where the women felt they could get more control of their lives and mental and physical wellbeing.

> *Having stable accommodation, having weekly appointments with my doctor for my mental health issues and my counselling … it just means I can have a life.* (Sara, 55)

Inability to fulfil their role as family nurturer

A series of questions explored the women's family networks. Many of the women had become estranged from their families through family conflict and reported the level of distress this caused them. Although 12 (55%) women said they currently had some level of family support, mainly in the form of their children, these women were still in the process of reconnecting. Their need to regain a connection and continue to engage with their children and grandchildren was integral to their physical and mental recovery and ongoing health status. Tanya initially left her children with her parents to live in her car for a short period of time to get herself 'sorted out' but ended up sleeping on the streets for an extended period and became estranged from her family for several years.

> *I felt like I was a failure as a parent, you know, a failure as a woman … the mistakes and things I've done in my life.* (Tanya, 52)

Furthermore, women spoke of how they sought regular contact with their families with virtually all of the women who had children (only two women had no children) stressing their need to find long-term accommodation. This would enable them to re-establish a relationship with their families and provide a place for their children and grandchildren to come and visit.

Carol (aged 60) stated that her main health need was "having a full day with family". Of the 16 women living in transitional accommodation, 14 commented on how they valued the support they had received from the homelessness service providers to regain lost contact with their children. Another participant who had been couch surfing and then moved into her car before finally moving into transitional accommodation noted that being homeless meant she didn't have a place where she could engage with her children:

> *I didn't have my family, my kids around me … I didn't know what the purpose was in my life anymore. One of the things about homelessness … is not having a home for my children and grandchildren.* (Jennifer, 69)

Women's experience of violence and abuse

Through both the questionnaire and interviews, women revealed the level of family violence they had been exposed to, which included physical, emotional and financial abuse that most of them had experienced during the course of their lives and had occurred both prior to and during periods of homelessness.

While they had escaped domestic violence, the women continued to recall their previous experiences of trauma and abuse that still impacted on their physical health and wellbeing. Eighteen women (82%) reported family and domestic violence had been a contributing factor to their homelessness, with 13 women having required medical attention for physical injuries inflicted by their partners when living at home. Two women said they had been too afraid to seek medical attention. Four women (18%) reported having acquired brain injuries (ABI) from severe beatings by their male partners. Two of these women had been hospitalised, one of whom was admitted to intensive care and then long-term rehabilitation.

> *I had a very difficult life with my husband, my life was hell with him, he wouldn't let me leave the house.* (Katy, 60)

Nearly one-third of the women said they needed to seek medical attention due to physical injuries while being homeless but

most of these incidents had occurred prior to being homeless.

More than half of the women (59%) also experienced violence after becoming homeless. Two had been physically abused by their ex-partners/husbands after they had moved out of their homes. Eleven women reported they had been kicked, attacked and physically assaulted while living on the streets. Those women who were sleeping rough remained at risk of further trauma, abuse and sexual assault and stressed their fear of being on the streets at night. This included three women who said they had been sexually assaulted (by men other than their partners) while living on the streets, one of whom had contracted HIV as a result.

> *It's dangerous out there… it's extremely dangerous and violent.* (Tanya, 52)

Almost all the women (86%) said the impact of the injuries and trauma resulting from domestic violence was their most common health concern.

> *You know, I had a pretty protected upbringing … never sort of came across these sorts of problems [I had] with my ex-husband, so I didn't know how to deal with it. I have the memories and the flashback of the bashings all the time."* (Gwenda, 65)

Financial insecurity

Financial insecurity was a contributing factor to becoming homeless. For many, the pathway to homelessness was due to a breakdown in their relationship and not having enough money to live on, including paying their rent.

> *During my second divorce, my husband left me half a house, like a house with a mortgage. And I tried to manage, but I couldn't; my car blew up, so I had to borrow, and the bank wouldn't let me borrow more money for my car, so I had to sell the house.* (Gwenda, 65)

Once homeless, many reported that the worry and anxiety about how to pay for food, rent and utility bills (and costs of running in a car and parking fines for those women sleeping in their cars) had impacted on their health, particularly their mental and emotional health.

> *I'd been living on the streets; I didn't even know how to write … I'd become illiterate … I couldn't even write my name I was shaking that much …* (Dawn, 65)

The majority of the women also reported that they had never previously sought social security and the lack of knowledge of how to access financial and social support after becoming homeless was a major stressor:

> *I always had an income, and this would be the first time that I found I just couldn't turn around and get that help.* (Jennifer, 69)

Others highlighted the additional financial and emotional costs of being without accommodation:

> *Your stuff gets pinched all the time … I'm constantly replacing medications and clothes and just everything I own … having to replace it all the time, so it ends up costing you more than it would if you were actually paying rent and had somewhere you could keep everything safe.* (Rose, 52)

Mental health

More than half the women reported mental health concerns that were either pre-existing or had developed as they spiralled into worsening circumstances. At the time of the study, three-quarters of the women indicated they had or were currently experiencing depression, with half of these reporting they also suffered from other mental health conditions including bi-polar disorders, anxiety and stress relating to their homelessness. Most of the women took prescribed antidepressants and insomnia medications with sleeping problems, fatigue and exhaustion reported by 73%.

> *The emotional side of it just brought me down to feeling worthless … and there's nothing worse than feeling like, so far in life, and then told you're worthless.* (Jennifer, 69)

Many of the women referred to prolonged episodes of grief, with several recounting how they mourned the death of their parents who had died during that time, or the loss of their relationship and their homes, such as Jennifer who had lost both parents after she became homeless.

> *That was just devastating. They were both in their nineties and dad died within two weeks … I was grieving my parents enormously. The grief counsellor said, "Do you realise it's not just your parents you are grieving for? … You're grieving the loss of your profession, the loss of your marriage, the loss of your farm and the loss of your parents so close together."*

Of those women who managed to find longer-term accommodation, many commented that their mental condition persisted and, in some cases, contributed to becoming homeless again.

> *Bruises heal. The mental stuff doesn't.* (Gwenda, 65)

Even after receiving transitional accommodation, another woman reported still feeling suicidal.

> *I thought what have I got to live for?* (Daphne, 54)

Complex interaction of physical and mental health needs

When asked to identify their current and previous health conditions from a range of health issues, the majority of women (91%) reported having a mix of both mental and physical health concerns including exhaustion, insomnia and pain that often originated prior to their homelessness and was related to the inter-relationship of their health and their homelessness situation. Almost three-quarters (74%) reported that they suffered from or currently experienced depression, with half reporting they suffered other mental health conditions compounded by their becoming homeless. Those women currently or recently living on the streets particularly reported high levels of anxiety and stress-related digestive problems.

The most common health concern across both periods of time related to injuries and trauma (86%) with almost three-quarters (73%) of women reporting mental health conditions. Almost two-thirds of women (60%) reported ongoing sleeping problems and fatigue (especially while living on the streets) with a similar number also having chronic pain.

This is demonstrated by the example of one woman, whose struggle with Lupus Erythematosus, hypertension, PTSD and deteriorating diabetes contributed to the stress she experienced after job loss, relationship breakdown and the subsequent eviction from her home onto the street:

> *As soon as I stopped working, I didn't realise how exhausted I had become. So, my body was starting to break down, but then when I became homeless … it worsened … it quickened again, it progressed … I can't believe what I've been through.* (Stella, 56)

Most confided they had major mental health concerns aggravated by multiple complex inter-related physical and mental health conditions including exhaustion, insomnia, pain, and chronic diseases including diabetes, osteoarthritis, which they felt had worsened since becoming homeless. In some cases, head injury sustained from domestic violence also resulted in ongoing headaches and episodes of memory loss. One woman stated

that coping with the ongoing emotional trauma was more difficult for her than the physical effects of violence from her partner:

> *The abuse … at the moment, that's the least of my worries. Abuse, I can deal with. Physical stuff like that you can deal with. It's the mental and emotional side of it that I find hard to deal with.* (Gwenda, 65)

Stigma, shame, embarrassment and fear of being judged

The women spoke constantly of their personal feelings of shame, the stigmatisation they had experienced being homeless, and their fear of being judged by homelessness and healthcare providers as well as the wider community.

> *It's really hard when you hit rock bottom … you feel worthless, you feel ashamed … and you know, people know you, from ages ago and they see you're homeless. There is a big stigma and embarrassment about being homeless.* (Jennifer, 69)

> *People make a judgement about you just for being homeless* (Tanya, 52)

Many women attributed their embarrassment in preventing them from seeking healthcare, especially when they had first become homeless. They were also reluctant to return for continuing care when they feared that medical and nursing staff would be judgmental. Tanya reflected how she had used the same GP for 35 years until she became homeless:

> *When I became homeless, I was too embarrassed to go and see my GP because he's known me all my life and I felt like … I'm going to have to admit I actually am a failure at the moment in my life …* (Tanya, 52)

The cost of healthcare services and pharmaceuticals

With scant financial resources and complex comorbidities, more than three-quarters of women raised the cost of healthcare as a major concern that stopped them from accessing healthcare. While many of the women had used GP services, they complained of limited access to bulk billing doctors and other healthcare professionals. Similarly, those requiring medical specialist consultations said they were required to pay a Medicare gap fee if they went outside the hospital sector regardless of their 'homeless' status.

The financial barrier spanned the full spectrum of services to include dental, allied health and mental health providers. Almost three-quarters of the women reported having dental problems but spoke of the difficulty finding a dentist they could afford. Almost all the women said allied health services were generally cost-prohibitive. Although 55% of women had used counselling where available, access to non-Medicare funded psychology services was unaffordable.

The cost of medications was also reported as an issue, especially if they had been prescribed numerous medications. Women found that this consumed a considerable proportion of their pension money and compromised their ability to meet their other basic needs.

> *There's a lot of money that goes toward medications … and it keeps building up, every time I see the rheumatologist, there's add on, add on.* (Stella, 56)

Need for ongoing support once housed

All the women regarded housing as their most basic need for their health, with those living in short-term accommodation stressing they required ongoing support until they were back on their feet. Those who had moved into transitional accommodation reported that their health had generally improved initially with the relief of moving into safe accommodation, but many still struggled with ongoing complex health problems. For example, Sarah (aged 55), who had been sleeping rough for years unmedicated with a bipolar disorder and now had stable short-term supported accommodation, explained that medical support providers "come out every Monday night to see me … it's so valuable I just look forward to Monday nights."

Similarly, the women spoke of how staff at the homelessness services had continued to help them access healthcare and social security, reconnect with their family and find more permanent accommodation.

> *It's just getting you back into society, so you signed a lease, so you can have a reference … that sort of helps you transition back into the world again.* (Tanya, 52)

Additional barriers to access support and healthcare services

In addition to issues captured within the themes, many of the women discussed their initial lack of knowledge of how to find housing and support services, including healthcare. Due to the impact of domestic violence, many women wanted access to health services provided by female health professionals.

> *We need more services designed for women that have women there, so they feel safe.* (Gina, 51)

Problems were also identified with arranging and attending clinical appointments, and the need to raise awareness of healthcare staff of the needs of older women experiencing homelessness, including early intervention so they could help women access homeless and social support services as soon as possible.

Discussion

As the number of older women living in poverty in Australia increases, their diminished financial resources and limited affordable housing make them vulnerable to becoming homeless.[7,9,10]

The findings of this and other comparable studies show that the pathways into homelessness comprise of a complex mix of social and economic factors and adverse experiences including poverty and financial distress, lack of safe and secure housing, family breakdown, abuse, trauma, social disconnection and mental health issues.[7,15,26,27]

While the health concerns of the homeless have been universally well described,[15-17] those of older homeless women are far less understood. The women in this study overwhelmingly identified that safe accommodation was pivotal to their health and wellbeing. This provided them somewhere secure where they could relax, heal, reconnect/engage with family and store their belongings and their medications, and removed them from other living situations that exposed them to physical and sexual abuse, as reported by others.[7,28,29]

In keeping with the view that shelter (housing) is a basic human need and an important determinant of health and wellbeing,[11,30,31] the women in this study reported that not having stable living conditions contributed to their physical and mental health problems that had further deteriorated as these living conditions worsened.

The fact that the women regarded housing as being their primary need related to health fits with concepts such as Maslow's hierarchical needs that suggest homeless

people address their basic safety and physiological needs (food, water, sleep, safety and security) before they try to find preventative care or seek appropriate healthcare outside of critical circumstances[32] and that safe accommodation is essential for homeless women to regain their lost autonomy and enable recovery.[7,33]

While accommodation was the fundamental solution for their homelessness, all of the women in this study had complex health and social needs requiring ongoing social and healthcare support that should continue even after being permanently housed. Such requirements have been identified by other researchers; in addition to contributing to the improvement in the health of older homeless women,[34] supportive housing and other community services can potentially provide these women access to ongoing support to prevent them becoming homeless again.[15]

Another key finding in this study was the extremely high proportion of women reporting domestic and family violence (82%). This is in keeping with national data that show domestic and family violence as the most common cause of homelessness for Australian women.[6] However, the proportion of women in this study who had experienced domestic violence (82%) far exceeded the one in six (17%) Australian women reported to experience physical and/or sexual violence from a current or previous cohabiting partner.[6] This higher figure may reflect the older age group of the current study but may also represent a more candid response due to the manner in which the data was collected. It indicates a need to raise awareness of the high proportion of older homeless women who may have experienced domestic violence. Importantly, other studies have found that older women are less likely to disclose having experienced abuse for a range of reasons including shame, denial (including self-denial), suppression, fear of isolation and estrangement from family including children and grandchildren, difficulty in leaving their lifetime home, and lack of knowledge about accessing support.[35,36]

Of further importance was that the consequences of domestic violence, both before and during periods of homelessness, had a significant and ongoing impact on many of the women's mental and physical health problems.[35,37]

In keeping with other studies, this study identified that, especially for those who were homeless for the first time, the women lacked knowledge of where and how to access social and healthcare services.[7,38] The women in this current study said that their financial situation limited their ability to access services largely due to the lack of bulk-billing GPs and the costs of medical specialists, allied health (including psychological) and dental services, and the women's abilities to pay for any Medicare gap fee. The cost of medications was also problematic, especially when women had been prescribed numerous medications and were unable to cover the gap of a pensioner discount for some medications. Access to healthcare systems (the healthcare sector) is a fundamental determinant of health.[39] Healthcare-related costs are among the most significant barriers to access health, most acutely affecting the poorest sectors of society.[40]

Women's access to services was compounded by their feelings of shame and embarrassment, and feeling they had been adversely judged when seeking support and healthcare due to the "stigma around homelessness". Other researchers have highlighted the importance of providers understanding how these negative perceptions can impact on people experiencing homelessness and that the stigma and stereotyping homeless women feel further compounds their reluctance to seek support.[41,42] Similarly, addressing the challenges of prejudice and poor staff communication, establishing trust and facilitating homeless people feeling welcomed, listened to and supported can make a profound positive difference to their health-seeking behaviour and overall wellbeing.[15,43]

Lack of availability of female healthcare providers also affected women accessing healthcare, especially those women who had experienced abuse from their male partners who were afraid or reluctant to see male providers and sought female doctors, nurses, and psychologists. This finding is also consistent with other studies that have found that access to female healthcare providers for counselling and screening is important for women affected by trauma.[44-46]

Study limitations and strengths

This is one of the first Australian studies to explore the health needs of the growing cohort of older women experiencing homelessness. The key strength of this study is the level of information obtained by in-depth probing of the health issues and barriers to accessing healthcare faced by the large number of older women with diverse lived experiences of homelessness.

While every attempt was made to ensure that a representative sample of older homeless women was invited to participate in the study, the process required representatives from homelessness organisations to identify and encourage homeless women to meet with the researcher and participate in the research. This approach means that this study will not reflect the views and insights of women who have had no contact with any specialist homeless service, although many of the women in the study do reflect on this phase of their personal experiences. There was a small sample size (characteristic of qualitative studies) and the women were living in a range of different situations; although this makes generalisability challenging to the broader homeless women population, it does provide rich information on women's experiences of homelessness, although the findings could vary depending upon their own unique set of circumstances.

Similarly, due to the transience of this population, this cross-sectional study may not enable broader conclusions about the direct effects of homelessness on healthcare needs to be drawn that may have been possible using a longitudinal design.

Conclusion

The study demonstrates the intrinsic links between homelessness and health and the underlying influence of the social determinants of health on women's lives. The study highlighted the importance of increasing the provision of safe, affordable housing before older women reach crisis point and the need for wrap-around social and healthcare support services to prevent them from becoming homeless again. The study also stresses the need for the provision of non-judgemental and supportive healthcare services and recommends that that policies and integrated service models should be developed within a social determinants of health framework to meet the unique needs of these women.

To help inform how to best address the needs of these older homeless women, further research into awareness-raising strategies for healthcare providers needs exploring so that

women at risk of homelessness and those who may have recently become homeless can be identified and linked to support services. Similarly, given the high proportion of women in the current study who had been subject to family and domestic abuse, further work is required to identify strategies for better understanding the long-term impact of domestic violence and how to best provide service supports to the increasing numbers of older women escaping violence.

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