

# Health Intelligence briefing

## Mental health of Travellers

**This document has been supplied to you in confidence as background for the purposes of a specific tender or small grants process. You may use extracted information from it but you may not electronically share this document or make it available via websites without prior arrangements with the author/s identified at the back of the document.**

The WHO defines mental health as “a state of well-being in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community. In this positive sense, mental health is the foundation for individual well-being and the effective functioning of a community”.<sup>1</sup>

This brief explores the evidence around the mental health of Travellers. Inevitably, the negative side of mental health – mental health problems and mental illness (ie diagnosable disorders) – are also examined. Many factors influence mental health and these are explored here, taking into consideration that these links can be bidirectional. Before addressing prevalence, influencing factors, help-seeking and treatment provision and uptake, a brief summary on Traveller culture is given which provides the context for understanding the association between influencing factors, mental health and help-seeking.

There is indication that Travellers experience worse mental health and a higher rate of suicide than the settled community (ROI data only). Mental health is interrelated with substance misuse and other factors (eg domestic violence, social support) which have also been identified as contributors to the mental health of the general population. However, Travellers often experience worse levels of such influencing factors. Their effects are compounded by discrimination and Traveller culture itself may ameliorate or exacerbate them. Low rates of help-seeking and negative perceptions of (mental) health services (ie as insufficient, inappropriate, culturally insensitive) can also be understood in this context.

---

<sup>1</sup> <http://www.who.int/mediacentre/factsheets/fs220/en/>

### *Sources for this brief*

One of the key sources for this brief is the All Ireland Traveller Health Study (AITHS).<sup>2</sup> Whenever possible, only the NI data are presented. However, for some issues ROI findings were used as no NI information was available; this is acknowledged in the briefing. The qualitative study of the AITHS, unfortunately, does not allow disentangling whether any issues were more relevant for the NI or ROI context. Due to the sparse NI-based information, many of the other references relate to Travellers' experiences in ROI or even GB; again, this is acknowledged.

---

<sup>2</sup> [http://www.dohc.ie/publications/traveller\\_health\\_study.html](http://www.dohc.ie/publications/traveller_health_study.html)

# Content

	Page
1. Traveller culture	1
2. Mental health and mental health problems	1
2.1. Prevalence – adults	1
2.2. Prevalence – children	2
3. Influencing factors	3
3.1. Living circumstances/accommodation	4
3.2. Discrimination	4
3.3. Traveller identity	5
3.4. Social support/social capital	6
3.5. Substance use and abuse	7
3.5.1. Alcohol	7
3.5.2. Illicit drugs	9
3.5.3. Prescription drugs	10
3.5.4. Substance misuse services: treatment provision and uptake	10
3.6. Domestic violence	10
3.7. Sexual orientation	12
3.8. Life events: loss and bereavement	12
4. Help-seeking for mental health problems and use of services	13
5. Mental health of Traveller prisoners	14
6. Suicide among Travellers	16
7. Summary and conclusion	18
References	19
Appendix	22

## List of tables

Table	Page
1. Number of days in the past 30 days that mental health was not good (NI)	1
2. Prevalence of mental health problems among Travellers	2
3. Wellbeing of children and young people in NI: findings from the Travelling and general population using the KIDSCREEN-10	3
4. Attitudes towards Travellers and other ethnic minority persons	4
5. Traveller children's experience of being picked on: parent report (NI)	5
6. Agreement with ' <i>Generally speaking, most people can be trusted.</i> ' among Travellers in NI	6
7. Number of close friends among Traveller children and young people in NI	6
8. Frequency of alcohol use among Travellers in NI	7
9. Quantity of alcohol consumed on days when respondent was drinking: Traveller and general population (NI)	8
10. Alcohol consumption among 14 year old Travellers in NI (N=56)	8
11. Percentage of Traveller women accessing help organisations for domestic violence in ROI	11
12. Perception of opportunities to access services as everyone else and service uptake in the last 12 months among Travellers in NI	14
13. Prevalence of mental health problems and substance abuse among prisoners	16
14. Crude suicide rate among Travellers (per 10,000 population) in ROI	17
15. Ongoing and immediate risk factors for suicide among Travellers in ROI	18
A1. Health related quality of life in children and young people in the Traveller and settled community in NI	22
A2. Which ethnic minority community is there the most prejudice against? Top 3 ratings for 2005-9	23
A3. Ever felt discriminated against as a member of the Travelling community (NI)	23
A4. Experience of bullying among 7-12 year olds in the last couple of months (Southern area, NI)	24
A5. Barriers to help-seeking and leaving an abusive relationship	25
A6. Irish Travellers in prison: population and risk of imprisonment	26
A7. Suicide profiles of Travellers according to Walker (2008)	27

Please note that whenever figures are presented, 'N' denotes base figure and 'n' denotes actual count.

## 1. Traveller culture

Traveller culture is marked by very close-knit families, where ties to even removed kin are strong (referred to as familial). The family offers immense social support, both emotional and practical, and security throughout life. Being physically close to family is so important that Travellers prefer to live in poor accommodation together rather than be split into different housing estates (see AITHS Team, 2010a; Walker, 2008 for summaries).

Traveller culture is also marked by patriarchy and strong gender role demarcations (AITHS Team, 2010a; Allen, 2011; Walker, 2008). Traditionally, women have been responsible for childcare and the home and have been financially dependent on their husbands who make the decisions. As Traveller women marry at a young age, they move into the husband's extended family network. Almost all Travellers are Catholic and religiosity is strong<sup>3</sup>; thus, religious values also underscore the importance of marriage (Allen, 2011).

As in many cultures where the family is highly valued, issues of shame and dishonour are significant and social sanctions are applied to preserve the interests of the family and the individual's responsibility to their family. Travellers keep dysfunctional family members within their group for longer than the settled population. However, if anyone is ever excluded, this individual suffers extremely serious consequences ("*social deaths*", Walker, 2008; p.46; van Hout, 2011a).

In recent times, there have been changes, with more Traveller women accessing education and work and their attitudes becoming more amenable to separation and divorce despite family pressures (eg Watson & Parsons, 2005).

## 2. Mental health and mental health problems

Overall, there is very little research on the mental health of Travellers in NI or ROI. Available evidence is generally of a qualitative nature, thus prevalence figures are scarce and often tied to small geographical areas. In addition, hardly any information on Travellers' presentation to health services and their uptake was available as an ethnic identifier in the health care recording systems has been lacking.

### 2.1. Prevalence – adults

The AITHS asked adult Travellers (aged 15+) about the number of days in the last month that an individual's mental health was not good. Table 1 shows that 57% of Travellers (59% of men, 55% of women) reporting at least one day when their mental health was not good. There was a considerable age gradient: having at least one day of not so good mental health increased with age (AITHS Team, 2010b).

Table 1. Number of days in the past 30 days that mental health was not good (NI)

	<b>None</b>	<b>1-7</b>	<b>8-14</b>	<b>15-21</b>	<b>22+</b>	<b>N</b>
<i>Total</i>	43.2%	48.5%	6.4%	1.6%	0.3%	373
Male	41.4%	51.6%	5.9%	1.1%	0%	186
Female	44.9%	45.5%	7.0%	2.1%	0.5%	187
Under 30	53.2%	41.6%	4.2%	1.1%	0%	190
30-44	35.4%	52.8%	11.0%	0%	0.8%	127
45+	26.8%	62.5%	3.6%	7.1%	0%	56

Source: AITHS Team (2010b); adults aged 15+

<sup>3</sup> Although the AITHS shows a weakening of religious beliefs (AITHS Team, 2010b).

It has been suggested that Travellers have higher rates of mental health problems than the settled population (see Walker, 2008 for summary). In Table 2, findings of several studies are summarised. Prevalence figures were scarce, particularly when looking for specific diagnostics categories, and none were found for NI. Comparison data from the 2010/11 NI Health Survey indicate that 1 in 5 adults in the general population had signs of a possible mental health problem (DHSSPS, 2011a).

Table 2. Prevalence of mental health problems among Travellers

Source	Area	Traveller prevalence
<b>Stress</b>		
Heron et al. (2000) <sup>a</sup>	ROI	<ul style="list-style-type: none"> <li>46% of mothers were psychologically distressed</li> </ul>
Leonard & O'Leary (2006) <sup>b</sup>	Donegal	<ul style="list-style-type: none"> <li>80% suffer stress in their daily lives</li> </ul>
<b>Depression</b>		
Pavee Point (1997, unpublished) <sup>c</sup>	ROI	<ul style="list-style-type: none"> <li>34% of Traveller women suffering from long term depression compared to 9% of settled population</li> </ul>
Leonard & O'Leary (2006) <sup>b</sup>	Donegal	<ul style="list-style-type: none"> <li>41% were diagnosed with depression by doctor (living in sites 50%; living in houses 26%)</li> </ul>
<b>Mental health problems</b>		
SAAT (2011)	SHSCT	<ul style="list-style-type: none"> <li>70% of adult population having mental health problems according to Traveller Support Workers</li> </ul>
<b>General population comparison – NI Health Survey 2010/11</b>		
DHSSPS (2011a)	NI	<ul style="list-style-type: none"> <li>39% reported high levels of worry and stress (12% a great deal, 27% quite a lot of)</li> <li>1 in 5 adults showed signs of a possible mental health problem (17% males, 23% females)</li> </ul>

Note: <sup>a</sup> in Walker (2008); <sup>b</sup> Donegal Travellers' Project: health survey 2005; <sup>c</sup> in Pavee Point (2006)

There is some anecdotal evidence of mental illness among Travellers presenting to Belfast HSCT. In a small sample of 11 Traveller women who attended maternity services, four had a history of depression or other psychiatric problems. The Primary Mental Health Team receives about 10-15 referrals per year. These are mainly Traveller women who present with depression which is primarily related to existing circumstances such as feuds, social issues, unemployment and a general feeling of hopelessness, while the harmful use of drugs or alcohol was not an issue.<sup>4</sup>

Qualitative accounts suggest that men see depression as a female malady but have started to question this (AITHS Team, 2010a). Traveller men admitted to mutual pretence and denial of depression, using macho image and bravado to mask low self-esteem and powerlessness.

## 2.2. Prevalence – children

In contrast to the adult population, for Traveller children more standardised information on their wellbeing/mental health is available. In the AITHS, children's and young people's wellbeing was assessed with the KIDSCREEN-10, a measure of health related quality of life (see Table A1 in Appendix for full detail; AITHS Team, 2010b). Comparison data for the general population is available from the Kids Life and Times survey (KLT) 2010.

<sup>4</sup> Personal communication with Stephen Long, Community Development Worker (BHSCT), 20 April 2012.

Overall, a larger proportion of Traveller children and young people seem to fare better in their wellbeing as indicated by the 'always'-responses, except for feeling sad, lonely, and treated fairly by their parents (Table 3). However, examining the detailed Table A1, it shows that Traveller children were more likely to occupy the extreme ends for each individual question. Please note, in the AITHS parents reported on their children as part of a face-to-face interview, while in the KLT 2010 children answered themselves which may account for the differences.

Table 3. Wellbeing of children and young people in NI: findings from the Travelling and general population using the KIDSCREEN-10

Thinking about the past week, ...	Traveller children aged 9 % always <sup>a</sup>	Traveller young people aged 14 % always <sup>a</sup>	General population year 7 % always <sup>b</sup>
Felt fit and well	71.9	72.7	35
Felt full of energy	69.2	66.1	36
Felt sad	4.7	7.3	2
Felt lonely	6.3	7.4	2
Had enough time for self	49.2	51.8	31
Used free time as wished	64.6	50.9	31
Felt treated fairly by parents	58.7	42.6	70
Had fun with friends	76.2	55.6	65
Got on well at school	62.9	44.2	37
Could pay attention	60.3	46.3	35

Sources: <sup>a</sup> AITHS Team (2010b) – parent report; <sup>b</sup> Kids Life and Times Survey 2010, child self-report, ages 10-11 in primary schools year 7: <http://www.ark.ac.uk/klt/2010/Kidscreen/>

For the Southern area in NI, information is also available on wellbeing through Traveller children's self-report (ages 7-12; Biggart et al., 2009). Also using the KIDSCREEN-10, Traveller children demonstrated the poorest outcome for social health compared to white NI children but were indistinguishable regarding mental health. Analysis of further measures of psychological wellbeing showed that Traveller children had the lowest level of positive psychological characteristics compared to white settled and other minority ethnic children. This was marked by low self-perception and a low internal locus of control.

### 3. Influencing factors

*"Poor mental health is ... associated with rapid social change, stressful work conditions, gender discrimination, social exclusion, unhealthy lifestyle, risks of violence and physical ill-health and human rights violations."*<sup>5</sup> Persistent socio-economic disadvantage (eg poverty, low levels of education) also negatively influences mental health (WHO, 2010). Please note that many of the discussed factors also affect the mental health of the settled community (eg substance abuse, domestic violence, sexual identity); a few factors, however, are more focused for Travellers (eg discrimination, accommodation, Traveller identity).

<sup>5</sup> <http://www.who.int/mediacentre/factsheets/fs220/en/>

### 3.1. Living circumstances/accommodation

Travellers face numerous problems around their accommodation needs (see summaries in AITHS Team, 2010b; Walker, 2008). Legal barriers, housing policies and discriminatory practices (by planning and the settled population: 'not in my backyard'; evictions) prevent the provision of suitable accommodation such as properly supplied sites and group housing schemes (AITHS, 2010b; Van Hout, 2011a; Walker, 2008). Poor accommodation and poor environment affects Travellers mental health and thus are a key problem (eg poor standard of services and facilities, see AITHS Team, 2010a, b; see also Walker, 2008). In Donegal, 50% of Travellers living on sites stated that the accommodation situation was cause for stress, with more Travellers living on sites reporting depression than those living in houses (Leonard & O'Leary, 2006). Standard housing also comes with problems, as disconnecting Travellers from their extended family network leads to social isolation which can result in depression (AITHS Team, 2010a; van Hout, 2011a). There were also fears that living away from family and mixing with settled people on housing estates promotes engaging in alcohol and drug misuse (Van Hout, 2010a, 2011a).

### 3.2. Discrimination

Travellers experience widespread discrimination and racism (AITHS Team, 2010a, b; NICEM, 2011; Walker, 2008). Over the period 2005-9, Travellers were rated among the top three (generally ranked second) ethnic minority communities that were perceived to receive most prejudice in NI (Table A2 in the Appendix). In relation to accepting a person in various social relationships (neighbour, colleague, friend, relative by marriage), Travellers received worse ratings than someone from a minority ethnic group in general (Table 4).

Table 4. Attitudes towards Travellers and other ethnic minority persons

Would you accept ...	an Irish Traveller as ...			someone from other ethnic groups as ...		
	Yes	No	Don't know	Yes	No	Don't know
	%	%	%	%	%	%
... a resident in local area?	43	55	2	90	10	0
.. a colleague?	69	30	2	90	9	1
... a close friend?	50	46	4	82	16	1
... a relative by marriage?	51	47	2	79	19	2

Source: NI Life and Times Survey 2009; <http://www.ark.ac.uk/nilt/results/mineth.html>; Please note that 'other ethnic group' means someone from a minority ethnic community in general; this question was NOT asked in comparison to Travellers; ie the questions were asked independently of each other.

High proportions of Travellers reported that they had felt discriminated against in all areas of life (see Table A3 in the Appendix). The lowest rate (42%) was reported for getting on a sports team, while over 7 in 10 (71%) had felt discriminated against in the street/in public, regarding being served in a shop/pub (72%) and getting accommodation (76%), with the latter two areas showing particularly high frequency of incidence. In general, more male than female Travellers have ever felt discriminated against, with some differences in the high incidence category (4+ occasions). Getting work and contact with the police/courts were highly problematic areas for Traveller men. When accessing health care services, over half had experienced discrimination, with 1 in 8 (13%) having done so 4 or more times (AITHS Team, 2010b).



Local information from the Southern area (NI) shows recent experiences of discrimination, with 12 incidents of refusal of services (eg for family functions such as christening, wedding; entry to restaurant/bar; and put out of shop) and 12 incidents of racism being reported. The local support group had to be involved in booking venues or arranging viewing accommodation; this situation is particularly aggravated in Lurgan and Craigavon (SAAT, 2011). Travellers in NI also have a higher risk of being subject to police stop and search (1 in 36 over period 2006-10) compared to the general population (1 in 96; see NICEM, 2011).

About three quarters of Travellers reported worrying about experiencing unfair treatment (51% sometimes, 24% most of the time; N=393), while one in four (25%) reported worrying about unfair treatment rarely or never (AITHS Team, 2010b). *“The context of Travellers’ lives includes stress generated by living in a hostile society where discrimination is a constant reality ...”* (Pavee Point, 2006; see also AITHS Team, 2010a). Perceived discrimination, as a main source of stress among Travellers, affects their mental health, *“leading to feelings of depression, anxiety and suicide”* (AITHS Team, 2010a, p.74f). In addition, feelings of paranoia and a sense of resignation and fatalism were also noted.

Feeling a sense of difference and shame, triggered by discrimination and social stigma, starts early in a child’s live (AITHS Team, 2010a). Already among 7-12 year old Traveller children there was an *“acute and widespread”* sense of exclusion (Biggart et al., 2009, p.45). Traveller children in the Southern area of NI had a strong negative sense of belonging at school and low participation rates in extracurricular activity. Moreover, they also reported a higher level and intensity of bullying than white or other ethnic minority children (see Table A4, Appendix). In contrast, findings from the AITHS, based on parental responses (AITHS Team, 2010b), suggest a lower rate of being ‘picked on’ among Traveller children and young people, with girls more likely to have experienced it.

Table 5. Traveller children’s experience of being picked on: parental report (NI)

	9-year olds		14-year olds	
	N	Yes	N	Yes
All	63	22.2%	53	17.0%
Males	38	18.4%	26	7.7%
Females	25	28.0%	27	25.9%

Source: AITHS Team (2010b), responses to the question: *Thinking back over the last year, would you say that anyone (either a child or an adult) picked on your child?*

### 3.3. Traveller identity

Although Travellers identify themselves as an ethnic group, they are not homogenous and show a variety of cultures and belief systems. The ideal of the nomadic lifestyle is still central to Traveller identity (AITHS Team, 2010a); unsurprisingly, those travelling frequently reported better mental health (Leonard & O’Leary, 2006).

Due to experiencing wide-spread discrimination and stereotyping, Travellers reported having internalised the negative views of them. Some Travellers resort to ‘passing off’, ie to hide their Traveller identity and blend in with non-Travellers, to avoid discrimination, for example, when accessing social and recreation facilities (AITHS Team, 2010a). In some contexts, such as prison, Travellers are reluctant to self-identify (Mac Gabhann, 2011). For Traveller men in particular, social exclusion and stigmatisation were among the biggest problems they faced (AITHS Team, 2010a).

### 3.4. Social support/social capital

The AITHS (AITHS Team, 2010b) examined various sources of social support/social capital for Travellers. In line with the high value placed on the family, family members were an important source of social support, particularly a Traveller's own parents:

- Parents ranked highest as a source that provided a lot of support: 46% (males 42%, females 50%), followed by other close relatives (28%), children (28%), and spouse/partner (27%);
- About 6 in 10 (males 63%, females 59%) said that spouse/partner was not applicable;
- Over 1 in 7 (15%; males 12%, females 17%) said that friends were not applicable in their situation and a priest/nun was not applicable for 4 in 10.

Trusting other people is an important aspect of social capital. Only 1 in 4 (27%) Travellers agreed/strongly agreed with the statement that most people can be trusted, while the largest proportion remained uncertain (Table 6). Younger adults were more likely to agree, with older adults more likely to be uncertain (AITHS Team, 2010b).

Table 6. Agreement with '*Generally speaking, most people can be trusted.*' among Travellers in NI

	<b>Strongly disagree</b>	<b>Disagree</b>	<b>Neither agree nor disagree</b>	<b>Agree</b>	<b>Strongly agree</b>	<b>N</b>
<i>All</i>	7.7	22.7	42.6	19.6	7.4	392
Male	6.8	23.0	46.1	18.3	5.8	191
Female	8.5	22.4	39.3	20.9	9.0	201
Under 30	10.3	20.6	38.7	24.0	6.4	204
30-44	5.4	25.6	42.6	17.1	9.3	129
45+	3.4	23.7	55.9	10.2	6.8	59

Source: AITHS Team (2010b)

Parents reported that both Traveller children and young people have good friendship networks (Table 7). In addition, parents showed high involvement in shared activities with their 9-year olds such as eating together (95%), visited relations (100%), chatted (95%), and sat and watched TV together (94%; N=62; all other N=64) (AITHS Team, 2010b).

Table 7. Number of close friends among Traveller children and young people in NI

	<b>9-year olds</b>			<b>14-year olds</b>			
	<b>N</b>	<b>0-10</b>	<b>11-20</b>	<b>N</b>	<b>0-10</b>	<b>11-20</b>	<b>21-30</b>
<i>All</i>	60	96.7%	3.3%	55	87.3%	10.9%	1.8%
Male	35	94.3%	5.7%	27	88.9%	11.1%	0%
Female	25	100%	0%	28	85.7%	10.7%	3.6%

Source: AITHS Team (2010b)

Qualitative accounts demonstrate that those who had more frequent contact with settled people reported better social relations (AITHS Team, 2010a). Moreover, Traveller women who took up training and work as Traveller Community Health workers highly valued the social contact, social networking, information exchange and social separation from the home which promoted their self-esteem. Once women leave school at an early age, they are bound to the home and can feel isolated as they miss the social contact facilitated in school. There was some indication that this isolation leads to young women presenting with 'dysteria' (unhappiness) at doctor's practices. However, modern technology seems to offer

new avenues for maintaining contact, particularly for young women, through social networking sites which in turn has a positive effect on their mental health (AITHS Team, 2010a).

### 3.5. Substance use and abuse

NI prevalence figures are available for alcohol use but not for drug use (AITHS Team, 2010b). Several studies in ROI explored alcohol and drug use (eg Fountain, 2006; Van Hout, 2010a, b, 2011a, b; Walsh, 2010), using qualitative methodology, but were biased by overly relying on the perceptions of service providers and non-drug using Travellers (primarily females) (see also Keane, 2011). These studies are also restricted to particular geographical areas (Walsh, 2010: Dublin; Van Hout: West of Ireland). As part of the AITHS, addiction-specific focus groups were conducted in ROI only (AITHS Team, 2010a).

#### 3.5.1. Alcohol

Traveller women were more likely than Traveller men to report never consuming alcohol and drinking alcohol at a lower frequency (Table 8; AITHS Team, 2010b). Fewer Travellers (61%; aged 15+) drink alcohol than in the settled population in NI (74%; aged 18-75; DHSSPS, 2011b). With increasing age Travellers were more likely to drink alcohol and to do so more often (AITHS Team, 2010b). The age-related drinking pattern among Travellers seems to be reversed to that in the settled population where it is decreasing with age.

Table 8. Frequency of alcohol use among Travellers in NI

	AITHS						Drink alcohol (ADP 2011)
	Never	Monthly or less	2-3 times per month	2-3 times per week	4+ times per week	N	
All	39.3%	19.3%	18.5%	15.0%	7.8%	399	74%
Male	32.8%	14.4%	22.6%	19.0%	11.3%	195	78%
Female	45.6%	24.0%	14.7%	11.3%	4.4%	204	72%
<30	45.4%	20.0%	18.5%	11.7%	4.4%	205	82%
30-44	32.1%	20.1%	18.7%	17.2%	11.9%	134	81%
45+	35.0%	15.0%	18.3%	21.7%	10.0%	60	75% (45-59) 59% (60-75)

Source: AITHS Team (2010b): adults aged 15+; ADP 2011 ... Adult Drinking Pattern Survey (DHSSPS, 2011b); adults aged 18-75 (N=2022), reported for the last week;

Among those who drink alcohol, 66% of male and 39% of female Travellers consumed at least 6 drinks on the days they were drinking (Table 9). This level of alcohol consumption can be considered binge drinking although it is difficult to establish as the NI definition of binge drinking is based on alcohol units (males: 10+ units, females: 7+ units; see Table 9). Compared to the latest prevalence in the general population (30%; DHSSPS, 2011b), Travellers seem to have a level of binge drinking that is almost twice as high (54%).

Table 9. Quantity of alcohol consumed on days when respondent was drinking: Traveller and general population (NI)

	AITHS						Binge drinking (ADP 2011)
	Number of drinks						
	0-5	6-10	11-15	16-20	21+	N	
All	46.4%	40.0%	8.1%	4.3%	1.3%	235	30%
Male	34.4%	48.4%	10.2%	5.5%	1.6%	128	35%
Female	60.7%	29.9%	5.6%	2.8%	0.9%	107	25%

Source: AITHS Team (2010b): adults aged 15+; ADP 2011 ... Adult Drinking Pattern Survey (DHSSPS, 2011b); adults aged 18-75; binge drinking at least once in the week prior to the survey of those that use alcohol (N=972); males 10+ units, females 7+ units;

The vast majority (>90%) of young Travellers aged 14 do not use alcohol (Table 10). In contrast, 55%<sup>6</sup> of settled young people (aged 11-16, YPBAS 2007) have ever had an alcoholic drink, with 19% having consumed alcohol in the last week (SMR, 2009).

Table 10. Alcohol consumption among 14 year old Travellers in NI (N=56)

	Never	Rarely	Every month	Every week	Every day
Beer	94.6%	1.8%	3.6%	0%	0%
Wine	94.6%	3.6%	1.8%	0%	0%
Spirits	92.9%	5.4%	1.8%	0%	0%
Alcopops	91.1%	3.6%	3.6%	1.8%	0%
Cider	94.6%	5.4%	0%	0%	0%
Other alcohol	92.9%	7.1%	0%	0%	0%

Source: AITHS Team (2010b)

Focus group evidence confirms the survey findings. Alcohol use was considered as socially acceptable and “as an important social outlet for men” (AITHS Team, 2010a, p.59), with even excessive alcohol use being seen as “normal” (Van Hout, 2010b, p.37). Similar to the general population, alcohol was neither viewed as a drug nor as dangerous (AITHS Team, 2010a). Alcohol abuse seems to be more common among men but is on the increase among women and young people, with women more likely to hide it (AITHS Team, 2010a; Pavee Point, 2004; Van Hout, 2010a, 2011b). The exclusion from pubs and other licensed premises is believed to fuel the unregulated excessive drinking in halting sites, fields and caravans, while others report that mixing with the settled community causes binge drinking (AITHS Team, 2010a; Van Hout, 2010a). Alcoholism seems to be accepted, to a certain level, among Travellers as “if this is ‘normal’ part of Traveller culture” (Van Hout, 2010a, p.61). It needs to be noted that alcohol abuse is a problem in Irish society in general, not just for Travellers (Walker, 2008; Van Hout, 2010a)

Excessive alcohol use is linked with domestic violence, mental health problems (eg depression), suicide, child neglect, poverty, and possibly initiating to experiment with drugs (SAAT, 2011; Van Hout, 2010a, 2011b; Walker, 2008). A lack of understanding of the signs of alcoholism remains (AITHS Team, 2010a). Shame/embarrassment is a major barrier to seek treatment, with women being prevented due to cultural norms. As alcohol use is also considered a coping mechanism, high levels of boredom, stress and depression may make reducing it difficult (AITHS Team, 2010a; Van Hout, 2010a, 2011b).

<sup>6</sup> In the 2010 YPBAS this was down to 46%

(<http://www.csu.nisra.gov.uk/YPBAS%202010%20Headline%20bulletin.pdf>).

### 3.5.2. Illicit drugs

About 2 in 3 respondents in NI (65%; N=367) considered illicit drug use to be a problem in their community (AITHS Team, 2010b). Hard drugs were less of a problem among Travellers in NI than in ROI or GB (ie restricted to one or two small towns) (AITHS Team, 2010a). In general, drug use in the Traveller community is lower than in the settled population but has been increasing (Fountain, 2006; Van Hout, 2010b). According to one service provider, drug use (particularly cocaine, ecstasy and marihuana) has been increasing since the ceasefire, in line with the settled population (AITHS Team, 2010a, p.58). In ROI, cannabis, cocaine, and ecstasy are the most commonly used drugs, with amphetamines, heroin, crack, LSD, and solvents being less commonly used (Fountain, 2006; Van Hout, 2010b).

ROI research suggests that drug use and abuse is almost exclusively a male problem (eg Fountain, 2006; Van Hout 2010b, 2011a) but this could be an artefact based on relying primarily on non-drug using female respondents. Young Traveller men report drug use among females (AITHS Team, 2010a). Yet, Traveller females' lower drug use could be understood as resulting from the lack of financial opportunity (traditionally men controlled the household income) and the strict control of young female Travellers (eg chaperoning, Van Hout 2010b, 2011a). In contrast young male Travellers enjoy freedom and experience unstructured leisure which may increase their risk for drug use (Van Hout 2011a)<sup>7</sup>.

Drug abuse is considered a serious problem and there are accounts of drug use being considered as both a taboo and becoming acceptable and normalised (AITHS Team, 2010a; Fountain, 2006; Pavée Point 2004; Van Hout, 2011a). Older Travellers in particular demonstrated fear of drugs and suspicion around their use whilst perceiving all drugs as equally dangerous which relates to the great sense of shame experienced when a family member misuses drugs (Van Hout, 2010b).

Drug (ab)use is seen as a consequence of discrimination, marginalisation and mixing with the settled community (AITHS Team, 2010a; Fountain, 2006; Pavée Point 2004; Van Hout, 2011a). It is made worse by these factors as well as by domestic violence, poor mental health, and stress, and in this context reflects to be a coping mechanism (Van Hout, 2010b). In addition, drug abuse has been associated with antisocial behaviour, community conflict, financial exploitation, suicide and parasuicide (linked to the inability to repay drug debt) (AITHS Team, 2010a). Drug dealing is increasing and provides a lucrative diversion of economic activity; this has increased income and status for some but also established violent gang-type behaviours between families (Fountain, 2006; Van Hout, 2010b, 2011a). Travellers' nomadic lifestyle and fear of purchasing drugs from settled people facilitate drug dealing, leaving drug use invisible and, therefore, "*difficult to control, quantify and address*" (Van Hout, 2011, p.212).

The close-knit community can facilitate shared drug use among family members (eg parents, siblings) but also contributes to families hiding drug use among their members (eg denial of a problem), thus drug use among Travellers is dually hidden (AITHS Team, 2010a; Fountain, 2006; Van Hout, 2011a). The shame and stigma attached to drug use prevent help-seeking; social sanctions may be applied which can include drug addicts being rejected by their community (AITHS Team, 2010a; Fountain, 2006; Van Hout, 2011a).

---

<sup>7</sup> This related to the concept of monitoring (or the lack of it). Monitoring refers to parental knowledge of their child's whereabouts, company and activities and is considered a protective factor in the general literature of adolescent substance use (Barnes et al., 2006; Dishion et al., 2003; Steinberg et al., 1994).

### 3.5.3 Prescription drugs

Misuse of and dependence on prescription medication emerged as a very common problem, particularly for Traveller women (AITHS, 2010a; Fountain, 2006; Pavee Point 2011; SAAT, 2011; Van Hout, 2010b). High levels of use of sedatives, tranquilisers, and antidepressants were reported (Fountain, 2006). There are issues regarding prescribing practices for such medications such as over-prescribing (long periods), repeat prescriptions without review, and Traveller women ordering medications for their husbands. Travellers themselves get prescriptions from more than one doctor, commonly engage in medication sharing (but not with children), self-medicate (change daily dose; take higher dose over shorter period), and even sell prescription drugs (AITHS Team, 2010a; Pavee Point, 2011; Van Hout, 2010b). There is also a misperception that *“benzodiazepines are not harmful as they are prescribed by medical professionals”* (Pavee Point, 2011, p.7). In addition to normalising their use, dependence and risk of poisoning (when combining use with other substances), medication over-use causes safety problems such as driving under the influence of prescription drugs and leaving appliances (eg cookers, heaters, stoves) unattended (Pavee Point, 2011).

### 3.5.4. Substance misuse services: treatment provision and uptake

In ROI, Travellers are underrepresented in counselling and residential treatment (Van Hout 2011b).<sup>8</sup> Due to the high stigma and shame of substance misuse, Travellers will try to deal with problematic substance use themselves through home detox and religion (AITHS Team, 2010a; Fountain, 2006; Van Hout, 2011a). Those presenting at treatment services were male, had alcohol dependence, attended *“once or twice, and usually in the advent of a court case”* (Van Hout, 2010a, p.62). Group counselling with settled people, residential treatment and after care are considered unsuitable by Travellers and treatment can be complicated by high rates of dual diagnosis (Van Hout, 2010b, 2011b). Other complaints about services/resources include a lack of understanding of Traveller culture, restricted opening hours (thus relying on A&E), and a lack of assisting with literacy issue (Fountain, 2006; Van Hout, 2010b, 2011b). The harm reduction approach taken by substance advice services clashes with Travellers' preference for abstinence (Van Hout, 2010a, b). Moreover, Travellers are reluctant to receive advice from settled people or women and prefer gender-based peer-led educational models (Van Hout, 2011b). Aside of cultural awareness training for health care staff, Travellers prefer trained Traveller health advocacy workers and addiction counsellors as well as greater outreach and family support (for homeless, domestic violence, prisons) (Fountain, 2006; Van Hout, 2010a, b, 2011b). In addition to changing service provision, demand for taking up services needs to be created among Travellers (AITHS Team, 2010a, p.66).

## 3.6. Domestic violence

Domestic violence is not specific to Travellers and it has been contested whether it is more prevalent within the Traveller community (Pavee Point, 2005). Yet, it has been suggested by Traveller women and service providers that domestic violence is more acceptable within the Traveller community (AITHS Team, 2010a; Allen, 2011; SAAT, 2011; Watson & Parsons, 2005). Factors contributing to domestic violence are endorsement of patriarchal views of marriage and women's sexual autonomy, social isolation, family/community members not intervening in domestic violence, and socio-economic disadvantage (eg poverty, lack of access to education and employment opportunities) (see Allen, 2011; WHC, 2009 for summary).

---

<sup>8</sup> Belfast HSCT Addictions Team do not receive many referrals of Travellers for their services and it is uncertain where Travellers receive support with addiction problems

It is not possible to identify the level of domestic abuse suffered by Traveller women (and men)<sup>9</sup>. A few studies of domestic abuse are available for ROI; however, these used focus groups with Traveller women and service provider information. Prevalence figures are only available for accessing help organisations (Table 11). While Traveller women defined domestic violence as including both physical violence and mental/emotional abuse, many did not see marital rape and sexual assault as serious offences (Watson & Parsons, 2005). Moreover, many Traveller women admitted having endured domestic violence, with some acknowledging that “*it had become normalised in the community, that is, it had existed through generations, ...*” (AITHS, 2010a, p.54). Traveller women are disproportionately represented in admissions to refuges and service users in gender-based violence (GBV) organisations (Watson & Parsons, 2005; WHC, 2009). They were also more likely to present more than once at a refuge compared to settled women (57% vs 35%; Watson & Parsons, 2005).

Table 11. Percentage of Traveller women accessing help organisations for domestic violence in ROI

Source	Method	Prevalence
Watson & Parsons (2005)	2003 Survey of 18 refuges, 15 responses	<ul style="list-style-type: none"> <li>49% of admissions by Traveller women (7.6% Traveller woman alone; 40.9% with children)</li> </ul>
WHC (2009)	Survey of N=62 GBV organisations (voluntary sector); 77% response rate	<ul style="list-style-type: none"> <li>15% of service users accessing GBV organisations</li> </ul>
	Survey of all registered GPs (N=2,226); 498 responses	<ul style="list-style-type: none"> <li>34% (n=169) reported to have one or more female patient from ME group who disclosed experience of GBV</li> <li>Of these 169 GPs, 23% reported Traveller women disclosed sexual violence by intimate partner</li> </ul>
Women's Aid (2011) <sup>a</sup>	N=297 minority callers to national free phone helpline	<ul style="list-style-type: none"> <li>4% of minority callers were Traveller women</li> </ul>

Note: Traveller women = 0.5% of female population aged 15+ in ROI Census 2006 (WHC, 2009); GBV gender-based violence; <sup>a</sup> Women's Aid Ireland annual statistics reports 2007-10: between 12 to 15 Traveller women called their helpline per year. <http://www.womensaid.ie/policy/publications.html>

Aside of physical damage, domestic violence results in loss of self-esteem, depression, anxiety, post-traumatic stress syndrome, alcohol/drug abuse, and even suicide<sup>10</sup> (Walker, 2008; WHC, 2009). Traveller women were also very concerned about the impact of domestic violence on their children. These worries centred around children becoming victims of violence themselves (as a way of further distressing their mother) and witnessing violence/abuse and how it impacts on their mental health, missing school, etc. One of the women's greatest fears was that their children might be taken into care which made them reluctant to report domestic abuse (Allen, 2011; Watson & Parsons, 2005; WHC, 2009). In NI, however, there was concern that social workers would not intervene soon enough in Traveller families with domestic abuse compared to the settled population (NSPCC, 2009).

<sup>9</sup> Traveller men would be unwilling to discuss this issue with any one due to their strongly endorsed masculine role (see Watson & Parson, 2005 for not including them in their research).

<sup>10</sup> See suicide section: Walker (2008) found cases in her detailed analysis of Traveller suicides where this was the woman's only perceived option of escape.

For any woman trying to escape from domestic abuse is difficult. Traveller women, however, have a double handicap due to the discrimination by the settled population (including a cultural bias that domestic violence is 'normal' among Travellers) and the entrenched gender roles, patriarchy and familial emphasis in their own culture (AITHS, 2010a; Allen, 2011; Watson & Parsons, 2005; WHC, 2009). Thus, Traveller women face a greater variety of barriers when seeking help (see Table A5, Appendix).

Disclosure of domestic violence is easier to a friend or a stranger than to a woman's mother, to spare her the upset and prevent interfamily dispute (Watson & Parsons, 2005; WHC, 2009). Refuges are considered a last resort and were used only when women were desperate and had nowhere else to go; any word of having stayed there compromises her reputation. Traveller women also face a dilemma when calling the Gardai: whether or not Gardai come and take effective action, the woman will face recriminations from her partner and/or her community, undermining her confidence in contacting the Gardai again (Watson & Parsons, 2005, p.155). Barring orders are often difficult to implement when women live on halting sites as partners may park their caravan next door. Any activity to seek help and protect herself puts a woman at increased risk of further retaliation from her partner and her community (eg being ostracised, physically assaulted). With suitable accommodation for safe re-homing being scarce, for some the only safe option may be to cut all links with their own and their partner's family and move to a different location. However, this also leaves her without vital social support (Allen, 2011; Walker, 2008). *"Even though she is the victim of crime, she is effectively 'on the run', living like a protected witness, but without the protection."* (Allen, 2011, p.10).

Exploring what might help women in abusive relationships, a number of suggestions arose (AITHS Team, 2010a; Allen, 2011; Watson & Parsons, 2005) and are summarised in the Appendix.

### **3.7. Sexual orientation**

Lesbian, gay, and bisexual (LGB) people experience worse mental health than the heterosexual people in the general population (Chakraborty et al., 2011; King et al., 2007). Homophobia is present in both the settled and Traveller community in NI. Among Travellers, the patriarchal culture and *"entrenched traditional male and female roles"* (AITHS Team, 2010a; p.55) can make it especially difficult for LGB people to openly display their sexual orientation. Although gay Traveller men may get married and then separate to be accepted as 'straight', women face greater difficulty due to the power imbalance. *"Being a gay Traveller was reported to risk double jeopardy sometimes as it was both difficult to come out gay in the Traveller community and difficult to declare a Traveller identity in the gay community. Being a lesbian might be considered a triple jeopardy."* (AITHS Team, 2010a, p.56). Entrenched traditional gender roles and close family ties constrain opportunities to build a new life and identity. *"Leaving a spouse or fiancé also means family exclusion to a large degree so there are more social, emotional and financial risks to consider"* (p.57). Overall, similar to the settled community, there are examples where LGB couples were accepted in their community and others where homosexuality was denied and hidden.

### **3.8. Life events: loss and bereavement**

Stressful life events are a risk factor for individual's mental health (Mentality, 2003; see also Walker, 2008). Travellers have a high experience of loss and bereavement due to their higher mortality at all ages compared with the settled population (based on ROI figures; AITHS Team, 2010c, d). The general mortality rate is 3.5 times higher among Travellers



compared to non-Travellers (infant mortality rate 3.6 times higher). Particularly worrying is the high number of excess deaths in male Travellers due to external causes of which suicide is common (AITHS Team, 2010c, d) and poses a significant risk for further suicide in those bereaved by suicide (Agerbo, 2005; Walker, 2008; see also section 6).

Loss of a child/pregnancy is another stressful life event. The birth cohort study of the AITHS (AITHS Team, 2010e) examined the health of Traveller infants and their mothers in ROI and provides information on Traveller women's experience of miscarriage, stillbirth and death of a baby. From the general health survey of the AITHS (AITHS Team, 2010b) some information is available for NI.

- Among Traveller women in NI who have ever been pregnant, 29.5% (N=95) reported having ever lost a baby (at any time during pregnancy or in the post-partum period). Half of these women (N=20) had experienced this once (AITHS Team, 2010b; p.164-165).
- In absolute terms, Traveller women (in ROI) experienced a higher rate (30.3%) of miscarriage (within 24 weeks) as compared to non-Traveller women (22.6%). However, Traveller women have a higher number of pregnancies. When miscarriages were seen as a function of total number of pregnancies, Traveller women had a lower rate than non-Traveller women (18.8% vs 23.2%; AITHS Team, 2010e).
- Traveller women (in ROI) had a higher rate of stillbirth than non-Traveller women (5% vs 1.6%; AITHS Team, 2010e).
- A higher proportion of Traveller women (in ROI) experienced that their live born child subsequently died as compared to the general population (5.3% vs 1.5%; AITHS Team, 2010e).

#### **4. Help-seeking for mental health problems and use of services**

Within the Traveller community there is strong stigma attached to mental health problems which impacts on Travellers' help-seeking behaviour (AITHS, 2010a; Pavee Point, 2006). Traditionally priests provided informal counselling and some Travellers used their doctors (AITHS, 2010a). The extended family had proven important; primarily older Travellers provided a source of *"informal but culturally appropriate 'counselling' in the form of listening and perceived wisdom"* (Pavee Point, 2006). This confiding in someone from within the family ensures confidentiality and protects the family. However, it does not allow privacy for the individual in such a close-knit community and so some Travellers reported that they confide in non-Traveller friends (AITHS, 2010a).

As part of folk medicine, faiths healers are an important health resource among Travellers. Almost 2 in 3 Travellers have ever used a healer (64.7%, N=385); of those 46.3% (N=246) consulted a healer because of depression/worries, with more women (51.2%, N=121) having done so than men (41.6%, N=125; AITHS Team, 2010b).

Mental health services were perceived as inadequate; counselling services were considered inappropriate and not specifically addressing Travellers' needs (AITHS, 2010a). There is distrust of psychiatric services and a fear that children are taken into care if the service of a psychiatric hospital was to be accessed (see summary in Walker, 2008). The AITHS explored Travellers' perceptions of accessing different health services. These perceptions were more positive towards GP services than mental health services. Moreover, despite having high rates of mental health problems and substance misuse, uptake of such services is very low (AITHS Team, 2010b).

Table 12. Perception of opportunities to access services as everyone else and service uptake in the last 12 months among Travellers in NI

Opportunity to access services as everyone else		Worse	Same	Better	N
Mental health services	All	26.3%	69.7%	4.0%	327
	Male	30.2%	64.5%	5.2%	172
	Female	21.9%	75.5%	2.6%	155
GP services	All	17.0%	73.0%	9.9%	382
	Male	19.7%	70.9%	9.4%	203
	Female	14.0%	75.4%	10.6%	179
Service uptake in the last 12 months		Not used	Once	More than once	N
Mental health services		92.9%	5.0%	2.1%	381
Psychology services		83.3%	0%	16.7%	12
Drug/alcohol outreach		100.0%	0%	0%	12

Source: AITHS Team (2010b; p.171, p.177)

Even if tailored services were available, a demand would need to be created. For Travellers to attend mental health services requires a cultural shift in attitudes as feelings of anxiety and embarrassment and a sense of losing face and self-control surface when interacting with services. For service providers it is important to recognise the stigma and culture problems related to Traveller lifestyle and mindset as well as the problems faced by Travellers (AITHS Team, 2010a).

“Service provider data variously refers to Traveller lifestyle as ‘chaotic’, ‘in crisis’, ‘frightened’, and ‘suspicious’.” (AITHS Team, 2010a). There was reference made to possible under-diagnosis of psychosis and depression among service providers due to a lack of understanding Traveller culture and what reflects the norm in that. Travellers themselves felt not properly assessed (eg for depression) and worried about the over-reliance on prescription medication (eg antidepressants), while the option of counselling was generally not explored (AITHS Team, 2010a). Although there is not the same stigma around the use of antidepressants (Walker, 2008), Traveller women were concerned about over-medication (eg antidepressants, sedatives, tranquilisers; see also Fountain, 2006), the lack of review and monitoring, and repeat prescriptions (AITHS Team, 2010a).

## 5. Mental health of Traveller prisoners

Prisoners in general experience a disproportionately high number of mental health problems, particularly women and ethnic minority groups (Sirdifield et al., 2009). Mental disorders are often pre-existing to or develop during imprisonment, with substance abuse being also very common among prisoners (see summary in AITHS Team, 2010f).

No information on Traveller prisoners in NI was found but two recent reports addressed this issue in ROI and GB. In ROI, the AITHS census 2008 suggested that 0.46% (n=168) of the total Irish Traveller population were in prison, while the Irish Prison Census 2008 estimated 320 Traveller prisoners, thus suggesting that between 4.6% to 8.7% of the prison population were Travellers (AITHS Team, 2010f). The Travellers in Prison Research Project (TPRP) for the Irish Chaplaincy in Britain (ICB; Mac Gabhann, 2011) found that between 0.6% to 1%

(n=453-850)<sup>11</sup> of the prison population were Irish Travellers in England and Wales in late September 2010 (Table A6 in the Appendix).

Compared to the non-Traveller population, Traveller women and men were more likely to be imprisoned (Table A6; AITHS Team, 2010f). The disproportionate representation of Travellers in the prison population is worse for Traveller women than for Traveller men (general population: men are 27 times more likely to be imprisoned than women; Traveller population: men are 8 times more likely to be imprisoned than women).

The AITHS summarised findings from earlier Irish studies showing that Traveller prisoners:

- were overrepresented among forensic psychiatric admissions and had more learning disability but less severe mental illness than other groups (Linehan et al., 2002);
- had excessive rates of substance misuse (all had history of alcohol dependence and abuse; 98% had lifetime history of substance use disorder; Kennedy et al., 2005).

Findings from previous studies and the AITHS and TPRP are summarised in Table 13. The AITHS was hampered by a very low response rate and findings should be treated with caution. The TPRP (Mac Gabhann, 2011) showed that 26% (n=71) of Traveller prisoners had a mental health problem; most suffered from depression (n=31) and psychosis (n=16; N=69). Mental health problems were particularly common among female Traveller prisoners (65%, N=17), who primarily suffered from depression and psychosis, but also had high rates of substance abuse and of a history of domestic violence. Considering the extreme social exclusion experienced within prison, these problems seem more likely to be exacerbated in prison. Comments from prison staff and chaplains suggest high rates of self-harm and suicide.

In prison, Irish Travellers experienced widespread discrimination in forms such as racism (from staff and fellow prisoners), unequal/limited access to services, and prejudicial licence conditions on release (Mac Gabhann, 2011). Poor literacy levels undermine integration in prison routine (written forms for any applications, requests, and complaints) and rehabilitation (eg demanding literacy courses, literacy requirements for education, training and therapeutic courses and prison jobs). This prevents prisoners from receiving discretionary privileges (eg re-categorisation, enhanced status, release on licence) and leads to Travellers appearing unwilling to engage and feeling further marginalised. Illiteracy also impairs maintaining vital family connection and support through letter writing and submitting applications for each visit. Requesting and relying on help with reading and writing results in shame and embarrassment and, combined with the often unmet request for being accommodated with other Travellers, leads to further social isolation. Thus, it is hardly surprising that Travellers experience high rates of mental ill health in prison (Mac Gabhann, 2011).

---

<sup>11</sup> 85 of the contacted 117 prisons stated that they had Traveller prisoners and identified 453 individuals; using further sources of information (ICPO's network of prison visitors and its database of Irish prisoners) lead to an estimate of a maximum of 850 Traveller prisoners.

Table 13. Prevalence of mental health problems and substance abuse among prisoners

Source		Prevalence
<b>General prison population</b>		
Centre for Health Promotion Studies NUI Galway, 2000 <sup>a</sup>	General Health Care Study of Prisoners, ROI	<ul style="list-style-type: none"> <li>• 50% of men and 75% of women were 'cases' based on GHQ 12 scores</li> <li>• 37% of men and 64% of women: moderately or extremely anxious and depressed</li> <li>• 12 months prevalence of drug use<sup>b</sup>: 63% of men and 83% of women</li> </ul>
Linehan et al., 2005 <sup>a</sup>	Forensic Mental Health Service, ROI	<ul style="list-style-type: none"> <li>• 19% remand prisoners with mental illness, adjustment disorder or personality disorder during screening</li> <li>• 31% lifetime diagnosis</li> <li>• 28% of remand prisoners with lifetime history of self-harm</li> <li>• 61% addicted to alcohol or other drugs</li> </ul>
Kennedy et al., 2005 <sup>a</sup>	Forensic Mental Health Service, ROI	<ul style="list-style-type: none"> <li>• All mental illness: men – 16% (committals) and 27% (sentenced); women – 41% (committals) and 60% (sentenced)</li> <li>• Psychosis: male committals 3.9%, on remand 7.6%, sentenced 2%; women: 5.4%</li> <li>• 79% addicted to alcohol or other drugs</li> </ul>
Toner 2008	Review of health needs assessment of prisoners, NI	<ul style="list-style-type: none"> <li>• 16% had psychological condition</li> <li>• 23% self-harm</li> <li>• 19% substance misuse</li> </ul>
<b>Traveller prisoners</b>		
AITHS Team 2010f	Health Status Study, ROI; N=26 (selective sample)	<ul style="list-style-type: none"> <li>• 39% had mental health problem</li> <li>• 58% had addiction problem</li> <li>• 62% interacted with psychiatric services</li> </ul>
Mac Gabhann, 2011	Travellers in Prison Research Project, England & Wales	<ul style="list-style-type: none"> <li>• Had mental health problem: 26% (N=272) <ul style="list-style-type: none"> <li>◦ 65% of female Traveller prisoners (N=17)</li> <li>◦ 22% of young offenders</li> </ul> </li> <li>• Had learning difficulties: 26% (N=278) <ul style="list-style-type: none"> <li>◦ 32% of female Traveller prisoners (N=19)</li> <li>◦ 21% of young offenders</li> </ul> </li> </ul>

Note: <sup>a</sup> cited in AITHS Team (2010f); <sup>b</sup> drugs other than cannabis or marijuana

## 6. Suicide among Travellers

Suicide occurs as a consequence of mental illness and in the context of severe physical illness and impulsivity during acute crisis (Gunnell & Lewis, 2005). Statistical information on suicide among Travellers is available for ROI via two recent studies but not for NI. The AITHS looked at deaths over a 12 months period (2008) and found 21 suicides (16 male, 5 female) among 188 Traveller deaths. Of the 12 GRO confirmed suicides, the main methods used were hanging, drowning, and overdose. There remains an uncertainty whether any of the further 15 deaths due to alcohol/drug overdose were also suicides. Traveller men had a 6.6 times higher suicide risk compared to settled men (AITHS Team, 2010b).

The second study examined all Traveller suicides in the period 2000-6 via interviews with social workers and other local authority personnel working with Travellers in all local authorities in ROI in each year of the study period (cross-checked against CSO tables; Walker, 2008). Of the 74 suicides reported, 91% (n=67) were male, showing a male to female ratio of 9.6:1 (settled population: 4.2:1). The majority of suicides occurred in the under 30s (65% vs. ROI: 34%) and were by hanging (80%, n=59), followed by poisoning (9%, n=7; mainly drug and alcohol-drug overdose), drowning (5%, n=4), and other (5%, n=4). Over the period 2000-6, the average crude suicide rate per 10,000 population was 3.7; annual rates are shown in Table 14. There seems to be a recent trend of an increasing suicide rate. Please note that Walker cautioned *“[g]iven that the Traveller population is small, and the incidence of suicide among the Travellers from a statistical point of view is low, even a variation of one or two incidences in a year will show a considerable variation in the annual rate”* (p.73).

Table 14. Crude suicide rate among Travellers (per 10,000 population) in ROI

Year	2000	2001	2002	2003	2004	2005	2006	2008
<b>Crude rate</b>	3.89	2.94	1.75	2.97	4.25	5.44	4.31	5.8
<b>n cases</b>	9	7	5	9	12	15	11	21

Source: 2000-2006 – Walker (2008); 2008 – AITHS Team (2010d; GRO confirmed and reported cases)

Walker (2008) also explored further demographic and contributory factors in Traveller suicides. The most common demographic profile of a suicide deceased was a young, single male. Those living on halting sites and unauthorised sites and the homeless had a higher risk of suicide. From 67 interviews information was available whether or not ongoing risk factors were present. For 57 of the 74 cases immediate risk factors (ie precipitating events) were identified. This information is summarised in Table 15. For example, a high level of alcohol/drug abuse and excessive drinking before suicide as well as a family history of suicide and recent bereavement were reported. In 11 cases no ongoing risk factors were mentioned, while 17 had no immediate risk factor. Combining both risk factor categories showed that five cases seemed to have had no motive for suicide (*“everything going for them”*, p.87), with eight cases being at the other extreme of the continuum, having had six or more risk factors. In addition, in 20 cases a troubled family background was reported which in its moderate form was described as chaotic due to maternal psychiatric illness (n=5) or alcohol abuse (n=3). For 12 cases, however, a *“horrific life history”* was described which raises the question *“not why the person died, but how they managed to stay alive for so long”* (p.85). Using this information on risk factor patterns and Traveller culture, Walker developed suicide profiles which are outlined in Table A7 (Appendix).

Overall, the identified risk factors do not differ from those experienced by the settled population. Traveller culture and the experienced discrimination may compound the detrimental potential of risk factors and give some of them a different connotation (eg distrust of mainstream services; Travellers’ bereavement rituals; suicide as escape from domestic violence – see also relevant section). Sexual orientation did not emerge as an issue of concern. One deceased had been living in a same sex relationship, while for a second case there may have been ambiguity around sexual orientation (Walker, 2008).

Table 15. Ongoing and immediate risk factors for suicide among Travellers in ROI

Ongoing risk factors (N=67)							
	Yes		No	Don't know			
Previous suicide attempt	11		45	10			
Family history of suicide	27		35	5			
Psychiatric illness <sup>a</sup>	22		34	11			
Alcohol/drug abuse <sup>b</sup>	34		23	10			
Immediate risk factors (n/N=57/74)							
	Experienced		Comparison with 2007 NI suicide cases <sup>f</sup>				
	n	% of 74					
(Excessive) Alcohol use	33	45%	<ul style="list-style-type: none"><li>• 41% over drink driving limit (&gt;80mg/100ml)</li><li>• 29% were drunk (150mg/100ml+)</li></ul>				
Bereavement	27	36%	<ul style="list-style-type: none"><li>• 5% relative/friend suicide</li><li>• 4% family bereavement (other)</li></ul>				
Violence	20	27%					
Marital conflict <sup>c</sup>	18	24%	<ul style="list-style-type: none"><li>• 17% relationship problems/break-up</li></ul>				
Trouble with law <sup>d</sup>	7	9%					
Serious illness <sup>e</sup>	6	8%					
Other	1	1%					
Presence of any number of risk factors (combined ongoing and immediate; N=74)							
N risk factors	None	1	2	3	4	5	6+
n cases	5	10	13	18	13	7	8

Source: Walker (2008); NI comparison data in Gossrau-Breen (2010)

Note: information on ongoing risk factors was only available on 67 cases as this question was included later on in the interview schedule; <sup>a</sup> Yes: mainly depression; No: includes some with suspected mental illness but not diagnosed/treated; <sup>b</sup> prescription drugs not included; n=13 alcohol only, n=7 drug only, n=14 alcohol and drugs; <sup>c</sup> n=11 with history of domestic violence; n=6 recently separated; <sup>d</sup> all male; <sup>e</sup> n=3 own illness, n=3 family member's illness; <sup>f</sup> in 2007, there were 213 suicides were recorded by CSNI; for N=200 blood alcohol concentration (BAC) was analysed at post-mortem

## 7. Summary and conclusion

There is indication that Travellers experience worse mental health and a higher rate of suicide than the settled community; however, the lack of prevalence figures for NI needs to be addressed. Mental health is interrelated with substance misuse and other factors (eg domestic violence, social support) which have also been identified as contributors to the mental health of the general population. However, Travellers often experience worse levels of such influencing factors (eg bereavement/loss). Their effects are compounded by discrimination and Traveller culture itself may ameliorate or exacerbate them. Low rates of help-seeking and negative perceptions of (mental) health services (ie as insufficient, inappropriate, culturally insensitive) can also be understood in this context.

*“The tight-knit community has positive effects, but also negative, in that there is literally little personal space for individuals and strong incentive to take part in group activities that can be damaging. Drinking patterns can aggravate mental health problem also, as binge drinking is associated with impulsivity and compounds clinical depression (World Health Organisation, 2008). Add to this a chronic problem with bridging to the general world around them and the corrosive daily relations with the general population Travellers themselves describe, and the mix is complete of poor self-esteem and self-efficacy in an unsupportive environment. There*

are a number of examples of fatalistic thinking in the narratives, particularly trying to break the cycle of education and employability. There is ample evidence in these data of risk factors for mental ill-health, depression and suicide, ..." (AITHS Team 2010c, p.161).

## References

- Agerbo, E. (2005). Midlife suicide risk, partner's psychiatric illness, spouse and child bereavement by suicide or other modes of death: a gender specific study. *Journal of Epidemiology & Community Health*, 59, 407-412.
- AITHS Team (2010a). *All Island Traveller Health Study. Our Geels. Qualitative Studies: Part A of Technical Report 3*. Dublin: UCD.  
[http://www.dohc.ie/publications/aiths2010/TR3/AITHS2010\\_TechnicalReport3\\_HR\\_PartA.pdf?direct=1](http://www.dohc.ie/publications/aiths2010/TR3/AITHS2010_TechnicalReport3_HR_PartA.pdf?direct=1)
- AITHS Team (2010b). *All Island Traveller Health Study. Our Geels. Technical Report 1: Health survey findings*. Dublin: UCD.  
[http://www.dohc.ie/publications/aiths2010/TR1/AITHS2010\\_TechnicalReport1\\_LR\\_A1.pdf?direct=1](http://www.dohc.ie/publications/aiths2010/TR1/AITHS2010_TechnicalReport1_LR_A1.pdf?direct=1)
- AITHS Team (2010c). *All Island Traveller Health Study. Our Geels. Summary of findings*. Dublin: UCD.  
[http://www.dohc.ie/publications/aiths2010/ExecutiveSummary/AITHS2010\\_SUMMARY\\_LR\\_All.pdf?direct=1](http://www.dohc.ie/publications/aiths2010/ExecutiveSummary/AITHS2010_SUMMARY_LR_All.pdf?direct=1)
- AITHS Team (2010d). *All Island Traveller Health Study. Our Geels. Demography and vital statistics: Part A of Technical Report 2*. Dublin: UCD.  
[http://www.dohc.ie/publications/aiths2010/TR2/AITHS2010\\_TechnicalReport2\\_HR\\_PartA.pdf?direct=1](http://www.dohc.ie/publications/aiths2010/TR2/AITHS2010_TechnicalReport2_HR_PartA.pdf?direct=1)
- AITHS Team (2010e). *All Island Traveller Health Study. Our Geels. Birth cohort study follow up: Part D of Technical Report 2*. Dublin: UCD.  
[http://www.dohc.ie/publications/pdf/AITHS\\_Birth\\_Cohort\\_follow\\_up.pdf?direct=1](http://www.dohc.ie/publications/pdf/AITHS_Birth_Cohort_follow_up.pdf?direct=1)
- AITHS Team (2010f). *All Island Traveller Health Study. Our Geels. Travellers in Institutions: Part C of Technical Report 2*. Dublin: UCD.  
[http://www.dohc.ie/publications/aiths2010/TR2/AITHS2010\\_TechnicalReport2\\_HR\\_PartC.pdf?direct=1](http://www.dohc.ie/publications/aiths2010/TR2/AITHS2010_TechnicalReport2_HR_PartC.pdf?direct=1)
- Allen, M. (2011). Domestic violence within the Irish Travelling community: The challenge for social work. *British Journal of Social Work*. Advance access to online publication. (doi: 10.1093/bjsw/ber140).
- Barnes, G.M., Hoffman, J.H., Welte, J.W., Farrell, M.P., & Dintcheff, B.A., (2006). Effects of parental monitoring and peer deviance on substance use and delinquency. *Journal of Marriage and Family*, 68, 1084-1104.
- Biggart, A., O'Hare, L., & Connolly, P. (2009). *A need to belong: An epidemiological study of Black and minority ethnic children's perceptions of exclusion in the Southern area of Northern Ireland*. Belfast: Centre for Effective Education, QUB.

- Chakraborty, A., McManus, S., Brugha, T.S., Bebbington, P., & King, M. (2011). Mental health of non-heterosexual population of England. *The British Journal of Psychiatry*, 198, 143-148.
- DHSSPS (2011a). *Health Survey Northern Ireland: First results from 2010/11 survey*. Belfast: DHSSPS. [http://www.dhsspsni.gov.uk/health\\_survey\\_northern\\_ireland\\_-\\_first\\_results\\_from\\_the\\_2010-11\\_survey.pdf](http://www.dhsspsni.gov.uk/health_survey_northern_ireland_-_first_results_from_the_2010-11_survey.pdf)
- DHSSPS (2011b). *Adult drinking patterns in Northern Ireland in 2011*. Belfast: DHSSPS. [http://www.dhsspsni.gov.uk/adult\\_drinking\\_patterns\\_in\\_northern\\_ireland\\_2011.pdf](http://www.dhsspsni.gov.uk/adult_drinking_patterns_in_northern_ireland_2011.pdf)
- Dishion, T.J., Nelson, S.E., & Kavanagh, K. (2003). The family check-up with high risk young adolescents: preventing early onset substance use by parent monitoring. *Behavior Therapy*, 34, 553-571.
- Fountain, J. (2006). *An overview of the nature and extent of illicit drug use amongst the Traveller community: an exploratory study*. Dublin: Stationary Office.
- Gossrau-Breen, D. (2010). *The role of alcohol and drugs in suicide cases in Northern Ireland: using data held by the Coroner Service for Northern Ireland*. Unpublished report, PHA.
- Gunnell, D. & Lewis, G. (2005). Studying suicide from the life course perspective: implications for prevention. *British Journal of Psychiatry*, 187, 206-208.
- Kean, M. (2011). Exploring illicit drug use in a Traveller community. *Drugnet Ireland*, 39, 16-17.
- King, M., Semlyen, J., Tai, S.S., Killaspy, H., Osborn, D., Popelyuk, D., & Nazareth, I. (2007). *Mental disorder, suicide, and deliberate self-harm in lesbian, gay and bisexual people: A systematic review*. National institute for Mental Health in England.
- Leonard, P. & O'Leary, A. (2006). *Mental health of the Traveller community in Donegal: The scope of the problem and the possibilities for change*. In: A Report from the National Conference HSE West. Addressing the mental health needs of minority ethnic groups and asylum seekers in Ireland. Sligo, January, 2006. <http://www.hse.ie/eng/services/Publications/services/SocialInclusion/MentalHealthNeedsOfMinorityEthnicGroups.pdf>
- Mac Gabhann, C. (2011). *Voices unheard. A study of Irish Travellers in Prison*. Irish Chaplaincy in Britain. [http://www.iprt.ie/files/Voices\\_Unheard\\_June\\_2011.pdf](http://www.iprt.ie/files/Voices_Unheard_June_2011.pdf)
- Mentality (2003). *Making it effective. A guide to evidence-based mental health promotion*. Radical mentalities – briefing paper 1. London: Menticity. <http://www.centreformentalhealth.org.uk/pdfs/makingiteffective.pdf>
- NICEM (NI Council for Ethnic Minorities) (2011). *Submission to the UN Committee on the Elimination of all forms of racial discrimination on UK 18<sup>th</sup> and 19<sup>th</sup> Periodic Report*. Belfast: NICEM. [http://www.nicem.org.uk/uploads/publications/NICEM\\_Submission\\_to\\_the\\_UN\\_Committee\\_on\\_the\\_Elimination\\_of\\_all\\_forms\\_of\\_Racial\\_Discrimination\\_2011.pdf](http://www.nicem.org.uk/uploads/publications/NICEM_Submission_to_the_UN_Committee_on_the_Elimination_of_all_forms_of_Racial_Discrimination_2011.pdf)
- NSPCC (2009). *Traveller children witnessing domestic violence – multi agency challenges to providing support*. Conference report on a workshop held at Waterfoot Hotel, Derry, 30 September 2009.



- Pavee Point (2004). *Submission from Pavee Point Traveller Centre on the mid term review of the National Drug Strategy 2001-8 to the National Drug Strategy Team, September 2004*. Dublin: Pavee Point. <http://paveepoint.ie/pdf/SubmNationalDrugStrategy04.pdf>
- Pavee Point (2005). *Challenging the misconceptions about violence against minority ethnic women, including Travellers, in Ireland: An information brochure for service providers*. Dublin: Pavee Point. <http://paveepoint.ie/pdf/MinorityEthnicWomen05.pdf>
- Pavee Point (2006). *Submission from Pavee Point Travellers Centre to Expert Group on Mental Health Policy. Department of Health and Children. 16<sup>th</sup> October 2006*. Dublin: Pavee Point. <http://paveepoint.ie/submissions/06-Mental-Health.pdf>
- Pavee Point (2011). *The use of benzodiazepines within the Traveller community. A service providers' report*. Dublin: Pavee Point. <http://pavee.ie/drugs/wp-content/uploads/2011/07/Benzo-Report.pdf>
- SAAT (2011). *Outcomes for children. Outcome monitoring report 2010/11*. HSCB.
- SMR (Social Market Research, 2009). *Secondary data analysis on YPBAS*. Belfast: DHSSPS. [http://www.dhsspsni.gov.uk/secondary\\_analysis\\_of\\_2007\\_ypbas.pdf](http://www.dhsspsni.gov.uk/secondary_analysis_of_2007_ypbas.pdf)
- Steinberg, L., Fletcher, A., & Darling, N. (1994). Parental monitoring and peer influences on adolescent substance use. *Pediatrics*, 93, 1060-1064.
- Van Hout, M.-C. (2010a). Alcohol use and the Traveller community in the west of Ireland. *Drug and Alcohol Review*, 29, 59-63.
- Van Hout, M.-C. (2010b). Travellers and substance use – Implications for service provision. *International Journal of Health Promotion & Education*, 48, 36-41.
- Van Hout, M.-C. (2011a). Assimilation, habitus, and drug use among Irish Travellers. *Critical Public Health*, 21, 203-220.
- Van Hout, M.-C. (2011b). Travellers and substance use in Ireland – Recommendations for drug and alcohol policy. *Drugs: education, prevention and policy*, 18, 53-59.
- Walker, M.R. (2008). *Suicide among the Irish Traveller community 2000-2006*. Wicklow County Council. <http://www.nosp.ie/book.pdf>
- Walsh, B. (2010). *Cultural dislocation and consequences: An exploratory study of illicit drug activity among a Traveller community in North Dublin*. Dublin: Blanchardstown Local Drugs Task Force.
- Watson, D. & Parsons, S. (2005). *Domestic abuse of women and men in Ireland. A report of the National Study of Domestic Abuse*. Dublin: Stationary Office. [http://www.esri.ie/pdf/BKMNEXT056\\_Domestic%20Abuse.pdf](http://www.esri.ie/pdf/BKMNEXT056_Domestic%20Abuse.pdf)
- WHC (Women's Health Council; 2009). *Translating pain into action. A study of gender-based violence and minority ethnic women in Ireland. Summary report*. Dublin: WHC. [http://www.dohc.ie/publications/translating\\_pain.html](http://www.dohc.ie/publications/translating_pain.html)
- WHO (2010). Mental health: Strengthening our response. Fact sheet 220. <http://www.who.int/mediacentre/factsheets/fs220/en/>
- Women's Aid (2011). *Annual statistics 2010*. Dublin: Women's Aid [http://www.womensaid.ie/download/pdf/3425\\_womans\\_aid\\_annual\\_report\\_web.pdf](http://www.womensaid.ie/download/pdf/3425_womans_aid_annual_report_web.pdf)

## Appendix

Table A1. Health related quality of life in children and young people in the Traveller and settled community in NI

Thinking about the past week, ...	Not at all %	Seldom %	Quite often %	Very often %	Always %	N
<b>9-year olds (AITHS – NI; parent report)</b>						
Felt fit and well	3.1	4.7	4.7	15.6	71.9	64
Felt full of energy	3.1	3.1	1.5	23.1	69.2	65
Felt sad	51.6	34.4	9.4	0	4.7	64
Felt lonely	62.5	25.0	4.7	1.6	6.3	64
Had enough time for self	4.6	3.1	10.8	32.3	49.2	65
Used free time as wished	0	1.5	10.8	23.1	64.6	65
Felt treated fairly by parents	0	1.6	9.5	30.2	58.7	63
Had fun with friends	0	6.3	3.2	14.3	76.2	63
Got on well at school	0	6.5	4.8	25.8	62.9	62
Could pay attention	4.8	7.9	4.8	22.2	60.3	63
<b>14-year olds (AITHS – NI; parent report)</b>						
Felt fit and well	5.5	0	1.8	20	72.7	55
Felt full of energy	3.6	1.8	3.6	25.0	66.1	56
Felt sad	47.3	30.9	9.1	5.5	7.3	55
Felt lonely	51.9	24.1	11.1	5.6	7.4	54
Had enough time for self	5.4	0	14.3	28.6	51.8	56
Used free time as wished	3.6	3.6	21.8	20.0	50.9	55
Felt treated fairly by parents	3.7	3.7	18.5	31.5	42.6	54
Had fun with friends	1.9	1.9	18.5	22.2	55.6	54
Got on well at school	7.7	1.9	17.3	28.8	44.2	52
Could pay attention	18.5	7.4	11.1	16.7	46.3	54
<b>Kids Life and Times Survey 2010 (N=5,192 year 7 pupils; self-report)</b>						
Felt fit and well <sup>1</sup>	2	6	19	38	35	
Felt full of energy	1	6	21	36	36	
Felt sad	39	43	12	4	2	
Felt lonely	70	19	7	3	2	
Had enough time for self	4	10	28	27	31	
Was able to do what they wanted in free time	5	11	24	29	31	
Felt treated fairly by parents	2	3	8	18	70	
Had fun with friends	2	4	8	21	65	
Got on well at school <sup>1</sup>	2	4	15	42	37	
Could pay attention	1	4	18	41	35	

Source: AITHS Team, 2010b, <http://www.ark.ac.uk/klr/2010/Kidscreen/>

Note: <sup>a</sup> answer categories were: not at all, slightly, moderately, very, extremely

Table A2. Which ethnic minority community is there the most prejudice against? Top 3 ratings for 2005-9

2005	2006	2007	2008	2009
22% Chinese	27% Polish	32% Polish	30% Polish	30% Polish
16% Travellers	14% Travellers	14% Travellers	19% Travellers	20% Romanian
15% Eastern Europeans	12% South Asian	13% Other Eastern Europeans	10% Black	16% Travellers

Source: NI Life and Times Survey; different categories provided across the years; <http://www.ark.ac.uk/nilt/results/mineth.html>

Table A3. Ever felt discriminated against as a member of the Travelling community (NI)

	All			Males			Females		
	Ever	4+ times	N	Ever	4+ times	N	Ever	4+ times	N
At school	67.0%	23.4%	394	68.9%	24.1%	191	66.0%	22.7%	203
Getting work	63.9%	28.9%	377	70.1%	33.7%	187	57.9%	24.2%	190
At work	52.8%	22.3%	373	61.8%	26.3%	186	43.9%	18.2%	187
Getting on a sports team	41.9%	16.5%	346	44.3%	15.6%	167	39.7%	17.3%	179
Getting accommodation	75.6%	43.9%	394	78.0%	42.9%	191	73.4%	44.8%	203
Accessing health care services	54.0%	12.7%	387	56.9%	13.3%	188	51.3%	12.1%	199
Getting social welfare	56.1%	20.2%	392	61.7%	21.8%	188	51.0%	18.6%	204
Being served in shop/pub	72.3%	43.1%	369	74.9%	44.0%	191	70.0%	42.4%	203
Getting insurance/loan	60.2%	23.8%	369	66.9%	24.9%	181	53.7%	22.9%	188
In the street/in public	71.1%	31.7%	398	77.2%	31.1%	193	65.4%	32.2%	205
By the police/courts	64.7%	30.2%	394	75.0%	34.4%	192	55.0%	26.2%	202
Landlord/local authority	64.2%	35.3%	371	69.3%	36.4%	176	59.5%	34.4%	195

Source: AITHS Team (2010b, pp. 157-159)

Table A4. Experience of bullying among 7-12 year olds in the last couple of months  
(Southern area, NI)

	White NI %	European migrant %	Asian %	Traveller %
<b><i>Frequency of general bullying experience</i></b>				
Hasn't happened	55	55	64	38
Once or twice	22	23	21	16
2 or 3 times	9	9	6	10
Once a week	6	5	2	12
Several times a week	8	8	8	24
N	501	108	52	50
<b><i>Any experience of bullying<sup>a</sup></i></b>				
Teased	43	36	29	64
Excluded	38	45	20	52
Hit, kicked or punched	33	29	22	48
False rumours spread	40	35	26	65
Property or money taken	32	19	18	18
Threatened	33	25	20	38
Racist name calling	20	31	26	63

Source: Biggart et al. (2009); <sup>a</sup> Please note that figures are percentage of those who were ever bullied

Table A5. Barriers to help-seeking and leaving an abusive relationship

Barriers	Effect through
<b><i>Traveller culture of patriarchy, close-knit families, religion</i></b>	
<ul style="list-style-type: none"> <li>• Traveller men controlling wives' social interactions and economically (ie financial dependence)</li> <li>• Religious emphasis on sanctity and dissolubility of marriage</li> <li>• Disclosure brings shame and dishonour to family</li> </ul>	<ul style="list-style-type: none"> <li>• Fear, apprehension, and experience of retaliation when raising the issue in the family or trying to seek help (eg further violence, inter-family dispute)</li> <li>• Lack of support from family</li> <li>• Male control complicates and limits the aid women can provide for each other</li> </ul>
<b><i>Practical issues</i></b>	
<ul style="list-style-type: none"> <li>• Lack of access to landline or mobile phone (particularly older women)</li> <li>• Lack of transport to refuge, solicitors or court</li> </ul>	<ul style="list-style-type: none"> <li>• Unable to contact helpline, police/Gardai</li> <li>• No money for bus or taxi</li> <li>• Bringing children to solicitor meetings/court</li> </ul>
<b><i>Refuge related</i></b>	
<ul style="list-style-type: none"> <li>• Rules on older children not permitted into refuges, particularly boys</li> <li>• Rule of admitting one Traveller woman at a time to maintain her privacy and security (ROI only)</li> <li>• Security set-up of refuge</li> </ul>	<ul style="list-style-type: none"> <li>• Fear/reluctance of leaving older children behind as they may become target of abuse</li> <li>• Others' experiences of being turned away when having too many children with them</li> <li>• Fear of men getting entry to refuges as they will look for wife</li> <li>• Fear of not sufficient privacy/confidentiality as this puts woman at risk</li> </ul>
<b><i>Accommodation</i></b>	
<ul style="list-style-type: none"> <li>• Lack of suitable emergency and longer-term accommodation</li> </ul>	<ul style="list-style-type: none"> <li>• Accommodation issue exacerbated by large number of children, long waiting lists for social housing</li> </ul>
<b><i>Gardai/criminal justice system</i></b>	
<ul style="list-style-type: none"> <li>• Perceived/experienced discrimination by Gardai and worry over taking effective action</li> <li>• Confusion over legal terminology<sup>12</sup> and legal options for protection and their applicability to different housing options</li> <li>• Difficulty accessing legal aid</li> </ul>	<ul style="list-style-type: none"> <li>• Reluctance to report as Gardai may not believe them or take them serious (eg cultural biased)</li> <li>• Fear of reprisal from partner and community (ie further violence, expulsion)</li> <li>• Literacy issues (filling in forms)</li> <li>• Problems with enforcing barring orders on halting sites</li> </ul>
<b><i>Other sources of help</i></b>	
<ul style="list-style-type: none"> <li>• Lack of awareness of where else to get help</li> <li>• Distrust of GPs, social services</li> </ul>	<ul style="list-style-type: none"> <li>• Fear of discrimination</li> <li>• Fear of children being taken into care and of services refocusing on child protection only and woman's parenting ability instead of husband's violence</li> </ul>

Sources: AITHS Team (2010a), Allen (2011), Watson & Parsons (2005), WHC (2009)

<sup>12</sup> This is also a problem generally faced by women (Watson & Parson, 2005).

**Suggestions of what might help women in abusive relationships** (AITHS Team, 2010a; Allen, 2011; Watson & Parsons, 2005):

- Women wished for preventative contact with Gardai (eg follow-up visits when leaving refuge) and changes to the system of court hearings and how orders are served (by Gardai instead of mailed out).
- Traveller women did not feel that Traveller women working in refuges would be a suitable solution. Perceived negative consequences included men's suspicion of a woman's motivation wanting to work there and the impact on confidentiality as the "news" would spread quickly throughout the Travelling community could put women's lives in danger." (Watson & Parsons, 2005, p.153). Cultural awareness training of refuge staff was considered sufficient.
- Refuges are only an emergency solution. Safe permanent accommodation suitable for a woman with more children is needed and transitional housing, as provided by housing associations, was much appreciated. Any long-term solution needs to provide distance and anonymity from the husband's family.
- For women and girls, education and opportunities to improve their self-esteem and confidence.
- Men and boys need educated on the need for equality and to gain conflict resolution skills.

Table A6. Irish Travellers in prison: population and risk of imprisonment

Source	N Travellers in prison (% of prison population per gender/of total)		
	Males	Females	All
AITHS census 2008 <sup>a</sup>	150 (4.2%)	18 (14.0%)	168 (4.6%)
Irish Prison Census 2008 <sup>a</sup>	299* (8.5%)	21 (16.3%)	320 (8.7%)
ROI census 2006 <sup>a</sup>	132 (4.4%)	13 (11.3%)	145 (4.6%)
TPRP 2010, England & Wales <sup>b</sup>			453-850 <sup>+</sup> (0.6%-1%)
<b>Risk of imprisonment compare to settled population</b>			
AITHS census 2008 <sup>a</sup>	5x	18x	
Irish Prison Census 2008 <sup>a</sup>	11x	22x	

Note: <sup>a</sup> AITHS Team (2010f); <sup>b</sup> Mac Gabhann (2011); \* estimate based on responses from 11 out of 14 prisons; Travellers: 0.5% of ROI population (2006 census) and 0.9% in AITHS census 2008; <sup>+</sup> 453 Traveller prisoners identified via 85 prisons; estimate of a maximum of 850 Traveller prisoners through use of further information sources

Table A7. Suicide profiles of Travellers according to Walker (2008)

Suicide profile	N	Characteristics				Other factors
		General	Family of origin factors	Mental health/ substance abuse	Significant event	
Troubled suicides	12	<ul style="list-style-type: none"> <li>Background of major social problems</li> </ul>	<ul style="list-style-type: none"> <li>Childhood abuse and neglect</li> <li>Domestic violence and feuding</li> <li>Alcohol abuse</li> <li>Family history of suicide</li> <li>Sibling suicide or other violent death (&gt;50%)</li> </ul>	<ul style="list-style-type: none"> <li>Alcohol or substance abuse</li> <li>History of self-harm or suicide</li> </ul>		<ul style="list-style-type: none"> <li>Relationship problems</li> <li>Violent behaviour</li> </ul>
	18	<ul style="list-style-type: none"> <li>Multiple crisis: 3+ precipitating events</li> </ul>		<ul style="list-style-type: none"> <li>N=8 bereaved: one had psychiatric treatment for depression</li> </ul>	<ul style="list-style-type: none"> <li>N=8: each had 2 significant bereavements (mainly by suicide)</li> </ul>	
No known motive		<ul style="list-style-type: none"> <li>Coming from loving and secure families</li> <li>Frequently involved in sport, education, work</li> </ul>		<ul style="list-style-type: none"> <li>Showed no sign of suicidal ideation,</li> <li>No depression or alcohol/substance abuse</li> </ul>	<ul style="list-style-type: none"> <li>Some: death or legal conflict</li> </ul>	
Bereavement suicides		<ul style="list-style-type: none"> <li>Usually by hanging</li> </ul>		<ul style="list-style-type: none"> <li>Many involved drinking sessions/ binges with others</li> </ul>	<ul style="list-style-type: none"> <li>Following death of somebody</li> </ul>	<ul style="list-style-type: none"> <li>Having to shoulder organisation and financial burden of</li> </ul>

				(part of grieving ritual: large alcohol amounts and possibly drugs)	close: in 40% death was a suicide	elaborate funeral
	3	<ul style="list-style-type: none"> <li>Relative seriously ill and may die</li> </ul>				
<b>Violent suicides</b>	20	<ul style="list-style-type: none"> <li>Domestic violence (couples, other family members) and feuding</li> </ul>	<ul style="list-style-type: none"> <li>N=4 perpetrators: violence as conflict solution</li> </ul>	<ul style="list-style-type: none"> <li>N=4 perpetrators: alcohol and drugs involved – violence escalating out of control</li> </ul>	<ul style="list-style-type: none"> <li>N=8 following violent episode – almost all involving large amounts of alcohol; hanging</li> </ul>	<ul style="list-style-type: none"> <li>N=4 victims: suicide as the only escape<sup>a</sup></li> <li>N=4 perpetrators: suicide as vengeance (if wife left for refuge) or as self-punishment due to extreme guilt</li> </ul>
<b>Shamed suicides</b>	7	<ul style="list-style-type: none"> <li>The older the individual, the more serious the act</li> <li>Perceived shame for individual and dishonour to family</li> <li>Fear of individual/family being marginalised and ostracised by whole community</li> </ul>			<ul style="list-style-type: none"> <li>Following disclosure of an alleged criminal act or awaiting trial</li> </ul>	

<sup>a</sup> Further detail around the dynamics and complexities for victims' mental health is discussed in the section on domestic violence



This briefing was produced by Health Intelligence in the Public Health Agency Northern Ireland.

If you would like further information please contact:

[healthintelligence@hscni.net](mailto:healthintelligence@hscni.net) or

[diana.gossrau-breen@hscni.net](mailto:diana.gossrau-breen@hscni.net) or phone 028 90311611.

CONFIDENTIAL - NOT FOR WIDER CIRCULATION