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EXPLORATION OF VIEWS ABOUT MENTAL HEALTH IN GYPSY, TRAVELLER, ROMA, AND SHOWMEN COMMUNITIES.

Section A: How do Gypsy, Traveller, Roma, and Showmen Communities understand mental health and what are their experiences of mental health services?
A review comprising a systematic search and thematic synthesis.
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Section B: Exploring perinatal mental health within Gypsy, Roma, Traveller, and Showmen communities.
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Major Research Project Summary

Section A

There is a lack of research exploring Gypsy, Traveller, Roma, Showmen and Boater (GTRSB) communities' experiences of mental health, despite the reported high levels of mental health difficulties within these communities. This review explored; how GTRSB people understand mental health, how they identify what impacts mental health, their experiences of mental health services, and their views about how services could be improved to meet the needs of their communities. A systematic search of four databases was completed, followed by a quality check of the 12 papers that met the inclusion criteria. The papers were deemed of adequate quality. A thematic synthesis was completed, resulting in four themes: interpersonal, systemic, and structural influences on mental health; perspectives of mental health; conflicts between identity and community, community, and family; and experience of services: past, present, and future wishes. Clinical and research implications include the use of co-production, an increase in cultural competence within services, and increased research on those GTRSB communities whose voices are less heard from in the literature.

Section B

Within the small amount of research exploring GTRSB mental health, women's mental health is even less considered. This study used a consultation approach with members of a GTRSB community at all stages of the project. Qualitative methodology was then used to explore GTRSB participants' understanding of perinatal mental health and what support they are currently offered and felt was needed. Following an extensive recruitment procedure, semi-structured interviews were conducted with ten GTRSB participants. Data was analysed using reflexive thematic analysis. Themes included: dilemmas of trust; experiences of discrimination; taboo and shame inhibit conversations around perinatal mental health; how additional GTRSB hardships impact perinatal mental health; noticing and hoping for change. Family and community were most trusted and health and social care staff were mostly distrusted. Participants experiences of discrimination resulted in an additional burden that affected well-being. Women reported rarely disclosing perinatal mental health difficulties and used a ‘keep going’ attitude. The hardship of being a GTRSB women was also talked about due to multiple demands and stressors. Participants discussed change within their GTRSB community in terms of increased awareness of perinatal mental health and a desire for services to be more culturally competent and collaborative with communities. Themes were separate but can be best understood as interacting. Clinical and research implications were considered.

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Section A

How do Gypsy, Traveller, Roma, and Showmen Communities understand mental health and what are their experiences of mental health services?

A review comprising a systematic search and thematic synthesis.

Word Count: 8,072

Abstract

Background:

There is disparity between the small amount of research exploring Gypsy, Traveller, Roma, Showmen and Boater (GTRSB) communities' experiences of mental health and the high levels of mental health difficulties and suicide reported in this population. Previous reviews have focused on GTRSB communities' physical health or focused on mental health only within one GTRSB community or are not specific to the UK.

Aim:

This systematic review explored: how GTRSB people understand mental health; how they identify what impacts mental health; their experiences of mental health services; and how services could be improved to meet the needs of their communities.

Method:

A systematic search of ASSIA, Web of Science, SCOPUS, and psychINFO yielded 12 papers. A quality appraisal was completed using the CASP framework. A thematic synthesis explored the research questions.

Findings:

The papers were of reasonable quality. Four themes were derived: interpersonal, systemic, and structural influences on mental health; perspectives of mental health; conflicts between identity and community; and experience of services: past, present, and future wishes. Clinical and research implications include the recommendation of the use of co-production, increase in cultural competence within services, and increased research on those GTRSB communities less explored in research.

Keywords

Gypsy, Roma, Traveller, Mental Health.

Introduction

Terminology

Gypsy, Traveller, Roma, Showmen, and Boater (GTRSB) or Gypsy, Traveller, and Roma (GRT) are umbrella terms coined by the NHS, the UK government, charity, and higher education organisations to describe ethnic and cultural groups of people (Buckingham New University, n.d; Friends, Families, Travellers, 2024a; HM Government, 2022; NHS Race & Health Observatory, 2023). The term GTRSB is favoured within this review as it encompasses a wider range of the individual groups, however, within the reviewed papers specific ethnic and cultural groups will be referred to as appropriate.

GTRSB

GTRSB are individual communities with their own rich histories. For example, Irish Traveller people are documented from the 12th century (migrating to Britain in the 19th century) and are distinct from the general Irish population. Whilst Romany Gypsy people have been estimated to have lived in Britain since the 16th century, originating from India (North et al., 2000; Traveller Movement, n.d.) and European Roma people migrated to Britain from Europe in the late 20th century (House of Commons Women and Equalities Committee (HCWC), 2019). The GTRSB term also includes English, Welsh and Scottish Travellers (Traveller Movement, n.d.). The Equality Act (2010) protects Romany Gypsies and Irish Travellers as recognised ethnic groups, however it does not protect New Age Travellers or Showmen who are described as cultural groups who may share similar cultural beliefs to Irish Travellers and Romany Gypsies. Showmen or Showpeople run funfairs and travel as part of their employment, whilst New Age Travellers are people who have started living nomadically during the 1960’s and 1970’s festival movement (Traveller Movement, n.d.).

It was not until 2011 in the England and Wales census that 'Gypsy or Irish Traveller' was added as an ethnicity and not until the 2021 version that 'Roma' was added (HM Government, 2022). In addition, Scotland planned to add 'Showman' or 'Showwoman' to the 2022 census, but this data is yet to be published (HM Government, n.d.). In 2021, the census recorded 71,440 people identifying as Gypsy or Irish Traveller within England and Wales, equalling 0.12% of the population total, and 4,685 people identifying as Showpeople from write in text options (Office for National Statistics, 2023, 2024). However, there is a high possibility that some people will not have disclosed their ethnicity and many will not have been counted in the census, a more realistic figure of 120,000 GTRSB people has been suggested (Traveller Movement, n.d.).

GTRSB Research

Despite GTRSB ethnic and cultural groups having distinct histories, unfortunately as a collective they are regarded as the "most disadvantaged groups" and experience discrimination and stigmatisation (Lane, Spencer, & Jones, 2014, p. 9; McFadden et al., 2018, p. 74). Cemlyn et al (2009) suggests experiencing racism and discrimination occurs across GTRSB peoples' lives amongst various contexts. The small research base highlights difficulties experienced by GTRSB communities such as lower socioeconomic status, lower levels of education attainment, and inadequate accommodation (HM Government, 2022).

GTRSB communities have been labelled as "hard to reach" groups within research, however, it must also be considered that GTRSB views can be considered as "marginal discourse" and not listened to as much as the dominant discourse (Condon et al., 2019, p. 1324; Foucault, 1972, as cited in Serrant-Green, 2010, p. 349). Marginalisation has been defined as "peripheralization of individuals and groups from a dominant, central majority" (Hall et al., 1999, p. 89). For instance, marginalisation can result in individuals being unable to access services or opportunities as they do not feel valued members of society (Mowat, 2015).

Physical Health

GTRSB communities experience the poorest health in comparison to other ethnic groups, in addition to a lower life expectancy and higher rates of infant mortality (Barry, Herity & Solan, 1987; Cemlyn et al., 2009; Peters et al., 2009). Unfortunately, their uptake of health services is poor: a key study exploring the trust felt by Gypsy, Roma, and Traveller people across 32 different countries when using health services reported a range of structural, economic, and individual barriers, this included a sense that services were inflexible, discriminatory experiences from staff, low levels of literacy and poor understanding of services (McFadden et al., 2018).

To understand health service use, various theories and definitions of help seeking have been developed (Rickwood & Thomas, 2012). The concept of candidacy suggests an intricate relationship exists between socio-economically disadvantaged and ethnically minoritised people and health services which makes it difficult for them to access services. The framework suggests accessing services involves the person recognising a health need, being aware of services, and knowing how to interact and engage with services to express their need, which may be more difficult for such groups. In addition to this, access to services is dependent on how services perceive the individual, availability of services within the area, and if a service offer is then accepted by the individual (Dixon-Woods et al., 2006). This framework is helpful in highlighting the various processes that help seeking depends on and considers the role of health services in relation to this.

Alternative models have highlighted the importance of culture in influencing help seeking behaviour. For instance, an individual's cultural perception of seeking or accepting help, may be positively or negatively regarded and this may then impact if they seek help or not (Saint Arnault, 2009). This model does not include factors such as socioeconomic status but highlights this as a significant factor in help seeking.

Mental Health Amongst GTRSB Communities

A rapid review of Irish Traveller mental health and suicide has acknowledged the paucity of mental health research and noted factors such as “powerlessness and loss of identity” alongside discriminatory experiences and stigmatisation of mental health as impacting mental health (McKey et al., 2022, p. 229). Indeed, mental health is reportedly considered a taboo subject within many Gypsy, Roma, and Traveller communities (McFadden et al., 2018). Despite the subject being taboo, epidemiological research suggests that Irish Travellers are 2.5 times more likely to report poorer mental health for the majority of a month than the general population of Ireland (McGorrian et al. 2013). Equally, a health comparison study found significantly worse health status of Gypsies and Travellers than age and sex matched controls from non-GTRSB population, this included increased levels of anxiety and depression (Parry et al., 2007).

Such findings would suggest mental health support would be useful, however, discrimination experienced by Irish Travellers can impact engagement with mental health services (Quirke et al., 2022). Research based in Ireland is relevant to the UK as the service structures organised by Health Service Executive are similar in that there are services free at the point of access for residents (Citizens Information, n.d.). A scoping review of GTRSB mental health across Europe highlighted general poor mental health, and socio-economic and communication barriers impacting access to mental health services (Guerrero, Civišová, & Winkler, 2024).

Current GTRSB Service Provision

Within the UK there are no statutory services specifically for GTRSB communities to support their mental health. Tailored support is currently being provided in different forms by the charity sector who also signpost individuals to generic NHS services (Friends, Families & Travellers, 2024b; Traveller Movement, 2024). In Ireland, a study found Irish Travellers use mental health services at a higher rate and also reported the services to be poorer in quality than a control sample of non-travellers (McGorrian et al., 2012). Therefore, exploration into how services can be improved is greatly required.

The NHS Long Term Plan proposed an increase in funding with the hope of generally improving access to mental health services and reduce health inequalities (NHS, 2019). However, within this there was no guidance to how this relates to GTRSB communities specifically. A landmark report by the NHS Race & Health Observatory (2023) reported that NHS services have not been adequately aware of the mental health needs of GTRSB communities. Therefore, services are urgently required to become more aware of inequalities faced by GTRSB communities and put in place more accessible services.

Review Rationale

Research highlights that GTRSB communities for many reasons do not have equal access to services (NHS Race & Health Observatory, 2023). A review of research exploring GTRSB communities' understanding of mental health and their experiences of services would allow a collective understanding of the perceived gaps in services.

Currently, literature reviews of GTRSB communities highlight a paucity of research and suggest poor mental health and engagement with services is associated with a range of socioeconomic inequalities, discrimination, and stigma (Guerrero et al., 2024; McFadden et al., 2018; McKey et al., 2022). Two of these reviews focused on Europe more broadly (Guerrero et al., 2024; McFadden et al., 2018) and one review focused exclusively on Irish Traveller people's experience (McKey et al., 2022). In addition, papers used a scoping review (Guerrero et al., 2024) or rapid review methodology (McKey et al., 2022). Given the lack of understanding by NHS services of the barriers to access for GTRSB communities, a review that explored community perspectives and understanding about mental health would allow services to understand more about the gaps.

Review Aims

This review aimed to critically appraise and thematically synthesise the literature exploring GTRSB people's perspectives of mental health who live in the United Kingdom (UK) or Ireland.

This review based on a systematic search aimed to answer:

- How do members of GTRSB communities understand mental health?
- What do the members identify as impacting the mental health of their community?
- What are the communities' experiences of mental health services?
- How do community members think services could be improved?

Method

Review Design

To address the aims a systematic search was completed. Results of this search was analysed using thematic synthesis (Thomas & Harden, 2008).

Literature Search

A preliminary search was conducted through Google Scholar to explore for relevant papers and keywords used within them to inform the systematic search terms. The following databases were searched; ASSIA, PsychINFO, Web of Science, and SCOPUS as they include health, social services, and psychological research which are relevant to the research aims. Table 1 details the search terms used for all databases alongside Boolean operators 'AND' and 'OR' to connect GTRSB and mental health literature.

Table 1

Search Terms used within the Review

OR	AND
gyps*	mental health
gip*	mental illness
Traveller	psych*
Roma	depression
Romany	anxiety
Romani	well-being
Showmen	
Boater	

Titles and abstracts were screened and then relevant papers were read in full. In addition, individual papers' reference lists were hand searched by the author and Google Scholar was used to check for any relevant papers. The searches took place during October 2023. All searches were exported to RefWorks, duplications were removed by the RefWorks software and by hand.

Inclusion and Exclusion

Table 2 details the inclusion and exclusion criteria. Qualitative papers were used exclusively in accordance with the aims of hearing from people's experiences. This included the authors' interpretations of the participant's experiences. Quantitative research including questionnaires may have been standardised on non-GTRSB populations and hold perspectives of mental health not nuanced to GTRSB communities (Haroz et al., 2017). Therefore, quantitative research was excluded. In total 12 papers were identified as meeting the inclusion and exclusion criteria.

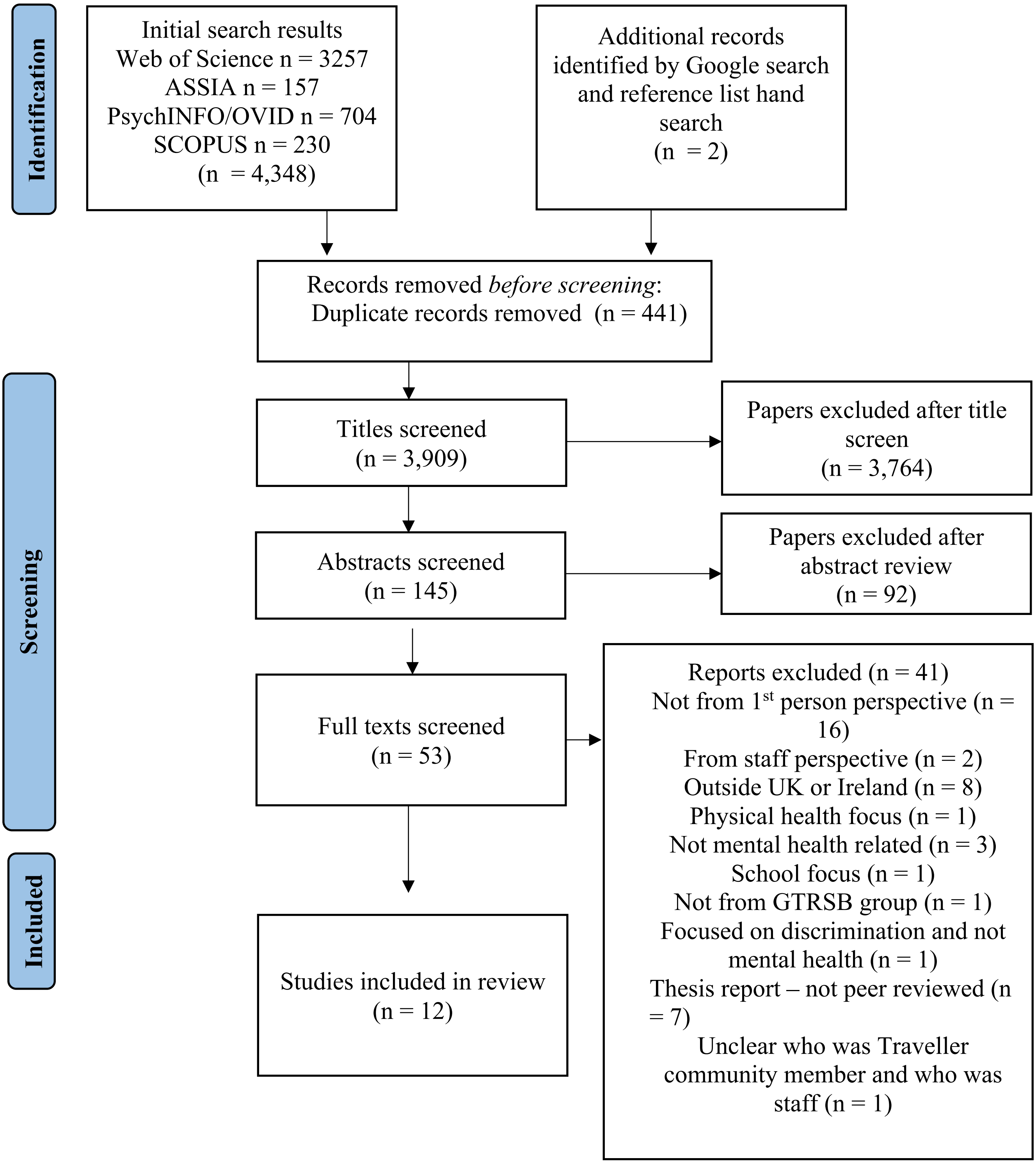
Table 2

Inclusion and Exclusion Criteria

Inclusion	Exclusion
Qualitative and mixed methods papers that included quotes from participants and/or directly summarised participant views	Quantitative analysis only
Perspective of members of any of the GTRSB communities on any aspect of mental health	Views of non-GTRSB people such as those who work with a particular GTRSB community
Participants had to identify as belonging to a GTRSB community	
Written or translated into English	Unavailable full texts – every effort was made to get these
From the UK or Ireland	Conducted outside of the UK or Ireland
Peer reviewed	
Original research	Papers that included only theoretical perspective
Include qualitative data	
From any date point	

Figure 1

PRISMA Diagram (Page et al., 2021)



Approach to Quality Assessment

The Critical Appraisal Skills Programme (CASP) was used to evaluate the quality of the 12 qualitative papers (CASP, 2018). The CASP (2018, p. 1) includes 10 questions that focus on different areas of the paper (e.g., sampling strategy and ethical considerations) and covers three issues; “are results of the study valid?, what are the results?, will the results help locally?”. The CASP is viewed as accessible, however, the yes, no, and can’t tell response options can be difficult to determine (Long et al., 2020). Therefore, this review incorporated using the response option of ‘partial’ to be able to include more of a nuanced response when some of the criteria was fulfilled but not all. Despite this, a ‘partial’ mark could be given for different elements of the criteria and therefore is subjective.

In addition, question five of the CASP (2018) explores data collection, a ‘hint’ is provided which concerns if data saturation has been discussed. Data saturation is not necessarily applicable to research using thematic analysis (Braun & Clarke, 2019). Therefore, although the CASP is helpful it should be treated with caution - as should all quality reviewing (Carroll & Booth, 2014). It is also noted that the CASP does not assess the quality of the structuring of a research paper, something which can be valuable in ease of understanding information for the reader.

Approach to Thematic Synthesis

A thematic synthesis was conducted in order to explore themes relevant to the research question across the 12 papers. Thematic synthesis is similar to thematic analysis as it identifies themes, which has been posited as adding value to the original research by showing similarities and differences across the papers and topic. It was developed within health promotion and public health domain to enable qualitative findings to be synthesised together (Thomas & Harden, 2008). Therefore is highly appropriate for the stated research aims.

Thematic Synthesis Process

Initial coding was conducted with the aid of NVivo (Lumivero, 2023). Papers were read through fully in order for the author to be familiar with the content. Coding was completed of the results and discussion section of each paper. Inductive coding kept codes close to the original data and no pre-determined or 'deductive' coding was used. Table 3 documents the three-stage process recommended by Thomas and Harden (2008). Appendix A also provides examples of coded exerts from papers.

Table 3

Thematic Synthesis Process (Thomas & Harden, 2008)

Stage	Description
1	• Line-by-line coding of the study's findings was completed which derived 'free codes', this included direct quotes from participants and the interpretation made by the authors • Papers were inductively coded without the consideration of the systematic review's research question as it felt this could detract from the original research • Initial codes were included if the line was clearly discussing mental health related issues • General comments about services where it was not clear if the paper was discussing mental health or physical health were not coded. The original text was checked to ensure consistency of coding • If appropriate codes were reused across papers
2	• 'Free codes' were considered all together and organised into groups if they shared similarities to each other. This process formed the initial concept of themes, described as 'descriptive themes' which encompassed the meaning of the group of free codes. At this stage the themes were mostly descriptive of the content
3	• Analytic themes were developed by considering the descriptive themes against the reviews aims stated • This process allowed the synthesis to explore meanings across the literature, further 'going beyond' the original findings and added more depth to the findings than simply grouping the original themes • Analytical themes were discussed with supervisors to check they met with the research questions • Analytical themes were checked back against the codes and descriptive themes to ensure they were representational of these • Example: descriptive themes around the importance of family and community were considered against descriptive themes around being unable to speak to family. These developed into a broader analytical theme of the dilemmas between these two experiences

Author Reflexivity

It is important to acknowledge one's position within research (Watt, 2007). To provide context, I am a white female who is not from a GTRSB community. Therefore, I will be limited in my interpretation of the analysis by not understanding the direct experiences of minoritised discrimination and I will hold my own (largely Global North) ideas about mental health. Supervision meetings were an opportunity to explore potential biases.

Step one resulted in 306 free codes being developed. At step two these codes were grouped by similarities or shared concepts into 39 descriptive codes. To explore the data against the review's research aims, descriptive codes were considered conceptually and grouped into four analytic themes.

Results

Included Studies

Figure 1 details the PRISMA diagram. The papers were published between 2006 and 2023, with half of the papers published within the last three years (2020-2023). Seven papers were from an Irish Traveller perspective within Ireland. Five papers reported participants identified as from either Gypsy, Traveller, or Roma communities. One paper included one participant who identified as Showmen. No papers reported participants identifying as from New Age Traveller or Boater communities. Six papers specifically focused on mental health, four papers focused on health more generally, one paper focused on experiences of bereavement, and one paper focused on alcohol use. It was felt appropriate to include these as they referenced the interaction of these topics and mental health. Key details from the papers are displayed in Table 4.

Table 4

Included Papers Information

Author (Year)	Stated Research Aims	Sample Size, Location, Gender, (Sample Strategy)	Design and Methodology	Stated Qualitative Findings	Data Analysis
Goward et al. (2006)	"How do members of the Gypsy and Traveller community understand their mental health? What would enable them to seek help and what help would they find useful? What are the experiences of service providers working with Gypsies and Travellers and what would enable them to meet the mental health needs of this community more effectively?"	17 adult Gypsies and Travellers gender not stated Sheffield (purposive)	Mixed methods (health status survey, semi-structured interviews, focus groups of service providers)	Five themes: • Financial • Physical environment • Employment • Grief • Family and community support	Not stated but alludes to generating themes
Hodgins et al. (2006)	"To explore Traveller women's perception of health and health inequalities (causes and social construction)."	41 adult Irish Traveller females Ireland (purposive)	Focus groups and use of a vignette	Five themes: • Perceived causes of ill-health • Perceived adequacy of health services • What Brigid needs • Wealth and health • Prominence of domestic violence	Thematic Content Analysis
Keogh et al. (2020)	"To present the findings from the evaluation which explored Travellers access to and reasons for accessing the	10 [age not stated] Irish Travellers 4 males, 6 females Ireland	Interviews	Three themes: • Factors affecting Traveller mental health • Accessing the TMHLN	Thematic Analysis

Author (Year)	**Stated Research Aims**	**Sample Size, Location, Gender, (Sample Strategy)**	**Design and Methodology**	**Stated Qualitative Findings**	**Data Analysis**
	Traveller Mental Health Liaison Nurse (TMHLN), the interventions provided and their experiences of and perceptions of the role of the TMHLN.”	(not explicitly stated but purposive)		• Travellers’ experiences and perceptions of the TMHLN	
O’Donnell & Richardson. (2020)	“What are the sources of psychological distress faced by middle-age men in Ireland and how do they approach seeking support?”	34 adult Males in total *4 Irish Travellers Ireland (purposive and snowball)	Focus Groups	Four themes: • Reconciling Increasing Expectations with Diminishing Capacities to Achieve at Middle-Age • Isolation at Middle-Age • Barriers to Support-Seeking • Catalysts for Change & Strategies for Improved Self-Care	Inductive Thematic Analysis
O’Regan et al. (2023)	“Explore Traveller women’s own experiences of health care services”	24 adult Irish Traveller Females Ireland (purposive)	Focus group using semi-structured interview guide	Three themes: • Conceptualizing what it means to be in receipt of health care • Respecting ethnic customs around death and dying • Strategies for enhancing cultural competence	Content Analysis
Richardson et al. (2023)	“Explore the lived mental health experiences of Traveller men affected by suicide (i.e., those who had in the past reported suicidal thoughts, attempted suicide, or having been bereaved by suicide,	13 adult Irish Traveller males Ireland (purposive and snowball)	Semi-structured interviews	Three themes: • Key determinants of Traveller men’s mental health • Contemporary Traveller masculinities	Inductive Thematic Analysis

Author (Year)	Stated Research Aims	Sample Size, Location, Gender, (Sample Strategy)	Design and Methodology	Stated Qualitative Findings	Data Analysis
	excluding within the preceding 3 months) in Ireland. What are the sources of psychological distress among Traveller men affected by suicide in Ireland? What are the barriers and enabling factors to Traveller men seeking help and accessing support during times of psychological distress?”			• Navigating support seeking and coping with distress	
Rogers & Greenfields. (2017)	“Explored the impact of bereavement on individuals and wider family members with consideration given to the close cognate kinship and collectivist nature of Gypsy and Traveller communities.”	24 [age not stated] Female Irish Traveller and English Gypsy Location not stated (purposive)	Focus group and narrative conversations	Four themes: • Cultural characteristics • Health status • Gender • Family	Thematic Analysis
Ruston & Smith. (2013)	“To examine Gypsies’ and Travellers’ understanding of factors that potentially put their health and well-being at risk in order to develop an intervention to mitigate these risks.”	39 adult Gypsies and Travellers adults 20 females, 19 males Southeast England	Interviews	Four ‘Categories’: • Experiencing spatial control • Living in stigmatised/dangerous spaces • Having limited access to appropriate health care • Engaging in unhealthy lifestyle and help-seeking behaviours	Not explicitly stated but process described

Author (Year)	**Stated Research Aims**	**Sample Size, Location, Gender, (Sample Strategy)**	**Design and Methodology**	**Stated Qualitative Findings**	**Data Analysis**
		(purposive & snowball)			
Smith & Ruston. (2013)	“Explored Gypsies’ and Travellers’ perceptions of how racial discrimination and social exclusion impacted on their patterns of social relations and how the nature of their social ties influenced their willingness to access formal healthcare services.”	39 adult Gypsy and Traveller adults 20 females, 19 males Southeast England (snowball – sought a range of socioeconomic characteristics)	Interviews	• Networks: proximity and health • Discrimination, social closure and use of health services • Lay consultation and collective knowledge	Grounded Theory
Thompson et al. (2022)	“Examine factors that contribute to the MH crisis of GRT people and the corresponding support needs of GRT people.”	9 adult Gypsy, Roma, Traveller adults 4 males, 4 females, 1 participant identified as non-binary Resident of British Isles (8 = UK 1 = Ireland) (Opportunity)	Semi-structured interviews	Three themes and eight subthemes identified: • Longing for acceptance (within wider society, within GRT communities) • Increased vulnerability (lack of prospects, adverse life experiences) • Barriers to help seeking (unsuitable services, awareness, stigma, trust)	Thematic Analysis

Author (Year)	Stated Research Aims	Sample Size, Location, Gender, (Sample Strategy)	Design and Methodology	Stated Qualitative Findings	Data Analysis
Van Hout (2010)	"To uncover the needs and feelings of Travellers, Traveller culture and substance use, problematic substance use and experiences of health, community and addiction services, in order to identify gaps in services, guide resources and give recommendations for improved service provision."	57 adult and youth Irish Traveller 19 males 22 females Ireland (random)	Focus groups	No themes provided but interview data discussed.	Thematic Analysis
Villani & Barry. (2021)	"Explore the views of a sample of Irish Travellers on their perceived mental health needs. Explore Travellers' understanding of mental health and its determinants. Examine Travellers' views on the strategies needed to meet their perceived mental health needs."	25 adult Irish Traveller 12 females, 13 males Ireland (convenience sampling)	Focus groups 1 semi-structured interview	Four themes across three levels plus one cross-cutting theme of Traveller Culture: • Traveller's conceptualisation of mental health • Travellers perceived determination of mental health • Prejudice, discrimination and bullying • Strategies to improve help-seeking and mental health service utilisation	Thematic Analysis

Note. * participants responses included within the review. Stated research aims and qualitative findings reported verbatim. The identification of the participants ethnic or cultural group is taken from the papers.

Quality Check of Papers

Quality reviewing was completed by the author. Table 5 documents the CASP findings. The CASP was used to highlight the quality of evidence used within the subsequent thematic synthesis and no papers were excluded due to lack of quality.

Aims and Method

All 12 papers clearly stated the aims of the research and appropriately used a qualitative methodology as they aimed to explore rich accounts of personal experiences, perspectives and/or understanding of mental health related factors.

Research Design

All papers used appropriate research designs; however four papers did not explicitly justify why they used such methods (Ruston & Smith, 2013; Smith & Ruston, 2013; Van Hout, 2010; Villani & Barry, 2021). One paper coproduced the research project with an Irish Traveller organisation (Richardson et al., 2023). Similarly, three papers used a participatory approach and/or a steering committee to help with the development of the project (Keogh et al., 2020; Villani & Barry, 2021). Such approaches may help to mitigate biases in data interpretation and support engagement within the project.

Sampling Strategy

Overall, the sampling strategy was documented clearly in ten papers. Four papers documented the sampling strategy partially but missed out full rationale. Purposive and snowball sampling strategies were most commonly used. One paper used individuals who volunteered from a random selection of halting sites (Van Hout, 2010), two used opportunistic samples (Keogh et al., 2020; Thompson et al., 2022) and one convenience sampling (Villani & Barry, 2021). These sampling strategies are limited in being more prone to self-selection bias and may represent a specific view of participants which may not be representative of their GTRSB community. However, such methodologies may be necessary when working with populations who may find it difficult to engage in research.

Two papers sampled females only. One paper explained how sampling took place however, it did not explicitly state the rationale of sampling females only (Hodgins et al., 2006). One paper did provide rationale around only recruiting females who identified as Irish Traveller and English Romany Gypsy, as they felt males may be less likely to speak about the subject of bereavement to a female researcher (Rogers & Greenfields, 2017). Two papers sampled males only, providing justification that they aimed to explore lived experiences of suicide and psychological distress in Irish Traveller men (O'Donnell & Richardson, 2020; Richardson et al., 2023).

Of the total 12 papers, 76 participants identified as male, 153 participants identified as female, and one participant identified as non-binary (not including a replicated sample).

Only two papers clearly stated how many people were approached but did not take part in the research (Thompson et al., 2022; Villani & Barry, 2021). Such detail is particularly helpful within GTRSB research as it may highlight potential barriers of engagement within the research process.

Two papers used the same sample to answer two different research questions. One paper explored discrimination and racism and health behaviour in regard to accessing healthcare (Smith & Ruston, 2013) and the other paper explored more broadly Gypsies' and Travellers' perspectives of what may impact their health and wellbeing (Ruston & Smith, 2013).

Data Collection

Details of data collection were provided within all papers. However, some accounts were less detailed than others. Six papers used interviews and six used focus groups. Two papers used a vignette model within a focus group framework, both papers justified the use of a vignette as recognising that mental health and suicide may be sensitive topics to discuss so a vignette may be less personal (Hodgins et al., 2006; Villani & Barry, 2021). A topic guide was used within eight papers. Interestingly, four papers discussed reaching data saturation as when no new information is gained from interviews (O'Donnell & Richardson, 2020; Richardson et al., 2023; Ruston & Smith, 2013; Smith & Ruston, 2013). Despite this not being necessary when conducting thematic analysis (Braun & Clarke, 2019). One paper used data saturation appropriately for the data analysis used (grounded theory) (Smith & Ruston, 2013).

Three papers considered factors such as a convenient time and place (e.g. own home or via the telephone) to conduct interviews (Goward et al., 2006; Keogh et al., 2020). In addition, the option of reading aloud information to participants or providing audio recordings was provided (Goward et al., 2006; Hodgins et al., 2006; Richardson et al., 2023; Thompson et al., 2022; Van Hout., 2010). Such initiatives are particularly useful for GTRSB research to increase engagement and be sensitive to literacy difficulties.

Relational and Ethical Considerations

The CASP quality tool considers if the relationship between researcher and participant had been adequately considered. Considerations of such dynamics is a significant point when evaluating GTRSB research as it enables researchers to consider the cultural sensitivity and relevance of the research (Condon et al., 2019).

Unfortunately, the consideration of this relationship was the most poorly documented in the papers. Four papers made no reference to the relationship (Goward et al., 2006; Hodgins et al., 2006; Ruston & Smith, 2013; Villani & Barry, 2021) and five papers did so partially (Keogh et al., 2020; Rogers & Greenfields, 2017; Smith & Ruston, 2013; Thompson et al., 2022; Van Hout, 2010). Villani and Barry (2021) considered how the status of the interviewer as a health professional may have impacted the responses from interviewees.

Two papers considered cultural factors with a peer researcher within recruitment and data collection stages (Keogh et al., 2020; Villani & Barry, 2021).

Only one paper explicitly considered power dynamics between researcher and participant and provided anti-racism training to consider any biases from the researchers. In addition, during data analysis the authors sought advice from Irish Traveller representatives to consider cultural sensitivity (Richardson et al., 2023).

Three papers did not document considering any ethical issues or ethical approval (Hodgins et al., 2006; Ruston & Smith, 2013; Smith & Ruston, 2013), interestingly two of these papers are the same study. Five papers made partial reference to considering ethical dilemmas (Goward et al., 2006; Rogers & Greenfields, 2017; Thompson et al., 2022; Van Hout, 2010; Villani & Barry, 2021). Four papers did consider ethical issues and documented they had sought ethical approval (Keogh et al., 2020; O'Donnell & Richardson, 2020; O'Regan et al, 2023; Richardson et al., 2023). One paper provided a space for participants and interviewers after the interview and highlighted how concerns were escalated, this paper explored a sensitive topic of suicide (Richardson et al., 2023). In addition, another paper signposted participants to services for support if concerns were identified (O'Donnell & Richardson, 2020).

Notably three papers scored poorly in relational and ethical considerations (Hodgins et al., 2006; Ruston & Smith, 2013; Smith & Ruston, 2013). Interestingly, these papers were from health and social care research, sociological, and health promotion backgrounds.

One paper stated it used a visual representation scale because "Gypsy and Traveller communities, who often choose not to value literacy" (Goward et al., 2006, p. 318). This was not provided with any reference and could be viewed as a negative stereotype.

None of the papers were written by GTRSB community members exclusively, therefore, there is a chance that non-community members are imposing their experiences and beliefs during the analysis.

Data Analysis

Partial description of the data analysis was provided within all papers. Six papers used thematic analysis (one was specific in stating the use of inductive thematic analysis), two papers used thematic content analysis, one paper used content analysis. Two papers explicitly referenced using Braun and Clarke's (2006) process of thematic analysis with varying detail (Rogers & Greenfields, 2017; Thompson et al., 2022). However, one paper transcribed each interview to refine future interview questions (Thompson et al, 2022). One paper described the analysis process as "akin to grounded theory" in that analysis and interviews ran concurrently and themes were added to the interview schedule. However, the paper recognises that it used an inductive approach rather than theory driven (Smith & Ruston, 2013, p. 1200).

Two papers data analysis was questionable in that the analysis used was not stated, (Goward et al., 2006; Ruston & Smith, 2013), whilst another paper reported to use thematic analysis but did not provide theme names and described findings generally (Van Hout, 2010). Therefore, the results should be considered with caution as to the rigorousness of the analysis.

One paper did provide rationale as to why specific quotes were included (Rogers & Greenfields, 2017). In comparison to one paper that provided brief one to two words quotes from participants, which did not fully illustrate themes (Keogh et al., 2020). This limits the paper's findings as detailed quotes enable readers to appraise the overall findings (Braun & Clarke, 2021).

In general papers were poor at considering the researchers' potential bias during data analysis. One paper rated well within all areas of sufficient data analysis, the paper was clear in the data analysis used and a section within the paper directly addressed rigor and trustworthiness of the data. The paper also considers researcher reflexivity within the data analysis process, specifically potential prejudices (O'Regan et al., 2023).

Findings

The majority of papers were explicit with stating findings, six papers considered the credibility of findings (for example the impact of a small sample size) (Goward et al., 2006; Keogh et al., 2020; O'Donnell & Richardson, 2020; Richardson et al., 2023; Van Hout, 2010; Villani & Barry, 2021).

One paper's themes stated a theme as "longing for acceptance" and reported that the theme explained participants longing for acceptance from wider society, the subtheme "longing for society" then referenced participant's experiences of racism and discrimination and the impact these experiences had on mental health (Thompson et al., 2022, p. 148). The theme titles could be considered confusing and suggested a lack of rigour in the research process.

Rogers and Greenfields (2017) reported doctoral thesis research project themes within a narrative review, meaning it was difficult to verify themes as the original data were not presented.

Value of the Research

Six papers included all of CASP criteria for deeming research as valuable, this included discussing the contribution to knowledge and understanding, identifying new areas in need of research, and discussing the transferability of findings to other populations. Three papers cited intersectionality theory or referred to interactions amongst findings (Hodgins et al., 2006; Keogh et al., 2020; O'Donnell & Richardson, 2020).

An area that was covered the least was how findings could be transferred to other populations, with one paper stating that its findings could not be applied further than the sample due to the nature of qualitative research (O'Regan et al., 2023) and another stating how findings could not be representative for GTRSB men (Richardson et al., 2023). No papers made suggestions of transferring results to other GTRSB groups, however, some papers included participants from a range of GTRSB groups. This may be in line with GTRSB groups expressing their desire to be viewed individually. Two papers suggested how findings could be transferrable to other marginalised or disadvantaged groups (Goward et al., 2006; Keogh et al., 2020). Indeed, research suggests many minoritised groups can experience barriers in accessing services from a patient, provider, and system level (Scheppers et al., 2006).

Overall Critique

Overall the quality of the papers was reasonable, with only two papers meeting most or all of the CASP criteria. It is interesting to note that the older papers (published between 2006 and 2013) were of a lower quality in comparison to more recently published papers (between 2020 and 2023). This may suggest that standards of research and publication in qualitative methodology have improved particularly thinking about research reflexivity. Indeed, there has been a desire for this to be the case (Berger, 2015).

Interestingly, the two lowest quality papers were from the same study suggesting the overall study was of lower quality (Ruston & Smith, 2013; Smith & Ruston, 2013). This would also suggest a sense of consistency within the quality check process.

Table 5

CASP Quality Criteria Checklist

Study	CASP (2018) Qualitative Checklist Criteria									
	Aims are clear?	Appropriate qualitative method?	Appropriate research design?	Appropriate recruitment strategy?	Appropriate data collection?	Considerations of Relationships?	Considerations of ethical issues?	Rigorous data analysis?	Clear statement of findings?	Valuable research?
Goward et al. (2006)	YES	YES	YES	YES	PARTIAL	NO	PARTIAL	PARTIAL	PARTIAL	PARTIAL
Hodgins et al. (2006)	YES	YES	YES	PARTIAL	PARTIAL	NO	NO	PARTIAL	PARTIAL	PARTIAL
Keogh et al. (2020)	YES	YES	YES	YES	YES	PARTIAL	YES	PARTIAL	YES	YES
O’Donnell & Richardson. (2020)	YES	YES	YES	YES	YES	PARTIAL	YES	PARTIAL	YES	PARTIAL
O’Regan et al. (2023)	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES
Richardson et al. (2023)	YES	YES	YES	YES	YES	YES	YES	PARTIAL	YES	YES
Rogers & Greenfields. (2017)	YES	YES	YES	YES	PARTIAL	PARTIAL	PARTIAL	NO	PARTIAL	PARTIAL
Ruston & Smith. (2013)	YES	YES	PARTIAL	YES	YES	NO	NO	PARTIAL	PARTIAL	PARTIAL
Smith & Ruston. (2013)	YES	YES	PARTIAL	YES	PARTIAL	NO	NO	PARTIAL	PARTIAL	PARTIAL
Thompson et al. (2022)	YES	YES	YES	YES	YES	PARTIAL	PARTIAL	PARTIAL	PARTIAL	YES
Van Hout. (2010)	YES	YES	PARTIAL	PARTIAL	PARTIAL	PARTIAL	PARTIAL	NO	PARTIAL	YES
Villani & Barry. (2021)	YES	YES	PARTIAL	YES	PARTIAL	NO	PARTIAL	PARTIAL	YES	YES

Thematic Synthesis

Thematic Analysis

These themes were: perspectives of mental health; interpersonal, systemic, and structural influences on mental health; conflicts between identity and community; and experience of services: past, present and future wishes. The themes covered an array of views of mental health and services which are described using subthemes. Table 6 depicts the themes and subthemes and corresponding papers. Appendix A details themes, subthemes, and example quotes.

Table 6

Themes, Subthemes, and Corresponding Papers.

Theme	Subtheme	Goward et al. (2006)	Hodgins et al. (2006)	Keogh et al. (2020)	O'Donnell & Richardson. (2020)	O'Regan et al. (2023)	Richardson et al. (2023)	Rogers & Greenfields. (2017)	Ruston & Smith. (2013)	Smith & Ruston. (2013)	Thompson et al. (2022)	Van Hout. (2010)	Villani & Barry. (2021)
Experience of services: past, present and future wishes	Desired Improvements from Services	X	X			X	X	X			X	X	X
	Impracticalities of Services	X	X	X	X	X	X	X	X		X	X	X
Perspective of Mental Health	Language to Express Mental Health	X	X	X		X	X	X	X	X	X	X	X
	Demographic Differences and the Perception and Experience of Mental health	X	X	X	X	X	X	X	X			X	X
	Variation of Managing Mental Health		X	X	X	X	X	X	X	X	X	X	X
Interpersonal, systemic, and structural influences on mental health	Grief	X		X			X	X					
	Socio-economic factors	X	X	X		X	X	X	X	X	X		X
	Complexity	X		X	X		X				X		X
	Discrimination			X	X		X			X	X	X	X
Conflicts between identity and community	Traveller identity and culture	X	X	X			X	X	X	X	X	X	X
	Dilemmas Between Family and Community	X	X	X	X		X	X	X	X	X	X	X
Total		9	8	10	6	6	11	9	7	6	9	8	10

Perspectives of Mental Health

The first theme details the similarities and differences referenced in each paper about what mental health meant to participants and was covered within all 12 papers. Specifically, differences were noted within demographics, the language used when speaking about mental health, and how participants managed their mental health.

Language to Express Mental Health

This subtheme was described in 11 of the papers. Indeed, poor mental health was reported as being highly prevalent in the population within four papers. Eight papers reported participants described mental health problems without diagnostic labels such as “feeling down” or “bad with me nerves” (Goward et al., 2006, p. 319), nerves in particular was used to describe what might be understood as a range of mental health problems (Thompson et al., 2022).

Interestingly, the language used to describe mental health was in a negative light. One paper recognised how participants did not express the concept of ‘good’ mental health and regarded this as an entirely negative concept (Villani & Barry, 2021).

Demographic Differences and the Perception and Experience of Mental Health

Interestingly, it appeared that perspectives on mental health was dependent on age and gender of participants. Two papers referenced a more open perspective of younger participants in consideration to older generations, however acknowledged that such perceptions can still be instilled into younger generations “bad nerves makes people not take care of themselves, drink and smoke too much and that rubs off on the kids and carries down the generations” (Ruston & Smith, 2013, p. 186).

There was also differing perspectives of mental health between male and female participants, as described in eight papers. Within this, distinct gender roles were apparent (Keogh et al., 2020). For women, the expectations and demands of being a wife and mother impacted their mental and physical health (Hodgins et al., 2006). There was a view that being a female meant there was no getting away from your role (Goward et al., 2006). In addition, two papers noted the impact of domestic and physical violence on women's mental health (Hodgins et al., 2006; Thompson et al., 2022). This not only impacted women, but the potential children witnessing this (Thompson et al., 2022; Villani & Barry, 2021).

In comparison, for men, the concept of masculinity was viewed as negatively impacting mental health, "[Irish Traveller men] had a tendency to hold in their emotions and not discuss them with others, even their families" (Keogh et al., 2020, p. 802). Indeed, being male within an Irish Traveller community was referenced as a risk factor for suicide (Richardson et al., 2023). However, one participant had expressed how he wished to "reject such masculine stereotypes" (O'Donnell & Richardson, 2020, p. 39).

Variation of Managing Mental Health

A range of methods for supporting mental health were noted. For instance, being active and having routine through employment, daily household tasks, or spending time with horses (Villani & Barry, 2021). More commonly, self-medicating with alcohol and substances was reported in nine papers as a way to manage mental health; "a couple of pints, that's your worries gone for a couple of hours" (Richardson et al., 2023, p. 11).

In addition, supporting mental health through religion was noted. This was referenced to when an individual was feeling suicidal (O'Regan et al., 2023) and when seeking support with drug addiction (Richardson et al., 2023). Family members may also gain support from religious practices when supporting someone with mental health problems (Richardson et al., 2023; Van Hout, 2010).

Interestingly, only one paper acknowledged the use of prescribed medication as being helpful for mental health difficulties, the same paper also provided the contrasting view that therapy would be more useful than medication or family support (Hodgins et al., 2006).

Interpersonal, Systemic, and Structural Influences on Mental Health

A second theme revolved around participants views of what impacts GTRSB mental health, which were mostly traumatic experiences and was noted within all 12 papers.

Grief

Grief was mentioned within four of the papers and was often experienced at a young age, preceded role changes within the family, and could be the result of loss from suicide. This subtheme featured heavily within Rogers and Greenfields as this paper focused on bereavement experiences (2017). The long-lasting impact of loss was noted on an individual's mental health (Goward et al., 2006). Sadly, grief also included baby and child loss which greatly impacted mental health (Rogers & Greenfields, 2017).

Socio-economic Factors

Socio-economic factors were widely noted as impacting participant's mental health and were mentioned in ten papers. For instance, poor housing conditions which did not meet the needs of the families. For some families, moving into housing was detrimental to mental health "people don't understand how it [moving into housing] destroys you. It's like – mentally and physically it can break your heart, honestly" (Smith & Ruston, 2013, p. 1202).

In addition to inadequate housing, participants reported unemployment as impacting their mental health (O'Regan et al., 2023). Sadly, socioeconomic struggles, loss of employment, accommodation difficulties, and pressures from family were also associated with suicide (Richardson et al., 2023).

Discrimination

Discrimination was spoken about widely within seven papers. It appeared to sadly be experienced from a young age within the school environment "because teachers consider them slow learners and they are treated as second class pupils" (Villani & Barry, 2021, p. 1456) and within social environments such as pubs (Van Hout, 2010). Social and health care services were also deemed as being discriminatory, with participants recalling personal experiences where they felt treated differently and that this impacted on the care they received (Thompson et al., 2022). Within six papers there was a clear emphasis on the impact that discrimination had on an individual's mental health, for instance, through feelings of shame.

Complexity

It was acknowledged in six papers that there is a complex interaction between multiple factors that impact mental health. Participants recognised this complexity and although separated as subthemes it was acknowledged that these themes interplay simultaneously;

> "The intersection of this potent mix of structural inequalities, internalized racism, Traveller masculinities, and strong historical associations between stigma and mental health/suicide within the Traveller community lies at the heart of the heavy burden of suicide carried by Traveller men and poses significant barriers to Traveller men accessing support during times of psychological distress" (Richardson et al., 2023, p. 13).

Conflicts between Identity and Community

The third theme revolved around differing views of the interactions between GTRSB identity, community, and mental health, and was highlighted in 11 papers. On the one hand GTRSB identity and community was viewed as very important aspect in supporting wellbeing. However, on the other hand it was viewed as impacting wellbeing. This theme was split into two subthemes in regard to traveller identity and culture, and family and community.

GTRSB Identity and Culture

Irish Traveller identity was viewed as important; “As a minority ethnic group, there was a strong commitment to honour and pass on traditional Traveller values and customs by outwardly displaying an allegiance to kinship and collegiate spirit within the wider Traveller community” (Richardson et al., 2023, p. 8). However, it was also recognised as being associated with hardship which negatively impacted mental health (Hodgins et al., 2006). Despite this, a loss of culture also impacted an individual’s mental health (Villani & Barry, 2021). These examples suggest an intricate relationship between identity and mental health.

Dilemmas Between Family and Community

Within Goward et al (2006, p. 324) the paper references the concept of a “buffering effect” in regard to how being part of a Gypsy or Traveller community may support against mental health difficulties. This concept was similarly described in four additional papers. This concept also encapsulated the idea of being supported in difficult times; “The thing about Travellers is when something happens. It brings people an awful lot closer together . . . it helps having people around you. You’re not sitting there all by yourself getting bad thoughts” (Richardson et al., 2023, p. 11).

This was further confirmed when participants discussed the impact of isolation from your community on mental health. For instance, feeling or being rejected by the community due to your sexuality or through separation due to housing policies having a significant impact on mental health of GTRSB people.

Despite tight knitted communities with family living close by being viewed as a source of comfort during difficult times, it could also cause difficulties because of the complexities of the family structure. Participants often described not feeling able to speak to their family for support for their mental health (Goward et al., 2006). This was linked to the fear of shame on the family and stigmatised attitudes within communities which led to conversations about mental health feeling unachievable “my mother and my brother are very, very uncomfortable with me discussing my issues. and they basically, they don’t acknowledge it and they don’t want to talk about it” (Thompson et al., 2022, p. 150). Therefore, hiding mental health struggles was common due to the stigma associated.

Experiences of Services: Past, Present and Future Wishes

The fourth theme considered participants’ previous issues with services and their desires for how services could be improved and was mentioned in 11 papers.

Impracticalities of Services

Eight papers referenced barriers that GTRSB people experience with services. This was wide ranging from their own ambivalence and disillusionment with services (Goward et al., 2006; Richardson et al., 2023) to practical factors such as literacy and poor communication (O’Regan et al., 2023; Richardson et al., 2023) and feeling that services were unsuitable, culturally inappropriate, and inflexible to meet the needs of GTRSB communities (Goward et al., 2006; Thompson et al., 2022; Van Hout, 2010). Overall, this meant that GTRSB community members did not present to mental health services (Thompson et al., 2022).

Desired Improvements from Services

Participants’ views of how services could be improved was wide ranging and clearly documented within 11 of the papers. A common desire was for staff to have sufficient interpersonal skills when engaging with GTRSB community members so they felt listened to and that they could trust what they spoke about was confidential.

Eight papers referred to a requirement for services to be culturally competent to GTRSB needs, specifically, cultural awareness training to be provided to staff so they could be respectful of traditions (O’Regan, 2023; Richardson et al., 2023; Villani & Barry, 2021).

There was also a suggestion that services work directly with the GTRSB communities as a co-produced venture.

Practical improvements were also suggested, this ranged from having flexible drop-in appointments, offering to support with writing letters, and offering appointments at home. Participants also valued being offered proactive strategies such as group, equine therapy, arts and crafts, and exercise.

Discussion

To the author's knowledge this is the first systematic review to include a quality review of literature exploring self-reported mental health amongst GTRSB community members. This reviewed aimed to synthesis the literature to explore: how members of GTRSB understand mental health; what communities identify as impacting mental health of their community; what are their experiences of mental health services; and how do they think services could be improved? A systematic literature search was conducted, followed by a quality appraisal of appropriate papers using the CASP tool. The 12 papers were then thematically synthesised resulting in four themes.

The findings of this review shares similarities with McKey et al's (2022) rapid review of Irish Traveller literature, specifically this is around how the majority of participants were female and how language such as "nerves" was used to discuss mental health. There were also similarities in links between mental health and substance use, bereavement, experiences of discrimination, and domestic violence. In addition, both reviews acknowledge the importance of GTRSB identity and included within this the closeness of families. However, unlike our study McKey et al., (2022) did not acknowledge the conflict between closeness of family being a buffer for mental health, but also negatively impacting an ability to talk about mental health difficulties. Despite this, the similarities here suggest whilst respecting the differences between GTRSB communities, findings from one community may have direct relevance to other GTRSB communities.

Returning to Saint Arnault's (2009) cultural model of help seeking, in the context of GTRSB communities the papers reviewed suggested there may be a culture around not speaking about mental health due to the stigma associated, which means support is not accessed. This also appeared apparent within the concept of masculinity which did not appear to align with seeking support.

The study shared similarities with a scoping review of GTRSB communities' mental health and access to services within Europe. Similarities included barriers due to poor communication and literacy issues, socioeconomic barriers around instable housing, and experiences of racism, discrimination, and poor cultural competencies from services (Guerrero et al., 2024). A subtle difference was Guerrero et al's (2024) inclusion of insurance issues impacting access to services, a factor which is not applicable within the UK.

It is also useful to compare the review's findings with GTRSB access and engagement to all health services. The review share similarities with McFadden et al's review (2018) which noted barriers to engage in health services such as experiencing discrimination, poor cultural understanding, age differences in perspectives of mental health, and poor understanding of services. In addition, similar factors that would increase engagement included collaboration with GTRSB communities and cultural awareness training. A difference between the reviews was in terms of religion, with McFadden et al., (2018) noting a degree of fatalism which this review did not.

The review highlights various interacting factors that map onto Dixon-Wood et al's (2006) framework of healthcare access for vulnerable groups. For example, the ability to interact with services may be impacted by the variation of understanding mental health. In addition, the discriminatory attitudes from healthcare professionals reported within the studies reviewed may impact a GTRSB person wishing to engage with the service. These factors interact to make health service use less likely.

However, this framework does not explicitly reference the socioeconomic factors which may also impact mental health and service use. This finding is corroborated by professional's working with GTRSB communities (Yin-Har Lau & Ridge, 2011).

This review also corroborated with research that highlights the impact of grief on mental health (McGorrian et al., 2013; Papadopoulos & Lay, 2007). Specifically, the trauma experienced through loss by suicide (Friends, Families & Travellers 2023). This finding it set within the context that suicide is seven times higher in Irish Traveller populations in Ireland than in non-Traveller populations (Department of Health, 2010). Indeed, Friends, Families, and Travellers (2020) have published numerous campaigns and reports to highlight this stark statistic and how within national and local suicide prevention plans there is an alarmingly poor consideration of GTRSB communities. This may highlight systemic racism that permeates organisations that GTRSB community members experience often. The findings from the study corroborate with Hall et al's proposed properties of marginalisation, particularly 'liminality' which recognises the impact of traumatic experiences which can hold a "heavy psychic strain" (Hall et al., 1999, p. 89).

In addition, despite factors such as poor housing and employment prospects and discrimination being separated within the results, there is acknowledgement that these are complex and intertwined. The subtheme complexity lends itself to an intersectional lens in which discrimination and inequality cannot be understood individualistically (Crenshaw, 1989). Indeed, such experiences have a detrimental impact on Irish Travellers' access to mental health services (Quirke et al., 2022).

In comparison to previous reviews mentioned, this review included less than 50% of the same papers, therefore there is only a small amount of overlap. In addition, the previous reviews have been broader in their aims, whilst this review aimed to specifically explore GTRSB community member's perspectives.

Overall, the review shared similarities to previous research which has explored Irish Travellers experiences, Roma experiences, and Gypsy, Roma, and Traveller experiences. This could suggest homogeneity of experiences. However, it must be noted that not every paper was included in each theme or subtheme and therefore there is heterogeneity of experience amongst the papers.

Limitations

A review including 12 papers may be deemed to be small. However, in relation to the GTRSB literature base this can be viewed as an appropriate amount. The review also did not included any papers that included perspectives from Boater communities, which will limit the generalisability of findings to this community.

A methodological critique of thematic synthesis is that it requires qualitative findings to be re-interpreted which may impart further bias the results, in addition, to that of the original authors. However, qualitative research is in essence a subjective process, and the author aimed for transparency and reflexivity to allow for the reader to understand the possible biases.

The review only included papers published in peer reviewed journals in order to explore how much information about GTRSB's perspectives of mental health is documented within journals. However, this means that sources of information from third sector organisations and unpublished manuscripts that support GTRSB communities was not included and therefore the review could be limited in its findings. It is well documented that organisations such as Friends, Families, and Travellers provide insightful and useful information on mental health and suicide and GTRSB individual's experiences of accessing services.

Clinical Implications

The findings from the review highlight a desire for services to be improved. Cultural competence, services being flexible in their approach, and working collaboratively with communities were viewed as useful ways of engaging GTRSB communities. These recommendations are replicated in NHS publications and literature reviews (Guerrero et al., 2024; McKey et al., 2022; NHS Race & Health Observatory, 2023). Indeed, a national inclusion health framework from the NHS has been published which aims to improve health services of groups of individuals who have increased barriers in accessing services, within this, Gypsy, Roma and Traveller communities are included (NHS, 2023). In addition, research suggests providing healthcare professionals with a reflective space to consider negative preconceptions of GTRSB communities was beneficial (Francis, 2013).

The review's findings opens up a possible debate of how mental health services can adapt to suit the needs of GTRSB communities within a context in which funding for mental health services despite increasing, is still not meeting demand and where there are vast inequalities within who is able to access services (Gilburt & Mallorie, 2024). Additional funding would be required to focus on inequalities, which most importantly needs to include GTRSB communities. A thorough recording of service use by GTRSB communities has been suggested in order for services to be kept accountable (NHS Race & Health Observatory, 2023).

In the context of Clinical Psychology, it is interesting that only one paper mentioned psychological therapy, this was within a positive context. This may suggest that psychological therapy may not be a current priority for GTRSB community members. This may require psychological therapists to reflect on what psychological support they offer and if this is suited to GTRSB communities. The potential buffering effect of community and family may be an avenue using a systemic collectivist approach instead of the generally individualistic approaches used currently. Additionally, it may be useful for clinicians to expand on flexible ways of working.

In addition, specialist positions such as Traveller Mental Health Liaison Nurses and Traveller Community Health Worker roles have been positively reviewed by GTRSB community members (Keogh et al., 2020; Tobin, Lambert & McCarthy, 2020). Therefore, it may be worthwhile expanding upon with Clinical Psychology consultation and supervision, specifically around the use of trauma informed care which could be highly beneficial when working with GTRSB community members.

Research Implications

It is positive that half of the papers reviewed have been published since 2020, which may suggest an increased research interest within the inequalities and difficulties experienced by GTRSB communities.

Both the quality check and thematic synthesis highlighted a need for co-production, which is corroborated by other reviews (Guerrero et al., 2024). For instance, through the use of participatory action research, this approach collaborates directly with communities who are experiencing the issue of interest to develop action points that can be taken through to practical outcomes (Cornish et al., 2023). In consideration of the current challenges faced by mental health services, co-producing feasibility studies to consider how services could be more accessible would be useful. This may revolve around creative means to engage GTRSB communities in conversations about their understanding of mental health and access to services. For instance, the use of art has been used to engage an Irish Traveller community in a conversation around suicide, this was well received and encouraged conversations around a sensitive topic (Malone et al., 2017).

It was noted that papers which focused on female GTRSB members referenced perinatal loss and the impact this has on women’s mental health. However, to date no papers have exclusively focused on perinatal mental health despite the papers reviewed including a majority female sample. This may be useful as a future research area in understanding women’s health.

Irish Travellers accounted for the majority of participants within papers reviewed, as it appears a large proportion of GTRSB research has been conducted in Ireland. The review had little or no stated representation from New Age Travellers, Showmen, or Boater perspectives, therefore, more research should be focused on these groups to explore if their experiences are similar or different to GTRSB groups included in this review. Indeed, Showmen have been regarded as invisible within research (Greenfields et al., 2023).

Conclusion

This review is the first (to the authors knowledge) to synthesis qualitative research exploring perceptions of mental health amongst GTRSB. From a systematic search twelve papers focused on GTRSB community members and a thematic synthesis identified four themes.

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Section B

Exploring perinatal mental health within Gypsy, Roma, Traveller, Showmen, and Boater communities.

Word Count: 8,228

Potential Journal: British Journal of Midwifery

Abstract

Background:

Very little is known about Gypsy, Roma, Traveller, Showmen, and Boater (GTRSB) perinatal mental health in the context of generally poor mental health outcomes for these populations.

Aims:

The study aimed to explore GTRSB communities understanding of perinatal mental health and what support is offered at this time, in order to consider if or how perinatal mental health services can be of most service to GTRSB.

Methods:

Semi-structured interviews explored ten participants experiences and were analysed using reflexive thematic analysis.

Findings:

Five themes in relation to perinatal wellbeing were identified: dilemmas of trust; experiences of discrimination; taboo and shame inhibit conversations around perinatal mental health; how additional GTRSB hardships impact perinatal mental health; noticing and hoping for change.

Conclusion:

GTRSB women experience multiple factors that impact how they speak about or access support for perinatal mental health difficulties. These factors can be viewed separately or more helpfully within a complex interaction. Despite this, there are signs of change and a hope for services to change to become more accessible.

Keywords: Gypsy, Roma, Traveller, Perinatal, Mental-Health

Introduction

Terminology

Gypsy, Traveller, Roma, Showmen and Boater (GTRSB) are distinct ethnic and cultural groups of people with their own documented histories, they share similarities in their culture of nomadism, but also may live in temporary or permanently settled accommodation (Friends, Families, & Travellers, 2024; Henry, 2022; Traveller Movement, 2024). The 2021 census recorded 0.12% of the total population identifying as Gypsy or Irish Traveller within England and Wales, equalling 71,440 people (Office for National Statistics, 2024). However, this has been considered an underestimation due to the likelihood of people not disclosing their identity (Traveller Movement, n.d.).

When describing GTRSB communities it is important to be aware that the phrase Gypsy can be deemed offensive (Friends, Families & Travellers, 2024). Previous literature has used Gypsy, Roma, and Travellers (GRT) or GTRSB as being more inclusive (Buckingham New University, n.d; Friends, Families & Travellers, 2024). Within this report the term GTRSB is predominately used as it best represents how participants self-identified. Whilst using this phrase, however, it is recognised that each community is distinct with some commonalities of experience (for example in experiences of discrimination), but with many differences (such as in cultural practices).

GTRSB Research Base

The health of GTRSB people is a largely unexplored area of research, which includes mental health (Yin-Har Lau & Ridge, 2011). What is clear from the small research base is that GTRSB communities are marginalised groups of people, meaning they have unequal access to social determinants of health which leads to them experiencing poorer health outcomes (Baah, Teitelman, & Riegal, 2019). For instance, in comparison to non-GTRSB population, GTRSB communities have lower socioeconomic status, poorer living conditions, increased financial stress, lack of employment opportunities, and experience increased discrimination, which all negatively impact their mental and physical health (Cemlyn et al., 2009; Goward et al., 2006; Hodgins et al., 2006; Office for National Statistics, 2022; Smith & Ruston, 2013; Traveller Movement, 2017; Villani & Barry, 2021).

Research exploring GTRSB women's views of health has suggested it is difficult to unpick how each of these inequalities impact GTRSB communities' health (Hodgins et al., 2006). An intersectional lens would suggest experiences of inequalities cannot be unpicked, due to the intersecting nature of "micro level" identities such as race and gender with "macro level" factors of discrimination which results in public health inequalities (Bowleg, 2012; Crenshaw, 1989, p. 1268).

Intersectionality theory has been used to explore Irish Traveller men's mental health who have been impacted by suicide which has highlighted various intersecting factors of poor living conditions, lack of education, unemployment, masculine identity, and experiences of discrimination as impacting both mental health and service access (Richardson et al., 2023). In the context of GTRSB women, Casey (2014, p. 810) describes the "triple burden" of being a female, of a lower socio-economic status, and identifying as GTRSB which impacts all aspects of life (Casey, 2014). For instance, stressors of being a Traveller mother taking on most domestic and childrearing responsibilities, set within a context of inadequate living conditions and experiences of discrimination, have been linked to stress and poor health (Casey, 2014; Hodgins et al., 2006). Therefore, considering female identity amongst other identities such as GTRSB is essential.

Frequent experiences of discrimination and prejudice can also mean that GTRSB communities feel unable to trust services (Villani & Barry, 2021). Such experiences or concerns around being discriminated by mental health services, are nearly twice as likely for Irish Travellers than non-travellers (Office for National Statistics, 2022; Quirke et al., 2022).

Indeed, discrimination and racism experienced by GTRSB people has been argued as “the last acceptable form of racism” (Cemlyn et al., 2009; Traveller Movement, 2017, p.1).

GTRSB Maternal Health and Perinatal Mental Health

In terms of general mental health, research suggests GTRSB communities experience higher levels of anxiety and depression in comparison to non-GTRSB communities (Goward et al., 2006; Parry et al., 2007). Specifically, a scoping review suggested GTRSB women’s mental health is worse in comparison to men’s (Guerrero, Civišová, & Winkler, 2024). Surprisingly, it appears that although GTRSB women participate in mental health research, there is very little research exclusively exploring their mental health. Therefore, experiences such as perinatal mental health difficulties are largely unresearched.

The perinatal period covers pregnancy and for up to two years following birth and can be regarded as a joyful yet demanding experience. For some, it can also be associated with significant distress, with between 10% to 27% of non-GTRSB women experiencing perinatal mental health difficulties (NHS England, n.d; NHS, 2023; Personal Social Services Research Unit, Centre for Mental Health, & Maternal Mental Health Alliance, [PSSRUCMH] 2014). In addition, perinatal mental health difficulties are associated with negative outcomes for children at a small to moderate effect size with lower socioeconomic status moderating this relationship (Stein et al., 2014) – a highly relevant statistic for GTRSB communities who tend to experience a lower socioeconomic status (HM Government, 2022).

With the recognition of the possible long-term implications for mothers and children when there is poor mental health, there has been a marked focus within UK health initiatives to improve perinatal mental health (PSSRUCMH, 2014). Both the Five Year Forward View for Mental Health plan in 2016 and NHS Long Term Plan in 2019 aimed to significantly increase access to perinatal mental health services for those experiencing such difficulties. This resulted in every local area having a specialist Perinatal Mental Health Team

(Department for Health & Social Care, 2024; Mental Health Taskforce, 2016; NHS, 2019). However, although there has been some consideration of vulnerable populations within these policies the specific needs and context of GTRSB communities were not made explicit within the reports. GTRSB perinatal mental health is set within a context in which the majority (65%) of maternity services within hospitals have been rated by the CQC as inadequate or requiring improvement (Campbell, 2023).

A systematic review that explored experiences of perinatal mental health and adjacent services from ethnic minoritised women's viewpoint reported feeling "isolated, fearful, stigmatised and suffering in silence" and that services are not culturally appropriate (Watson et al., 2019, p. 12). This review did not include GTRSB participants, further highlighting the paucity of research. However, due to the minoritised position of these women, the review may be relevant to GTRSB women.

A scoping review hoped to summarise experiences and outcomes of GTRSB women during pregnancy (O'Brien, Dempsey & Higgins, 2022). However, to the author's knowledge this is yet to be published, further highlighting the paucity of perinatal focused research.

What is known about the perinatal period for GTRSB women is that miscarriage, stillbirth, perinatal mortality, infant mortality, and caesarean birth is higher and GTRSB women are less likely to attend antenatal care (Barry, Herity, & Solan, 1987; Friends, Families & Travellers, 2023; Ekezie et al., 2024). Correlational links between maternal bereavement and anxiety and depression amongst GTRSB women have been hypothesised (Rogers & Greenfields, 2017). However, these theories have not been explicitly explored.

In addition to these distressing experiences are additional maternal health inequalities experienced by women from GTRSB communities including issues around communication, discrimination, feeling mistrustful and fearful of services, and poor cultural awareness from services (Friends, Families & Travellers, 2023; O'Regan et al., 2023). These inequalities are set within a context in which there is a marked taboo, shame and stigma surrounding mental health within GTRSB communities (McFadden et al., 2018; Villani & Barry, 2021). Within a perinatal context, there may be concerns around social service involvement and children being taken into care if perinatal mental health difficulties are disclosed (Friends, Families & Travellers, 2023).

Meyer's (1995) minority stress model may help to understand the experiences of GTRSB women within the perinatal period as it considers how being from a minoritised group, experiencing discrimination and stigma, and hiding one's identity are additional stressors not experienced by individuals who are not from a minoritised group. These stressors then increase the risk of negative health outcomes. Similarly to intersectionality theory, minority stress model highlights the complex web of interconnected stressors (Meyer, 1995, 2003; McConnell et al., 2018). Considering the minority status of GTRSB communities, the theory has been applied to Irish Traveller women's perception of stress, highlighting experiences of discrimination and unsuitable services, however this study also acknowledged the impact of economic stressors which are not covered within the minority stress model (Darragh, 2022).

There is some evidence that inequalities within healthcare are starting to be acknowledged by statutory services which does include a GTRSB perspective. For example, the inclusion health framework outlines five action points to increase services access for people who often experience barriers, however, this is not mandatory guidance (NHS England, 2023). In the context of GTRSB women, the Women's Health Strategy for England, has recognised numerous disparities and aims for equality and informed choices for all women, including GTRSB women throughout the perinatal period so that services are more accessible, and stigma and discrimination are reduced (Department for Health & Social Care, 2022).

Interestingly, the concept of marginalisation and minority stress model both acknowledge a ‘buffering effect’ that family and community have on lessening the impact of disadvantage experienced by such groups (Baah et al., 2019; Meyer, 2003). This theorising has been corroborated within GTRSB research exploring mental health in both acknowledging the positive impact of family and community for supporting mental health and the negative impact of loss of cultural traditions and lifestyle (Smith & Ruston, 2013; Villani & Barry, 2021). Yet as stated it is unclear if this is applicable to perinatal mental health.

Rationale

The statistics of women experiencing perinatal mental health difficulties within the non-GTRSB population are known, however to the author’s knowledge there has been no research exploring perinatal mental health within GTRSB communities. Qualitative research directly asking the communities about their experiences may provide a better understanding of stressors, supports, and needs (Hodgins et al., 2006). This project particularly aligns with the NHS value of everyone counts (Department of Health & Social Care, 2023).

Aims

The overarching aim of the study was to understand perspectives of perinatal mental health within GTRSB communities. The study explores the following questions:

1. How do people who identify as GTRSB talk about and understand threats to wellbeing for mothers during the perinatal period?
2. Do the above participants have perceived needs of support for women during this period (including support from within and outside their GTRSB community)? Support was self-defined by each participant, there were no limits to this. For instance, this could include support from family and friends. This was in order to capture the broad range of understandings of support and not impose any preconceived assumptions.

3. Do the above participants have views about how perinatal mental health services can be of most service to women within this community (if at all)?

Method

Design and Epistemological Position

A qualitative design was used which included the reflexive thematic analysis of semi-structured interviews with individuals who identified as GTRSB. Semi-structured interviews allow for rich data to be gathered, accounts for potential literacy difficulties, and mirrors how GTRSB communities use verbal communication more commonly (McCaffery, 2015). A main aim for this study was to allow members of GTRSB communities to speak their own truths and care was taken, therefore, through expert by experience consultation, supervision, and reflexivity to attempt to not impose any prejudices or prior beliefs on to the participants' accounts.

In consideration of this, reflexive thematic analysis (RTA) was deemed an appropriate analysis method as it actively considers the researcher's role within the analysis (Braun & Clarke, 2014, 2019, 2021b; Clarke & Braun, 2017). RTA is theoretically flexible and therefore fits with the social constructionist position that informed the research (Braun & Clarke, 2006). This position aligned most with the lead researcher in that it acknowledges how knowledge is constructed through language, social, and cultural interaction (Burr, 2015). This felt highly relevant to GTRSB communities as it suggests there is no single reality of perinatal mental health and that local understandings will be made through such interactions. Indeed, what may be understood as perinatal mental health difficulties within dominant discourses may not be the same for a GTRSB person's experience.

Reflexivity

Reflexivity is an integral part to RTA and was considered particularly important due to the possible prejudices that might arise as the lead researcher was not from a GTRSB community (Braun & Clarke, 2021b). To set the context, the lead researcher was a trainee Clinical Psychologist (TCP), white British female with no connection to any GTRSB communities and was on placement within a Perinatal Mental Health Service whilst analysing the data. Reflexive conversations were held within supervision meetings and the lead researcher attempted to remain open to the ideas that problems during the perinatal period may be understood in completely different ways within GTRSB communities in comparison to their position.

During interviews the language remained as open as possible in order to not close down diverse understanding of distress which might not be from a global North position – for example by not presuming mental health involves individual responsibility. A social constructionist stance helped the lead researcher to be mindful of the danger of imposing dominant understandings of perinatal mental health onto participants' accounts. An example of reflexivity within the project was checking with a consultant around the naming of themes to ensure the lead researcher's preconceived ideas were not imposed onto GTRSB perspectives.

Ethical Considerations and Consultation

The study was provided with ethical approval from Salomons Institute for Applied Psychology (Appendix B). As documented in Table 1, in order to increase accessibility and cultural sensitivity, individuals from a Romany Gypsy community provided feedback throughout the project and were reimbursed for their work. Consideration was given to speak in a sensitive manner around a topic which can be regarded as taboo. Confidentiality was discussed with participants rather than presented in written form to ensure they understood and felt comfortable with boundaries (Appendix C). The British Psychological Society (BPS) code of ethics was followed (BPS, 2021).

Table 1

Expert by Experience Consultation Feedback Examples

Item	**Advice Provided**
Information Sheet	• Not use ‘mood’ but ‘experiences’ and ‘feelings’ • Request for confidentiality discussion rather than in written format • Alteration of words to be more suitable e.g. conduct • Length of interview should be around an hour • Offering individual interviews important in case potential participants feel embarrassed • Should aim to reduce the length of the information sheet
Consent Form	• Request of tick box rather than signatures to reduce anxiety around identifying information • Use participant identification number
Social Media Advert	• Not use ‘mood’ but ‘experiences’ and ‘feelings’
Interview Schedule	• “We’re not like the other groups” “Don’t lump us in all together” Ask what community a participant is from and reference this throughout, so use the participants terminology • Remove word mental health as some people may feel defensive talking about this • Each family has different culture and morals so appreciate the nuance • Suggestion to not conduct mixed gendered focus groups unless participants express preference to this
Thematic Map	• Consider language used is accessible • General agreement with findings

Participants

Between 12 to 20 participants are recommended for a professional doctorate level project using RTA (Braun, Clarke, Hayfield, Davey & Jenkinson, 2023). Inclusion to the study included self-identifying as from a GTRSB community (regardless of living in permanent or semi-permanent housing), able to be interviewed in English or willing to have an interpreter present and agreeing for the interview to be recorded. Participants were thanked for taking part in the project with a £10 voucher.

Recruitment Procedure

Due to the documented difficulty of recruiting a GTRSB sample, a proactive recruitment strategy was employed using purposive and snowballing sampling over an 18-month period. Table 2 documents the recruitment methods which were recurrent in nature and consisted of frequent networking and following up on links by the lead researcher.

Table 2

Description of Recruitment Methods

Method	Detail
Social media advert (Appendix D)	Advertised via Instagram page where potential participants could make contact. A mobile phone number also was provided to widen accessibility.
Networking	Lead researcher attended relevant GTRSB conferences or research groups in order to network and share the project
Lead researcher met with numerous GTRSB spokespeople and organisations	Explore if they would be able to share the project verbally or via social media. This resulted in one organisation sharing the project and three spokespeople sharing the project.
External supervisor had personal links to GTRSB communities	Advertised via connections within community
Participants	Following interview three participants shared the project with people they knew

Through networking with a Traveller Liaison Officer (TLO), the lead researcher was also able to visit a Traveller site. The TLO had a good relationship with residents and consent was sought for the lead researcher to be on the site. During the site visit the TLO asked residents if they would be interested in taking part in the project. Additional visits were planned; however these were not completed due to the TLO’s time constraints.

Overall, 11 people expressed an interest in taking part in the project (one person had recently given birth so declined to take part). In total, ten people participated. Participants self-reported their GTRSB identity and referenced their gender during interviews, but with the need for privacy being considered, no further participant details were asked for. Also, in consideration of the stigma around discussing mental health, no direct further information about mental health experience was gathered. Table 3 provides participant information.

Table 3

Participant information

	Frequency
Self-Identified Ethnicity or Cultural Group	
Romany Gypsy	6
Traveller	2
Showman and Romany Gypsy	1
New Age Traveller	1
Gender	
Male	1
Female	9
N	10

Procedure

Potential participants were provided with an information sheet (Appendix E) and consent form (Appendix F) and provided opportunities to ask questions about the project. Due to literacy difficulties these were verbally discussed with one participant. Participants were given a week to withdraw from the study before their interviews were transcribed and analysed.

An interview schedule (Appendix G) was developed by the lead researcher and two supervisors, comments were provided by consultants as detailed in Table 1. A pilot interview was conducted to check flow of questions, this resulted in rewording of one question.

Participants were able to choose a time and format convenient for them to take part in the project, five participants opted for in person and five participants opted for online. Six participants took part in individual interviews and four participants took part in interviews in pairs. Three participants were interviewed by the external supervisor at their preference as she was known to them. All other interviews were carried out by the lead researcher. Interview lasted between 43 and 93 minutes (M = 66.16).

At the start of the interview a confidentiality discussion was completed (Appendix C). The interview schedule was followed which prompted the use of the participant's language and allowed for flexibility.

At the end of the interview a check in was conducted and a signpost support services sheet was provided if participants expressed an interest in this (Appendix H). Consent forms, recorded interview data, and transcripts were stored securely on a password protected OneDrive. Interviews were transcribed verbatim.

Data Analysis

The method outlined by Clarke and Braun (2017) for RTA was followed. As recommended and detailed in Table 4, the analysis process moved between a six-phase process as the reflexive nature means exploring the meaning you are prescribing to the data (Braun & Clarke, 2021a, 2021b). Inductive latent coding respected participants' experiences and understanding of perinatal mental health. This coding was set within the context that analysis cannot be conducted within a 'vacuum' and that themes are generated as a form of 'story telling' in how the lead researcher understood the participant's experience (Braun & Clarke, 2021b, p. 4; Clarke & Braun, 2018). NVivo and Excel was used to support the process (Lumivero, 2023).

Analysis occurred over a three-month period, allowing time for familiarisation and space away from the data. This allowed the lead researcher time to reflect on their position as a TCP and key experiences reported by participants that had been coded. The lead researcher noticed how they may represent mental health services to the participants and how this may impact what they felt willing to share. Returning to the transcripts provided valuable insight to codes and themes. Along with supervision, these processes supported the development of central organising concepts. Appendix I details the iterations of themes.

Table 4

Six Stage Process of Reflexive Thematic Analysis according to Braun & Clarke (2021)

Process	Description
1. Familiarisation to dataset	Reading of dataset multiple times in order to familiarise with the content. Brief notes may be made.
2. Coding	Systematic identification of interesting, relevant or meaningful sections of data that are relevant to the research question from the entire dataset.
3. Generation of initial themes	Actively identify patterns amongst dataset, begin clustering codes together into potential themes.
4. Development and review of themes	Check initial fit of themes by returning to dataset. Potential for themes to be collapsed. Consideration of relationship between themes.
5. Theme refinement	Checking themes are centred around a core concept and fit with the research aims. Succinct name developed and brief description of themes created.
6. Write up	Process of portraying the analysis in words through use of key quotes. Aim for the reader to follow the story of the analysis.

Quality Assurance

A reflexive journal (Appendix J) documented decisions and thoughts throughout the project, and a bracketing interview (Appendix K) was conducted prior to data analysis which brought awareness to the lead researcher’s potential biases.

All participants were offered the opportunity to have the transcription sent back to them to check and remove information they felt uncomfortable with sharing. Five participants requested this. Transcripts were sent password protected via email and participants were given three weeks to request changes. One participant made several amendments to expand on their comments and one participant made small spelling amendments.

In addition, a thematic map was sent to six participants who expressed an interest in providing their thoughts on the analysis via email (Appendix L). Such respondent validation techniques have been used successfully within GTRSB health belief research and thematic maps are considered accessible to participants without a research background (Van Cleemput et al., 2007; Braun & Clarke, 2014). Two participants responded, providing positive feedback and suggesting the themes represented their experiences. The thematic map was also shared with a consultant who provided feedback in Table 1.

Results

The data was rich in experiences and viewpoints. In consideration of the research aims, RTA resulted in five themes and ten subthemes as depicted in a thematic map (Figure 1). Table 5 provides example quotes of themes and subthemes. Pseudonyms are used. Together, the themes revolved around the concept of perinatal health and wellbeing. Language used by participants to refer to perinatal mental health problems was “baby blues, postnatal depression, feeling bad in yourself, having bad nerves, depressed or down”. The majority of participants expressed speaking from their own understanding and experiences, and not for other GTRSB communities.

Figure 1.

Thematic Map

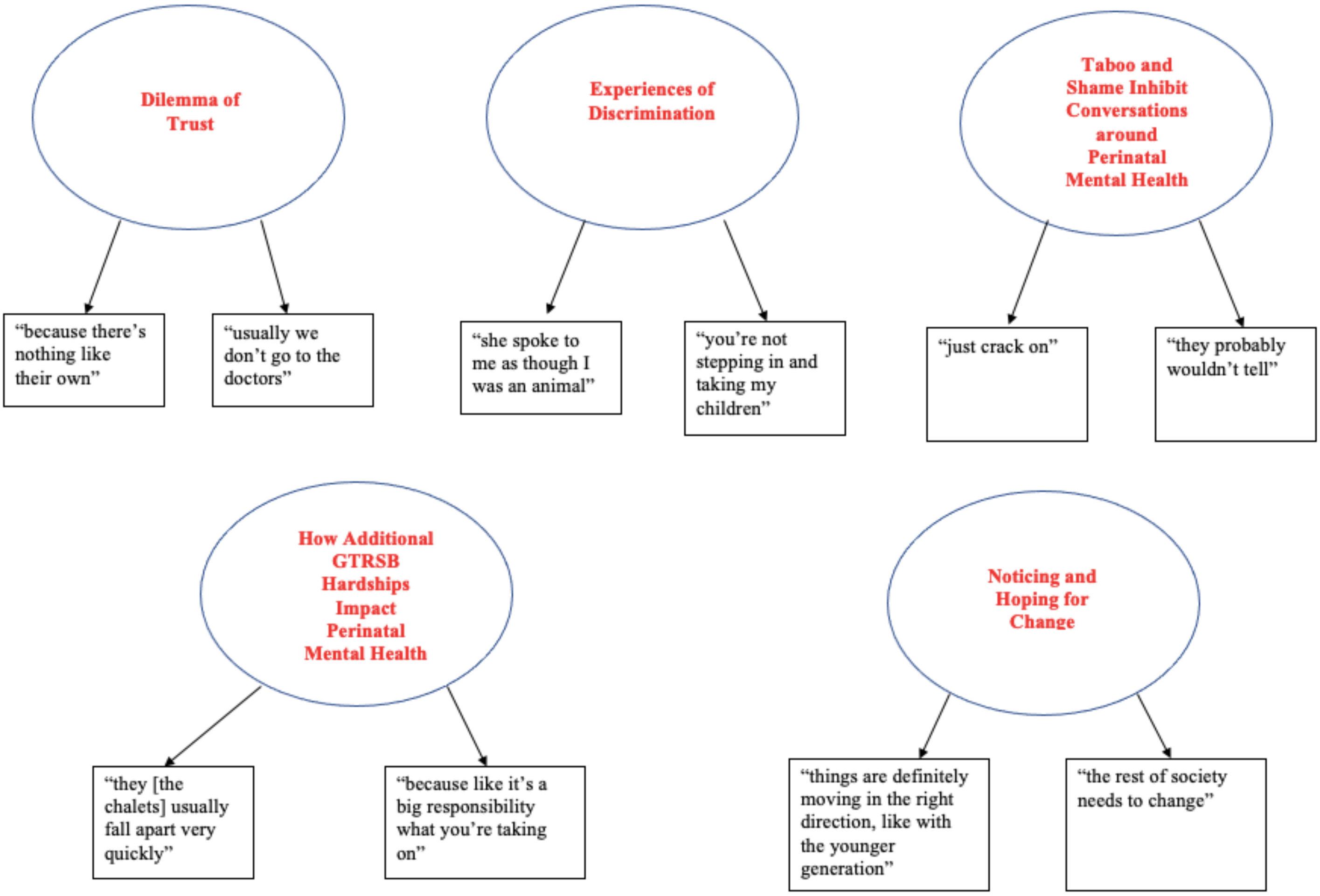


Table 5

Themes, Subthemes, and Example Quotes

Themes	Subtheme	Example Quote
Dilemmas of Trust	Because there's nothing like their own	"But why would they go there when they can get that support from their community? Because to them they can stay at home, be around their family, get support from their family, and be more relaxed, so for them it just makes more sense to get that support from home." [Joe]
	Usually we don't go to doctors	"a lot of Travellers will say no you aint coming in here, we aint having no health visitor around here" [Dawn]
Experiences of Discrimination	She spoke to me as though I was an animal	"I felt confident that she would see that, you know, my home was suitable for a baby. But there was, like a bit of anticipation or like, a slight worry that, you know, you might just get someone who was really, you know, not. I don't know. Not supportive of this way of life or had some, like negative preconceptions about it," [Ruby]
	You're not stepping in and taking my children	"I knew my 2 little girls were due their check-ups. Their one and two year check-ups and that was something else that really stressed me out because I was like if I get behind on them while they're not done, that's gonna flag me up with social services that I'm not keeping up to their health records and their checks, and so that really stressed me out" [Laura]
Taboo and Shame Inhibit Conversations around Perinatal Mental Health	Just crack on	When I actually stop and I actually think about what I've been through, it's like, oh, actually, I can't do that just right [mimes with hands moving thoughts away], actually, I and it's not quite running away from it. But you kind of just keep, so it's out of focus." [Laura]
	They probably wouldn't tell	"You have to be in a tight, you know, when things are going bad and it's bad stuff. You have to be quite closely related or, you know, good friend." [Tina]
How Additional GTRSB Hardships Impact Perinatal Mental Health	They [the chalets] usually fall apart very quickly	"With the lack of site accommodation, there is a national shortage, this shortage is definitely preventing many from living communally." [Helen]
	It's a big responsibility what you're taking on	"Lucy – urm, I just think like things get on top of ya, Jess – yeah, everything, everything just builds up. Like your main priority is that baby, it feels like you've got no time for yourself. Do you know what I mean?" [Lucy & Jess]
Noticing and Hoping for Change	Things are definitely moving in the right direction, like with the younger generation	"It probably has helped because they do like to scroll through stuff, don't they? And there's you get yourself down rabbits holes. And I think it has given them a little bit of an insight of different things, whether they like, they like to admit it or not and social media has a lot to answer for sometimes [laughs]. But yeah, I think I think they get themselves watching these. It can be quite helpful things that pop up." [Laura]
	The rest of society needs to change	Yeah, having, having links with, sort of post natal care like health visitors and stuff that you. But like how, being able to have the same one, I guess like. And having a choice if you felt like if you felt like the one that you got wasn't. Didn't understand you or wasn't helpful. Then you could just go to, you'd have the opportunity to go to another one or it would be good to have, you know, someone who is in touch or some sort of link with, you know, the healthcare like post-natal healthcare, someone who was generally trusted or like had a link to your community already." [Ruby]

Dilemmas of Trust

Participants clearly expressed who they felt they could trust and who they felt they could not. This followed an ‘insider-outsider’ perspective, in regard to family and community and healthcare professionals respectively.

Because there’s nothing like their own

There was a strong narrative from every participant that emphasised the importance of their community and family during the perinatal period and “always [having] their families to go to” [Frankie]. Specifically, participants made explicit links to the importance of having female family and community member’s support at that time. Females were deemed the most trusted due to their wisdom following their own perinatal experiences meaning they understood implicitly how the perinatal period felt.

> “so usually when Romany Gypsy women have their children, they have a kind of a support network with them of women, so they'll have their mother, their mother, in-laws, sisters, sister in laws. They're like we have like a bit of a support network” [Laura]

There was a sense of loss and sadness when four participants described not having those trusted females close by and suggestion this made the perinatal period harder.

In addition to female support, husbands or partners were also trusted during the perinatal period and might provide practical support, for instance attending neonatal wards; “Like if it weren’t for him [husband] I wouldn’t know what I would have done because I never had the strength to do none of that” [Lucy].

However, three participants acknowledged variation within this support, being dependent on the individual husband. There was a strong sense from three participants that females within the family and community were still most trusted for support around perinatal mental health difficulties. It was alluded to by four participants that men have limited knowledge of women's health and the perinatal period, this was corroborated by both male and female participants. Conversely, one participant felt able to speak to both men and women about the perinatal period if they were parents.

Usually we don't go to doctors

In contrast to trusted family and community, there was a strong sense that health and social care professionals were not trusted. Indeed, five participants did not regularly access their GP and two participants referenced a lack or loss of relationship impacting their engagement with their GP.

It was suggested that GP's were consulted only if the symptoms were severe, multiple, or in relation specifically to their child(ren)'s health. One participant referenced this lack of trust being a generational learnt factor. There was an angered sense that support should be gained from inside the community rather than outside; "and they're very much like no why would you tell like the Gorja [non-travelling person] anything, anything else, like anyone from outside, why would you? You know what I mean, and there's big groups of Travellers like that" [Dawn].

A sense of frustration was noted when one participant had tried to access support for perinatal mental health difficulties but felt this was not helpful; "I had the baby blues and antenatal depression, the two in together, he [GP] said we've faxed in your prescription over to the pharmacy and it will be ready to collect. That's it" [Lucy]. This suggested that at a time of need and despite a lack of trust Lucy attempted to seek help but felt unsupported.

Some participants did express trust towards professionals, in total four participants respected GP's, one participant trusted their midwife, three participants trusted their Traveller Liaison Officer's, and one participant referred to a health visitor as a professional that could be trusted. It appeared in particular that the GP and TLO had built a trusting relationship and rapport with participants which meant participants felt able to share how they were feeling;

"Lucy – no, well [TLO's name] [laughs] because she sits and listens to us. Jess - yeah we tell her all our troubles, [to the TLO] I think I moaned all year didn't I?".

Interestingly, trust may be more likely if the healthcare professional was also from a minoritised background as suggested by Jess.

> "But the midwife that borned him she was lovely, I couldn't fault her on anything she was really nice…yeah and she wasn't, she weren't white, she was from another country, I want to say Africa maybe. So she was not a white person so if you know what I mean?" [Jess]

Tina provided a balanced view in acknowledging that negative experiences may be remembered more so than positive ones; "I think when you encounter good midwives and good people you don't they don't get the credit they deserve. Because let's face it, we only complain when things hit the fan, don't we?" [Tina].

The element of trust and mistrust appeared to also touch on healthcare professionals using medical interventions and understanding, whilst communities used social and practical strategies to support perinatal women; "there is a danger in labelling, post Natal depression, it is a medical Gorja term. Which some may fear means the only solution is drugs (prescription medication)" [Helen].

Indeed, Helen spoke emotionally about the negative impact of feeling like she had to trust professionals during labour when she wanted to listen to her mum who was most trusted to her.

Experiences of Discrimination

The majority of participants provided examples of discrimination within wider society and from health and social care professionals. This had a severe consequence of increasing fear within participants and reducing their likelihood of accessing support.

She spoke to me as though I was an animal

Eight participants described experiences of discrimination from healthcare professionals within various settings. Examples of how discrimination was experienced ranged from perceived subtle looks and comments to not being supported or listened to during and following birth.

> “Many Travelling women my family, relatives, and women I know have had similar experiences with feeling as though midwives, health visitors, nurses, doctors, and GP’s talk down to them, I can't say whether that's discrimination or just because we look young and they think we're immature, it could be ageism for all I know, but whatever it is, it exists and it's real.”. [Helen]

Sadly, discriminatory experiences resulted in some participants not disclosing ethnicity status for themselves and their children. Jess explained she stopped disclosing her GTRSB status as she felt “everyone look at you or talk to you different.”

Negative experiences with healthcare professionals, where participants did not feel listened to or supported during birth was often vividly remembered and recalled within interviews, this provided a suggestion that the events had been traumatising for the participants and directly impacting their mental health.

You’re not stepping in and taking my children

Participants reported hearing of instances of children being removed from their parents care by social services and feeling like this had been due to their GTRSB status. These stories were shared widely within the community and were met with anger and fear that it could happen to anyone from a GTRSB community. Sadly, Helen recalled a situation she had heard of where social services involvement resulted in the suicide of the mother. There was a sense that the fierce love felt by mothers meant they would sacrifice themselves and put their children above them at all costs. Two participants declined mental health support for fear this would increase their vulnerability for further discrimination; “we were living at the side of a road and to top it off, you've got mental health problems. They would have took the kids straight off you” [Laura]

One participant did not explicitly report experiences of discrimination or a fear of social services.

Taboo and Shame Inhibit Conversations around Perinatal Mental Health

Six participants described a sense of taboo and shame around experiencing perinatal mental health difficulties and women’s health more generally, for instance menstruation. There was a strong sense that difficulties with perinatal mental health were not spoken about within GTRSB communities, and five participants reported not being aware of others who had experienced perinatal mental health difficulties, with a suggestion that this may be because it had been hidden.

Just crack on

Due to the shame and taboo of perinatal mental health difficulties seven participants described persevering with daily life as a coping strategy.

> “you just learn to like live with it, like just crack on…like somedays you can just sit there and cry. But you just sort of just get on and think to myself I got all my children, I wouldn’t change anything for the world” [Lucy].

One participant provided an example of how women might speak to themselves which reflected the mindset of keeping going; “shutup, for fucks sake, suck it up [laughs]” [Dawn]

Two participants related gender roles within GTRSB communities where women are expected to be mothers and home makers, therefore being seen to struggle during this period could be viewed as shameful.

> “it was a little bit like well, you know if you can't run a house look after children cook and clean. What sort of woman are you? So I don't think people overly complain too, that much because you were seen as lacking” [Tina].

They probably wouldn’t tell

Five participants expressed an understanding that perinatal mental health difficulties may be hidden from the wider community, with only very close relatives potentially being aware; “never been round anyone like that, well not that I’ve known of, or they’ve hidden it well if they have” [Frankie].

One participant differed with this view and felt women would speak openly with family or community members; “I wouldn’t say it’s like in any way, like taboo subject or anything. I think people are quite open to conversations around that [perinatal mental health] kind of thing” [Ruby].

This contrasted with a view that talking about perinatal mental health difficulties could in fact exacerbate them. Indeed, due to the well-established taboo and shameful nature of perinatal mental health, the likelihood of speaking about it was slim; “but I don’t think that you can force that, I just think that once that taboo I don’t think you can force someone to say actually no it aint” [Dawn].

How Additional GTRSB Hardships Impact Perinatal Mental Health

It was understood that the perinatal period brings its own challenges to any mother. However, there appeared an additional stressor for GTRSB mothers during this time due to the hardship associated.

They [the chalets] usually fall apart very quickly

Poor living conditions was mentioned by six participants as highly stressful during the perinatal period. This revolved around poor site availability and accommodation being substandard; “pre giving birth is like there is a massive lack of site provision so. There, are a lot of people, roadside or on little bits of land where they are on their own” [Ruby].

In addition to accommodation stressors, one participant described uncertainties of self-employment as likely to cause women stress within the perinatal period; “work is not guaranteed for Show People or Romany people 'cause most Romany people go out hawking…urm so that can cause a lot of stress if there's a lot of problems with work or urm” [Joe].

It’s a big responsibility what you’re taking on

It was recognised by five participants that having a child was a significant responsibility. This was in addition to the existing daily household tasks females within GTRSB communities were responsible for.

> “because moving about is a lot harder on women than it is men, because your waters not on tap or anything like that and you’ve got the washing, and you’ve got to be doing to be able to keep on top” [Dawn]

Such responsibilities were felt by GTRSB women as hardship; “everything just builds up. Like your main priority is that baby, it feels like you’ve got no time for yourself. Do you know what I mean?” [Jess].

On top of hardships of everyday life, Joe expressed concerns around birth marks being an additional stress due to concerns around being accepted.

> “You know, how is it gonna grow up? Is it gonna be treated even more differently because not only is that baby from a that child now from a Travelling Community, but it has what I don't like to use the term, but people might see as defects or things that are you know are wrong with them?” [Joe]

Noticing and Hoping for Change

Theme six focused on change within communities and a desire for services and wider society to change to become more accessible for GTRSB communities.

Things are definitely moving in the right direction, like with the younger generation

Six participants signalled a potential generation shift in terms of greater awareness of mental health (including during the perinatal period) and openness to speak about such difficulties within GTRSB communities; “that's only really been in the last few years before that it was kind of, pretty unheard of a man was a man and a woman dealt with woman's things” [Laura].

Three participants felt that younger generations use of social media and information being accessible on the internet, and one participant suggested staying in education for longer as factors attributed to mental health being spoken about more.

The rest of society needs to change

In comparison, despite an increase in awareness of perinatal mental health, four participants were unaware of what services could offer, how to access them or known of anyone who had accessed them; “Issie – I don’t know a lot of people, like Travellers who has done therapy, Frankie- I don’t know anyone that does therapy”.

Despite a lack of awareness and distrust of services, there was a desire for services to be more accessible. Every participant provided their views of how services could improve. Six participants expressed a desire for services to be more culturally aware of GTRSB customs and beliefs, this was also extended to all minoritised backgrounds by one participant. For instance, this included customs around the possibility of being married and having children at a younger age, inappropriateness of male doctors performing intimate procedures, and the importance of having large family groups visit the new-born baby. Two participants expressed a level of understanding that healthcare professionals may feel ill-equipped due to a lack of training provided by organisations. With Frankie succinctly stating, “because they [healthcare professionals] can’t help it if they’re not taught can they?”

It was positive that seven participants felt able to share their views and opinions to healthcare professionals around their care either via speaking to them directly or through an official feedback or complaints process. It appeared that participants valued the opportunity to do this, however, it was acknowledged by one participant that this may not be the case for every GTRSB women. In consideration of feedback experiences, there was a desire from two participants for healthcare professionals to be open and honest and acknowledge any wrongdoings; “I thought it was nice that she came up, actually up to the ward and apologised” [Dawn].

Part of acknowledging wrongdoings involved a sense of services building relationships with GTRSB communities, with this being key to GTRSB community members feeling able to access services. For instance, three participants expressed a desire for services to be mindful in their interactions so they are not overbearing. Issie expressed it being “enough” to have conversation where someone felt heard.

It appeared that verbal communication was important to build relationships and also advertise services. With three participants referencing low literacy levels within GTRSB communities; “I encountered some really, really good midwives and you know, people that listen to you. But. And I think that's the key, isn't it being listened to” [Tina].

Within this building of relationships there was a desire for services to work alongside communities, described by four participants. This included working with trusted GTRSB organisations and spokespeople in trusted environments such as the home. Three participants referenced the power of ‘word of mouth’ in building such relationships; “so I think that if someone were, you know, to go out and support them, go into those communities, I think that would make a big difference” [Joe].

Interestingly, two participants directly referenced Tyson Fury ‘The Gypsy King’ (a professional boxer who identifies as Irish Traveller) as being a well-respected individual who has spoken openly about his mental health difficulties. There was a desire for this to be replicated within GTRSB females.

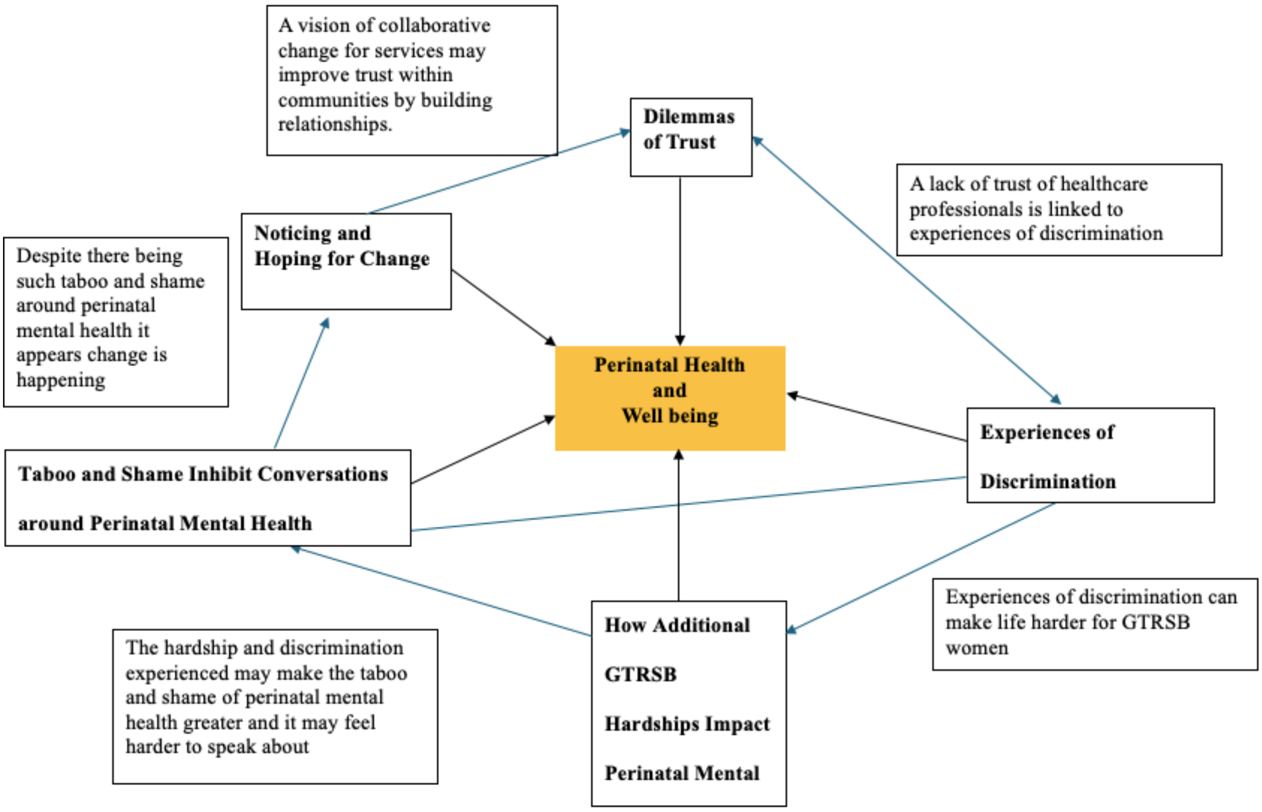
Particular examples that were positively described by two participants was women’s health groups which were relaxed and trusted GTRSB spaces which healthcare professionals could be invited to in order to build relationships and share information; “You know it's a female get together. Low key helping to create a relaxed environment so all are at their best to take in new information” [Helen].

Thematic Summary

Despite separate distinct themes developed from the data it was clear that themes interact to make talking about perinatal mental health or accessing help from services even more difficult. Such a method showing interactions have been used previously within thematic analysis (Anderson & Clarke, 2019). Figure 2 depicts how themes interlinked.

Figure 2

Conceptual Map of Interlinking Themes



Discussion

To the author's knowledge this was the first study to explore experiences and perspectives of perinatal mental health from members of GTRSB communities. The first aim was to explore how member of GTRSB's communities talk about and understand threats to wellbeing in mothers during the perinatal period. The findings from this study reflect a complex interaction of trust, discrimination, shame, and taboo which inhibit GTRSB communities from speaking about or accessing support for perinatal mental health difficulties or disclosing their ethnic or cultural group. Similarities around male gendered expectations and discrimination has been shown to impact male GTRSB members mental health (O'Donnell & Richardson, 2020). Participants' experiences resonate with the minority stress model in regard to the additional stress engendered by experiences of discrimination and feeling the need to hide one's identity meaning they did not access support for their mental health.

This study corroborated findings that GTRSB women prioritise children and their role as a mother above their mental health (Hodgins et al., 2006). The fear of judgement for accessing mental health support has been documented within GTRSB communities (Goward et al., 2006). Interestingly, it appears that this permeates both GTRSB communities and non-GTRSB communities as mothers fear judgement from loved ones and social services and may conceal their difficulties and 'keep going' as a way of coping (Law et al., 2021; NICE, 2020).

However, for GTRSB women there is a real and distinct threat, with statistics suggesting an overrepresentation of GTRSB children in state care (Allen & Hamnett, 2022; Friends, Families & Travellers, 2023; NHS Race & Health Observatory, 2023). The finding that GTRSB women may not disclose their ethnicity due to this fear is common within the GTRSB literature (Francis, 2013; HCWC, 2019; Traveller Movement, 2017).

Despite a reluctance to speak about perinatal mental health within GTRSB communities, participants were clear in describing structural and systemic level threats to the wellbeing of mothers including poor quality accommodation and site provision, and employment concerns. These factors have been widely documented within the GTRSB literature as underlining the many inequalities experienced by GTRSB communities (Cemlyn, 2009). Minority stress model does not account for economic disadvantage; therefore, an intersectional lens may best explain the complex nature of factors that impact GTRSB perinatal mental health. For instance, in relation to Bowleg's (2012, p. 1268) intersectionality framework suggesting intersecting "micro" and "macro" factors, participants spoke of the hardships of being a GTRSB women and a mother where there are multiple demands often meaning women do not have time to attend to their own wellbeing. This was set within a wider structural context of experiencing discrimination and feeling unable to trust healthcare professionals. Through an intersectional lens it can be understood why perinatal mental health may not be spoken about or support accessed.

The second aim was to explore what support is provided during the perinatal period. Despite perinatal mental health not being widely spoken about, it was clear that support was provided. Indeed, the close relationships within GTRSB families and communities has been regarded as central to members' wellbeing and adds further evidence to a potential buffering effect of family and community (Office for National Statistics, 2022; Goward et al., 2006).

In contrast, no participants referenced the use of religion as support for perinatal mental health specifically. Although it was mentioned for mental health in a general sense, which is found within the research (O'Regan et al., 2023; Richardson et al., 2023; Van Hout, 2010).

Interestingly, the results corroborate with a review exploring how GTRSB communities' access general health services, similarities included a fear of social services and a sense of stigma and shame of using healthcare for more intimate issues. This review also highlighted a desire for communities to collaborate with services to improve cultural competence within services. An example provided within the review was how female healthcare professionals within women's health services is regarded as more culturally appropriate in comparison to male healthcare professionals (McFadden et al., 2018).

The findings from the study appear to be applicable to other ethnic minoritised women due to the similarities to a review exploring ethnic minoritised women's experiences of perinatal mental health (Watson et al., 2019). This was around themes of discrimination, stigma and shame, and desires for services to improve in cultural awareness.

Strength and Limitations

Despite the novelty of the study, limitations are noted. In consideration of the lead researcher not being from a GTRSB community and a healthcare professional, which the findings suggested are often not trusted by GTRSB communities, there is a possibility that participants may not have openly shared all of their thoughts, experiences, and feelings. In addition, the impact of the fear of social services may have also impacted what participants felt able to share in regard to perinatal mental health. It is also possible that participants may have spoken more freely to someone who identifies as GTRSB. In addition, the analysis being conducted through the lens of an individual who is not from a GTRSB community could impact the results. It is hoped that consultancy efforts and sharing of results will have minimised the impact of this.

The study did not achieve the recommended minimum 12 participants. The lead researcher worked extensively on recruitment for 18 months which involved numerous networking with GTRSB professional and research networks, individual professionals, and GTRSB spokespeople. This was important as it enabled a relationship to be formed. In addition, a social media presence and the use of WhatsApp was used to increase accessibility.

In consideration of the shame and taboo and distrust of healthcare professionals outside of the community when talking about perinatal mental health there is a chance that GTRSB community members may not have been willing to engage with the project, and therefore findings may be limited to those who are willing to engage.

Despite this, the study included the perspective of a participant from a Showmen community which is hopeful in reducing the groups invisibility within research (Greenfields et al., 2023). The majority female sample meant a female view was dominant, this felt appropriate being a perinatal focused project. The one male who did take part was able to provide a GTRSB male perspective of the perinatal period. In addition, a male consultant provided thoughts on the themes developed.

It may have been helpful to collect additional demographics such as ages and number of children to set the context of participants' experiences, however, with the difficulties of building trust with GTRSB communities in research it felt appropriate not to.

It must be noted that within this study there was contrasting views of ability to speak openly about perinatal mental health and participants were clear in stating they could not speak for other GTRSB communities. This highlights the distinctions between GTRSB communities, and importance of them being recognised as individual ethnic and cultural groups. For instance, one participant who identified as New Traveller felt more open to speak to both male and females about perinatal mental health. The majority of participants identified as Romany Gypsy, therefore the findings are more likely to talk to their experiences. Indeed, the research has suggested that GTRSB communities value being viewed as individual groups without preconceptions (ONS, 2022).

Clinical Implications

The third aim was to consider if and how perinatal mental health services can be of most use to GTRSB women. Overall, the study supported findings that a lack of trust towards healthcare professionals impacted access to services (O'Brien et al., 2022). However, this study corroborated research to suggest in the right environment GTRSB women may be willing to speak about perinatal mental health difficulties, if they felt healthcare professionals had built trusting relationships with them (Francis, 2013; ONS, 2022). For instance, health visitors have been demonstrated to be build trusting relationships with GTRSB women (Papadopoulous & Lay, 2007). Therefore, it is imperative that health visitors training includes information about GTRSB women's cultural and health needs. A further way forward would be for some health visitors to become specialist in working with these communities and to offer consultation to their colleagues. This would be particularly helpful in counties such as Kent and Essex where there are higher populations of GTRSB communities (Office for National Statistics, 2023). It is hoped that if there were good relationships between health care professionals, some women from GTRSB communities might consider training to become health care professionals themselves.

The study did not show that participants were particularly seeking specialist mental health services. Instead, GTRSB women may be more likely to speak to those who are trusted such as community led organisations or spokespeople, Traveller Liaison Officers, or potentially GP's. In addition, community led female groups were reported favourably, which replicates a review of a similar group in Lincolnshire and views from male GTRSB members (NHS Race & Health Observatory, 2023). This suggests a need for such groups on a wider national basis, state funding would allow more equitable access (Law et al., 2021; NHS Race & Health Observatory, 2023; O'Donnell & Richardson, 2020).

These factors suggest that perinatal mental health services could link in with trusted professionals and initiatives to provide information that can be signposted to GTRSB women. Such co-produced initiatives should include payment (NHS Race & Health Observatory, 2023).

For this model to be successful, services would need improved cultural awareness, which was raised by participants in the study and corroborated within the literature as poor (Davies, 2021; Francis, 2013). Cultural awareness training is necessary to consider the intersecting "layers of oppression" (Keefe et al., 2018, p. 231; Law et al., 2021). It has been argued for this to be at a systemic service level which may improve relationships and allow healthcare professionals to challenge their preconceptions (Francis, 2013; O'Regan et al., 2023). For instance, included within mandatory equality, diversity, and inclusion training (NHS Staff Council, 2021).

Arguably part of cultural awareness is also for services to acknowledge their wrongdoings. It was hopeful that the majority of participants felt able to tell healthcare professionals when they had been treated badly. However, this may not be true for all GTRSB women so this must be considered. The frequent descriptions of not feeling listened to or supported during birth would suggest every woman should have the opportunity for post-birth support, as recommended within NICE guidance (2021).

Clinical Psychologist's skills would be highly suited to support within aspects of all of the clinical implications. For instance, in building trusting relationships and holding in mind complex dynamics, providing cultural awareness training, and facilitating reflective practice for staff working with GTRSB populations.

Research Implications

In consideration of the paucity of research, more research is required to explore perinatal mental health within GTRSB communities. This should involve co-production techniques to explore how community led initiatives such as the women's group are helpful. This may then enable a blueprint to be used nationally to support more GTRSB communities. It may also be interesting to explore further the 'buffering' protective nature of family and community and process around family support.

In addition, in consideration of the discrimination experienced by participants, it would be valuable to explore midwives and health visitors understanding and knowledge of GTRSB communities and what training they receive, as this currently appears limited. Such research would hopefully uncover how these professions can be better informed to support different GTRSB communities and hopefully reduce the discrimination experienced by GTRSB women.

Conclusion

This study looked exclusively at mental health needs amongst pregnant and new mothers within the GTRSB communities. The study's findings shared similarities with minoritised communities experience of health care, and experiences of GTRSB men's experiences of mental health, however, there were also differences. Notably, the importance of a community of women as support, and the extreme hardship that women might need to endure due to a nomadic lifestyle.

There is a case to be made that findings from qualitative GTRSB research are often centred around particular narratives, notably within this study experiences of discrimination, trust, shame and taboo (McKey, 2022; Sehmbi & Kamboz, 2023). However, this study has also highlighted themes of change and desire for changes, which is helpful in allowing the NHS to develop and work towards their values of non-discriminatory practices.

The fact that GTRSB people continue to express similar themes may suggest that their experiences are not changing. The study's findings are novel within the perinatal mental health area and also add impetus for services to make large changes in how they engage and potentially support GTRSB people.

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Section C: Appendices of Supporting Material

Appendix A

Table of Themes, Subthemes, Codes, and Example Quotes

Theme	Subtheme	Code	Total Papers	Example Quote
Interpersonal, systemic, and structural influences on mental health	Grief	Roles change due to grief at young age	2	"When you lose your mother you're head of the family. You've lost your mentor so you're having to fill a pair of shoes as well as grieve a pair of shoes"
		Long term impact of grief	2	"though the loss had often occurred many years ago, the consequences were still sharply felt"
		Baby and child loss	1	"I lost five [children], stillbirths, miscarriages and premature birth. But a lot of trouble comes with it and you know when you have nervous systems and what's that word anxiety, depression and all that and all that comes with it"
		Grief impacting mental health	4	"participants described the loss of children and/or loved ones as having a significant impact on their mental health"
	Socio-economic factors	Poor housing conditions impacting mental health	9	"Mental illness is big in the housed Gypsies. I've seen it. It's massive and I see it all through the country. They put them in substandard housing because they think that's what they are: substandard people"
		Lack of opportunities	5	"There is [are] many young Traveller men going around the city with nothing to do who have very poor mental health"
	Complexity	Interactions between factors	6	"The intersection of this potent mix of structural inequalities, internalized racism, Traveller masculinities, and strong historical associations between stigma and mental health/suicide within the Traveller community lies at the heart of the heavy burden of suicide carried by Traveller men and poses significant barriers to Traveller men accessing support during times of psychological distress"
	Discrimination	Discrimination directly linked to mental health	6	"End racism and discrimination and we'll be fine. I think a lot of that is what leads to poor mental health"

Theme	Subtheme	Code	Total Papers	Example Quote
		Societal discrimination	5	“The issues of prejudice and discrimination was not discussed by all participants but when it was, it was perceived as worsening and they provided examples of discrimination in terms of accommodation, access to leisure activities and employment”
		Discrimination in school	2	“According to them, mental health problems start in school, because teachers consider them slow learners and they are treated as second class pupils”
		Discrimination from services	1	“An ambulance won’t actually come to the site until they have a police escort, and you are suicidal, and they treat you as if you’re a criminal and you might actually attack them”
Perspectives of Mental Health	Demographic Differences and the Perception and Experience of Mental Health	Age - Youth challenging perceptions	3	“This represented a generational shift, whereby younger participants contested the pretence of a more stoic and self-reliant embodiment of Traveller masculinity in favour of an increased openness to acknowledging fluctuations in mental health and to normalizing help-seeking during times of psychological distress”
		Domestic Violence impacting women’s mental health	2	“Maybe she’s worried that he’s going to beat her If she has a husband and he’s givin’ her a hard time that could make her depressed”
		Women’s Role	6	“The treatment they described amounted to negation of their role as a mother, and understandably was a significant contributor to their poor mental health”
		Masculinity	7	“Masculinity, showing your weakness. Imagine crying in front of another man? A Traveller man. You’d be the talk of the place . . . you’re not allowed to cry. I’d hide an awful lot from them (family). It’s an awful lot of pressure”
	Variation of Managing Mental Health	Self-medication	10	“they start taking pills and drinking, that’s the effect it has on them because they are not handling it properly”
		Use of Religion	3	“If someone was suicidal, they would go to a priest first”
		Active Lifestyle	3	“When participants were asked to describe the circumstances in which they felt they have good mental health, they described situations where they were active, had a routine and a structured life, they were busy and were able to accomplish daily tasks”
		Use of Therapy	1	“Counselling was described as ‘‘better than medication cause it helps you cope with depression in the home situation’’

Theme	Subtheme	Code	Total Papers	Example Quote
	Language to Express Mental Health	Language Used to Describe Mental Health	8	“Most of the individuals interviewed talked about ‘‘feeling down’’ or ‘‘bad with me nerves’’ at least some of the time”
		Mental Health = Negative	2	“Travellers in the study conceptualized mental health primarily in negative terms and initially could not think of mental health as a positive concept”
		Prevalence of Mental Health	6	“Many of the participants empathized with the vignette characters presented at the beginning of the focus groups and confirmed that many of their peers go through similar circumstances and often experience poor mental health”
Conflicts between identity and community	Traveller Identity and Culture	Hardship associated with being a traveller	6	“because we’re Travellers it brings on an awful lot of the depression in your life”
		Positive view of traveller identity	2	“As a minority ethnic group, there was a strong commitment to honor and pass on traditional Traveller values and customs by outwardly displaying an allegiance to kinship and collegiate spirit within the wider Traveller community”
		Loss of culture impacting mental health	5	“Two Travellers in different focus groups commented that the loss of their cultural way of living is one of the root causes of the mental health crisis affecting Travellers”
		Differences between travellers and non-travellers	5	“At a societal level, this study found that Travellers seem to have a low level of cohesion with other communities in Ireland, despite a high level of internal cohesion”
	Dilemmas Between Family and Community	The importance of family and community, acts as a buffer for mental health	8	“Research participants had a good understanding of the positive effect of social relations and how socializing with friends and having good relationship with family could be a protective factor for mental health”
		Impact of isolation from family and community on mental health	3	“You know that feeling of like I’m totally on my own. Then if you are beginning to feel suicidal, uh, which of course you would, it’s much easier to feel like you’ve got nowhere to go”

Theme	Subtheme	Code	Total Papers	Example Quote
		Not asking family or community for support due to stigma	9	“. . . so there’s the whole stigma that if I show weakness, or I show that I’m not mentally well, would I be treated differently within the community . . . would I be judged and am I bringing shame on the family?”
Experience of services: past, present and future wishes	Impracticalities of Services	Ambivalence and mistrust towards services	6	“There was an air of pessimism and disillusionment among participants, many of whom felt invisible because of not having their needs met by the State and by a perception that nothing was going to change”
		Unsuitability of services	3	“The quality of service was unpredictable, and required a “trial-and-error” procedure to find a suitable and helpful professional”
		Lack of cultural awareness	4	“the use of therapy sessions to enhance professional knowledge of GRT culture was deemed inappropriate”
		Communication Issues	5	“So, if you’re going into your doctor, and you’re asking your doctor for some antidepressant tablets, and you’re asking them how to take them. How to take it? When to take it? There was a difficult thing there the other day when all the doctors were changing the medication to the cheaper medication because of some new regulation. A doctor does not have time, or they will not sit down with you to explain. They’re just going to say, ‘Here—take this’.”
	Desired Improvements from Services	Culturally appropriate services	7	“Participants felt their engagement with statutory services could benefit greatly from staff undertaking antiracism training”
		Interpersonal skills	9	“If she [TMHLN] knows I’m going away for, to [names relative] for a few days, she’ll always ring me. Make sure I’m alright do you know, so very, very, very good of her like, so. Yea, it’s just great support, great support do you know what I mean? Because you set yourself on, you know there’s someone that cares”
		Co-working with communities	6	“The Travellers commented: ‘responses need to come from everyone in the community...that’s us the Travellers, the Traveller organizations and drugs services...we need to know where to go for help... where there’s a friendly face and someone who understands... someone to listen to me”
		Practical and Proactive Improvements	7	“There was a clear preference for more informal and flexible supports over mainstream professional services”

Appendix B – Ethical Approval Letter

This has been removed from the electronic copy.

Appendix C – Confidentiality Discussion

Confidentiality and limits to confidentiality will be discussed with the participant verbally. This conversation will cover the following areas. The researcher will tick off and sign what has been discussed: The reason for this is that the feedback from our expert by experience consultants is that this is an area that has to be done respectfully and sensitively and that written information will not be an acceptable way of managing this process and is likely to result in dis-engagement with the research.

All the following areas will be discussed with room for questions and in a language and tone suitable for each participant.

- How the audio and transcripts will be kept securely on a password protected computer device and that only the researchers will have the password to this. Once transcribed the audio recordings will be deleted. From this point onwards all data will be anonymous.
- The participant will have the right to check the accuracy of the transcript and they are welcome to correct any errors. If they wish to take this opportunity, they will need to indicate how the transcript will be sent to them (either email or postal address with SAE). There will be a limit of 4 weeks for returning any changes.
- The interviewer will explain the limits to confidentiality. In particular, if the participant says anything that would suggest that a child under 18 or a vulnerable adult (including the participant themselves) might be in danger of harm.
- The interviewer would discuss what steps would be taken if there were concerns of harm. The interviewer would talk with participant away from anyone else or make a further appointment (if it were a focus group) about what their concern was and think together with participant about the best way of keeping the participant or others safe.
- What disclosure might involve. For example, asking for more details of a child or vulnerable adult and liaising with other services about additional support for the child or adult.
- When this might happen – disclosure would happen if the participant gave the full name of a child or vulnerable adult and clearly stated a concern about their well-being. There would be no disclosure if the comments remain vague or if the participant did not refer to any third parties by name.
- If the participant talked about someone they were worried about, but did not disclose, or wish to disclose a name, then the researcher would give the participant details of support organisations that they could discreetly pass onto the person they were worried about.
- In terms of the participant themselves, disclosure would only happen if the participant fell into the category of being a vulnerable adult, for example if they had a learning disability. The participant would also have access to information about support organisations for adults to pass over at the end of the interview.
- It will be emphasised to the participant that disclosure of information in a research setting is very rare and only for the purposes of keeping a child

or vulnerable adult safe. No other information will be shared except anonymously for the purpose of the research.

- Participants are made aware that they are welcome to a paper copy of this discussion sheet for their own records.

Researcher name:………………….Researcher signature:…………………….
Date of discussion:………………….
Participant identification:……………

Appendix D – Social Media Advert

Are you from a Gypsy, Roma, Traveller Community?
We would love to hear from you
Rosie Booth and Athena Duffy would like to speak to people about their experiences and understanding of feelings during pregnancy and two years afterwards.
We would like to speak to anyone who has either had a baby or knows someone who has.
We are hoping this project will make any support more relevant to your community.
Everyone who takes part will be provided with a £10 shopping voucher as a thank you.
If you are interested and would like to know more about the project please text message or WhatsApp this number 07549441428
@grtcpregnancyresearchproject

Appendix E – Information Sheet

Information Sheet

Salomons Institute for Applied Psychology
One Meadow Road, Tunbridge Wells, Kent TN1 2YG
r.booth858@canterbury.ac.uk

Information about the project

Understanding views and experiences about feelings during pregnancy and the first 2 years after birth.

Hello. My name is Rosie Booth, and I am a Trainee Clinical Psychologist at Canterbury Christ Church University. I would like to invite you to take part in a research study. Before you decide whether to take part, it is important that you understand why the research is being done and what it would involve for you. Please talk to others about the research study if you wish.

Part 1 is a summary of the study so that you know what it involves. Part 2 gives you more detailed information about the study which you should read if you decide you are interested in taking part.

Part 1

General information about research

Research is a way of understanding more about a topic. A research project is where a group of researchers look in depth at an area they are interested in and use this information to change the way we think about a topic or to help change services to make them better. By taking part in research it means that you are helping the researchers understand more about the topic which might help people from your community in the future. For this study you will be helping the researchers to understand more about your views and experiences of feelings that can happen during someone's pregnancy and for a couple of years after.

What is the purpose of the study?

The purpose of this study is to work in partnership with the people from the Gypsy, Roma, or Traveller Communities to hear about their experiences of feelings during pregnancy and up to a couple of years after birth, or the experience of people they know well. We would also like to learn about their beliefs, or the beliefs of people they know from their community, around feelings during pregnancy and for the time after the baby was born. This can be from your own personal experience of pregnancy or of someone you know. This is an area that has little research within the Gypsy, Roma, Traveller Community and the researchers feel by exploring this further we can hopefully find out how best to help Gypsy, Roma, and Traveller families during this period, if they needed it.

Why have I been invited?
You have been invited to take part in this study because you identify as being a member of a Gypsy, Roma, or Traveller Community and may wish to share your thoughts, experiences or views of pregnancy and feelings during this time and for around 2 years after it.

This completes part 1.

If the information in Part 1 has interested you and you are considering taking part, please read the additional information in Part 2 before making any decision.

Part 2

Can I get advice to help me decide if I should participate?
Taking part is voluntary, this means that it is your decision. It might be helpful to speak to the research team such as Athena or Rosie, or to friends and family if you would like advice about whether or not to take part. Taking part in research would allow you to share your thoughts on this topic.

Do I have to take part and what will happen if I don't want to carry on with the study?
Taking part in this study is your choice. If you agree to take part, I will then ask you to agree on a consent form, this shows that you have agreed to take part. You are free to change your mind at any time, without giving a reason. This would not affect the standard of any care you receive from services. After you have done your interview, if you change your mind about us using your interview in our study, you can ask us to delete your tape, up to one week after the interview happened. After that we will have already analysed the data so we will not be able to remove the things that you have said. The transcript will always be anonymous.

What happens next if I decide to take part?
The research project plans to run until March 2024. We hope to speak to you to understand your thoughts during this time. This would be by talking to you one to one, or within a group of people that you know, called a focus group. It is your choice if you would like to speak to the researcher within a group or speak to them on your own. The interviews will last around 1 hour. During the focus group or interview the researcher will bring up some areas that you can discuss, you are free to say your thoughts on the questions. During the interview or focus group you would only be expected to speak in a general sense about your experiences, this means we would **not** be asking you to identify certain people. An example of a question that might be asked is 'What's your understanding of what might change the way pregnant women, think and feel during pregnancy and the year or two after?'

The research project will involve the focus groups being audio recorded. This means that what you say will be recorded. This will be **completely confidential**. This will then be transcribed, this means what you say will be listened to by the researcher and written down. All the names will be removed from what was said. You are welcome to read the transcript once I have transcribed it and to remove parts that you may feel uncomfortable with being shared. If you would like this option, please let me know after the interview how you would like me to provide this to you. You will have three weeks once you have received the transcript to make changes. The transcription will be kept within a secure online university system called OneDrive and will be deleted at the end of the project. The only people who will have access to the recordings and transcripts is Rosie, Athena and Trish who supervise the project.

Expenses and payments

For taking part we would like to give you a £10 shopping voucher to say thank you. To be given the voucher I would need to provide a name and email address to the universities finance department. We'll also pay for your fuel or transport to and from the place where you will be interviewed.

What will I be asked to do?
To take part in this study you will have two choices. You can either be interviewed on your own, or if there were two or more of you that would like to be interviewed in together from your community then I would be happy to set up a group interview (called a focus group). There will be a choice of interviews happening as a video interview, but my preference would be for the interviews to be in person if possible. If you would like to you are welcome to continue taking part in the project, for example, with thinking about the findings from the group and how to help us meet with other people from the community. If you would like to take part but would like an interpreter this can be arranged. You are also welcome to bring someone along with you as support please just let the Rosie or Athena know first.

What are the possible disadvantages and risks of taking part?
The questions will ask about pregnancy and feelings during this time and for around 2 years after birth and there is a chance this may feel upsetting for some people. Our researchers can talk to you about any worries that you might have about the topic before the interview and you only need to share what you feel comfortable with. Our researchers can also provide a ten-minute check ins to see how you are feeling after the interview and talk with you about how best to get support if you needed it. It may be helpful to arrange to speak to someone you trust after the interview.

What are the possible benefits of taking part?
We cannot promise the study will help you personally, but the information we get from this study may help improve how outside services offer support for pregnant or mothers within the Gypsy, Roma or Traveller Communities when they feel distressed.

What if there is a problem?
Any complaint about the way you have been dealt with during the study or any possible harm you might suffer will be addressed. If there are any problems, issues or concerns you are welcome to discuss with the researcher Rosie Booth, Dr Athena Duffy or Dr Trish Joscelyne.

Concerns and Complaints
If you have a concern about any aspect of this study, you should ask to speak to me and I will do my best to address your concerns. You can contact me directly by leaving a message or voice note or WhatsApp on the mobile phone number 07549441428. Only the researchers involved in the project will have access to this number. Please leave a name and contact number so that I can get back to you as quickly as possible. If you remain dissatisfied and wish to complain formally, you can do this by contacting Dr Fergal Jones, Clinical Psychology Programme Research Director, Salomons Institute for Applied Psychology –fergal.jones@canterbury.ac.uk._ You can also contact via post, the postal address is Lucy Fildes Building, 1 Meadow Rd, Tunbridge Wells TN1 2YG.

Will all information I give in the study be kept confidential?
Rosie or Athena will spend time discussing this with you now [please see confidentiality discussion sheet]. You will be provided with a copy of the confidentiality discussion sheet.

What will happen to the results of the research study?
The findings of the study will be shared back with you and we will seek your thoughts on them. The findings will also be written up into a paper that will form part of Rosie Booth's qualification for a professional doctorate in Clinical Psychology. The researchers also hope

to submit the paper for publication to a journal. Some anonymised quotes from the conversations may be used in the paper to highlight the findings being reported.

In addition, the results may be used to inform policies and improve practice in the NHS for the whole community. There will not be any identifiable information in any policy reports. The data may be used in subsequent studies, this would all be anonymised.

Who is sponsoring and funding the research?
Canterbury Christ Church University.

Who has reviewed the study?
All research in the NHS is looked at by an independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and approved given favourable opinion by The Salomons Ethics Panel, Salomons Institute for Applied Psychology, Canterbury Christ Church University. Ethics number: ETH2223-0058
The information that goes to the ethics committee is about the project in general and happens before any interviews.

Appendix F – Consent Form

Salomons Institute for Applied Psychology
One Meadow Road, Tunbridge Wells, Kent TN1 2YG

Ethics approval number: ETH2223-0058
Version number: 2
Participant Identification number for this study:

CONSENT FORM

Title of Project: Understanding Views and Experiences of Mood issues during Pregnancy
Name of Researcher: Rosie Booth

Please tick box with initials and year of birth

1. I confirm that I have read and understood the information sheet dated.................... (version............) for the above study. I have had the time to think about the information, ask questions and have had these answered satisfactorily. ☐

2. I understand that taking part is my choice and that I can change my mind at any time without giving any reason and without my medical care or legal rights being affected. ☐

3. I understand that information collected during the study may be looked at by the supervisors Dr Trish Joscelyne and Dr Athena Duffy. I agree that they can see this information. ☐

4. Any information I give will be anonymised. I agree that this information could be used in published and unpublished reports of the study findings. ☐

6. I agree to take part in the above study. ☐

Participant identifier______________________
Name of Person taking consent _______________ Date______________

Signature of person taking consent ____________________

Appendix G – Interview Schedule

Exploring views and experiences of perinatal mental health within Gypsy, Roma and Traveller Communities.

Thank you for agreeing to be interviewed as part of this project. We are hoping to find out more about different communities' experiences during and after childbirth and really value that you have taken the time to speak to me today.

I will be asking you a few questions but mainly hope to open up a conversation so please do let me know if any questions I ask don't seem relevant, or let me know if there is something you would rather not answer. There are definitely no right or wrong answers as I am most interested in your own personal experiences.

Also as we have mentioned in the information sheet I will provide a check in at the end of the interview to see how you're feeling about anything you have mentioned today and sometimes it can be helpful to have someone you trust to speak to if there is anything that comes up and you would like extra support with. As I said I can check in with this at the end.

Firstly I want to make sure that I get things right. Please could you let me know what name I should use when talking about your particular community? [name preferred by participant] Thank you. I will be using that name from now on in our questions if that is OK with you.

In the NHS we often talk about something we call perinatal mental health. This is when a new or pregnant mother becomes unwell, not just physically but also with their feelings. Sometimes that can mean she feels sad or tearful or lacks motivation to do things. Sometimes she becomes different from how she had been, and even starts imagining things she wouldn't have before. Does this make sense? If you do recognise this, do you have a name in your community for when this happens, or how is it referred to. Are you OK if we use that name in our conversation from now on?

Lastly, do you have a name that you commonly use for people like me who are not members of your community? Is it OK if we use that name from now on? Generally when I talk about non-community members I will be referring to people who work in health such as midwives or GPs.

Then start with an open question:

Understanding of PND

Do you have any direct experience of anyone who has gone through [insert word preferred by participant] – either your own experience or **someone you know well**? Can you tell me a bit more about that.

What is your understanding of why those feelings or changes happen during pregnancy or after?

What kinds of things do you think might change or influence a woman's feelings during pregnancy or after the baby is born?
 Prompt: Either something that allows her to feel better, or something that means she feels worse?

Support from community

Who would you or **women** from your family or community normally go to for support?
What kind of support would they **ask** for or **get** do you think?
Is this common?

Would a woman or her family and friends ever ask for or get support from people outside the community? Who would people tend to go to first? Who would tend to be most trusted to give support?

Support from outside the community

What would make getting support from outside services easier or more likely?

What makes it harder or less likely do you think?

What in your opinion do women and men in the community think about support from [insert word preferred by participant]?

Is there anything that support services for women could do to be more helpful to women at this time in their lives? What shouldn't they do?

Appendix H – Signposting Sheet

Support

It can be helpful to have someone you trust to speak to after the interview in case anything came up for you so do reach out to a friend or family member if that works for you. If you would prefer to look at information or speak to someone who you don't know, here are a list of organisations who might be able to offer support:

Support from community organisations

- Friends, Families and Travellers – information page on bad nerves and mental health and where you can get support https://www.gypsy-traveller.org/advice-section/bad-nerves-mental-health/ They also provide advocacy casework, advice and information to Gypsies and Travellers on their national helpline. Phone: 01273 234 777. The helpline is open Monday to Friday from 10am to 4.30pm, with the exception of bank holidays.
- The Traveller Movement – information and support https://travellermovement.org.uk/information-and-support
- Moving for Change – support information and contact numbers for various support networks https://www.movingforchange.org.uk/our-resources/gypsy-and-traveller-suicide-and-mental-health-resources/

Out of community support

- GP – your GP can provide support and offer suggestions with any difficulties, this is not just physical health but also to do with your feelings
- NHS website with information of feelings generally and where you can access support https://www.nhs.uk/mental-health/. Phone: 111 for if you feel you need immediate support
- MIND website provides more information about feelings https://www.mind.org.uk Phone: 0300 123 3393 | Text: 86463
- Samaritans phone number provide a listening service free to call 24 hours a day, 7 days a week. Phone: 116 123

Pregnancy

- NHS website with information of feelings during pregnancy - https://www.nhs.uk/pregnancy/keeping-well/mental-health/
- Tommys – charity website that offers advice during pregnancy https://www.tommys.org/pregnancy-information/im-pregnant/mental-wellbeing/getting-help-and-support-mental-health

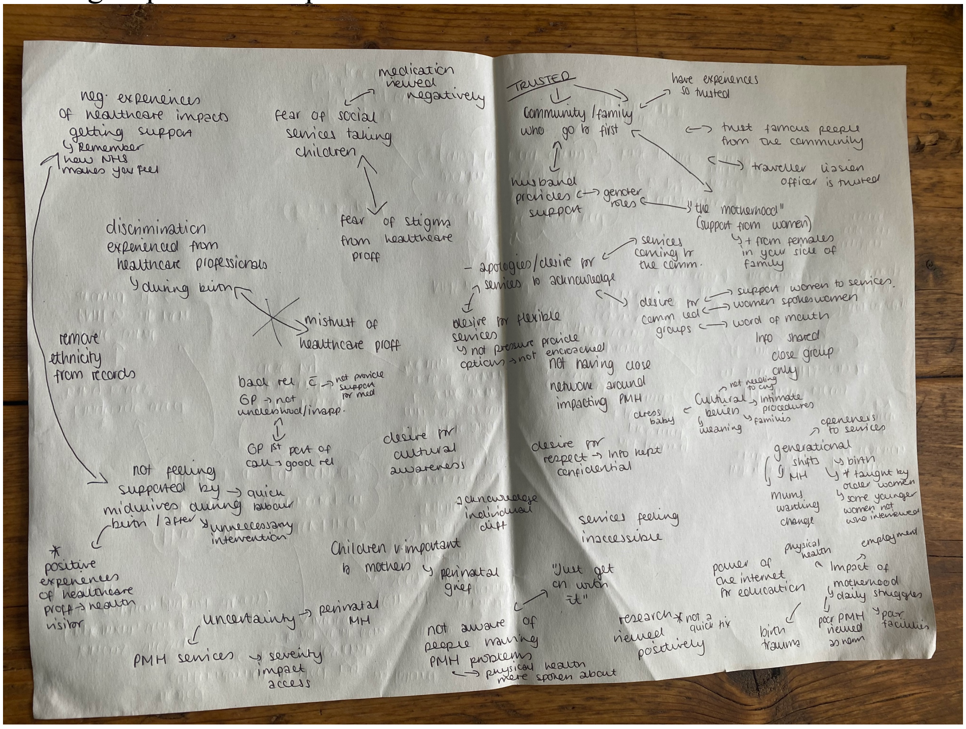
Kent Services

- Perinatal Mental Health Community Service (PMHCS). The team supports women who have found things difficult in pregnancy and afterwards. To speak to them team call 01622 722321 (open Monday to Friday 9am-5pm).
- Thrive - Psychological Support for Birth Trauma and Loss. To speak to the team call 01227 768928
- Live Well Kent and Medway provides free mental health support. They can help you in lots of different ways. Please call on 0800 567 7699 and someone will talk you through how we can help you and give the support and advice you need. Website is: https://livewellkent.org.uk/

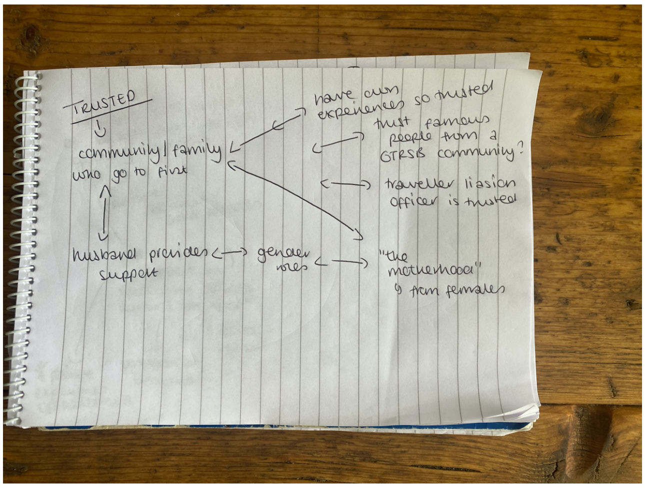
- Kent and Medway Urgent Mental Health Helpline. If you are worried about how you are feeling or how someone else if feeling and need urgent help, 24 hours a day, 7 days a week call 0800 783 9111
- Womens Health Counselling Service – if you were treated at East Kent Hospital you may be able to get support from this service. Email : ekhuft.womenshealthcounsellors@nhs.net for more information.
- Making Miracles – is a birth trauma and baby bereavement care charity. It provides counselling for yourself or also with your partner, has support groups and lots more Email: kelly@makingmiracles.org.uk Phone: 01622 735230

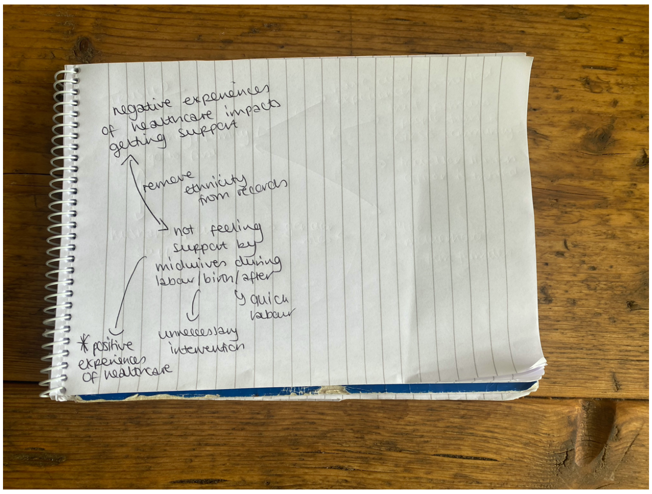
Appendix H Theme Development

Initial group codes and potential links

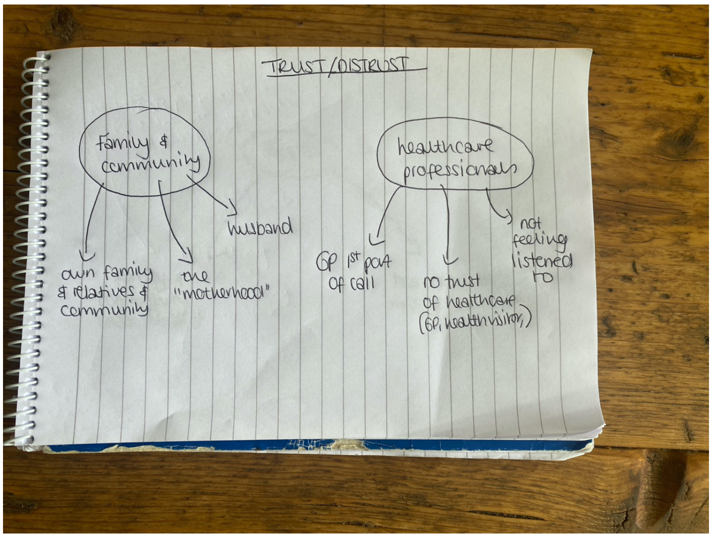


This example focuses on codes that clustered around trust and distrust

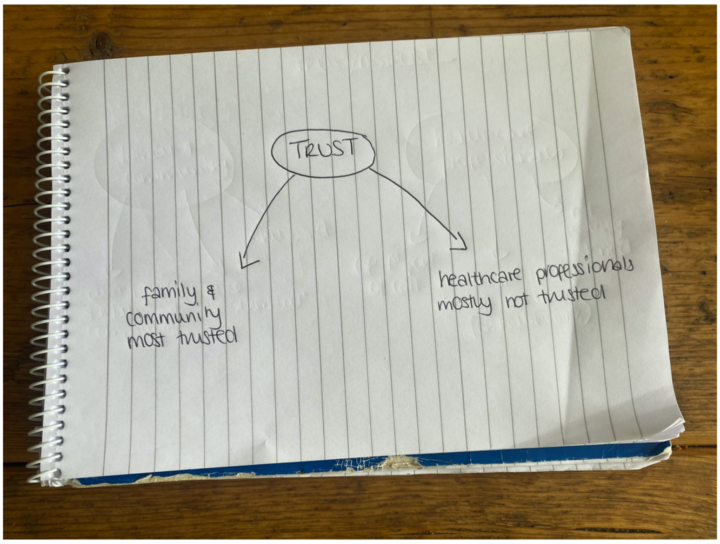




Initial theme development – at this point two themes trust and distrust, along with subthemes.



Discussions in supervision we explored how trust and distrust may not be separate central organising concepts and the two themes may be better understood as one, therefore, they were collapsed into a theme of trust.



Appendix J - Abridged Research Diary

13th January 2023 – ethical approval

Great news received ethical approval! I am signing up to attend networking events to hear more about research within the area. Am aware that external supervisor is pregnant and will be going on maternity leave so am very grateful she is going to have chance to meet with consultants so they can provide feedback on the materials for the project. This feels really important as I am mindful I want the project to be as accessible as possible.

30th March 2023 – data collection

First interview completed, went well, the person was chatty and engaged. I noticed I felt nervous beforehand and wondered how the participant may feel talking to someone who works for the NHS when they bought up experiences they had with NHS professionals in the past. I am aware of the importance of me building a good rapport during the interviews. I want to hold onto these thoughts when I come to the analysis.

13th April 2023 – recruitment

Recruitment has been slow, in supervision we have discussed a contingency plan of speaking to professionals. I am keen to keep trying with recruitment before using the contingency as it would be great to hear from people's personal experiences. I have networked with a few men from different GTRSB communities – I am wondering if due to the project being around pregnancy this may be more difficult to bring up with women. I am due to speak to a female GTRSB community member about the project which I think will be helpful.

1st June 2023 - recruitment

Am exploring with GTRSB organisations if the project can be shared on their social media. I was aware that recruitment might be challenging and lengthy so am considering how best to reach as many people as possible.

2nd October 2023 – data collection

Another interview completed, this was with a male participant, it was really interesting to hear his perspective as I have only spoke to females so far. I noticed similarities with previous interviews around clear gender roles and who women go to if they were having problems with their mental health. It was useful to get this perspective and find that it corroborated with other participant's perspective. I'm aware this may not always be the case and need to remain open to this.

3rd February 2024 – bracketing interview

Ahead of analysis I completed a bracketing interview. I considered my position as a women from a non-traveller community, and how my life experiences could be different from the participants. I also considered my position as working in mental health services within the NHS. I notice a feeling of pressure of wanting to be able to accurately convey the participants experiences. I am grateful for having the consultants and supervision meetings to check out things with.

16th February 2024 – thoughts on transcription

Meeting with supervisor, discussed how I have found the transcription and coding process. Found it challenging to re-read the transcripts, we discussed how being a trainee clinical psychologist you have both your research and clinical hat on interchangeably and how this has been a challenge when interviewing. I found myself wanting to do more of a clinical role but recognise this is a research role and my role is to explore a topic and signpost if necessary.

25th February 2024 – coding

Coding is now completed, with over 700 codes it feels quite overwhelming. The coding of the data has highlighted to me my privileges within society, I cannot imagine feeling discriminated against when I access healthcare. This has made me consider how I might feel unable to trust healthcare professionals, it might be unsafe and scary.

29th February 2024 – development of themes

Meeting with supervisor was helpful, we explored how my first iteration of themes is descriptive, and how it is important for me to go beyond this. This conversation has been really helpful. I think I may have been wanting to stay so close to the participants' experiences and views that this is why it ended up being so descriptive. Through the meeting it was really helpful to think more broadly about the concepts behind the description.

I am also noticing that my themes link to much of what the papers from my literature review found. This is intriguing and potentially shows that Gypsy, Roma, and Traveller communities are coming up against similar issues in different services – at first I felt it was useful that the result corroborate, however I then felt frustrated and it made me wonder what will it take for change to happen so services are more accessible? I noticed a sense of frustration that I am part of services. This has highlighted to me going forward in my career I will be asking questions about who is represented within services and who is not and what changes need to happen to improve accessibility.

9th April 2024

I am grateful to have some study leave to complete the write up of this project. It has allowed me some time to be amongst the findings without placement distraction. I have a sense of wanting to do justice to the write up, that feels important. I attribute that to my values of wanting voices to be heard. I keep going back to thoughts from the bracketing interview.

Appendix J Extracts from bracketing interview

A bracketing interview was conducted in order to explore what biases the lead researcher might hold from their own experience growing up and as an adult about perinatal and about GTRSB community.

Points of reflection during the bracketing interview:

- Considered Social GRACES, my position as a female who does not have children and is not from a GTRSB community. A worry I have is if I will be able to understand participant's experiences. Important to hold onto my experiences but acknowledge that I can have the capacity to understand someone's perspective as my clinical experience and clinical training has taught me. Perinatal mental health has always interested me to work in post-qualifying due to the interaction of women's health and supporting both mum and baby – this feels like this area you can have double the impact as you support mum's mental health and in turn baby's early years.
- My interests of doing the project revolved around how I feel it's important to hear the voices of people who are not often heard. This goes back to my undergraduate dissertation where I explored homelessness and the relation to mental health. It is an important value for me that people are heard.
- I reflected on how little experience I have with GTRSB communities, I was aware of a halting site in the town that I grew up and as a child thought it was odd that it was placed right by the motorway as no one else lived near there. This project has highlighted to me that this is a common occurrence.
- Clinically my first experience of supporting someone from a GTRSB community was in first year, this experience highlighted to me how it might be difficult to find language to describe difficulties with mental health. I need to hold this in mind in terms language used may not replicate my language but also be mindful that this is one person's experience and I cannot expect this to be the same for people I interview.
- I have noticed within the media for example how GTRSB communities can still be spoken about in a derogatory way quite openly. I think I am intrigued by this as to me it does not feel acceptable.
- A reflection at the end of the bracketing interview was how I was very aware I was being recorded, I then considered how this might feel for participants who are speaking to someone they do not know well and sharing their personal experiences.

Appendix K – Email Sent to Participants Regarding Results

Dear [insert name],

Thank you again for taking part in the pregnancy project. I am emailing as you expressed an interest in seeing the initial results.

As an update of the project, I have now spent some time gathering together everyone's experiences and thoughts. I have used something called thematic analysis to do this. Thematic analysis means I have looked at all the interviews to see if there are patterns in what was being said. The interviews were full of meaningful thoughts and experiences and I have tried to include as much of your ideas as I can. When developing the themes I focused on wellbeing in mothers, what support was needed for mothers, and if or how services could be more helpful to women from Gypsy, Traveller and Roma communities.

I have also attached a thematic map, this shows all the themes in circles and some of the general ideas that made sense of the themes for me. This is very much my interpretation of what you and others told me, so I would be really interested to hear what you think of my thoughts. I have also attached the information sheets on the project as a reminder, this is just for your records so no need to do anything with this.

You might recognise what is being said in a theme from your own experiences that you shared. You might also not recognise it and that might be because the theme was made up from other people's experiences.

I would like to encourage you to look at the map and let me know if you think I have grouped the ideas together in a way that makes sense to your thoughts and experiences. If you would like me to talk through the themes in more detail, please email me to let me know and we can arrange a time.

There is no pressure or expectation to provide your thoughts. If you would like to let me know of your thoughts on my ideas, please can you do so by 29th of March 2024.

I am happy to answer any questions.

Best wishes,
Rosie

Appendix M Author Guidelines for British Journal of Midwifery

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Appendix N – Feedback Report for Participants and Ethics

Name of the project: Understanding views and experiences about feelings during pregnancy and the first 2 years after birth.

Background information: Gypsy, Traveller, Roma, Showmen and Boater (GTRSB) communities are individual ethnic and cultural groups who unfortunately all experience poor physical and mental health and can find it difficult to access health services. In terms of mental health, GTRSB communities experience higher levels of anxiety and depression than non-GTRSB communities. This might also be described as feeling down or having bad nerves. For GTRSB women's mental health there is even less research. There are no known studies that explore views and experiences of feelings during pregnancy and for the first 2 years after birth.

What the project hoped to answer: The project asked people who identified as GTRSB for their views and experiences of feelings during pregnancy and for the first 2 years after birth. The research questions were:

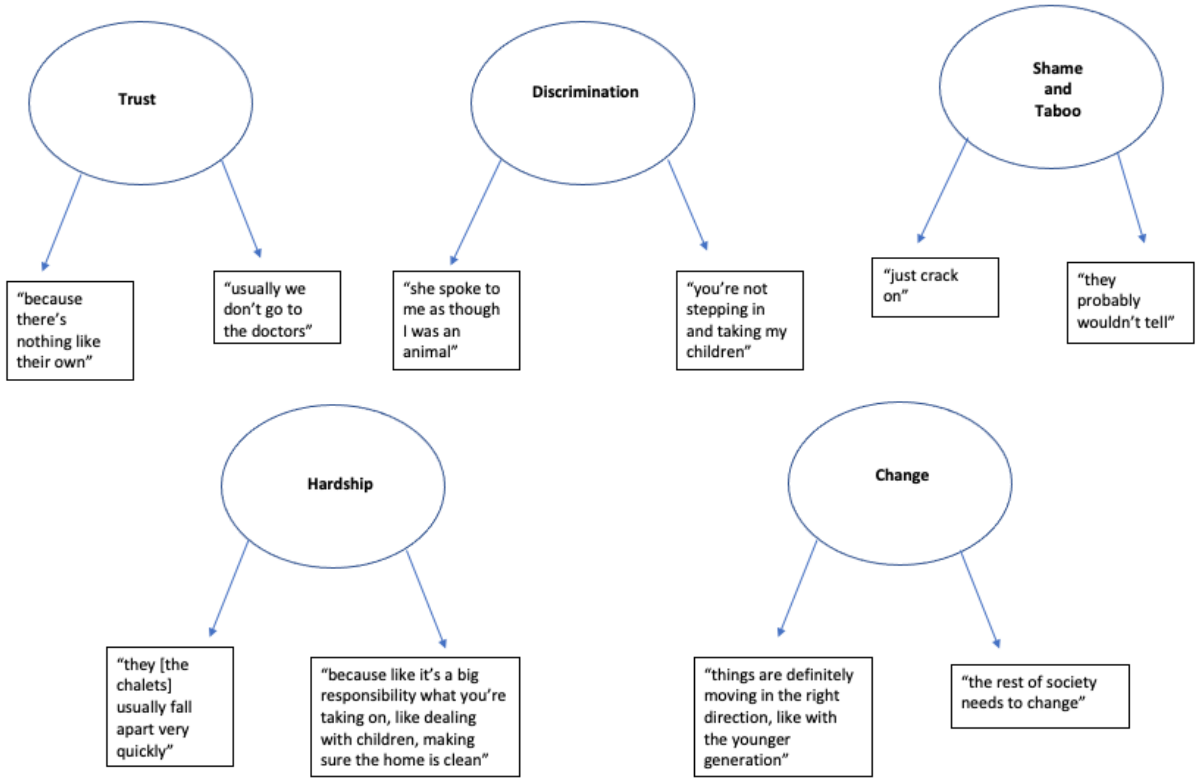
1. How do you talk about and understand what might impact a women during pregnancy and for the first 2 years after birth?
2. What support do women need during this period? (inside and outside the community)
3. How could mental health services be helpful to women during this time (if at all)?

How the project happened: People from a GTRSB community provided their thoughts on the project before it was advertised to make sure that the project was worded right. The project was advertised on social media and the researcher met with different people to speak about the project to see if they could share it with others. People who identified as GTRSB were asked if they would be interested in taking part in the project and were provided with an information sheet and consent form and they were welcome to ask any questions about these. In total 10 people were interviewed about their views and experiences either face to face or by videocall. The interviews were written up and people who took part were welcome to check this over. The written up interviews were then looked at all together to see if there were patterns in what was being said, through a process called thematic analysis.

What the project found: In total there were five patterns or 'themes' that came across from all the interviews. These were:
Trust – during pregnancy and for 2 years afterwards women mostly trusted their family and community (particularly other women and their husband) and mostly did not trust health and social care services.
Discrimination – people who were interviewed spoke of times they felt discriminated against from wider society (like pubs), and health and social care staff (like who work for the NHS). Feeling discriminated against could mean that people felt worried about social services because they had heard about bad experiences with social services from others which they felt was due to their GTRSB identity.
Taboo and Shame – people who were interviewed felt that 'baby blues' or 'postnatal depression' was not spoken about widely within their communities. Women would 'get on with it' as a way of managing how they felt.
Hardship – people who were interviewed described the many demands on GTRSB women as they are responsible for raising a family and daily household activities. On top of this there was stressors around finances and employment for the family and poor living conditions which made life difficult, especially when pregnant or shortly after having a baby.

Change – people who were interviewed felt that younger people have more of an awareness of ‘baby blues’ or ‘postnatal depression’ and speak about it more openly. This might be because they use the internet and social media or stay in education for longer. People who were interviewed would also like services to understand their way of life better and work with communities to make services more accessible.

The themes have been separated, however can interlink to impact someone’s feelings during pregnancy and for 2 years afterwards.



Conclusion:
Overall the project showed that women who are pregnant and for 2 years afterwards experience lots of difficulties which can make it hard to speak about ‘baby blues’ or ‘postnatal depression’. They are supported by other women and their husbands. Unfortunately, women during this time find it hard to trust services and can feel discriminated against or that services are unsuitable for them. It is positive to hear that ‘baby blues’ and ‘postnatal depression’ is being spoken about more and people who were interviewed gave lots of good examples of how services can change to support GTRSB women better.

Appendix O – Coded Transcript

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