The Forest Bus Ltd

COMMUNITY ENGAGEMENT PROJECT:
The NIMHE Mental Health Programme

REPORT OF THE COMMUNITY LED RESEARCH PROJECT FOCUSSING ON Mental health, equality and wellbeing of Gypsies and Traveller in Hampshire

Undertaken by The Forest Bus Mobile Project
and the Gypsy Community in Hampshire
Date: May 07 – March 2008

Funded by NIMHE, managed and supported by
The Centre for Ethnicity and Health, University of Central Lancashire.

Contents

Acknowledgements

The following people were involved in the development of this project

Erica Arnold – Erica is a volunteer community worker and has a long association with working with families living in Bricks and Mortar in South Hampshire. She has forged strong links in the community and has been instrumental in ensuring that services are delivered to the to the community and in advocating on their behalf to service providers

Basil Burton – Basil is currently Chair of the National Romani Rights Association, an organisation which advocates on behalf of the Gypsy community on issues relating to legislation, planning etc. He is a well known advocator for Romani rights, and gives up much of his time on a voluntary basis. As well as being involved in undertaking some of the face to face interviews, Basil is a member of the steering committee, where his expertise has been highly valued.

Jane Peacock – is General Manager of the Forest Bus, a qualified Social Worker with years of experience in working with children and families living in rural areas. She has years of experience in the field of community development work and in working with people of Gypsy origin. In 1999, 2001, 2006 and 2007, Jane undertook four major pieces of research into the health and social needs of Gypsies and Travellers in different areas of Hampshire. Jane is the lead researcher on this UCLAN project, and co author of this report.

Paul Southwell – is a Trustee of the Forest Bus and has been involved with the UCLAN project from the beginning. He is a member of the steering committee and is involved in helping to analyse the data. Paul has many years experience of working with the Forest Bus in a voluntary capacity, and has been involved in the previous research projects undertaken in 2006 and 2007

Pearl Smith is resident from one of the sites in Hampshire. Over the last few years, she has been involved in representing the views of Gypsies and Travellers at a number of events including conferences and public meetings. Pearl undertook a number of interviews for this project, focussing on those living on permanent sites.

Grace Wilson – is resident on one of the Hampshire sites. She was involved in undertaking the Gypsy Traveller Accommodation Assessment for another county and has been involved as a researcher for this project. Grace has focussed her interviews on those living on permanent sites.

Sam Wilson – is a Specialist Teacher Advisor for Hampshire County Council Ethnic Minority Achievement Service, as well as being a representative from the Gypsy Community, Sam has been involved in assisting with research projects in the past and is a member of the steering committee for this project, and co author of this report.

Acknowledgements

The research was undertaken by the Gypsy Community, Community workers, and Forest Bus community development team, who forged strong relationships in the community and through this were able to exercise extensive interviews. It was as a result of the needs identified through their everyday work in the community since 1993, and small scale research conducted over the years, (Jane Peacock reports 1999 & 2001) that this research was commissioned.

The study would not have been possible without the help of the Gypsy community themselves, as well as the valuable help and contribution given by the late **Len Smith**, local Gypsy activist, **Basil Burton** Chair National Romani Rights Association and **Sam Wilson** Specialist Teacher Advisor at HCC Ethnic Minority Achievement Service - our sincere and grateful thanks to them all for their support.

The following people were involved in the development and delivery of this project:

Poppy Jarman, Race Equality Lead
Jan Parker, Social Worker Children's Services, Hampshire
Neil Sanyal, Senior Practitioner/ASW Romsey Community Mental Heath Team
Beverley Meeson, Focussed Implementation Site Co-ordinator, Delivering Race Equality in Mental Health Care, Hampshire & IOW Health and Social Care Community
Centre for Ethnicity and Health, University of Central Lancashire steering group

Special thanks to Beverley and Neil for their endless support and advice from the beginning of this project – I have learnt so much from you both.

Jane Peacock & Sam Wilson
Co -Authors

Executive summary

The research set out to identify the mental health needs of Gypsies in Hampshire and to establish their experience of treatment and managing depression. The consultation involved 141 respondents from the Gypsy community and split the findings according to accommodation in either bricks and mortar (housing), permanent site or unauthorised site.

The consultation found that the vast majority of respondents had a knowledge of or experience of depression or mental illness either from personal experience or with a family member or friend from within the Gypsy community.

Most respondents are not currently accessing mental health services even when they are aware that it is available. The treatment that the majority of respondents felt was most suitable for depression or mental illness was within the family and were reluctant to involve outside support agencies as it might escalate the problem which respondents felt would ultimately lead to sufferers being admitted into hospital for fulltime care which was not a desirable option.

Respondents living in bricks and mortar reported the highest instances of suicidal feelings and feelings of self harm which were not replicated in either of the other groups.

Respondents did not always feel they had control over their lives and those living in bricks and mortar fared worst. Better transport links, culturally appropriate accommodation and location and financial security were key factors for giving respondents back control of their lives. Contrary to previous government initiatives and drives, the desire to travel and return to a nomadic lifestyle was seen as desirable amongst all groups and those on unauthorised sites felt that living in bricks and mortar was damaging to Gypsies' mental health a sentiment which appears to be validated by the poor mental health reported by respondents in bricks and mortar.

The research highlighted that the key gaps in provision were the need for culturally appropriate mental health services and accommodation and the need for better transport links to enable access to family, service providers and social activities.

Recommendations

1) Cultural awareness training should be given to all service providers
2) Funding should to sought to enable people from the Gypsy community to access training to enable them to inform and advise representatives from outside agencies, or to be recruited as workers within these service providers
3) Service providers need to be made aware of the transport difficulties and to work in partnership with mobile service providers to target isolated and hard to reach communities
4) Transport services need to meet the needs of rural communities
5) The planning and building of future sites needs to take into account the geographical location in terms of transport, health services and local amenities
6) A more creative way of meeting the gaps in housing could investigate the possibility of including small plots for residential caravan use in new house builds
7) Specialist mental health services should be culturally sensitive and should be delivered discreetly so as not to cause embarrassment or stigma .

8) Consideration should be given before future survey are undertaken with the Gypsy community as this community report that they have undergone several major surveys (such as the Gypsy Traveller Accommodation Needs Assessment) in recent years with no real outcomes for change. In addition the promise of these outcomes have not been delivered

9) Funding is needed to address the critical mental health needs of Gypsies – particularly to those living in bricks and mortar and should the young people

10) Information about services should be circulated orally as well as in written form

11) The research findings from this project should be circulated to a number of statutory and voluntary agencies including those who provide services to young people such as the CAMHS team

Emerging issues for discussion

Those involved in analysing the themes found the responses very moving, which indicated that respondents understood about depression and a high percentage had a personal experience of depression and anxiety.

Although respondents have had experience of mental health issues they were reluctant to request help from outside services, relying on family members for support. Traditionally support from family has met the multiple needs of members of the Gypsy communities suffering from illness. However, the accommodation crisis and current legislation which has forced the dispersal of Gypsies has meant that their family support networks have crumbled leaving them with limited access to support from their own community or professional health care.

Respondents felt that they had very little choice about where they lived and felt forced to accept the first offer of accommodation regardless of the location. This often led to feelings of isolation and alienation. Living in accommodation that was not felt to be suitable or appropriate for need led to residents having no pride in their home and feelings of low self worth and self esteem. When multiplied among a large housed Gypsy community the problems manifest in rundown housing and residents feeling they have no control over their own lives.

In addition people in bricks and mortar report that they feel marginalised by the wider community and alienated from other Gypsies because of their changed lifestyle. Gypsies living in bricks and mortar were shunned by other Gypsies and felt exiled and lose their cultural identity.

The majority of Gypsies living on unauthorised sites said that they felt happy despite the pressure and stress that unauthorised camping generates. During two interviews undertaken for this research, interviewers witnessed vehicles drive past and shout abuse at the unauthorised site residents, one of which was two minibuses of children. These respondents felt they had more control over how they want to live their lives despite legal enforcements that infringe on their way of life.

Those Gypsies living in bricks and mortar were most likely to have suicidal feelings or feelings of self harm.
Respondents from all groups felt that they value the travelling way of life and feel that it was something they would like to return to.

Financial constraints featured highly from all groups as this affected their ability to access transport, work and social activities.

Most respondents, including the young people, could identify and were familiar with the symptoms of depression and showed an awareness of mental health issues. We provided respondents with some guidelines into the symptoms of depression from the MIND website, www.mind.org.uk

The focus of the report
Why Gypsies and Travellers were chosen as part of this research?

It is estimated by experts that around 250,000 - 300,000 Gypsies are living in Britain today - fewer than half of these are Nomadic. There are currently less than 400 local authority sites in the U.K. *(Health status of Travellers in the South West region, 2002, Bristol University)*

The report focuses upon the social and health needs of settled, housed and transient Gypsies in areas of Hampshire. We have discovered that nationally, there is very little research into the needs of housed (referred to as 'bricks and mortar') families as opposed to those living on authorised and illegal sites. This is because of the lack of ethnic recording in the data – this includes routine mortality and morbidity data, as well as statistics relating to service use. The 1999 Health Survey for England in to the health of minority ethnic groups, *(Evans et al, 2001)*, did not include Gypsies or Travellers. *(Health status of Travellers in the South West region, 2002, Bristol University)* Assessments undertaken by the Department of Health in 1998 and in 1999 also excluded this group. However, a numbers of studies have suggested that Gypsies and Travellers are among the unhealthiest of all minority ethnic groups (*Bunce, 1996, Hawes, 1997, Van Cleeput, 2000, Van Cleeput & Parry et al, 2004*.) Van Cleeput , Perry et al state that obtaining accurate health status data for Gypsies/Travellers requires:

a) good access to Traveller communities through trusted intermediaries
b) face to face interviews rather than postal questionnaires
c) health status measures which are relevant, valid, reliable and which in total, do not place unrealistic demands on the respondent in terms of time taken or complexity. (*Van Cleeput & Parry et al, 2004.)*

The 1968 Caravan Sites Act defined Gypsies as "persons of nomadic habit of life, whatever their race or origin." The Race Relations Act 1989 saw that Gypsies were at last confirmed as an ethnic group. Not all Travellers are Gypsies, and not all Gypsies are nomadic. "Travellers" is used as a generic term, although some prefer to be called Gypsies, so there is some inter-changeability. The cultural identity of Gypsies is

based upon self-employment, self-help and nomadism. *(Okey, 1983)* while persecution and discrimination has been a consistent theme for them all. *(Liegeois, 1986) (In Cemlyn, 1993,pp246 – 261)*

In the 1960's, various attempts were made by both National and Local Government, to conduct censuses of 'resident' Gypsy populations. These indicated that the Traveller population of Britain was probably about 25,000. *(Ministry of Housing & Local Government, Gypsies and other Travellers, HMSO, 1967)* It is thought however, due to the elusive nature of many Gypsies, coupled with the fact that those who have been housed may have generally not been included, that the figures are inaccurate and underestimated. This has been confirmed by the count of numbers of Gypsy children not receiving regular schooling in five West Midland counties. These statistics, which use techniques less likely to be inaccurate than those previously employed, would suggest that the total population must now be closer to 60,000. This figure is likely to be increasing at the rate of 2,000 per year. *(Kenrick & Clark, 1999, p21)*

Local Background

Local historian (the late Len Smith *Forest Bus oral history project, 2005)* suggests that many of the Gypsy community living in various parts of England may have originated from the New Forest – we have certainly evidenced that this is the case in areas of Hampshire, Wiltshire and also the Severn Valley. Our local research shows that although the integration of the families during the post-war period until the early 1960's was considered a success, we have evidence to show that there are groups of people living in areas the county, who continue to be marginalized by the wider community. Poverty and high levels of unemployment and disability hinder development and the ability for people to make changes to their lives as access to services is limited. *(Source, Van Cleeput & Parry et al, 2004, Jane Peacock, a report on the Health & Social needs of the Gypsy Traveller community, 2003. Source, Jane Peacock, Investigating the Health & Social needs of the New Forest Gypsy Traveller community,2007, Forest Bus, The Health and Social needs of Gypsies and Travellers in Hampshire as part of the Black Minority Action Plan, 2006))*

Previous research background

The following extracts from the previous study undertaken by the Forest Bus, show how mental issues were first discussed. *(Source, Jane Peacock, a report on the Health & Social needs of the Gypsy Traveller community, 2003. Source, Jane Peacock, Investigating the Health & Social needs of the New Forest Gypsy Traveller community,2007, Forest Bus, The Health and Social needs of Gypsies and Travellers in Hampshire as part of the Black Minority Action Plan, 2006)*

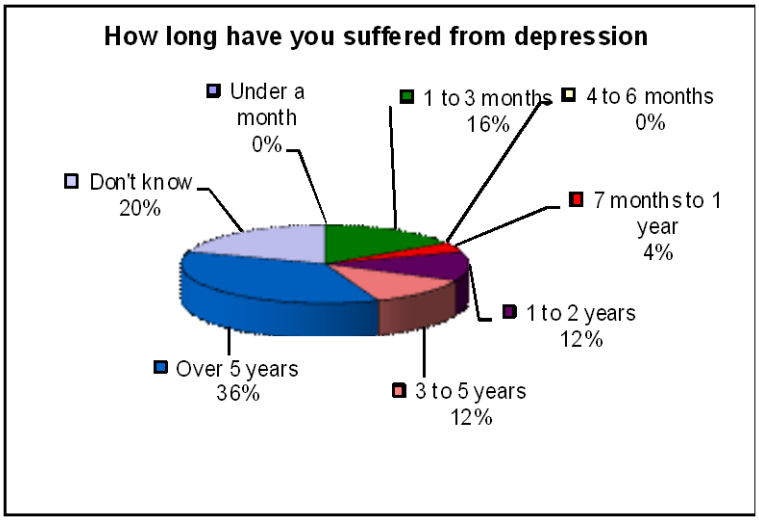
Authorised site in Hampshire, photo the Forest Bus, 2003

For example, in this research, 58 people were asked,

Have you ever suffered from depression?

- Yes 35
- No 23

If so, for how long?



Do you receive any medication for this?

- Yes 26
- No 07

Do you know how to access specialist clinics?

52 people answered this question

- 19 said Yes (37%) they did know how to access specialist clinics
- 33 said No (63%) they did not

Have you ever visited a specialist clinic?

- Yes 15
- No 39

Over half the people who answered this question did not know how to access a specialist clinic and had never visited one.

Specialist clinics include: -
Family planning, sexual health, well women, well men, midwifery, baby clinics and chiropody - the statistics given are very low attendance for such essential services.

A research project undertaken on one of the sites in 1991 highlighted the concerns of the residents at that time. Comments from those living there were:

> *"This place is depressing, we feel like animals in a zoo. The plots are too close together, there's no privacy."*

> *"It's like a prison, there is nowhere to walk. We love to walk."*

> *"They shouldn't put us in a hole, I need my freedom. I'm not ashamed of my way of life – they shouldn't shut us up."*

(Source, Sue Davidson, 1991, Hampshire Health Service).

Selection of Case Studies

Permanent Site Resident

Case Study 1

A young mother of three children under five year's old, experiencing depression.

The Worker encouraged the mother to visit her G.P. The roof of the trailer in which they live has been damaged and is leaking. Water has been pouring down the walls in the living area and the walls are now peeling. Both parents sleep in the living area, the youngest child being a small baby. The floor in the hallway is damaged and rotten underneath and mould is now visible on most of the walls of the trailer. Rats have built a nest in the insulation under the floor of the trailer. Two of the three children suffer from asthma. The Community Worker liaised with Environmental Health and a visit was made. The Officer told the family that they would need to survive there until the end of winter when alternative accommodation may be made available; this will be housing.

The Community Worker reports frequent, tearful calls from the mother who says she is desperate. Her partner is known to the Mental Health Service and has a history of self-harming, including the cutting off of two fingers on one occasion. In order to stay on the site, the family would need to raise in the region of £20,000 for a new trailer.

Bricks and Mortar Resident

Case Study 2

The Forest Bus Community Worker has been liaising with Occupation Health in respect of an older person who has been unable to cope with the stairs in her house. This has involved liaising with the District Council so that adaptations to her home can be made. Through lack of trust of officialdom, the Community Worker has been called upon to be present during visits from Council officials so that information can be explained to her. This woman has enduring health problems, including frequent epileptic fits and other health problems. This woman has literacy difficulties which

makes bureaucracy confusing for her. In addition, she has an adult son with severe learning difficulties and who is reliant on her for support, since her husband died. The role of the Community Worker has been to ensure doctors' appointments are kept, medication followed and help in recording the number and frequency of her fitting. The Worker has also liaised with agencies to develop a more independent life for her son.

Introduction

The Centre for Ethnicity and Health's Model of community engagement

Background to the community engagement model

We often hear the following words or phrases:

- Community consultation
- Community representation
- Community involvement/participation
- Community empowerment
- Community development
- Community engagement

Sometimes these terms are used inter-changeably; sometimes one term is used by different people to mean different things. The Centre for Ethnicity and Health has a very specific notion of community engagement. The Centre's model of engagement evolved over several years as a result of its involvement in a number of projects. Perhaps the most important milestone however came in November 2000, when the Department of Health (DH) awarded a contract to what was then the Ethnicity and Health Unit at the University of Central Lancashire (UCLAN) to administer and support a new grants initiative. The initiative aimed to get local Black and minority ethnic community groups across England to conduct their own needs assessments, in relation to drugs education, prevention, and treatment services.

The DH had two key things in mind when it commissioned the work; first, the DH wanted a number of reports to be produced that would highlight the drug-related needs of a range of Black and minority ethnic communities. Second, and to an extent even more important, was the process by which this was to be done.

If all the DH had wanted was a needs assessment and a 'glossy report', they could have commissioned researchers and produced yet another set of reports that may have had little long term impact. However this scheme was to be different. The DH was

clear that it did not want researchers to go into the community, to do the work, and then to go away. It wanted local Black and minority ethnic communities to undertake the work themselves. These groups may not have known anything about drugs, or anything about undertaking a needs assessment at the start of the project; however they would have proven access to the communities they were working with, the potential to be supported and trained, and the infrastructure to conduct such a piece of work. They would be able to use the nine-month process to learn about drug related issues and how to undertake a needs assessment. They would be able to benefit and learn from the training and support that the Ethnicity and Health unit would provide, and they would learn from actually managing and undertaking the work. In this way, at the end of the process, there would be a number of individuals left behind in the community who would have gained from undertaking this work. They would have learnt about drugs, and learned about the needs of their communities, and they would be able to continue to articulate those needs to their local service providers, and their local Drug Action Teams (DATS). It was out of this project that the Centre for Ethnicity and Health's model of community engagement was born.

The model has since been developed and refined, and has been applied to a number of areas of work. These include;

- Substance misuse
- Criminal Justice system
- Policing
- Sexual health
- Mental health
- Regeneration
- Higher Education
- Asylum seekers and refugees

New communities have also been brought into the programme: although Black and minority ethnic communities remain a focus to the work, the Centre has also worked with;

- Young people
- People with disabilities

- Service user groups
- Victims of domestic violence
- Gay, lesbian and bi-sexual and trans-gender people
- Women
- White deprived communities
- Rural communities

In addition to the DH, key partners have included the Home Office, the National Treatment Agency for Substance Misuse, the Healthcare Commission, the National Institute for Mental Health in England, the Greater London Authority, New Scotland Yard and Aim higher.

The key ingredients of the model
The key ingredients of the model

There are four essential ingredients or building blocks to the UCLAN Community Engagement model.

An issue about which communities and other key stakeholders such as commissioners and policy makers share some concern

The issue can be almost anything, but frequently involves a concern about inequitable access to, experience of or outcome from services. The community and other stakeholders may not agree about the causes of inequity or what to do about it – the key however is that they share a concern. Usually the concern will be framed within some kind of local, regional or national policy context (e.g. teenage pregnancy reduction).

The Community

According to the Centre for Ethnicity and Health model, a community engagement project must have the community at its very heart. In order to achieve this, it is essential to work through a host community organisation. This may be an existing

community group, but it might also be necessary to set up a group for this specific purpose of conducting the community engagement research.

The key thing is that this host community organisation should have good links to the defined target community[1], such that it is able to recruit a number of people from the target community to take part in the project and to do the work (see section on task below).

It is important that the host community organisation is able to co-ordinate the work, and provide an infra-structure (e.g. somewhere to meet; access to phones and computers; financial systems) for the day-to-day activities of the project. One of the first tasks that this host community organisation undertakes is to recruit a number of people from the target community to work on the project.

3. The Task or Tasks

The third key ingredient is the task or tasks that the community undertakes. According to the Centre for Ethnicity and Health model, this must be action oriented. It should be something that is meaningful, time limited and manageable. Nearly all of the community engagement projects have involved communities in undertaking a piece of research or a consultation exercise within their own communities. In some cases there has been an initial resistance to doing 'yet another piece of research', but this misses the point. As in the initial programme run on behalf of the DH, the process and its outcomes have equal importance. The task or activity is something around which lots of other things will happen over the lifetime of the project. Individuals will learn; awareness will be raised; stigma will be reduced; people will opportunities to volunteer and gain qualifications; new partnerships will be formed; and new workers will enter the workforce. Besides, it is important not to lose sight of

[1] The target community may be defined in a number of ways – in many of the community engagement projects it has been defined by ethnicity. We have also worked with projects where it has been defined by some other criteria, such as age (e.g. young people); gender (e.g. women); sexuality (e.g. gay men); service users (e.g. users of drug services or mental health service users); geography (e.g. within a particular ward or estate) or by some other label that people can identify with (e.g. victims of domestic violence, sex workers).

[2] This is not always possible, for example, where potential participants are in receipt of state benefits and where to receive payment would leave the participant worse off.

the fact that it will be the fist time that these individuals have undertaken a research project.

4. Support and Guidance

The final ingredient, according to the Centre for Ethnicity and Health's model, is the provision of appropriate support and guidance. It is not expected that community groups offer their time and input for free. Typically a payment in the region of £15-20,000 will be made available to the host organisation. It is expected that the bulk of this money will be used to pay people from the target community as community researchers[2]. A named member of staff from the community engagement team is allocated as a project support worker. This person will visit the project for at least half a day once a fortnight. It is their role to support and guide the host organisation and the researchers throughout the project. The University also provides a package of training, typically in the form of a series of accredited workshops.

The accredited workshops give participants in the project a chance to gain a University qualification whilst they undertake the work. The support workers will also assist the group to form an appropriate steering group to support the project[3].

The steering group is an essential element of the project: it helps the community researchers to identify the community they are engaging with, and can also facilitate the long term sustainability of the projects recommendations and outcomes. The community researchers undertake a needs assessment or a consultation exercise. However the steering group will ensure that the work that the group undertakes sits with local priorities and strategies; also that there is a mechanism for picking up the findings and recommendations identified by the research. The steering group can also support individuals' career development as they progress through the project

The UCLAN community engagement team

The Centre for Ethnicity and Health has a large and experienced community engagement team to support the work. The team comprises of two programme

[3] Very often we will have helped groups to do this very early on in the process at the point at which they are applying to take part in the project.

directors, senior support workers, support workers, teaching and learning staff, an administration team and a communications officer. They work across a range of community engagement areas of specialisation, within a tight regional framework.

Table 1

<table>
<tr><td colspan="4">National Programme Directors</td></tr>
<tr><td>Northern Team</td><td>Midlands Team</td><td>Southern Team</td><td rowspan="2">Senior Programme Advisors</td></tr>
<tr><td colspan="2">Senior Support Worker</td><td>Senior Support Worker</td></tr>
<tr><td rowspan="2">Support Workers</td><td rowspan="2">Support Workers</td><td rowspan="2">Support Workers</td><td>Drug Interventions Programme</td></tr>
<tr><td>Citizen Shaped Policing</td></tr>
<tr><td colspan="4">Teaching And Learning Team</td></tr>
<tr><td colspan="4">Administration Team</td></tr>
<tr><td colspan="4">Communications Officer</td></tr>
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Programme outcomes

Each group involved in the Community Engagement Programmes is required to submit a report detailing the needs, issues or concerns of the community. The qualitative themes that emerge from the reports are often very powerful. Such information is key to commissioning and planning services for diverse and 'hard to reach' communities. Often new partnerships between statutory sector and hard to reach communities are formed as a direct result of community engagement projects.

In 2005/-6 the Substance Misuse Community Engagement Programme was externally evaluated. This concluded that:

- The Community Engagement Programme had made very significant contributions to increasing awareness of substance misuse and understanding of the substance misuse needs of the participating communities. It also raised awareness of the corresponding specialist services available and of the wider policy and strategy context.

- The Community Engagement Programme had enabled many new networks and professional relationships to be formed and that DATs appreciated the

links they had made as a result of the programme (and the improvements in existing contacts) and stated their intentions to maintain those links.

- Most commissioners reported that they had gained useful information, awareness and evidence about the nature and substance misuse service needs of the participating organisations.
- All DATs reported positive change in their relationship with the community organisations. They stated that the Community Engagement Programme reports would inform their plans for the development of appropriate services in the future.
- A significant number of the links established between DATs and community organisations as part of the Community Engagement Programme were made for the first time.
- The majority of community organisations reported their influence over commissioners had improved.
- Training and access to education was successful and widely appreciated. 379 people went through an accredited University education programme.
- A third of community organisations in the first tranche reported that new services had been developed as a result of the Community Engagement Programme.
- The vast majority of participants and stakeholders expressed high levels of satisfaction with the project.

The capacity building of the individuals and groups involved in the programme is often one of the key outcomes. Over 20% of those who are formally trained go on to find work in a related field.

The views expressed in the report are those of the group that undertook the work, and are not necessarily those of the Centre for Ethnicity and Health at the University of Central Lancashire.

Who are Gypsies and Travellers?

The first Gypsies were travellers or nomads, thought to have originated in India over 1,000 years ago. They are a distinctive group of people whose origins lie in nomadic tribes, and have been part of the culture of the world for centuries. Historical records show that they arrived in Europe in the 16th century, where they were first given the name of Gypsy.

In most parts of the world, Romani people have been the subject of prejudice, discrimination and even genocidal persecution. They were subject to slavery in Eastern Europe and were amongst the first victims of West European racism from the foundation of nation-states in the sixteenth century, to the death camps of Hitler's Europe. In Nazi Germany, an estimated 300,000 were exterminated in concentration camps. *(BBC Education, 1997, p20).* Today, Gypsies are often seen as a problem by social workers, educationalists, health workers, police and other officers of local and National Government who are faced with the challenge of providing improved education, housing, sites and health services and also bring about better community relations without threatening Romani identity. Since early times, the nomadic existence of Gypsies has been a focus for the fears and prejudices of the settled community. Laws banishing Gypsies and threatening anyone associating with them under pain of death were passed under Henry VIII in the sixteenth century and only repealed in the late eighteenth century.

Travellers

The umbrella term 'Traveller' covers Gypsies, Irish Travellers, Showman, Circus and New Travellers. However it is widely documented and accepted that the most vulnerable group and those have most difficulty accessing local services are Gypsies and Irish Travellers. For that reason the data contained herein does not refer to any other group.

In this document the term Gypsies and Travellers refers to the distinct ethnic groups of Gypsies and this information is given in regard only to Gypsies travelling or abiding in the Hampshire area.

Cultural roots

The common perception that Travellers are merely a 'social group of nomads', with no bona fide cultural values distinct from the host society has threatened to undermine the Gypsy identity. (*Leigious,1987,In O'Nions, 1995, p2)* Whilst the Council of Europe and the European Commission for Human Rights *(Buckley v UK App 20348/92 11.1.95)* have been actively defending and promoting the Gypsy culture, the United Kingdom has pursued a policy of integration and assimilation culminating in the Criminal Justice and Public Order Act 1994. This Act made is unlawful to travel in groups of more than six vehicles and gave police powers to arrest offenders and confiscate vehicles, the intention of the act is to make it easier for the police and local authorities to act on Travellers when they park up anywhere and it also removes the duty on local authorities to provide authorised sites. *(Jane Peacock 2001)* Because they are an adaptable community, Gypsy people, whether they live in bricks and mortar or trailers, have survived through centuries and have managed to maintain their own culture.

Photo, Appleby Fair, Forest Bus,, 2004

Lack of secure tenure on public caravan sites, and anxiety that travelling for part of the year will result in having nowhere to return to leads people to choose local

authority accommodation instead, (either bricks and mortar or authorised sites) as this offers more security.

Those who do decide to continue with their nomadic lifestyle, face hostility, lack of suitable provision, poor health and interrupted education for their children. This leads to difficulties in employment, setting up self employed businesses, and endless dealings with the local authority and the police.

> *"Cos were Gypsies they thinks they can put us where ever they wants. They only build sites on places nobody else would live, look where they've put 'em round here. It's always the same – sites are next to a dump, the middle of a woods on yer own miles from nowhere, under electric lines and next to the motorway. Who wants to live here, but where else can you go, what can we do?"*
>
> **Gypsy Man**

Source: (The Forest Bus report on the Health of Gypsies and Travellers in Hampshire, 2006)

It is clear from evidence from many sources that the settled community has always marginalised Gypsies. Gypsies and Travellers are reared to respect very specific cultural traditions, cultural attitudes beliefs and ways of life. Both their feelings of alienation and strong cultural needs should be considered to ensure the provision of adequate services.

"Any attempt to understand the interaction between Gypsies and Travellers on one hand, and the settled community and the State on the other, must be undertaken against some understanding of the long history of that relationship, its origins and the various phases of official response to the Gypsy phenomenon." *(Hawes & Perez, 1996. p13)*

The Forest Bus (mobile community project)

Established in 1995, The Forest Bus is a mobile community project which operates in the Hampshire area. Because the charity operates a specially converted lorry which becomes a mobile community centre, resources, staff and equipment are delivered onto the doorstep of isolated communities in need of services. In particular, over the last 13 years the project has focussed its work on families of Gypsy origin – (delivering work with children, young people and their families) to those who live on sites and those who live in bricks and mortar accommodation. Gypsies and Travellers constitute the largest ethnic minority group in Hampshire. Over the last 13 years, the Forest Bus has established a reputation delivering services to these families. We have forged strong links with the community, and have gained the skills and experience to deliver effective work with this marginalised group.

The Forest Bus visits a site in Hampshire

Aims and Objectives of the research

Aims

1. The research focus was to investigate the perception of Gypsies and Travellers in specific areas of Hampshire into whether mental health services meet their needs
2. To determine the additional kinds of service that individuals would like to be in place to support their mental well being
3. To determine the levels of awareness and access/barriers to current mental health services
4. To gain greater awareness of the perceived mental health experienced by Gypsies and Travellers living and working in a given community through active enquiry.
5. To raise awareness of the mental health needs of Gypsy groups
6. To act as a point of reference and information for practitioners and service providers.

Objectives

1. To identify groups and individuals from where opinion can be sought.
2. To work with the Gypsy community themselves as researchers who would gain the views of participants.
3. To collect evidence and disseminate the information into a final report.
4. To raise awareness of mental health issues within the Gypsy community of Hampshire

Methodology

Through our links in the community and also further to the completion of two other major pieces of research into the Health and Social needs of Gypsies and Travellers in the New Forest and in Hampshire, we applied for funding to enable us to conduct this further piece of research on behalf of UCLAN. (*Source, Jane Peacock, a report on the Health & Social needs of the Gypsy Traveller community, 2003. Jane Peacock, Investigating the Health & Social needs of the New Forest Gypsy Traveller community, 2007, Forest Bus, The Health and Social needs of Gypsies and Travellers in Hampshire as part of the Black Minority Action Plan, 2006)*

We were fortunate to be able to recruit people from the community to work as researchers. The researchers were made up of 4 members of the community, along with a community worker from a local voluntary organisation. The group were led by lead researcher, Jane Peacock, the General Manager of the Forest Bus. The group met on a regular basis with the steering committee. Because we have identified that attendance at events organised outside the county is very low, and because there was no take up of training places, we were fortunate to be able to arrange with UCLAN for training in research to be held at the Forest Bus office. The researchers did not appear interested in achieving the certificate from the university – they were motivated to undertake the research but there was no demand from the team in accessing additional training.

When we embarked on the project, we liaised with communities in which the Forest Bus already had a profile. Through our daily work, we had established that there were many issues faced by families in these communities, and much of our work focussed upon advocating on behalf of families, older people and children to statutory providers. The data collected is as a result of semi structured interviews.

The data in this document is provided primarily with the assistance and support of the Gypsy and Traveller communities so although ostensibly reliable does by its nature fail to include those who do not wish to make themselves obvious.

Because ethnic recording on data collection has excluded Gypsies and Travellers, there is a lack of routine data on the health and social needs of this group. We wanted

in this report, to substantiate our working knowledge by gaining factual evidence to support what we had learnt through our work. In order to gain the views of the community, we used questionnaires, surveys and creative ways of gaining information. As we are aware of the fact that the traditions and culture of the Gypsy community are passed down through the generations orally rather than through the written form, we decided to use semi-structured interviews in order to gather information. By ensuring questions were open-ended, participants were not restricted to fixed answers. We felt that open interviews would be more adaptable. Due to personal preference of participants, questions were asked verbally in some cases. As questions relating to health needs are considered very personal, we were aware of the need to take extra care in the wording and positioning of questions. (*Bell, 1993,81).*

Through our working relationships with the families, which have been forged over a period of time, we decided to focus our work on families of Gypsy origin, both in housing and on residential sites. We were also fortunate to be able to interview 11 people who were travelling through on a transient basis or were living on unauthorised sites. Participants were made aware of the aims of the study, and were ensured of confidentiality. The interviews were conducted at suitable times convenient to the participants. In the areas where voluntary organisations such as the Forest Bus and First Steps Family Group are known, participants were, or appeared to be, pleased to help. Our own local knowledge aided the research.

The Role of the steering group

Steering Group

Several meetings of the Steering Group took place during the course of the research. In the early stages, it was important for the Steering Group to approve the changes made to the proposed research focus which had arisen from discussions with UCLAN trainers and support workers. The Group offered suggestions and support, and served as a liaison forum between the researchers and CAMHS (The Child and Adolescent Mental Health Service) locally.

Primary Sources

- We produced the questionnaire as in appendix 1, in consultation with the steering committee. This gave us the framework from which questions were asked in the form of semi-structured interviews. We targeted families living on sites, families living in housing (we refer to as bricks and mortar) and those who were living on unauthorised sites who were transient. We examined previous and past legislation which has had direct effect on the lives of those future generations of Gypsies in the New Forest.

Secondary Sources

- Previous reports and research and undertaken by the Forest bus:- *Source, Jane Peacock, a report on the Health & Social needs of the Gypsy Traveller community, 2003. Source, Jane Peacock, Investigating the Health & Social needs of the New Forest Gypsy Traveller community, 2007, Forest Bus, The Health and Social needs of Gypsies and Travellers in Hampshire as part of the Black Minority Action Plan, 2006)*

- Contemporary newspaper articles, relevant books on Gypsies and Community work in rural areas, comparing the views of writers and giving examples of their conflicting views

- Reference journals, reports and newspaper articles relating to health, education and social needs of the Gypsy community

- In order to evidence the history, we used documented reports from the Archives of Hampshire County Council and the Association of Parish Councils, plus articles from the media published at this time.

Family living in a bender, circa 1930 Source, New Forest Museum, Lyndhurst.

Ethical considerations

Some of the ethical issues involved in a study of a qualitative nature are common to any form of research involving human participants. The primary aim of ethical considerations in research is to ensure that the goals of the research do not override the interests of the research participants. Researchers conducting qualitative studies have to address issues of an ethical nature. In order to conduct this research, it was necessary to seek and gain ethical approval from the relevant organisation. The purpose of the ethics committee is to ensure that the research to be conducted on human participants abides by ethical principles. Thus it was essential that the research to be conducted caused no harm to any of the participants (Polit *et al.* 2001). The researchers obtained informed consent (see appendix 2) from all participants involved and had followed a rigorous methodology and design in line with the University of Central Lancashire ethics committee. This study was underpinned by four ethical principles such as autonomy, beneficence, justice and non-maleficence (*Beauchamp and Childress 1994)* and gained approval by UCLAN

List of tables and figures

The Questionnaire results.

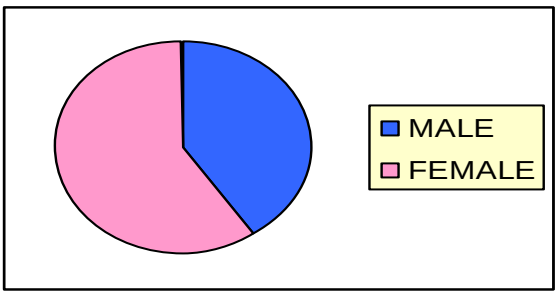


Table 2

The respondents who took part were 57 male and 84 females from 16 years to 88 years of age.

In total 141 people of Gypsy origin were interviewed, using the questionnaire which was agreed by the steering committee. (See Appendix 1) Questions were open ended to promote further comments. All respondents were asked to give to their consent which was recorded. The sample group were made up of those who are living on:

- Permanent sites – local authority
- Unauthorised sites
- Bricks and mortar accommodation – local authority

It was unusual to be able to interview those who were living unauthorised sites because of the legislation surrounding unauthorised encampments. However our contacts in the community informed us of where people had stopped by the roadside and we took the opportunity to include these families in the research.

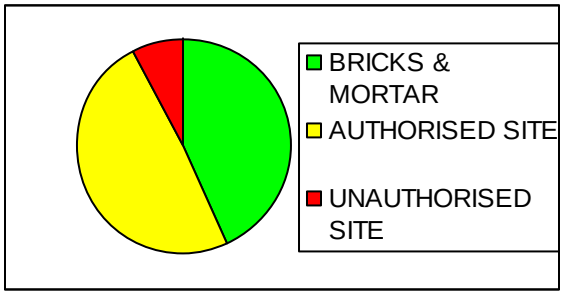


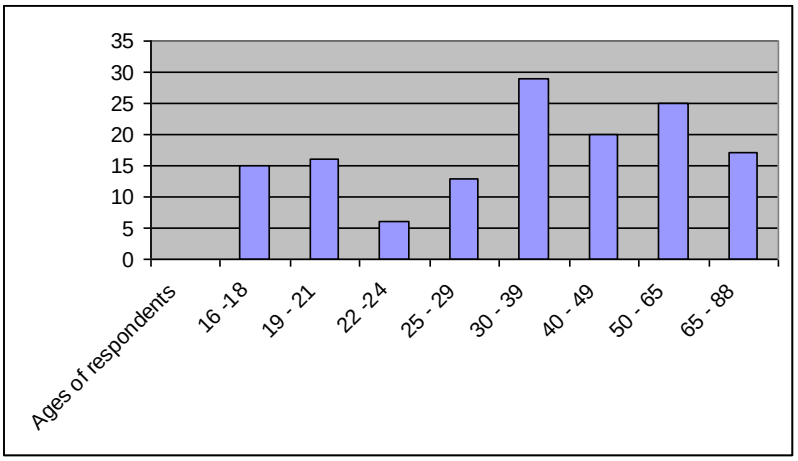
Table 3

Of those interviewed, 61 lived in bricks and mortar

69 on permanent sites

11 on unauthorised encampments

Ages of respondents:



We were delighted that some of the young people showed an interest in participating in the project.

Table 4
Ethnicity

All of the respondents interviewed are of Gypsy origin, and were specifically targeted for this reason. All were born in the UK. All respondents speak English as their first language, although some Romany dialect is used as part of their everyday language.

Bricks and Mortar

A large number of respondents living in bricks and mortar are living in one very rural Hampshire village and their needs and concerns are so critical that they often eclipse those of bricks and mortar respondents living in other locations.

Question 2
Are you happy here?

With just under half saying that they were.

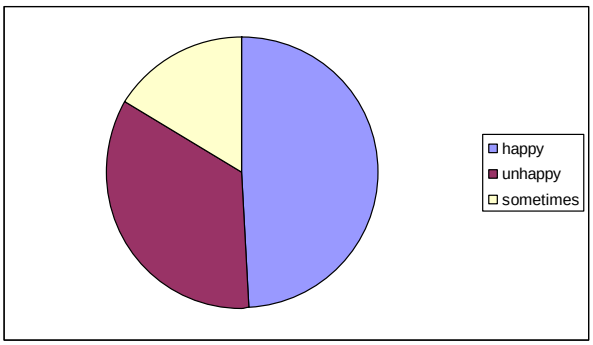


Table 5

"I feel my life is good as I am near my family."

"I don't like it, I hate it, I want to get away from here. There is nothing to do, people are really unkind to me and constantly making my life difficult."

For some respondents from this group the large gardens and spaces that come with some rented local authority housing can be difficult to manage, especially when elderly or living alone. It is unnatural for members of the Gypsy community to live in isolation and respondents seemed to find it difficult to manage a large house and garden when not living in close proximity to family and friends from the Gypsy community.

"I worry about the garden because there is no one to help me."

"I can't walk very far, my money doesn't last. I'm fed up I can't do anything I can't reach my electric meter to put my key in even."

Question 3
Do you feel you have a choice about how you lead your life?

The high cost of living in rural areas also led respondents to remark that they did not have sufficient income to manage and the life choices available to them were limited because of this.

*"I like living in *** ****** but do find it isolating. It hard to access anywhere as the local shops are a long way and here is no pavement or street lights which makes it difficult to get there".*

"... you have to rely on public transport everyday which is not reliable there are no street lamp which is scary, there is no zebra crossing by the park it is dangerous. By not having transport it is hard to access, shops, work and lots of other things to do."

"The public transport is unreliable and very expensive. The local shop is very expensive. I am unwell and find getting out and about really difficult."

" It's a nightmare to get shopping and carry everything home. Buses are not very regular or convenient"

Some respondents felt that the level of prejudice they experienced restricted them.

"I have nothing to do. I want to go to college but I am scared that no one will like me as I don't have a nice house or nice clothes. And I am a Gypsy."

People felt there is cultural pressure from the wider community, and also from Travellers from other communities.– people wanted to be left alone to get on with their lives. People felt they had little choice about where they lived, and this effected employment due to poor transport systems .

People felt they are not accepted and that they are not given a chance e.g. in jobs etc

People felt they had little choice about where they live. Most talked about poverty and the effects of this means they can not afford public transport – if there is any available.

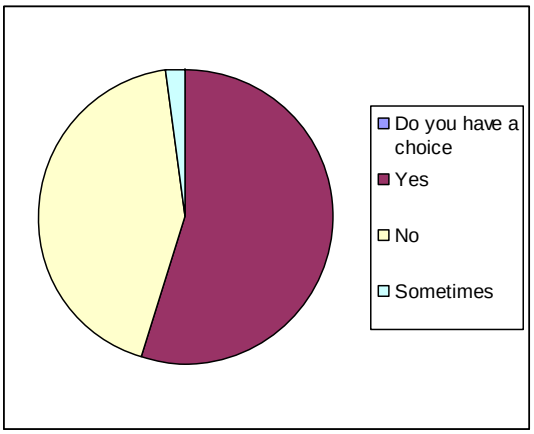


Table 6

Those respondents who did wish to live in bricks and mortar felt that their options were restricted and that because of high housing costs and mortgage difficulties arising from self-employment their only option was to rent from the local authority.

"Not really because there is no choice where I live."

Respondents living in bricks and mortar also said that they felt lonely and suffered from both isolation from the Gypsy community and rural isolation from being so geographically remote.

"Yes it's nice to live here, but it is very lonely and hard at times"

"It's hard to get out, the buses are expensive and don't go very often"

Question 4
What do mental health and mental distress mean for you?

"Mental health and distress is when you're worried and nervy. You panic and all things are on top of you."

"Being worried or keep crying all the time."

2Being or going dinlo. You could be just sad or proper radgi."

Question 5

Do you know any symptoms of depression

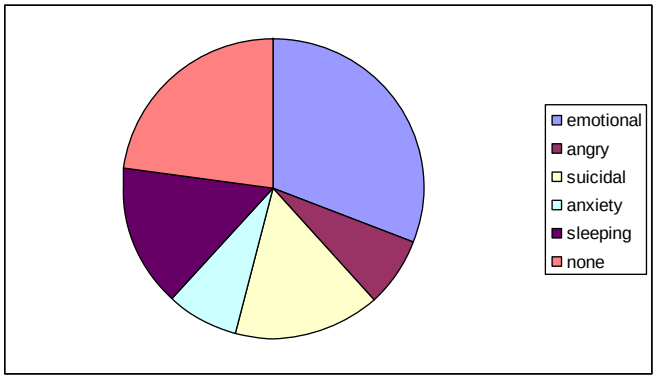


Table 7

The respondents in this group were able to identify the symptoms of depression and reported actual instances, and repeated suicidal feelings and self harm which respondents living on permanent and unauthorised sites did not claim personal knowledge of. A number of people also relied on medication.

"I have no friends and nothing to do. I feel suicidal a lot of the time. I have tried taking pills to get myself away from all of the problems."

*"I'm lonely, no one talks to me, I don't see anyone. I wish I had never moved here, I should have stayed in **** *****, I only came here because of my family now they don't bother with me"*

"No I feel miserable, uncomfortable, I feel down and very isolated."

"Feeling like killing myself. Not talking to anyone, not sleeping."

"Suicidal, I think about jumping in front of cars about twice a day."

"I want to make something of myself and that can't happen here."

"[I feel depressed] all the time. I don't want to be here I feel like no one understands me. I didn't speak to anyone. But when I took some pill from the doctor for my problems I took too many and ended up in hospital."

Question 6

If you have ever felt depressed or experienced any of the feelings – who did you turn to for help?

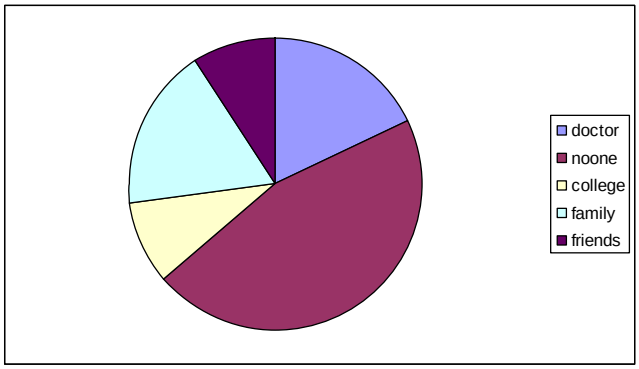


Table 8

In common with the majority of respondents, those living in bricks and mortar felt that their GP, family and friends were the first stops to accessing support and care, and again were wary of intervention from professional agencies as it could possibly escalate the situation and would mean the sufferer and family losing control and might eventually lead to the sufferer being sectioned and permanently admitted to a hospital.

Access to GPs surgeries and mental health services was difficult for respondents in this group as they felt they were restricted by their geographical remoteness and as the majority did not drive or own a vehicle, coupled with limited public transport services, they were not able to travel outside their immediate vicinity to access services.

"It is difficult to get anywhere, buses are not reliable, it costs a fortune to get anywhere."

For respondents in bricks and mortar who felt that their rural isolation restricted the control they could exercise over their life, the poor street lighting and lack of paved pathways was a serious concern, and that if addressed would improve their mental health.

Question 7

If there was a team of people (crisis intervention team) who could come out in an emergency situation, would you want that help?

Due to a lack of trust, people were risking exclusion of initiatives that potentially could benefit their communities. People were concerned that if a specialist team came out to see them, everyone would know their business.

"Only if I could trust them not to tell my family."

"It depends on who it was and what the problem was. But if someone came out to help everyone would know about it. I like to keep my problems private."

"No I wouldn't. I don't like people coming over and seeing where I live its horrible."

Question 8
If people, were feeling low and depressed what could be done to help?

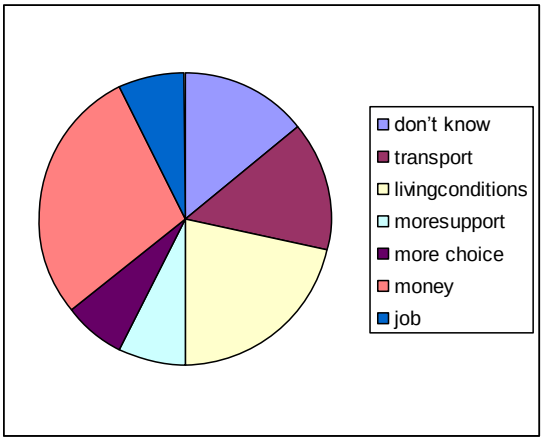


Table 9

"Take them to their doctors, try to find out why they are low"

"Try to talk to them and encourage them to seek medical help"

"Try to help their problem out by talking to them"

"They could go to the doctors or sort their problems out themselves"

"Go to their doctors"

"Their family should look after them"

"Go to the doctors or talk to close friends"

"Don't know"

"Nothing"

Question 9: Is there anything else that would help people feel more in control about their lives?

"If I wasn't discriminated so much by the people who had more money. If people better off than me didn't judge me by my appearance and accepted me as an equal. Because those snobs are no better than me."

Permanent Sites

The research revealed that the majority of Gypsy and Travellers resident on permanent sites were happy living in their current accommodation. However, there were some provisos on this which indicated how accommodation affects their mental health and wellbeing.

Question 2
Are you happy here?

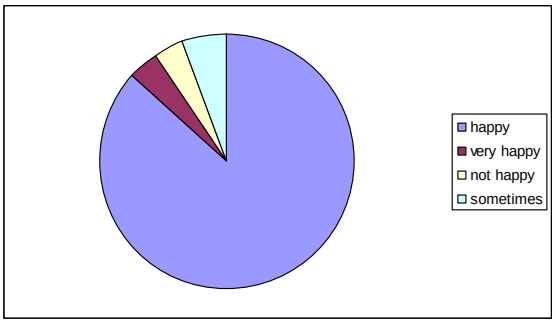


Table 10

"No, not really [happy], we want to get off."

"No, not very happy because we don't get any help from the council and are put on sites to rot!"

The support of family and friends from within the Traveller community was seen as essential to support the physical and mental health and wellbeing of residents and close proximity and access to family was a key point in maintaining health and wellbeing and upon being asked if they were happy where they were living? The following responses summed up the feeling of many.

"Keeping families closer together."

"Yes, near my mum and dad so I can keep an eye on them."

"Yes, I have my family around me."

Question 3
Do you feel you have a choice about how you lead your life?

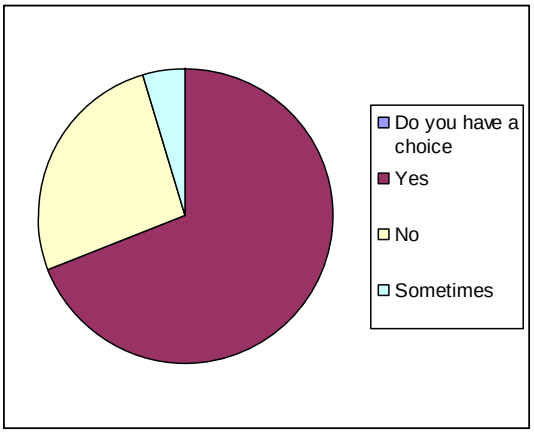


Table 11

"*Not really. Got to keep so many people happy and make sure that you don't stick out but does the same as all the other Travellers. There's a pressure to live in a certain way. I'm happy with that, I was brought up like that and will bring my children up the same, but you got to fit in where ever or whoever you live with."*
"In a way but sometimes we are restricted in what we can do."

"Not so much as if I owned it (the plot)."

"Yes, I make all my own decisions."

"I wouldn't let anyone push me around."

"As long as I please my husband and family – yes."

Residents were concerned about the suitability of their accommodation and that although it was possible to have other family members on site if pitches became available the lack of site provision meant that when pitches became available there was a lengthy waiting list and by which time those awaiting a pitch had settled in another area.

Permanent sites are licensed to residents and the license agreement does not offer the security of a tenancy agreement which left many residents feeling that they had no security. Respondents reported feeling a lack of security and that they wished to be able to purchase and own their own pitches, or a share in it, as with shared ownership houses provided by Housing Associations. Through the consultation, respondents demonstrated a clear desire to own their own property and have security and a stake in society.

"I would like to live on our own land, then I would be content."

"I want a place of my own, I don't feel I'm advancing here."

"Not really, the sites ain't looked after, rather have a place of my own."

"Being secure in …where you live."

The consultation also revealed that because the Local Authority only provides four sites for Gypsy and Traveller accommodation there is little choice about location of accommodation and the Traveller communities are forced into congregating in the areas around sites to maintain family links.

Question 4
What do mental health and mental distress mean for you?

"Mental health is about people that have problems with their self and feel there is no way out and no one can help them."

"I don't know, feeling something's wrong in your mind, like it's not balanced."

The respondents indicated that there were cultural pressures which dictated acceptable behaviour around mental health issues.

"Got to keep so many people happy and make sure that you don't stick out but does the same as all the other Travellers. There's a pressure to live in a certain way. I'm happy with that, I was brought up like that and will bring my children up the same, buy you got to fit in wherever or whoever you live with."

Question 5

Do you know any symptoms of depression?

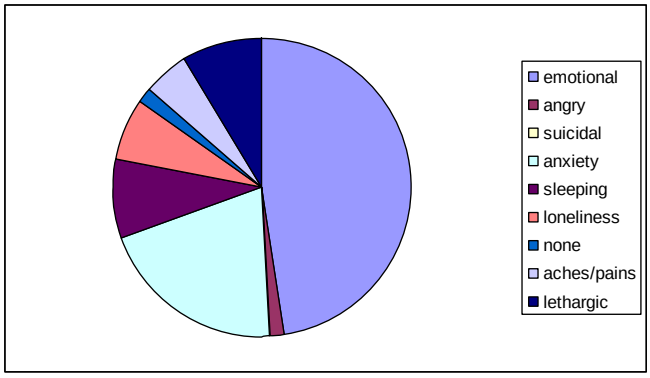


Table 12

96% of those involved in the consultation could recognise and were aware of some of the signs and symptoms of depression and had an understanding of what mental health or mental distress meant to them. Some had experienced the symptoms or had family members or friends who had and so had first or second hand knowledge of living with depression.

Question 6

If you have ever felt depressed or experienced any of the feelings – who did you turn to for help

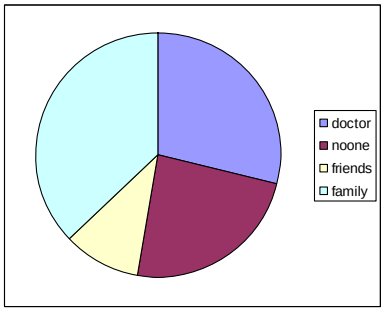


Table 13

There was still a lingering sentiment within the community that mental illness was shameful and a disgrace to the family. Over 26% of respondents believed that it was acceptable to contact a health professional for advice and support, with almost a further 35% saying that they would turn to family and friends first.

"I have a good family, mother, father, sisters and brother plus aunts, uncles and cousins."

"I have been depressed and my family helped me overcome it."

"I did have those feelings and went to my doctor who put me in touch with a psychiatric nurse who really was a great help."

However, for some respondents it is still something that you didn't share outside the family.

"Didn't turn to anyone, just seem to cope. Travellers don't have mental illness, they worry and get stressed, but not mental. If you're mental it's a bad thing and you get locked up, you're not safe to be around."

"What could I do? I've got to go to work to keep my family so I can't go and say I'm depressed, I can't do nothing. Her [wife] family would be ashamed to death of me if I did that. I wouldn't show myself up like that."

Over 10% of respondents living on permanent sites said that they would not seek help but would keep it to themselves.

Question 7

If there was a team of people (crisis intervention team) who could come out in an emergency situation, would you want that help?

Respondents were similarly sure of the best treatment for depression with over 65% saying that they would not want the involvement of a crisis intervention team. There was concern that involving such a team could escalate the situation and might lead to sufferers being sectioned and removed from the family and the community.

"I don't think I would in case they thought I was mental and wanted to put me in some kind of hospital."

For other respondents the notion of having health professionals involved and working on site was a concern.

"…if you were so ill that you didn't care you would, but on a site or around other Travellers, you wouldn't really want them to know."

"I wouldn't really want people out around me but I suppose it would be okay to go to them."

"I wouldn't want people like that coming on site. If you were in a house it might be different."

Question 8

If people, were feeling low and depressed what could be done to help?

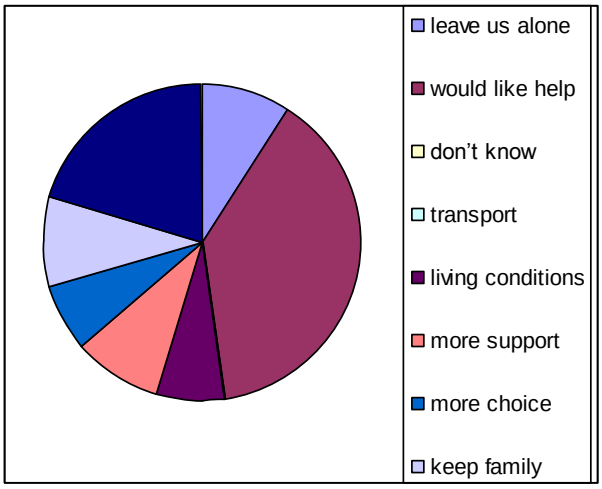


Table 14

Respondents resident on permanent sites felt that the restrictions placed on their lifestyle and culture by the settled communities adversely affected their mental health. When asked what could be done to help people feel more in control of their lives, 26% responded with comments like these.

"Let us travel the roads the way we do."

"Let us live our own way of life."

"Let Gypsies and Travellers live their lives the way they want, without people trying to find out things all the time."

"If the Government or who is running this country have more feelings for our culture."

A further 22% or respondents felt that their low income was a barrier to achieving mental health and was a source of concern.

Question 9: Is there anything else that would help people feel more in control about their lives?

"A lot of Gypsies don't understand a lot of things some live back in time, where as some are in 2007 and know more about other peoples way of life. Some cannot read or write and want to learn but don't know where to go for help. Some have got mental problems with themselves but are frightened to get help and don't know where to get help. A lot of younger Gypsies have problems and have had to deal with it within the family because they have been brought up being told they will be put away."

"*If I was treated with more respect."*
"If a person is happy he is in control."
"Having enough money to help in the hard times when there's not much work."
"Left to get on with their lives and not have to answer these questions."
"Knowing that the police are not going to move them on."
"If the government or who is running the country have more feelings for our culture."

Unauthorised Sites.

Respondents who were living on unauthorised sites were mostly happy with their travelling lifestyle and nomadic way of life but felt they wanted somewhere as a permanent base to overwinter and in times of crisis.

Question 2
Are you happy here?

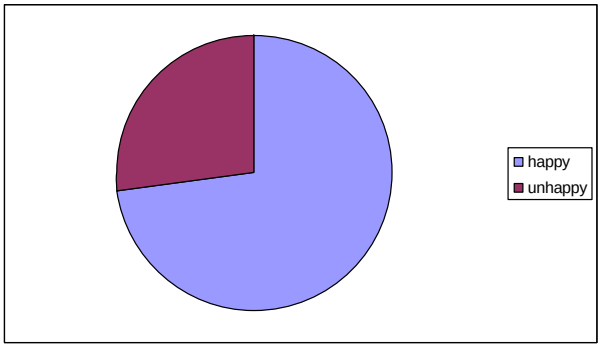


Table 15

Question 3
Do you feel you have a choice about how you lead your life?

There was a feeling amongst respondents that Government and Local Authority had too much power to restrict and control their way of life for them to have any real control over their own lives.

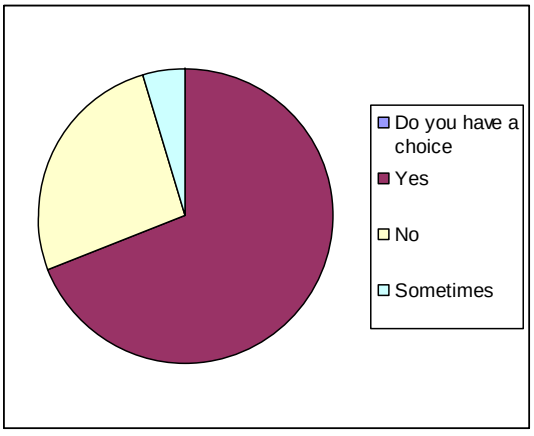


Table 16

They felt there was too much intervention in life to have real control

Question 4
What do mental health and mental distress mean for you?

"Living in bricks and mortar"

"Don't know, mental health is depression and going into a dinni ken"

"I worry all the time about money and where we'll live next month and next year"

"Wany, going dinlo"

Some respondents felt that living houses damages mental health. People found it stressful "waiting all the time to hear if we'll get kicked off here"
No one will leave us alone

It was felt by some respondents that despite the stress and strain of living a nomadic lifestyle on unauthorised sites, it was living in bricks and mortar which was damaging to mental health.

Question 5

Do you know any symptoms of depression

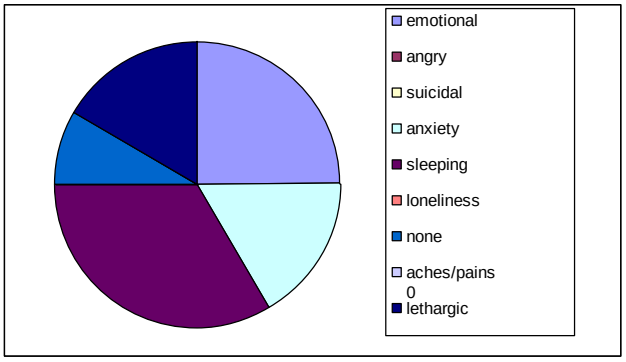


Table 17

"[I felt depressed] all the time when I was in Bricks & Mortar and living in a "gauges" way of life being forced into the way of living by government."

People felt they would have more control of their lives if the following issues were addressed:

- More money.
- Freedom to travel.

- Ability to limit interaction with police.
- Family remain close.
- Poor access to public transport restricts access to local services and amenities.

This group of respondents despite having least representation numerically were still able to accurately identify the symptoms of depression and were aware of mental health issues. Respondents identified avenues for support and suggested GP, family and friends as the primary support services. However, previous research has shown that Gypsies and Travellers living on unauthorised sites often do not have access to GP services and will use Hospital Accident and Emergency as their primary route to accessing health care.

Question 6

If you have ever felt depressed or experienced any of the feelings – who did you turn to for help?

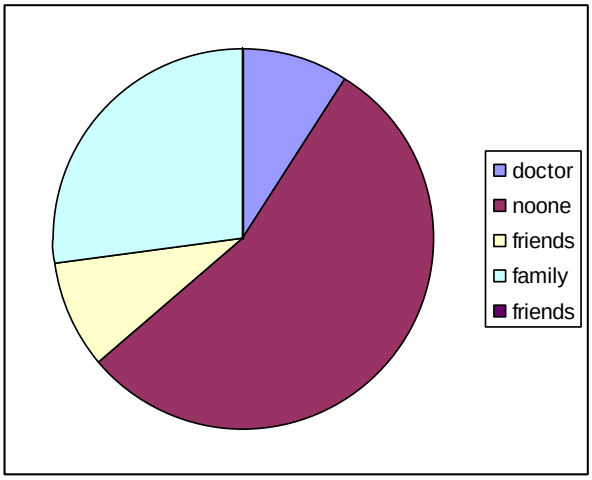


Table 18

Question 7

If there was a team of people (crisis intervention team) who could come out in an emergency situation, would you want that help?

It was felt among this group, and echoed by other groups, that professional intervention could lead to the incident escalating and the sufferer and their family

losing control of the situation. Anonymous or discreet professional intervention that would not lead to the sufferer or their family losing control was felt to be preferable as it would not lead to the family suffering shame from within the community that they attach to mental health issues. Public intervention that would not allow the sufferer and their family to maintain their privacy was only acceptable as a last resort. When asked if they would like support the answers were simple:

"Listen to see what they offer and choose from there."

"No."

"No, people would think I was Sado!"

"No thanks."

"Yes."

"No."

"No."

Question 8

If people, were feeling low and depressed what could be done to help?

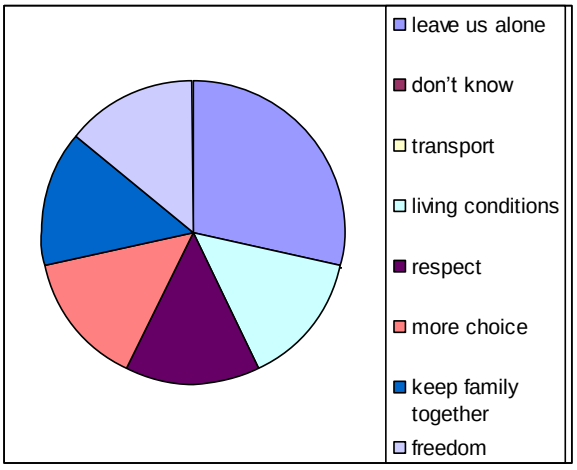


Table 19

This group of respondents felt that the best treatment was to spend time with family and friends and that a lifting of the legal restrictions which impeded their lifestyle would also improve the mental health of Gypsies.

Question 9:
Is there anything else that would help people feel more in control about their lives?

These feeling were echoed when respondents were asked about what would allow them more control of their own lives, with freedom to travel and less involvement with the police coming out as key points. Coupled with this the respondents felt, as the majority of respondents did, that it was very important to be able to keep their family with them and travel together which many were not currently able to do. Lack of income was also an issue as some respondents were moved so often that they had not time to be able to earn an income.

"More rights freedom plus power to travel a nomadic life in England. Respect for this way of life."

"Not having to worry about the police being prejudiced and getting hassled by them."

"Permanent address."

"Having a Permanent place that's your own."

"Leave people to live as they wish, we Gypsies are being put on sites like the cowboys put the Indians in camps."

"Leave us alone."

In some cases we identified a breakdown of normal human relationships and an adoption of siege/survival mentality to cope with the onslaught of abuse, dis-trust, violence – (both physical and psychological)

Conclusion

Overall conclusion

This research has clearly highlighted that there is a need to address the mental health, accommodation and transport needs of all the Gypsy community, including the young people. It seems that all of these needs are affected by the poverty in which many of those we interviewed feel they are trapped. The Gypsy people themselves are clearly aware of mental health issues and although they may know where to access these services, there is a reluctance to accept help from agencies which are seemingly not sensitive to their cultural needs. There is a tendency to rely on family and friends for support which is not always adequate due to family pressure, what can be interpreted as interference, and the severity of the illness. In addition family members are frequently some distance away and not always accessible. There were overriding feelings of isolation and alienation as well as suicidal tendencies. A common theme throughout the research was that people want to be left alone. There is a distinct lack of trust of the gorger (non Gypsy) community and people were suspicious of how the survey would make a difference to their lives, having been let down before.

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Mental Health questionnaire

Are you male/female?	Male/female

What is your age?

What type of accommodation do you live in On a permanent site Bricks and mortar On an unauthorized site

The first question to ask is a general introduction:

1) How long have you lived here?

2) Would you say you are happy here?

3) Do you feel you have a choice about how you lead your life?

4) What do mental health and mental distress mean for you?

5) Do you know any symptoms of depression?

6) If you have ever felt depressed, or experienced any of the feelings above, who did you turn to for help?

7) If there was a team of people (crisis intervention team) who could come out in an emergency situation, would you want that help?

8) If people were feeling low and depressed, what could be done to help?

9) Is there anything else that would help people feel more in control about their lives)

Appendix i

Explanation of depression

www.mind.org.uk

What are the symptoms of depression?

Depression shows up in many different ways. People don't always realise what's going on, because their problems seem to be physical, not mental. They tell themselves they're simply under the weather or feeling tired. But, if you tick off five or more of the following symptoms, it's likely you're depressed.

- being restless and agitated
- waking up early, having difficulty sleeping, or sleeping more
- feeling tired and lacking energy; doing less and less
- using more tobacco, alcohol or other drugs than usual
- not eating properly and losing or putting on weight
- crying a lot
- difficulty remembering things
- physical aches and pains with no physical cause
- feeling low-spirited for much of the time, every day
- being unusually irritable or impatient
- getting no pleasure out of life or what you usually enjoy
- losing interest in your sex life
- finding it hard to concentrate or make decisions
- blaming yourself and feeling unnecessarily guilty about things
- lacking self-confidence and self-esteem
- being preoccupied with negative thoughts
- feeling numb, empty and despairing
- feeling helpless
- distancing yourself from others; not asking for support
- taking a bleak, pessimistic view of the future
- experiencing a sense of unreality
- self-harming (by cutting yourself, for example)
- thinking about suicide.

Anxiety

People who are depressed are often very anxious. It's not clear whether the anxiety leads into the depression or whether the depression causes the anxiety. A person feeling anxious may have a mind full of busy, repetitive thoughts, which make it hard to concentrate, relax, or sleep. They may have physical symptoms, such as headaches,

aching muscles, sweating and dizziness. It may cause physical exhaustion and general ill health.

Appendix ii

Themes

Permanent Sites

Accommodation

- Suitability for need
- Poor geographical location
- Ownership – option to purchase pitches from LA or buy land and gain planning permission for residential use.
- Few sites mean lack of options about where you chose to live.

Cultural Pressure

- Conform to cultural norms
- Not labelled as dinlo or radgi.
- Freedom to travel.
- Preferred isolation to protect culture

Awareness of Depression

- Identify symptoms
- Avenues for support (GP, family, friends)
- Intervention could lead to escalation
- Visible professional intervention as a last resort

Treatment

- Time with family/friends
- Mental health problems caused by restrictions imposed on lifestyle.

More Control of Life

- More money.
- Freedom to travel.
- Ability to limit interaction with settled community.
- Family remain close.
- Poor access to public transport restricts access to local services and amenities.

Unauthorised Sites

Accommodation

- Happy with travelling lifestyle
- Too much intervention in life to have real control
- Living houses damages mental health

Awareness of Depression

- Identify symptoms
- Avenues for support (GP, family, friends)
- Intervention could lead to escalation
- Visible professional intervention as a last resort

Treatment

- Time with family/friends
- Mental health problems caused by restrictions imposed on lifestyle.

More Control of Life

- More money.
- Freedom to travel.
- Ability to limit interaction with police.
- Family remain close.
- Poor access to public transport restricts access to local services and amenities.

<u>Bricks and Mortar</u>

Accommodation

- Larger gardens and space – can be negative when elderly or living alone.
- High cost of housing – rental or LA accommodation is often only option.
- Isolation from Traveller communities.
- Rural isolation
- Lonely

Awareness of Depression

- Identify symptoms
- Higher reports of suicidal feeling, self-harm from B&M communities.
- Avenues for support (GP, family, friends)
- Intervention could lead to escalation and eventually to being sectioned.

Treatment

- Support from family and friends.
- Access to GP and health services restricted by location.

More Control of Life

- Can’t get out because of poor street lighting and paving
- Poor access to and cost of public transport leads to isolation.
- High cost of living from living in rural area coupled with low wages and/or benefits restricts opportunities.