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TRAVELLER EXPERIENCES OF ACCESSING SERVICES

Section A: Gypsy, Roma, and Traveller Healthcare Service Access

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Acknowledgements

First, I would like to express my heartfelt thanks to everyone who participated in this study, especially the men in prison who placed their trust in me and shared their stories. I only hope I have done their experiences justice. Next, I am deeply grateful to my supervisors, Rachel and Taanvi, for their invaluable insights and steady support in overcoming numerous challenges. Lastly, I want to thank my partner and friends for their unwavering support and for patiently listening to me discuss my research—often more than they probably wanted to hear.

Summary of Major Research Project

Section A: A systematic literature search and meta-ethnographic synthesis of research focused on individual Traveller experiences of accessing services was undertaken. This review focused on eleven qualitative studies based in an array of health services. Five third-order constructs were developed, consisting of 22 second order constructs which were identified from the research. The findings from this review provide supporting evidence for the impact of discrimination in healthcare, appropriate communication means, developing trusting relationships with professionals, consideration of cultural identity and structural barriers and facilitators to services. The implications are discussed with a focus on the structuring of services and use of outreach.

Section B: This narrative analysis study aimed to understand male Irish Traveller and clinician narratives of help-seeking for psychological distress and psychological intervention in prison, while also exploring cultural narratives and their influence on identity development. Eight interviews were conducted, four with service user participants, and four with clinician participants. Findings highlighted the personal stories of Irish Travellers who have accessed psychological intervention in prison, which were contributed to by cultural and community narratives. Of particular note were navigating power dynamics through identity, experiences of discrimination and stereotyping, trust and relationships, prison as a context for mental health and psychology, and beliefs about health and services. Implications are discussed for developing cultural competence in professionals, development of therapeutic relationships and areas for future research.

Contents

Section A

List of Tables

Section A

Section B

List of Figures

Section A

Section B

List of Appendices

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Abstract

Background: Research has long focused on the barriers minoritised individuals face when accessing services, however little of this research has focused on the specific barriers faced by Gypsies, Romas and Travellers. The aim of this review was to explore the barriers and facilitators Gypsies, Roma and Travellers face when accessing healthcare services.

Method: A systematic literature search and meta-ethnographic synthesis of qualitative research focused on Traveller experiences of accessing services was undertaken. This review focused on eleven studies based in an array of health services.

Results: Five third order constructs were developed, consisting of 22 second constructs which were identified from the research. The findings from this review provide supporting evidence for the impact of discrimination in healthcare, appropriate communication means, developing trusting relationships with professionals, consideration of cultural identity and structural barriers and facilitators to services.

Limitations: The breadth of healthcare settings across papers may have contributed to a lack of depth for constructs. Participants in the papers selected were predominantly female, meaning there may have been gender bias in beliefs.

Implications: Structuring of services and wider use of outreach should be considered by services to remove barriers.

Keywords: Healthcare access, barriers to health services, Travellers, Traveller experience

Introduction

The label Gypsies, Roma, and Travellers (GRT) encompasses an array of travelling ethnicities including Welsh Gypsies, Scottish Gypsies, Scottish Travellers, Irish Travellers, Roma, Showmen and New Age Travellers (Race Disparity Unit, 2022). All are distinct, recognised ethnicities with characteristics which are protected under the Equality Act 2010, with a foundation of nomadism (Cromarty, 2019). The term Gypsy has been considered pejorative in Europe and thus can be problematic in wider contexts (Bancroft, 2005), however within the United Kingdom (UK) the word Gypsy connotes a specific ethnicity and a distinct traveller culture.

The clustering of Traveller cultures may undermine the distinctiveness of individual cultures and contribute to a sense of social exclusion (Myers, 2019). However, they are often grouped for research due to some shared health inequalities and difficulties in accessing services (Greenfields, 2017). In addition, there is a dearth of literature focused on individual Traveller communities and so for the purpose of this review, they have continued to be grouped together. Throughout this review, the term Traveller has been employed to encompass broad and diverse Gypsy, Traveller, and Roma communities. This is used in reference to those who are either settled or nomadic.

The use of ethnic classifications can result in the attribution of physical or mental “illnesses” to genetic and/or cultural problems (Culley, 2006). Consequently, it can dismiss the influence of systemic power and the impact of this on health inequalities across individuals. Health inequalities encompass a range of disparities including, health status, life expectancy, and access to and experience of health services (The Kings Fund, 2022).

Research has identified significant health inequalities affecting Traveller communities. It is reported Travellers have the poorest health outcomes of any ethnicity or social group, with a life expectancy 10 to 25 years shorter than that of the non-traveller population (Parry et al., 2007). Travellers have poorer health than that of the non-traveller population, even when controlling for other variables such as socioeconomic resources (Matthews, 2008). Research has identified Travellers have significantly lower healthy life expectancy and disability-free life expectancy (Abdalla et al., 2013). Travellers are more likely to live with a long-term health condition (Gill et al., 2013) and more likely to experience the loss of a child (Cambridgeshire Travellers, 2010).

The health inequalities experienced impact mental health as well as physical. Suicide prevalence in Traveller communities is up to seven times that of the non-traveller population (All Ireland Traveller Health Study [AITHS], 2010). Despite this, there is a lack of attention to the mental health needs of Travellers, which is demonstrated by only 2.5% of English local authorities including Travelling communities in their suicide prevention strategies (Sweeney & Billie, 2020). It is of note reporting for Traveller communities can be inconsistent, leading to a potential underestimation of the prevalence of health conditions. Many researchers have experienced barriers to engaging Travelling communities in research (Condon et al., 2019) further reducing the lack of available data to accurately assess health outcomes.

Research has identified adverse life events and social exclusion can negatively impact health (Payne, 2006; Straatmann et al., 2020), with studies finding Travellers experience greater adverse life events (Tobin et al., 2018; Yin-Har Lau, 2011). Travellers frequently experience discrimination, higher rates of poor mental health, mistrust of outsiders and withdrawal into their communities (Greenfields & Rogers, 2020).

Theoretical Framework

Anderson and Newman's (1973) model of health service utilisation provides a foundation for this review. The model integrates individual and societal factors with the health service system, and how they may contribute to the use of health services. The model consists of three main components: 1) predisposing factors, 2) enabling factors and 3) need factors.

The predisposing factors encompass the characteristics which exist prior to illness, including demographic factors, social structures/experiences and health beliefs. Enabling factors are those resources which may facilitate or impede the access of healthcare services. This includes financial resources, service availability and logistical factors. The need factors relate to an individual's health needs, involving perception of health and professional assessment of illness.

Past research has identified that minoritised individuals face a multitude of barriers when accessing healthcare services. The Anderson and Newman model has been developed further by Scheppers et al. (2006) to organise potential barriers. The barriers to health services were found to exist on three levels: personal, provider and service. Barriers include cultural or linguistic barriers (Barr & Wanat, 2005), a lack of culturally sensitive services (Lu et al., 2021) and attitudes of healthcare professionals (Drewniak et al., 2017). When considering the Travelling communities, the personal barriers may be individual characteristics which might include cultural beliefs, ethnicity, or gender. The provider level barriers include those who work within services, their attitudes to Travellers, and their ways of communicating. The service level barriers may be the way in which services are set up that limit or restrict access for certain groups.

Aims of the Review

Past systematic reviews have reported on Traveller access and engagement with health services (McFadden et al., 2018); however, they have not focused solely on the experiences of Travellers and have included perspectives of healthcare professionals working with this population. Due to the reports of Travellers experiencing discrimination when accessing healthcare services (Quirke et al., 2022) the inclusion of healthcare professional perspectives may include prejudicial views. Aspinall (2006) reviewed health beliefs, status, and service access for minority ethnic groups, however, the high levels of social exclusion faced by Travelling communities may mean there are barriers and experiences which are unique to them (Clarke & Cemlyn, 2005). For example, healthcare professionals may face greater challenges in developing a relationship with Travellers due to historical racism, maltreatment, and institutional prejudice (Cemlyn et al., 2009).

This review aimed to identify the barriers and facilitators to accessing health services for Travellers, based on current research.

With this aim in mind, the review synthesised qualitative research that discusses the experiences of individuals, with a sole focus on first-person accounts of service access. Due to the lack of literature, any study employing a qualitative approach to analysis was included. The review was aligned with two NHS values (Department of Health and Social Care, 2023). Firstly, “Everyone counts” by fostering a deeper comprehension of how adversity is experienced within the framework of social disadvantage. It also seeks to consider the factors which may hinder and/or improve patient experience for this population, meeting the “Commitment to Quality of Care” value.

Methodology

To address the aims, this review assessed qualitative research within peer-reviewed journal articles and dissertations. The review process comprised three main phases: initially, a systematic exploration of existing literature; secondly, critical appraisal using a structured tool; and lastly, synthesis, employing a meta-ethnographic approach inspired by Noblit and Hare's (1988) framework. Meta-ethnography is a systematic approach to synthesise data from qualitative studies in such a way that it may demonstrate consistent themes, or “constructs”, in addition to presenting new interpretations (Urrieta & Noblit, 2018). It allows for the inclusion of multiple qualitative study designs and involves a reciprocal and refutational translation, highlighting similarities and differences between results (Sattar et al., 2021).

Systematic Literature Search

The review inclusion and exclusion criteria are outlined in Table 1. The aim of the research was to focus on the experiences of Travellers in accessing health services, ensuring only studies that provided first person accounts were included. This means that direct experiences of Travellers are reported rather than that of professionals.

Table 1

Initial study inclusion and exclusion criteria

Inclusion criteria:
• Studies that specifically focused on the experiences of Travellers (as previously defined). • Studies that presented first person accounts • Studies that used a qualitative methodology • Studies in English language • Published in a peer-reviewed journal
Exclusion criteria:
• Studies where the focus was not on experiences of accessing services or where the focus was on health experiences more broadly. • Studies not describing first person accounts • Studies not reported in the English language.

Search Strategy

The literature search was conducted in July 2023 and comprised of searches of five databases: ASSIA, OVID, MEDLINE, PSYCinfo and CORE. Key terms were searched for in titles and abstracts. Search filters were added to limit to articles in the English language, and no date ranges were imposed. A search of references found in included studies was conducted to supplement database searches, in addition to a search using Google Scholar.

Table 2

Literature search terms

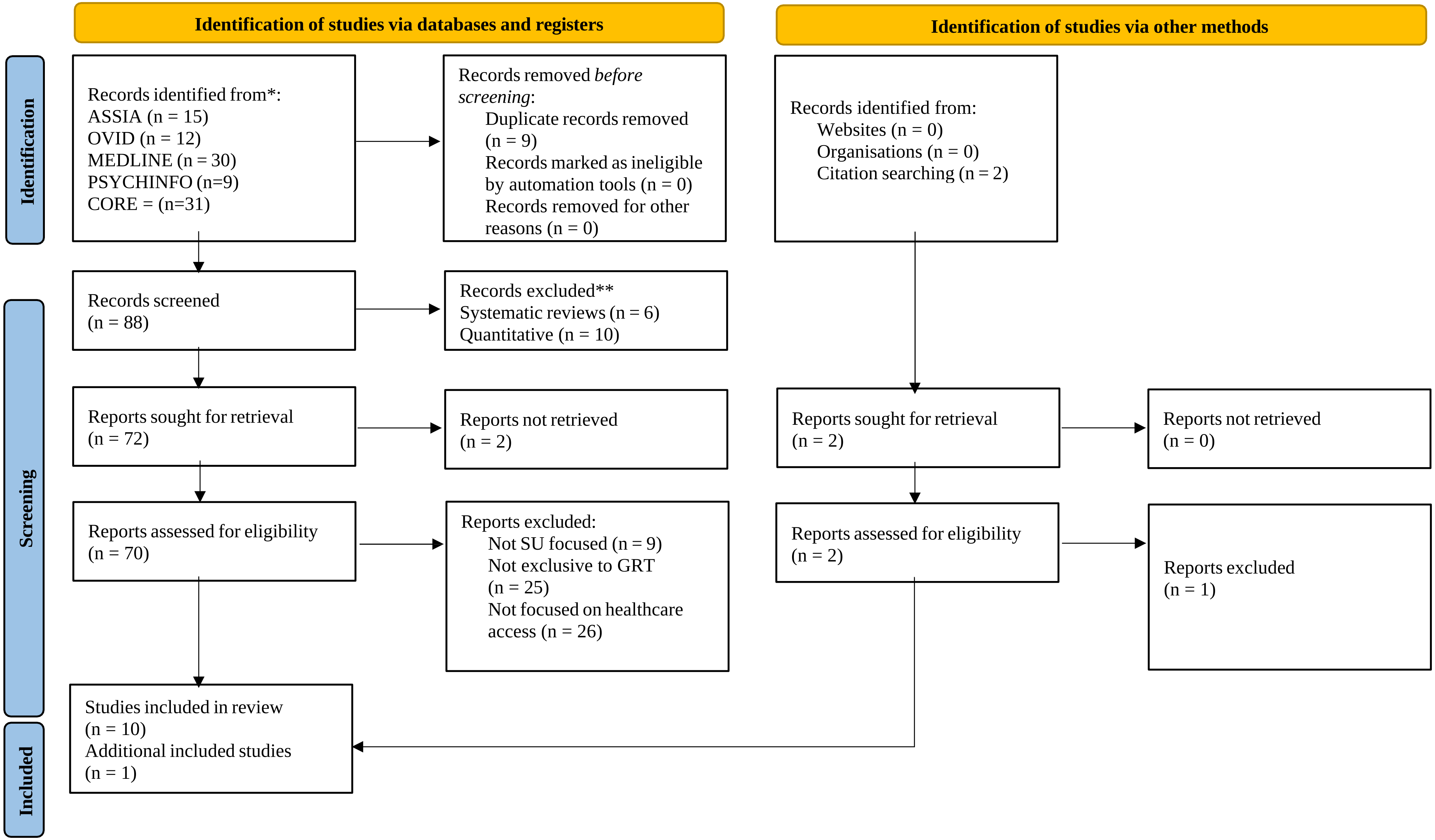
Search Terms Used (and combined with AND)	**Search of**
"access" or "barriers"	Title and abstract
"mental health" or "health services" or "mental health support"	Title and abstract
"irish traveller" or "travell* community" or "gyps*" or "traveller"	Title and abstract

*Signifies wildcard search

The literature search process is depicted in Figure 1. The literature search resulted in 97 records, of which nine were duplicates. The titles of the remaining 88 were screened against the exclusion criteria in Table 1. Following this, a further 16 were excluded. The remaining 70 records were assessed via their abstracts, with ten included in the final review. An additional citation search was conducted via the included articles. Two records were identified and reviewed against the exclusion criteria, with one included in the review.

Figure 1

Systematic literature search process (PRISMA flow diagram) (Page et al., 2021)



Critical Appraisal

To give context to the findings of the review, the studies included were quality assessed using the Critical Appraisal Skills Programme tool (CASP, 2018). The checklist assesses for quality in qualitative research focusing on ten areas including the aims of the research, appropriateness of study design, methodology, collection of data and analysis, and clarity of results. In addition, it includes an assessment of the research ethics and the contribution it makes to the field. For assessing quality in health-related research, the CASP qualitative checklist is the most commonly used method (Long et al., 2020). Due to the lack of research in this area, studies were not excluded based on quality following appraisal, however, the limitations of the studies were discussed and the impact this had on the results.

Synthesis

Noblitt and Hare’s (1988) seven meta-ethnography stages were used as the foundation for this review. These stages can be seen summarised in Table 3. When reported appropriately, this method is a rigorous and systematic approach for synthesizing qualitative research, which aims to generate new insights and a deeper understanding of a phenomenon (France et al., 2014). An inductive approach to synthesis was taken, with no priori constructs used in the analysis.

Table 3

Summary of the stages of analysis based on a seven-stage approach to meta-ethnography (Noblitt & Hare, 1988)

Phase	**Key tasks**
1. Assessment of suitability	The first stage involved identifying a research area of importance and searching databases to identify relevant papers.
2. Deciding what is relevant	Studies were identified and reviewed against the inclusion and exclusion criteria. Quality of each paper was assessed. All studies were included due to the limited research available.
3. Reading the studies	Familiarisation with the studies took place, including identifying key concepts, themes, and findings within each. The studies were read in order of publication date, starting with the most recently published (Thompson et al., 2022).
4. Determining how studies are related	Themes were extracted from the studies which then formed the second order constructs. Second order constructs consist of researcher interpretations of the data in each paper. Participant quotes were included where available, forming first order constructs as direct data. This involved identifying patterns, discrepancies, and overarching themes across studies.

Phase	Key tasks
5. Translating the studies	All constructs were mapped verbatim using Excel, listed in chronological order. Themes were compared between studies by comparison to the previous study, progressively until all studies had been translated.
6. Synthesising translations	The initial phase of synthesis comprised reciprocal synthesis, where common themes found in second-order constructs were identified and incorporated into overarching third-order constructs. In the second stage, the focus shifted to pinpointing conflicting second-order constructs across various studies. Subsequently, a line of argument synthesis was crafted to conceptualize third-order constructs, providing a fresh perspective. Second-order constructs were categorized under emerging third-order constructs, as illustrated in Appendix A – E.
7. Expressing the synthesis	Data was summarised and reported on, including the strengths and limitations of the review.

Data analysis involved identifying first, second and third order constructs. First order constructs encompass direct quotes from participants, and second order constructs are the researchers' interpretations of participant quotes. Third order constructs are derived from synthesising first and second order constructs across studies (Noblit & Hare, 1988). Development of third order constructs can be complicated by specificity of the context of the original studies, loss of nuance and conceptual conflicts across studies (Toye et al., 2014). To accommodate these complications, line-by-line coding was used to integrate second order constructs.

Reflexivity

Using Noblitt and Hare’s approach, researcher positioning is considered key to the results of the synthesis. Author reflexivity is essential to understand the lens through which the data is interpreted (Hammersley & Atkinson, 2019). The author has taken a social constructionist approach, which emphasises the role of context and culture in the formation of meaning and highlights a lack of objective knowledge.

This approach rejects the concept of "othering” and an emphasis on systemic factors influencing those who can access services and those who do not. However, this is in the context of being a healthcare professional who is outside of the travelling community, with inherent Eurocentric views. Researchers must be sensitive to the relational and dynamic nature of ethnicity and ensure self-reflexivity throughout the course of research (Mason, 2003). A research diary was kept throughout the course of the research to provide an opportunity for researcher reflexivity (see Appendix A for excerpt).

Results

Description of the Studies

Following the eligibility assessment, eleven studies were included, with publication dates ranging between 2006 and 2022. Seven studies were conducted in the UK, with three exclusively in the Republic of Ireland (ROI), and the final study conducted across the UK and ROI. The studies included in the review comprised 390 participants (309 women (79%), 80 men (20%), and one non-binary (1%)). Six studies did not include a breakdown of ethnicities. Four did not provide details regarding the participants' ages.

All studies were focused on the experiences of adults, with the ages of participants ranging between 16 and over 65 (no upper age was defined). Three studies focused specifically on access to mental health services. Two studies focused broadly on health care services, with two focused on immunisation services, and two on maternity services. Cancer and dermatology service access were the focus of one study each. Ten of the studies were from peer-reviewed journals, and one was a thesis from which the abstract had been published in a peer-reviewed journal. Due to the brevity of the published abstract, the unpublished thesis has been used in this review. All included studies and their characteristics can be seen in Table 4.

Assessment of Quality

All eleven studies were assessed using the CASP (CASP, 2018). The outcome of the quality assessment can be found in Table 5. The papers were rated on each domain; however, ratings were viewed in the context of the research as a whole.

All studies had clearly stated research aims, with the exception of Smith and Newton (2016). Though the paper discussed the context for the research, it failed to clearly state the aims of the study. A qualitative methodological approach was deemed appropriate in all studies due to the key focus on the exploration of individual experiences, with suitable research designs. The approach to recruitment was appropriate in all studies, giving due consideration to the hesitancy to participate in services/research by members of the community. To facilitate recruitment, six studies recruited participants via a member of the community, with three studies utilising a trusted link with the community. Methods of data collection were reported to be adequate, although Thompson et al. (2022) did not report how topic guides were developed and there was no mention of data saturation. All studies used either semi-structured interviews or focus groups. The rationale and limitations of these methods were discussed within each paper, although the amount of detail in which this happened was variable.

Table 4

Study characteristics of included studies

Study no.	Author(s)	Year	Location	Source	Sample size and demographic information	Health service	Research Aims	Data Collection	Method for Analysis
1	Thompson et al	2022	UK and ROI	Peer reviewed journal	9 (4 women, 4 men and 1 non- binary) Aged 20 to 56 Romany = 3 Irish Traveller = 3 Showman = 1 Scottish Traveller = 1 Irish/Romany = 1	Mental health	"The current study aims to examine factors that contribute to the MH crisis of people and the corresponding support needs of GRT people."	Interviews	Thematic analysis
2	Condon et al.	2021	England and Wales	Peer reviewed journal	41 (11 men and 30 women) Aged 16 to 50+	Cancer	"This topic required an in-depth, sensitive, and highly participatory approach, with community members were involved at all stages of the research process. This article focuses on cancer diagnosis, treatment and care, aspects of health care that are under-researched among these ethnic minorities."	Interviews/focus group	Framework analysis

Study no.	Author(s)	Year	Location	Source	Sample size and demographic information	Health service	Research Aims	Data Collection	Method for Analysis
3	Keogh et al.	2020	ROI	Peer reviewed journal	10 (6 women and 4 men) Ages not available	Mental Health	"The aim of this paper is to present the findings from the evaluation which explored Travellers access to the and reasons for accessing the [Traveller Mental Health Liaison Nurse] TMHLN, the interventions provided and their experiences of and perceptions of the role of the TMHLN."	Interviews	Thematic Analysis
4	Gilhooley et al.	2019	Leitrim, Mayo, Galway	Peer reviewed journal	30 women Aged 27 -65	Dermatology	"We aimed to investigate Travellers' experience of skin disease and their relationships with healthcare providers."	Focus groups	Thematic analysis
5	Jackson et al.	2017	Bristol, York, Glasgow, London	Peer reviewed journal	174 (139 women and 35 men) Ages not available. English Gypsy = 63 Irish Traveller = 36 Romanian Roma = 17 Slovakian Roma = 20 Scottish	Immunisation	"1. Investigate the views of Travellers in the UK on the barriers and facilitators to acceptability and uptake of immunisations and explore their ideas for improving immunisation uptake 2. Examine whether and how these responses vary	Interviews/small groups	Framework analysis

Study no.	Author(s)	Year	Location	Source	Sample size and demographic information	Health service	Research Aims	Data Collection	Method for Analysis
					Showpeople = 14		across and within communities, and for different vaccines (childhood and adult)."		
6	Smith and Newton	2016	South East England	Peer reviewed journal	16 women Ages not available Romany gypsy = 7 Irish Traveller = 4 Roma migrants = 3 New travellers = 2	Immunisation	"Why uptake is low, the extent to which the organisation and delivery of immunisation services impact on MMR uptake, or how wider social factors shape immunisation decisions."	Focus groups	Framework analysis
7	Condon et al.	2014	South west England	Peer reviewed journal	22 women Age not available Romanian Roma = 11 Irish Traveller = 6 English Gypsies = 5	Maternity services	"The aim of this study was to explore the views of Gypsy–Traveller mothers and grandmothers on infant feeding and health service provision."	Interviews	Framework analysis
8	Smith and Ruston	2013	South East	Peer reviewed	39 participants	General healthcare	"explores how networks mediate between	Interviews	Adapted grounded

Study no.	Author(s)	Year	Location	Source	Sample size and demographic information	Health service	Research Aims	Data Collection	Method for Analysis
			England	journal	from Traveller communities (20 women and 19 men) Aged between 18 and 66	services	collective experiences of discrimination and racism, and the health behaviour and health outcomes of minority groups by presenting the findings of a study that 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."		theory
9	Van Cleemput	2009	UK	Peer reviewed journal/thesis	27 (male = 7, female = 20). Aged 16 to 65+.	General Health Services	"The first phase of my research was applied policy research, contributing to theory by providing greater understanding of the associations between health status and Gypsies' and Travellers' beliefs,	Interviews/focus groups	Framework analysis

Study no.	Author(s)	Year	Location	Source	Sample size and demographic information	Health service	Research Aims	Data Collection	Method for Analysis
							attitudes and experiences of health care, as well as to understand perceived barriers to service access. The aim of the second phase was to understand communication processes between Gypsies and Travellers and primary health care staff, and to explore how perceived barriers to accessing health care might be overcome.”		
10	Treise and Sheperd	2006	East Anglia	Small scale service study	9 Roma Gypsy women Aged 20 to 50	Mental Health	“1. To explore Gypsy Travellers’ perceptions of mental health problems, their coping strategies, and expectations of mental health services 2. To inform the development of culturally relevant mental health service to meet their needs.”	Interviews	Framework analysis

Study no.	Author(s)	Year	Location	Source	Sample size and demographic information	Health service	Research Aims	Data Collection	Method for Analysis
11	Reid et al.	2006	ROI	Peer reviewed journal	13 women Aged 19 – 42	Maternity care	“The aim of this study was, therefore, to explore Traveller women’s experiences of maternity care in the Republic of Ireland.”	Interviews	Framework Analysis

Table 5

Assessment of study quality based on CASP Checklist

	Thompson et al. (2022)	Condon et al. (2021)	Keogh et al. (2020)	Gilhooley et al. (2019)	Jackson et al. (2017)	Smith & Newton (2016)	Smith & Ruston (2013)	Condon & Salmon (2014)	Van Cleemput (2009)	Reid & Taylor (2006)	Treise & Sheperd (2006)
Aims	Y	Y	Y	Y	Y	CT	Y	Y	Y	Y	Y
Methods	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Design	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Recruitment	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Data collection	CT	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Reflexivity	N	Y	Y	Y	N	N	N	Y	Y	Y	N
Ethical Issues	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	Y
Data analysis	Y	Y	CT	CT	Y	CT	CT	Y	Y	Y	CT
Findings	Y	Y	N	Y	Y	Y	Y	Y	Y	N	Y
Value	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	CT

Y=Yes, CT=Can’t tell, N=No

Researcher reflexivity was seemingly absent from four of the studies, with Smith and Newton (2016) partially discussing reflexivity, however, this was in the context of participant behaviour with no reflection on the influence of the researcher's positioning. Smith & Ruston (2013) made no mention of ethical considerations, however all other studies included discussed this. Six of the studies provided a thorough analysis of the data, while five studies offered a partial description of a rigorous analysis. Most studies analysed data using a variation of thematic analysis, with seven implementing a framework approach which is popular in research for policy related questions such as health service access. Findings were clearly stated in all studies but two, Treise and Sheperd (2006) and Keogh et al. (2020). Clearly stated findings included adequate quotes to support the results and the application of the results to the wider research area. Ten of the studies addressed the value of the research, however this was only partially stated by one.

Synthesising Findings

Findings were synthesised using a meta-ethnographic approach. Third and second order constructs can be seen in Table 6.

Table 6

Summary of third order and second order constructs

Third Order	Second Order
Experiences of Rejection	Discrimination Shame Isolation
Communication with Healthcare Professionals and Services	Communication differences Dissemination of information Being heard
Cultural Identity and Health Management	Fatalism Privacy Network Support Gender Roles Living Arrangements Religion
Trust of individuals, services, and society	Experiences of healthcare professionals Mistrust of services/outsiders Trusted healthcare professionals Communal narratives of experiences Community as a trusted source of information
Structural barriers and facilitators to services	Outreach Incompatibility of services Late attendance at services Lack of information Follow up

In total, 22 second order themes were conceptualised under five third order constructs. The third order constructs were experiences of rejection; communication with healthcare professionals and services; cultural identity and health management; trust of individuals, services, and society; and structural barriers and facilitators to services. Table 7 presents a synthesis of findings. In addition, it notes which studies contributed to each third order construct. For synthesis, Thompson et al. (2022) was identified as the index study for comparison. This was chosen due to the recency of the publication, but also due to the similarity in quality scores across the papers.

Table 7

Synthesis of constructs and underlying themes

	Thompson et al. (2022)	Condon et al. (2021)	Keogh et al. (2020)	Gilhooley et al. (2019)	Jackson et al. (2017)	Smith & Newton (2016)	Condon & Salmon (2014)	Smith & Ruston (2013)	Van Cleemput (2009)	Reid & Taylor (2006)	Treise & Sheperd (2006)	No. first & second order	No. second order only
Experiences of rejection													
Discrimination	X	X	*	X	X	X	X	X	X	X	X	10	1
Shame	X	X							X	X		4	
Isolation	X					X		X				3	
Communication													
Communication differences	X	X	*						X	X		4	1
Dissemination of Information				X	X	X	X	X	X	*		6	1
Being heard			*	X					X	X		3	1
Identity													
Fatalism		X							X			2	
Privacy	X		*						X		X	3	1
Network Support		X					X	X	X	*	*	4	2
Gender Roles		X				X			X	X		4	
Living Arrangements					X	X	*		X			3	1
Religion									X	X		2	
Trust													
Experiences of HCPs		X		X	X	X	X	X	X	X	X	9	
Mistrust of services/outsiders	X					X	X		X			4	
Trusted HCPs			*				X	X	X		*	3	2

	Thompson et al. (2022)	Condon et al. (2021)	Keogh et al. (2020)	Gilhooley et al. (2019)	Jackson et al. (2017)	Smith & Newton (2016)	Condon & Salmon (2014)	Smith & Ruston (2013)	Van Cleemput (2009)	Reid & Taylor (2006)	Treise & Sheperd (2006)	No. first & second order	No. second order only
Communal narratives of Experiences						X	X	X				3	
Community as a trusted source of Info					*	X	X	X				3	1
Structural													
Outreach						X				*	*	1	2
Incompatibility of Services	X	X			X				X	X		5	
Late attendance at services		X						X				2	
Lack of information				X					X	*		2	1
Follow up			X									1	

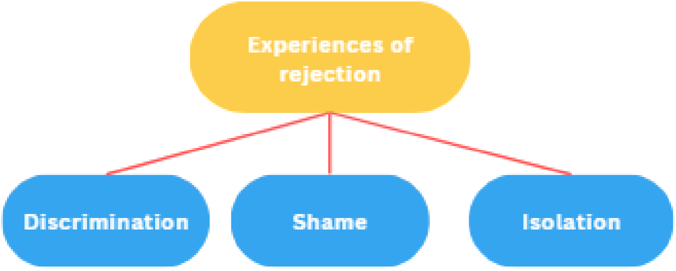
*Indicates second order only

Experiences of Rejection

The first third order construct identified was Experiences of Rejection (seen in Figure 2). Second and first order constructs contributing to this can be seen in Appendix B.

Figure 2

Experiences of rejection and second order constructs



Experiences of rejection were identified in all studies, particularly experiences of discrimination by those outside the community. This included discriminatory practices when seeking mental health support (Thompson et al., 2022), experiences of discrimination from authorities (Keogh et al., 2020; Smith & Ruston, 2013) and from wider society (Van Cleemput, 2009; Treise & Sheperd, 2006). Two studies found discrimination resulted in their health concerns not being taken seriously and delayed referrals to specialists (Condon et al., 2021; Gilhooley et al., 2019). Smith & Ruston (2013) discussed the wide reaching implications of discrimination, with one participant stating "*Prejudice has a big impact on your physical health because you withdraw from society. So, you won't go to the doctors and then you withdraw and that's what's happening"* (p. 9). This highlights the withdrawal from society and subsequent isolation as a result of discrimination, which consequently impacts healthcare access.

Shame "is provoked by the realization that others consider oneself deficient" (Schott, 1979, p. 1325), and is perpetuated by potential and realised experiences of rejection (Dickerson et al., 2004). A sense of shame was identified in four studies (Thompson et al., 2022; Condon et al, 2021; Van Cleemput, 2009; Reid & Taylor, 2006). Studies found a reluctance to discuss mental health difficulties due to stigma in the community (Thomspon et al, 2022) in addition to a perceived sense of shame in discussing physical health difficulties (Condon et al., 2021; Reid & Taylor, 2006). However, it was noted that for some participants this sense of shame is shifting and consequently creating more openness for some members of the community. For example, one participant in Condon et al. (2021) stated "*I know that there are such Roma who do not speak about it [but] there is no point feeling ashamed because of a sickness...it is not their fault, right" (p. 8).*

In spite of this, Condon et al. (2019) reported continued stigma as a result of socio-economic vulnerability if they were to become unwell and unable to work. Van Cleemput (2009) noted this sense of shame extended to the need for certain physical care, such as "intimate examinations".

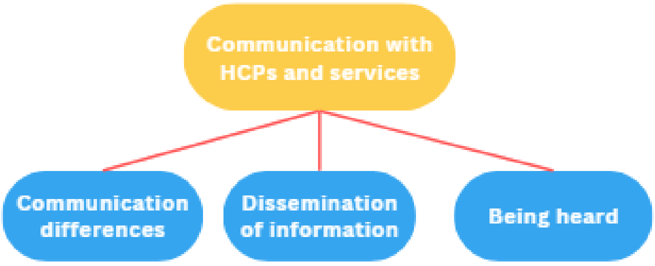
Isolation was noted in three studies (Thompson et al., 2022; Smith & Newton, 2016; Smith & Ruston, 2013). Smith & Ruston (2013) described isolation as occurring on two levels: isolation from outside of the community, and isolation from within. They found enforced isolation occurred through spatial ordering, which in turn reduced participants' abilities to manage their health through the community. Spatial ordering is whereby limits are imposed on the number of Travellers who can stop in one place and can impact the ability to travel as family units and contribute to social exclusion. This was discussed in a further study, finding isolation from the community as negatively impacting participants' mental health, due to experiencing exclusion from wider society already (Thompson et al., 2022). Smith & Newton (2016) noted the social exclusion that existed due to structural constraints and the location of sites.

Communication with Healthcare Professionals and Services

Communication with healthcare staff was identified as a third order construct present in all studies (seen in Figure 3). Second and first order constructs contributing to this can be seen in Appendix C.

Figure 3

Communication with Healthcare Professionals and services and contributing second order constructs



Difference in communication styles between healthcare professionals (HCPs) and

Travellers was identified in five studies (Thompson et al., 2022; Condon et al., 2021; Keogh et al., 2020; Van Cleemput, 2009; Reid & Taylor, 2006), and can alter individuals' experiences of services (Van Cleemput, 2009). The use of jargon increased miscommunication and confusion, with HCPs not adopting language used by Travellers (Thomson et al., 2022; Condon et al., 2021). A first order construct stated, "*They talks in a different way, language than what we do and we understand blunt words and they don't want to put them blunt words, but that's better for us if they did*." (Condon et al., 2021, p. 5)". Keogh et al. (2020) identified positive communication experiences came when HCPs tailored their communication style to the needs of the service user, with non-verbal communication also being identified as important (Reid & Taylor, 2006).

Six studies discussed communication in the context of literacy and services means of disseminating information to those accessing services (Gilhooley et al., 2019; Jackson et al., 2017; Smith & Newton, 2016; Condon & Salmon, 2014; Van Cleemput, 2009; Treise & Sheperd, 2006). Many participants reported being given written information regarding health, despite being unable to read (Gilhooley et al., 2019; Jackson et al., 2017; Smith & Newton, 2016; Van Cleemput, 2009). In addition to inaccessible written information, Condon & Salmon (2014) found additional language barriers for Roma participants, who were not always given access to interpreters.

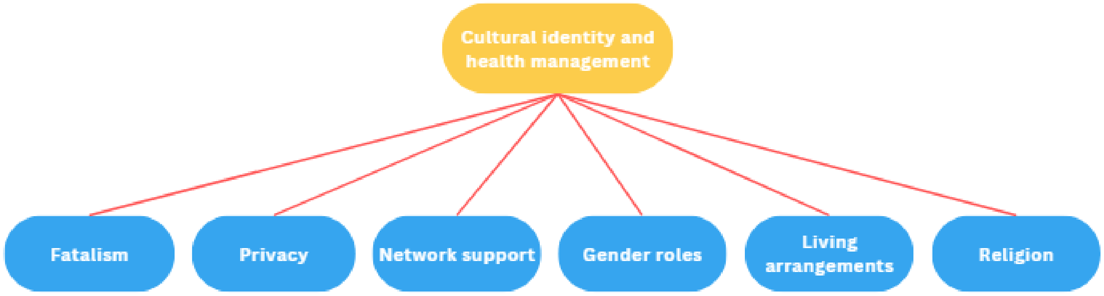
Being able to communicate their personal story and a sense of being heard was identified in four studies (Keogh et al., 2020; Gilhooley et al., 2019; Van Cleemput, 2009; Reid & Taylor, 2006). They described a need to be listened to (Keogh et al., 2020) and a chance to “tell their story” (Gilhooley et al., 2019). Two studies identified a range of experiences of not being heard and the appreciation when participants felt they had been listened to by HCPs (Van Cleemput, 2009; Reid & Taylor, 2006).

Cultural Identity and Management of Health

A third order construct of cultural identity and its relation to how health is managed (Figure 4) was present in all studies bar one (Gilhooley et al., 2019). Second and first order constructs contributing to this can be seen Appendix D.

Figure 4

Cultural identity and management of health and its contributing second order constructs



Two studies identified the role of fatalism in reducing access to health services (Condon et al., 2021; Van Cleemput, 2009). The belief that health is pre-determined limits motivation to seek preventative health care, with a participant stating “*If I said I think there's something wrong with you, he'd just go ‘No, nothing* *wrong with me, I'm fine. If I die, I die. It's fine. It's my time to go, I go"*" (p. 5, Condon et al., 2021). The importance of privacy was emphasised in four studies (Thompson et al., 2022; Keogh et al., 2020; Van Cleemput, 2009; Treise & Sheperd, 2006). One participant stated, "*Don't forget, from the day we are born, it's drummed into us, 'don't tell anybody anything'*." (p. 3, Treise & Sheperd, 2006) emphasising the cultural focus on privacy.

Six studies discussed the centrality of the community network and the importance of these social networks in maintaining cultural identity (Condon et al., 2021; Condon & Salmon, 2014; Smith & Ruston, 2013; Van Cleemput, 2009; Reid & Taylor, 2006; Treise & Sheperd, 2006).

Five studies discussed gender roles within Travelling communities and the impact this can have on service access (Condon et al., 2021; Smith & Newton, 2016; Van Cleemput, 2009; Reid & Taylor, 2006). Reid & Taylor examined gender roles in the context of women's childbirth experiences, and the expectation for men to attend prenatal classes. "*I have never been to classes. They think husbands should go but Traveller men don't get mixed up in such things that's the world of women."* (p. 6).

The impact of housing on the ability to access services was identified in five studies (Jackson et al., 2017; Smith & Newton, 2016; Condon & Salmon, 2014; Van Cleemput, 2009). For example, Jackson et al. (2017) noted the practicalities of receiving letters when travelling, meaning letters from GP surgeries may be missed. The importance of religion in healthcare access was highlighted by both

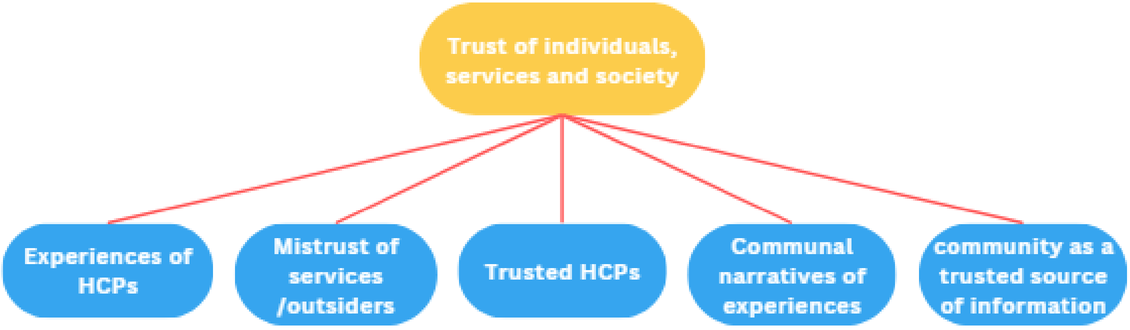
Van Cleemput (2009) and Reid & Taylor (2006). A participant discussed how a Traveller woman incorporated her religious and cultural beliefs into her birthing plan. "*I wore a red cord around my tummy during all my labours to save me from pain and help the child get an easy birth*" (Reid & Taylor, 2006, p. 6).

Trust of Individuals, Services, and Society

Experiences of trust in individual HCPs, services and wider society were discussed in relation to accessing services. Second and first order constructs contributing to this can be seen Appendix E.

Figure 5

Trust of Individuals, Services, and Society, and second order constructs contributing



One study discussed positive experiences of healthcare professionals and how this may increase access to services (Condon et al., 2021). Jackson et al. (2017) discussed both positive and negative experiences, with positive experiences increasing the likelihood of seeking medical advice/accessing healthcare services.

The increase in service avoidance following negative experiences was also discussed with a participant stating "*If you don't have a good relationship with your doctor sometimes you might feel a bit intimidated to say, "look, I'm sorry, I do want this appointment*" (Gilhooley at al., 2019, p. 4). Negative experiences more generally were identified in four studies (Smith & Newton, 2016; Smith & Ruston, 2013; Van Cleemput, 2009; Reid & Taylor, 2006). Experiences of healthcare professionals are shared widely in the community, developing a communal narrative of service experiences (Smith & Newton, 2016; Condon & Salmon, 2014; Smith & Ruston, 2013).

Five studies discussed the value of trusted HCPs to Travellers when accessing services (Keogh et al., 2020; Condon & Salmon, 2014; Smith & Ruston, 2013; Van Cleemput, 2009; Treise & Sheperd, 2006). Mistrust of outsiders and services were themes in four studies (Thomspon et al., 2022; Smith & Newton, 2016; Condon & Salmon, 2014; Van Cleemput, 2009), with a participant in Thompson et al. (2022) describing a fear of services:

> *"It's a real driven, fear-based thing why a lot of the time we don't access those things. It's like a discrimination thing that's gone down and a fear of like actual services coming and taking your kids. If you reach out with your mental health, that mental health issue may be used as a reason for taking away your children or involving social services" (p. 7).*

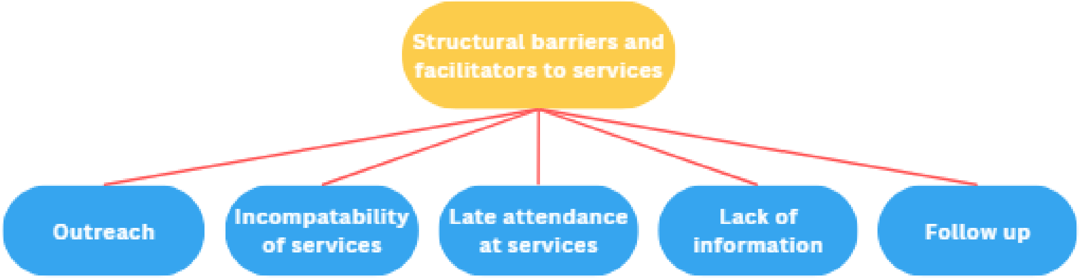
The use of collective knowledge and the community as a source of information and advice was identified in four studies (Jackson et al., 2017; Smith & Newton, 2016; Condon & Salmon, 2014; Smith & Ruston, 2013). A participant in Smith & Ruston (2013) described liaising with their family before seeking healthcare, *“We don’t go and see a doctor erm, straight away. We’d seek family first, so it could be something that’s potentially dangerous and its gonna go undetected”* (p. 10).

Structural Barriers and Facilitators to Services

The fifth third order construct, found in all studies bar Condon and Salmon (2014), was structural barriers and facilitators to services (Figure 6). Second and first order constructs contributing to this can be seen Appendix F.

Figure 6

Structural barriers and facilitators to services and contributing second order constructs



Three studies identified the value of outreach services (Smith & Newton, 2016; Reid & Taylor, 2006; Treise & Sheperd, 2006). Participants also reported a positive view of home visits (Reid & Taylor, 2006; Treise & Sheperd, 2006).

Five studies identified an incompatibility of services with the travelling community (Thomspon et al., 2022; Condon et al., 2021; Jackson et al., 2017; Van Cleemput, 2009; Reid & Taylor, 2006). This incompatibility was based on practical issues such as attending appointments (Thompson et al., 2022) and inaccessible services (Condon et al., 2021; Jackson et al., 2017).

Being provided with insufficient information from health services was a theme in three studies (Gilhooley et al., 2019; Van Cleemput, 2009; Reid & Taylor, 2006). Keogh et al. (2020) identified the significance of HCPs providing signposting and check-ins after appointments, with follow ups appreciated by those accessing the service.

*"If she [Traveller Mental Health Liaison Nurse] 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." (*p. 6)

Discussion

This review aimed to gain insights into the factors that can hinder or facilitate access to healthcare services for Travellers. To achieve this objective, eleven qualitative research studies were reviewed, which explored individuals' experiences with various healthcare services. A systematic literature search, critical appraisal, and meta-ethnographic synthesis were conducted. The synthesis led to the development of five third order constructs, derived from the 22 second order constructs initially created by the original researchers in their respective studies. The third order constructs were experiences of rejection;

communication with healthcare professionals; cultural identity and health management; trust of individuals, services, and society; and structural barriers and facilitators to services. The themes of communication with healthcare professionals and services and trust of individuals, services, and society were the most supported themes within the reviewed studies. Several high-quality studies contributed to each of the themes. A summary of constructs and how they relate to Scheppers et al. (2006) barrier levels can be seen in Table 8.

Table 8

Second and third order constructs integrated with health service barrier levels as described by Scheppers et al. (2006)

Barrier Level	**Second order constructs**	**Third order constructs**
Patient	Discrimination	Experiences of rejection
	Shame	Experiences of rejection
	Isolation	Experiences of rejection
	Fatalism	Cultural identity and health management
	Privacy	Cultural identity and health management
	Network Support	Cultural identity and health management
	Gender roles	Cultural identity and health management
	Living arrangements	Cultural identity and health management
	Religion	Cultural identity and health management
	Mistrust of services/outsiders	Trust of individuals, services, and society
	Communal narratives of experiences	Trust of individuals, services, and

		society
	Community as a trusted source of information	Trust of individuals, services, and society
Provider	Communication differences	Communication with healthcare professionals and services
	Being heard	Communication with healthcare professionals and services
	Experiences of healthcare professionals	Trust of individuals, services, and society
	Trusted healthcare professionals	Trust of individuals, services, and society
System	Incompatibility of services	Structural barriers and facilitators to services
	Dissemination of information	Communication with healthcare professionals and services
	Lack of information	Structural barriers and facilitators to services
	Outreach	Structural barriers and facilitators to services
	Late attendance at services	Structural barriers and facilitators to services

The Sense of "Othering" in Healthcare and Society

Findings from this review were consistent with past research into healthcare barriers for minoritised individuals (Quirke et al., 2022; McFadden et al., 2018). For example, experiences of rejection, trust in individuals, services and society, and structural barriers and enablers to service access were most aligned with past research into health inequalities for minoritised groups. The current review identified discrimination experienced by Travellers, which has previously been shown to lower the quality of their experience, leading to a reduced trust in services (Quirke et al., 2022; Siebelt et al., 2017). Traveller experiences of discrimination across services have been documented, reducing trust in wider services (Yin-Har Lau & Ridge, 2011). This review demonstrated how these negative experiences can lead to Travellers withdrawing from mainstream healthcare services. These experiences contribute to a sense of othering, repeating findings from wider research into health inequalities, whereby minoritised groups are othered, which serves to reinforce difference as the “problem” and locate difficulties within these categorisations (McFadden et al., 2018).

This review also highlighted the positive experiences of healthcare and valued professionals. Trusted professionals were reported to be highly valued in the community, in keeping with previous recommendations for the use of outreach workers (Cemlyn & Allen, 2016; Lhussier & Forster, 2015). Outreach workers were identified as facilitators to health service access in three studies, which may be due to the nature of the role considering “outreach workers do not build their relations to people in settings where professional power is mediated through spatial structures” (Andersson, 2011, p. 179). Outreach services move away from pathologising “hard to reach” groups through service provision which is accessible. This shifts the focus from groups as “difficult to engage” to reflect on whether the set-up of services is suitable.

The findings are in keeping with the concept of culturally sensitive services (Chin, 2000; Anderson, 2003). Many services in the UK currently are based solely on Western medicine concepts of health (Antic, 2021), creating an experience of cultural dissonance for minoritised individuals accessing these services (Primm et al., 2005). Cultural sensitivity in services can impact how individuals respond to services and thus access services (Meyer & Zane, 2013). Thompson et al. (2022) identified how key it is for healthcare professionals to develop their cultural competence outside of clinical time, ensuring that it does not negatively impact the care received by those accessing services. This review has highlighted some practical adaptations HCPs could make to become more culturally sensitive when working with Travellers including adapting communication in line with those accessing services, incorporating religious beliefs into care plans and considering the role of gender, such as matching the gender of the HCP to the individual.

The identification of service level structural barriers included a lack of outreach, unsuitability of services, and a lack of information. These barriers have been previously identified in research (Atterbury, 2010; McFadden et al., 2018), particularly identifying inappropriate methods of health promotion considering levels of literacy in Travelling communities, and the inability to register with services without a permanent address. Despite these structural barriers, they remain in place with little evidence of services progressing beyond these.

Relationships with Healthcare Professionals and Services

Relationships with healthcare professionals were highlighted in this review. This is in keeping with past research, which found trusting relationships with professionals improve health-related behaviours and uptake of health service provisions (York & Stakem, 2015; Forster, 2019). The findings related to communication are a unique addition to the research base. The use of medical jargon and staff not adopting language used by the community, influence the experience of accessing services and likely further reinforce the sense of cultural dissonance. This is in combination with the literacy levels in the community regularly not being accounted for.

The review demonstrated a multitude of cultural aspects, such as fatalism, which influences beliefs about how health should be managed, and consequently impacts access to services. In addition, the value of others' experiences and shared knowledge within the community were identified, perhaps meaning the knowledge of health services is not valued as highly and therefore less sought after. Past research has highlighted the centrality of cultural identity for Travellers, and how incorporation of this is key to mental health promotion (Villani & Barry, 2021).

Reported experiences of stigma and shame in approaching services may mean an increase in a sense of vulnerability, which past research has reported is not valued by the Travelling community (Heaslip et al., 2018). However, Condon et al. (2021) participants highlighted how this sense of shame is shifting, and generational change is occurring. Research has emphasised the importance of social cohesion for Travellers, due to the exclusion they face from wider society (Greenfields & Smith, 2010). This would suggest that it is seen as beneficial for Travellers to close off the community, strengthen their identity and limit engagement with formal services, further reducing inclination to access healthcare services.

The findings regarding the impact of housing in relation to health service access does not only pertain to the structural barrier of registering for services without a permanent address, but also to the isolation Travellers' experience when they are housed (Greenfields & Smith, 2010). This is due to the isolation from their social network, restricting their usual means of managing their health.

Strengths and Limitations

There were a number of strengths and limitations for this review. Firstly, the papers represented a broad range of services, bringing a breadth of experiences and information. This allowed for common experiences to be highlighted, demonstrating experiences which are not service or diagnosis specific, but common to Travellers' accessing services. The variety of data collection methods also provided a vast number of participants for qualitative studies.

However, the benefit of the range has come at the cost of depth and nuance. The difference between services, for example preventative services (Jackson et al., 2017; Smith & Newton, 2016) and mental health services (Thompson et al., 2022) are likely to be linked to different beliefs which may not have been adequately reflected due to the small proportion of studies included. Further research may benefit from focusing on specific areas of healthcare to fully encapsulate the individual experiences.

Secondly, much of the research included focused on women's experiences of services. 79% of participants were female, with two papers focused exclusively on women's services (Reid & Taylor, 2006; Condon & Salmon, 2014). This speaks to the strongly demarcated gender roles within the Travelling community and the concept of masculinity and stoicism (Richardson et al., 2023). Broadening the scope to include a focus on experiences and beliefs around health may expand the range of studies and increase the number of male participants.

Thirdly, due to the quality of some papers, first order constructs were not always available. This decreased the reliability of some third order constructs as there were no first person accounts evident. It is of note that there is some criticism regarding the reliability of the meta-ethnographic method due to the subjective nature of the synthesis. Throughout the review, I have attempted to counter potential bias through reflexivity and evaluation of my position. The original language of the studies was attempted to be maintained, however due to the broad range of the papers included this was not possible. Despite this, there is still value to be taken from the broad perspectives provided.

Recommendations and Conclusions

This review utilised a meta-ethnographic approach to qualitative synthesis, building on the existing literature focused on the barriers and facilitators to healthcare service access for Travellers. It added to the body of evidence regarding experiences of rejection and service level structural barriers. The emphasis on communication was highlighted and how this adds to the experience of services, in addition to the centrality of cultural identity in health management. There are implications for future research and clinical work. Future research may also wish to explore individual experiences of Gypsies, Romas and Travellers due to the distinct nature of their cultures. This would allow for a depth of understanding in the cultural identities. The focus on network support and shared knowledge within the community indicates it may be appropriate to consider a more community-based model of mental health (Goward et al., 2006). The review also highlighted the importance of outreach services and the value of communication in services. The structural barriers to accessing services and experiences of discrimination are well established within the literature, indicating an understanding of the barriers that exist.

Further research might benefit from developing a deeper understanding of the narratives held around specific health interventions, particularly when considering areas of health which may be subject to greater shame, such as mental health. Further research may also focus on understanding how cultural narratives may influence access when the role of the community might be less present, so understanding when the usual network sources of support are gone, and what are the narrative of services and help-seeking.

References

Abdalla, S., Kelleher, C., Quirke, B., Daly, L., & All-Ireland Traveller Health Study team. (2013). Social inequalities in health expectancy and the contribution of mortality and morbidity: the case of Irish Travellers. *Journal of Public Health*, *35*(4), 533-540. https://doi.org/10.1093/pubmed/fds106

All-Ireland Traveller Health Study Research Team. (2012). The health care experiences of Travellers compared to the general population: the All-Ireland Traveller Health Study. *Journal of Health Services Research & Policy*, *17*(3), 173-180. http://hdl.handle.net/10147/111897

Andersen, R., & Newman, J. F. (1973). Societal and individual determinants of medical care utilization in the United States. *The Milbank Memorial Fund Quarterly. Health and Society*, 95-124. https://www.milbank.org/wp-content/uploads/mq/volume-51/issue-01/51-1-Societal-and-Invidual-Determinants-of-Medical-Care-Utilization-in-the-United-States.pdf

Anderson, L. M., Scrimshaw, S. C., Fullilove, M. T., Fielding, J. E., Normand, J., & Task Force on Community Preventive Services. (2003). Culturally competent healthcare systems: A systematic review. *American Journal of Preventive Medicine*, *24*(3), 68-79. https://doi.org/10.1016/S0749-3797(02)00657-8

Antić, A. (2021). Transcultural psychiatry: Cultural difference, universalism, and social psychiatry in the age of decolonisation. *Culture, Medicine, and Psychiatry*, *45*(3), 359-384. https://link.springer.com/article/10.1007/s11013-021-09719-4

Atterbury, J. (2010). Fair access for all? Gypsies and travellers in Sussex, GP surgeries and barriers to primary healthcare. *Friends, Families and Travellers.* Brighton. Available at*: www. gypsy-traveller. org/wp-content/uploads/2017/03/fair_access_health. pdf* (accessed 28 October 2023).

Bancroft, A. (2005). *Roma and Gypsy-travellers in Europe: Modernity, Race, Space and Exclusion.* Ashgate publishing.

Barr, D. A., & Wanat, S. F. (2005). Listening to patients: cultural and linguistic barriers to health care access. *Family Medicine*, *37*(3), 199-204. https://fammedarchives.blob.core.windows.net/imagesandpdfs/fmhub/fm2005/March/ Donald199.pdf

Cambridgeshire Travellers. (2010). *Joint Strategic Needs Assessment.* https://cambridgeshireinsight.org.uk/wp-content/uploads/2017/08/Travellers-JSNA-2010.pdf

Cemlyn, S., & Allen, D. (2016). Outreach: care experiences among Gypsy, Traveller and Roma families. In C. Williams & M. Graham (Eds.), *Social Work in a Diverse Society* (pp. 161-180). Policy Press. https://doi.org/10.51952/9781447322634.ch010

Cemlyn, S., Greenfields, M., Burnett, S., Matthews, Z. & Whitwell, C. (2009). *Inequalities experienced by Gypsy and Traveller communities: A review*. Manchester: Equality and Human Rights Commission.

Chin, J. L. (2000). Culturally competent health care. *Public Health Reports*, *115*(1), 25. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1308553/pdf/pubhealthrep00023-0027.pdf

Clark, C., & Cemlyn, S. (2005). The social exclusion of Gypsy and Traveller children. In G. Preston (Ed.), *At Greatest Risk: The Children Most Likely to Be Poor* (pp. 150-165). CPAG, London, UK.

Condon, L., Bedford, H., Ireland, L., Kerr, S., Mytton, J., Richardson, Z., & Jackson, C. (2019). Engaging gypsy, Roma, and traveller communities in research: Maximizing opportunities and overcoming challenges. *Qualitative Health Research*, *29*(9), 1324-1333. https://doi.org/10.1177/1049732318813558

Condon, L., Curejova, J., Leeanne Morgan, D., & Fenlon, D. (2021). Cancer diagnosis, treatment, and care: A qualitative study of the experiences and health service use of Roma, Gypsies and Travellers. *European Journal of Cancer Care*, *30*(5), e13439. https://doi.org/10.1111/ecc.13439

Condon, L. J., & Salmon, D. (2014). 'You likes your way, we got our own way': Gypsies and travellers' views on infant feeding and health professional support. *Health Expectations: An International Journal of Public Participation in Health Care & Health Policy*, *18*(5), 784–795. https://doi.org/10.1111/hex.12214

Critical Appraisal Skills Programme. (2018). *CASP qualitative checklist*. https://casp- uk.net/casp-tools-checklists/

Cromarty, H. (2019). "Gypsies and Travellers 08083." *House of Commons Library*, London. Available at: http://researchbriefings.files.parliament.uk/documents/CBP-8083/CBP-8083.pdf (Accessed 13 September 2023).

Culley, L. (2006). Transcending transculturalism? Race, ethnicity and health-care. *Nursing Inquiry*, *13*(2), 144-153. https://www.researchgate.net/profile/Lorraine-Culley/publication/7080293_Transcending_transculturalism_Race_ethnicity_and_hea lth-care/links/5c65d8e0a6fdccb608c3b629/Transcending-transculturalism-Race- ethnicity-and-health-care.pdf

Department of Health and Social Care. (2023). *The NHS Constitution for England.* https://www.gov.uk/government/publications/the-nhs-constitution-for-england/the-nhs-constitution-for-england

Dickerson, S. S., Gruenewald, T. L., & Kemeny, M. E. (2004). When the social self is threatened: Shame, physiology, and health. *Journal of Personality*, *72*(6), 1191-1216. https://doi.org/10.1111/j.1467-6494.2004.00295.x

Drewniak, D., Krones, T., & Wild, V. (2017). Do attitudes and behavior of health care professionals exacerbate health care disparities among immigrant and ethnic minority groups? An integrative literature review. *International Journal of Nursing Studies*, *100*(70), 89-98. https://doi.org/10.1016/j.ijnurstu.2017.02.015

Forster, N. (2019). Traveller Community and health practitioner stories of self and each other: A poststructural narrative analysis. [Doctoral dissertation: University of Edinburgh]. https://era.ed.ac.uk/bitstream/handle/1842/36050/Forster2019.pdf?sequence=1&isAll owed=y

France, E. F., Ring, N., Thomas, R., Noyes, J., Maxwell, M., & Jepson, R. (2014). A methodological systematic review of what's wrong with meta-ethnography reporting. *BMC Medical Research Methodology*, *14*(1), 1-16. http://www.biomedcentral.com/1471-2288/14/119

Gilhooley, E., Daly, S., Gallagher, O., Glacken, M., & McKenna, D. (2019). Experience of skin disease and relationships with healthcare providers: a qualitative study of Traveller women in Ireland. *British Journal of Dermatology*, *180*(6), 1405-1411. https://doi.org/10.1111/bjd.17697

Gill, P., MacLeod, U., Lester, H. & Hegenbarth, A. (2013). *Improving access to health care for Gypsies and Travellers, homeless people and sex workers: An evidence-based commissioning guide for Clinical Commissioning Groups and Health & Wellbeing Boards.* RGCP Clinical Innovation and Research Centre. https://www.rcgp.org.uk/getmedia/8d2d4d30-09b1-4eda-bb37-4a3ab99998e3/RCGP-Social-Inclusion-Commissioning-Guide.pdf

Goward, P., Repper, J., Appleton, L., & Hagan, T. (2006). Crossing boundaries. Identifying and meeting the mental health needs of Gypsies and Travellers. *Journal of Mental Health*, *15*(3), 315-327. https://doi.org/ 10.1080/09638230600700888

Greenfields, M. (2017). Good practice in working with Gypsy, Traveller, and Roma communities. *Primary Health Care*, *27*(10), 24-29. http://doi.org/10.7748/phc.2017.e1263

Greenfields, M., & Rogers, C. (2020). *Hate: "As regular as rain": A pilot research project into the psychological effects of hate crime on gypsy, traveller and Roma (GTR) communities*. GATE HERTS and Ministry of Housing. https://bnu.repository.guildhe.ac.uk/id/eprint/18142/1/18142_Greenfields_M%20Rog ers_C.pdf

Greenfields, M., & Smith, D. M. (2010). Housed Gypsy Travellers, social segregation, and the reconstruction of communities. *Housing Studies*, *25*(3), 397-412. https://doi.org/10.1080/02673031003711022

Greenfields, M., & Smith, D. (2011). A question of identity: the social exclusion of housed gypsies and travellers. *Research, Policy, and Planning*, *28*(3), 65-78. https://www.researchgate.net/profile/David_Smith238/publication/304747972_A_question_of_identity_the_social_exclusion_of_housed_Gypsies_and_Travellers/links/577 93f3108ae4645d611ef2e/A-question-of-identity-the-social-exclusion-of-housed- Gypsies-and-Travellers.pdf

Hammersley, M., & Atkinson, P. (2019). *Ethnography: Principles in Practice*. Routledge.

Heaslip, V., Hean, S., & Parker, J. (2018). The etemic model of Gypsy Roma Traveller community vulnerability: is it time to rethink our understanding of vulnerability?. *Journal of Clinical Nursing*, *27*(17-18), 3426-3435. https://doi.org/10.1111/jocn.13499

Jackson, C., Bedford, H., Cheater, F. M., Condon, L., Emslie, C., Ireland, L., Kemsley, P., Kerr, S., Lewis, H., Mytton, J., Overend, K., Redsell, S., Richardson, Z., Shepherd, C., Smith, L. & Dyson, L. (2017). Needles, Jabs and Jags: a qualitative exploration of barriers and facilitators to child and adult immunisation uptake among Gypsies, Travellers and Roma. *BMC Public Health*, *17*(1), 1-17. https://doi.org/10.1186/s12889-017-4178-y

Keogh, B., Brady, A. M., Downes, C., Doyle, L., Higgins, A., & McCann, T. (2020). Evaluation of a Traveller mental health liaison nurse: Service user perspectives. *Issues in Mental Health Nursing*, *41*(9), 799-806. https://doi.org/10.1080/01612840.2020.1731889

The Kings Fund. (2022, June 17). *What are Health Iinequalities?* https://www.kingsfund.org.uk/insight-and-analysis/long-reads/what-are-health-inequalities

Lhussier, M., Carr, S. M., & Forster, N. (2016). A realist synthesis of the evidence on outreach programmes for health improvement of Traveller Communities. *Journal of Public Health*, *38*(2), e125-e132. https://doi.org/10.1093/pubmed/fdv093

Long, H. A., French, D. P., & Brooks, J. M. (2020). Optimising the value of the critical appraisal skills programme (CASP) tool for quality appraisal in qualitative evidence synthesis. *Research Methods in Medicine & Health Sciences*, *1*(1), 31-42. https://doi.org/10.1177/263208432094755

Lu, W., Todhunter-Reid, A., Mitsdarffer, M. L., Muñoz-Laboy, M., Yoon, A. S., & Xu, L. (2021). Barriers and facilitators for mental health service use among racial/ethnic minority adolescents: a systematic review of literature. *Frontiers in Public Health*, *9*, 641605. https://doi.org/10.3389/fpubh.2021.641605

Matthews, Z. (2008). *The health of Gypsies and Travellers in the UK.* Race Equality Foundation. https://www.gypsy-traveller.org/wp-content/uploads/health-brief.pdf

Mason, D. (2003). Changing Ethnic Disadvantage: An Overview in D. Mason (Ed.), *Explaining ethnic differences: changing patterns of disadvantage in Britain* (pp. 9-19). Policy Press.

McFadden, A., Siebelt, L., Gavine, A., Atkin, K., Bell, K., Innes, N., Jones, H., Jackson, C., Haggi, H. & MacGillivray, S. (2018). Gypsy, Roma and Traveller access to and engagement with health services: a systematic review. *The European Journal of Public Health*, *28*(1), 74-81. https://doi.org/10.1093/eurpub/ckx226

Meyer, O. L., & Zane, N. (2013). The influence of race and ethnicity in clients' experiences of mental health treatment. *Journal of Community Psychology*, *41*(7), 884-901. https://doi.org/10.1002/jcop.21580.

Myers, M. (2020). An inheritance of exclusion: Roma education, genetics, and the turn to biosocial solutions. *Research in Education*, *107*(1), 55-71. https://doi.org/10.1177/0034523719880205

Noblit, G. W. (2018). Meta-ethnography: adaption and return. In L. Urrieta, & Noblit, G. W. (Eds.), *Cultural Constructions of Identity: Meta-Ethnography and Theory* (pp. 34-50). Oxford University Press.

Quirke, B., Heinen, M., Fitzpatrick, P., McKey, S., Malone, K. M., & Kelleher, C. (2022). Experience of discrimination and engagement with mental health and other services by Travellers in Ireland: findings from the All Ireland Traveller Health Study (AITHS). *Irish Journal of Psychological Medicine*, *39*(2), 185-195. https://doi.org/10.1017/ipm.2020.90

Page, M. J., McKenzie, J. E., Bossuyt, P. M., Boutron, I., Hoffmann, T. C., Mulrow, C. D., Shamseer, L., Tetzlaff, J. M., Akl, E. A., Brennan, S., Chou, R., Glanville, J., Grimshaw, J. M., Hrobjartsson, A., Lalu, M. M., Li, T., Loder, E. W., Mayo-Wilson, E., McDonald, S., McGuinnes, L. A., & Moher, D. (2021). The PRISMA 2020 statement: an updated guideline for reporting systematic reviews. *International Journal of Surgery*, *88*, 105906.

https://doi.org/10.1016/j.ijsu.2021.105906

Parry, G., Van Cleemput, P., Peters, J., Walters, S., Thomas, K., & Cooper, C. (2007). Health status of Gypsies and Travellers in England. *Journal of Epidemiology & Community Health*, *61*(3), 198-204. https://doi.org/10.1136/jech.2006.045997

Payne, S. (2006). Mental health, poverty and social exclusion. In C. Pantazis, D. Gordon & R. Levitas (Eds.), *Poverty and Social Exclusion in Britain* (pp. 285-312). Policy Press.

Primm, A. B., Osher, F. C., & Gomez, M. B. (2005). Race and ethnicity, mental health services and cultural competence in the criminal justice system: Are we ready to change?. *Community Mental Health Journal*, *41*, 557-569. https://doi.org/10.1007/s10597-005-6361-3

Race Disparity Unit. (2022). *Gypsy, Roma and Irish Traveller Ethnicity Summary.* UK Government Ethnicity Facts and Figures. https://www.ethnicity-facts- figures.service.gov.uk/summaries/gypsy-roma-irish-traveller

Reid, B., & Taylor, J. (2007). A feminist exploration of Traveller women's experiences of maternity care in the Republic of Ireland. *Midwifery*, *23*(3), 248-259. https://doi.org/10.1016/j.midw.2006.03.011

Richardson, N., McDonnell, K., Carroll, P., & O’Donnell, S. (2023). Using an intersectional approach to explore the lived mental health experiences of Traveller men affected by suicide in Ireland. *American Journal of Men's Health*, *17*(5), 15579883231189063. https://doi.org/10.1177/15579883231189063

Sattar, R., Lawton, R., Panagioti, M., & Johnson, J. (2021). Meta-ethnography in healthcare research: a guide to using a meta-ethnographic approach for literature synthesis. *BMC Health Services Research*, *21*, 1-13. https://doi.org/10.1186/s12913-020-06049-w

Scheppers, E., Van Dongen, E., Dekker, J., Geertzen, J., & Dekker, J. (2006). Potential barriers to the use of health services among ethnic minorities: a review. *Family Practice*, *23*(3), 325-348. https://doi.org/10.1093/fampra/cmi113

Siebelt, L., Jackson, C., McFadden, A., Dyson, L., & Atkin, K. (2017). Use of UK health services by Gypsies, Roma, and Travellers: triangulation of two mixed methods studies. *The Lancet*, *390*, S81. https://doi.org/10.1016/S0140-6736(17)33016-7

Singer, M. (2009). *Introduction to Syndemics: A Critical Systems Approach to Public and Community Health*. John Wiley & Sons.

Smith, D., & Newton, P. (2017). Structural barriers to measles, mumps and rubella (MMR) immunisation uptake in Gypsy, Roma and Traveller communities in the United Kingdom. *Critical Public Health*, *27*(2), 238-247. https://doi.org/10.1080/09581596.2016.1211254

Smith, D., & Ruston, A. (2013). 'If you feel that nobody wants you you'll withdraw into your own': Gypsies/Travellers, networks, and healthcare utilisation. *Sociology of Health & Illness*, *35*(8), 1196-1210. https://doi.org/doi: 10.1111/1467-9566.12029.

Straatmann, V. S., Lai, E., Law, C., Whitehead, M., Strandberg-Larsen, K., & Taylor- Robinson, D. (2020). How do early-life adverse childhood experiences mediate the relationship between childhood socioeconomic conditions and adolescent health outcomes in the UK?. *Journal of Epidemiology & Community Health*, *74*(11), 969- 975. http://doi.org/10.1136/jech-2020-213817

Sweeney, S., & Billie, D. (2020)*. A research paper: Suicide prevention in Gypsy and traveller communities in England.* Friends Families and Travellers: Brighton. Available at: www.gypsy-traveller.org/wp-content/uploads/2020/10/Suicide- Prevention-Report-FINAL.pdf

Tobin, M., Lambert, S., & McCarthy, J. (2020). Grief, tragic death, and multiple loss in the lives of Irish Traveller community health workers. *Journal of Death and Dying*, *81*(1), 130-154. https://doi.org/10.1177/0030222818762969

Toye, F., Seers, K., Allcock, N., Briggs, M., Carr, E., & Barker, K. (2014). Meta-ethnography 25 years on: challenges and insights for synthesising a large number of qualitative studies. *BMC Medical Research Methodology, 14*, 1-14.

Thompson, R. M., Stone, B. V., & Tyson, P. J. (2022). Mental health support needs within Gypsy, Roma, and Traveller communities: a qualitative study. *Mental Health and Social Inclusion*, *26*(2), 144-155. https:/doi.org/10.1108/MHSI-09-2021-0066

Treise, C., & Shepherd, G. (2006). Developing mental health services for Gypsy Travellers: an exploratory study. In *Clinical Psychology Forum-New Series* (Vol. 163, p.6). British Psychological Society.

Van Cleemput, P. (2008). *Gypsies and Travellers accessing primary health care: interactions with health staff and requirements for 'culturally safe' services*. [Doctoral dissertation, University of Sheffield].

https://etheses.whiterose.ac.uk/3634/2/487635_vol1.pdf

Villani, J., & Barry, M. M. (2021). A qualitative study of the perceptions of mental health among the Traveller community in Ireland. *Health Promotion International*, *36*(5), 1450-1462. https://doi.org/0.1093/heapro/daab009

Yin-Har Lau, A., & Ridge, M. (2011). Addressing the impact of social exclusion on mental health in Gypsy, Roma, and Traveller communities. *Mental Health and Social Inclusion*, *15*(3), 129-137. https://doi.org/10.1108/20428301111165717

York, M., & Stakem, M. (2015). Relationship and trust as a vehicle to improved health outcomes: A qualitative study of a Primary Health Care Programme for Travellers. *Irish Journal of Applied Social Studies*, *15*(1), 4. https://doi.org/10.21427/D7QT5W

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Section B: Exploring Narratives of Psychological Intervention and Help-seeking for Irish Travellers in Prisons: Staff and Service User Perspectives

For submission to the Prison Service Journal

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Abstract

Male Irish Travellers are over six times more likely to take their life by suicide than the general population, with those in prison potentially facing additional pressures on their mental health. Intersecting identities and the prison environment may pose additional barriers to seeking help for psychological distress and access to psychological therapies. This study aimed to use narrative analysis to explore the help-seeking narratives of male Irish Travellers and clinicians working with them, focusing on psychological distress and interventions in prison. It also examined cultural narratives and how these may influence identity. Eight interviews were conducted, four with service user participants, and four with clinician participants. Findings highlighted the personal stories of Irish Travellers who have accessed psychological intervention in prison, which were contributed to by cultural and community narratives. Of note were identity and the role of power, experiences of discrimination and stereotyping, trust and relationships, prison as a context for mental health and psychology, and beliefs about health and services. Implications are discussed for developing cultural competence in professionals, development of therapeutic relationships and areas for future research.

Keywords: *Irish Traveller, mental health, prisons, psychological intervention, help-seeking*

Introduction

A Note on Language

The term Gypsies, Roma, and Travellers refers to distinct travelling ethnicities, all legally protected under the Equality Act 2010 (Race Disparity Unit, 2022). In this study, "Traveller" is used to include Gypsy, Traveller, and Roma communities, both settled and nomadic. Where distinctions for the specific culture are made, the term used by the individual or in the paper will be applied. "Settled people" refers to those outside Traveller ethnic groups.

"Prisoner" is used in accordance with Her Majesty’s Probation and Prison Service (HMPPS; Inside Time, 2022), and "service user" refers to those accessing services, whether in prison or the community.

Irish Traveller Mental Health

Irish Travellers are an indigenous ethnic group, with some records documenting their separation from the settled population in Ireland up to 1000 years ago (The Traveller Movement, n.d.). Travellers often speak a distinct language called *Cant*, also known as Shelta or Gammon. Shelta combines Irish Gaelic, English, and Romani influences, though its vocabulary and structure are unique (Binchy, 1985). Traditionally, Irish Travellers lived a nomadic or semi-nomadic lifestyle, moving from place to place in caravans. Although many Irish Travellers are now settled, often due to legal restrictions criminalising a nomadic way of life (Police Act, 2022), the cultural attachment to travel and mobility remains strong.

Due to the method of data collection by the Office of National Statistics (ONS), an accurate estimation of the proportion of Irish Travellers living in the United Kingdom (UK) is not possible. This is in part due to missing many of those living nomadically, and also the grouping of Traveller identities. In the 2021 census, 71,440 people (0.12% of the population) identified as “Gypsy or Irish Traveller” (ONS, 2021). Of these, 94.9% resided in England, with 25% of the total Gypsy or Irish traveller population living in the South East.

Studies have found an observed difference in mental health difficulties, with rates of suicide among male Irish Travellers over six times more likely, compared to the general population (Tanner & Doherty, 2021). Research states that Travellers report greater use of health services, including mental health services, however, they consistently report poorer service experience than the settled population (All Ireland Traveller Health Team [AITHT], 2012). Negative perceptions of mental health services within the Traveller community have been reported, with discrimination and poor treatment being a shared experience (Quirke et al., 2020).

The Prison Context

Mental Health in Prisons

Compared to the general population, the prevalence of mental health issues in prisons is significantly higher (Fazel & Baillargeon, 2011; Fazel & Seewald, 2012). Research indicates prisoners are more likely to have had prior contact with mental health services before incarceration (Tyler et al., 2019), and high rates of co-morbidity (Dalbir et al., 2024). Additionally, the anticipated stigma of being labelled an offender may contribute to psychological distress (Moore et al., 2016).

There are several environmental factors within prisons which have been found to impact mental health including loss of social and relational connections (Nurse et al., 2003; Burns et al., 2023), unpredictability of the prison environment (Pickering et al., 2023) and a loss of autonomy (Favril & van Ginneken, 2023). This is compounded by an ongoing sense of threat (Maier & Ricardelli, 2019). These environmental risks may be considered to have a significant effect over time, with those serving longer sentences more likely to access mental health support while in prison (Ratkalkar & Atkin-Plunk, 2020).

Research guidelines emphasise that access to mental health support in prisons should have parity with community services (Bradshaw et al., 2017), with studies demonstrating similar efficacy of interventions in prison to the community (Adamson et al., 2015). Several psychological interventions in prison settings have been evaluated including EMDR (Every-Palmer et al., 2023), mindfulness (Bouw et al., 2019), and therapeutic communities (Blagden et al., 2016).

Masculinity

Gender differences in help-seeking behaviour have been identified, with men less likely to seek help than women (Parent et al., 2018). Traditional ideals of masculinity reject the notion of men accessing therapy (Silver et al., 2018). Research has found those who subscribed to more traditional masculinity norms have greater hesitancy in seeking help for mental health difficulties (Addis & Mahalik, 2003; Yousaf et al., 2015; Ramesh et al., 2023). Those with intersecting identities which reduce their social power can present more strictly within the confines of their gender role (Pyke, 2006).

The intersection of masculinity, trauma and incarceration produces ideals of masculinity which further prohibit help-seeking and limit the ability to present with vulnerability (Cesaroni et al., 2023). Byrne et al. (2023) systematic review of men's help-seeking in prisons identified three core aspects of social identity which influence help-seeking for mental health which included maintenance of a group identity, an "us and them" mentality, and prison context restraints. These findings have been replicated within a UK prison setting (Ramesh et al., 2023).

Irish Traveller Mental Health in Prisons

Despite limitations to reporting, Travellers are overrepresented in prisons (Gavin, 2019) and are more likely to report negative experiences in prison compared to the general population (Her Majesty's Prison Inspectorate, 2014). Irish Travellers in prison reported experiences detrimental to psychological well-being such as depression, isolation and paranoia (Gavin, 2020). Irish Travellers may face barriers when accessing mental health services in prison, including difficulties with literacy, lack of trust in staff, decreased engagement in the prison regime (Mac Gabhann, 2011) and additional mental health stressors due to discrimination (Gavin, 2019).

Some key concepts of contemporary masculinity in Irish Traveller culture are stoicism, self-reliance and reduction of vulnerabilities (Richardson et al., 2023). This may pose an additional barrier to services within the Irish Traveller community, where traditionally gender roles and masculinity are intertwined with cultural norms for Traveller men (Hodgkins & Fox, 2012).

Culturally Sensitive Services and Interventions

Culture provides a context in which an individual’s framework for the world is developed (Ibrahim, 1985). In many therapeutic relationships there is a cultural difference between the client and therapist, in part due to the lack of diversity within psychology (British Psychological Society, 2015). Bridging the cultural gap between the two involves addressing cultural complexities and providing culturally sensitive services (Wong, 2016). Multiple studies have found that promoting, and sensitivity to, Irish Traveller culture is key to facilitating engagement with community mental health services (Villani & Barry, 2021; Cullenbrooke & Gupta, 2021).

For services to be able to accommodate cultural sensitivity, the identity of the relevant cultural group must be understood. Narrative Identity Theory posits that individuals make sense of the world through stories, deriving meaning from those narratives (Fisher, 1984). According to McAdams and McLean (2013), an individual’s narrative integrates past experiences with future expectations, providing a sense of purpose. The tripartite model of narrative identity incorporates personal, social, and cultural contexts in shaping a person’s identity (Hammack, 2008). Identity is seen as dynamic, continually shaped by one’s environment and experiences (McAdams, 2001).

McKey et al. (2022) identified an intersection between Traveller identity, social impacts, and psychosocial consequences exacerbating mental health difficulties in Traveller communities. Factors highlighted included loss of identity, experiences of discrimination, cultural beliefs (fatalism, stoicism) and pressure to conform to society. Certain social impacts which are heightened in prison such as isolation, loss of identity, stigma, and perception of threat are likely to increase mental health needs for Irish Travellers in prison.

Present Study

There is little research into understanding narratives held for Irish Traveller men accessing psychological intervention, and an even greater absence of research for those in prison. This lack of research highlights the need to understand the stories of service users and clinicians providing the interventions, and how these might be shared or diverged.

Understanding Irish Traveller and clinician narratives of help-seeking for psychological distress and psychological intervention in prison would potentially increase the development of cultural competence in practitioners, which could contribute to better outcomes, service adaptions and removal of structural barriers.

Aims

To address these gaps in the literature, the current study had the following research questions:

1. What are the personal stories of male Irish Travellers who have accessed psychological intervention in prisons?
2. Do community and cultural narratives of help-seeking and psychological intervention feature in their personal stories?
3. What are the stories of clinicians providing interventions to Irish Travellers in prison?
4. What are the parallels and divergences in the stories told?

Method

Theoretical framework

This study takes the epistemological approach of social constructionism, whereby there is no “objective truth”, but rather the understanding that meaning is constructed through the identities and experiences of those constructing it (Burr, 2015). Due to the cross-cultural nature of the study, the integration of both Emic and Etic perspectives, as described by Pike (1967), was crucial. These perspectives form a symbiotic relationship. The Emic perspective reflects the view of the phenomenon from the culture of those being studied, while the Etic perspective consists of the researcher's interpretations, which may connect these experiences to broader human phenomena. Narratives held by clinicians contribute to the experience of those accessing services, creating community narratives which are integrated into identity development. The aim is to understand the personal stories of both service users and clinicians and understand how community and cultural narratives influence their ways of understanding psychological intervention and help-seeking.

Design

Narrative analysis encompasses a range of analytic approaches, united through an interest in “storytelling” and the narrative accounts people produce (Earthy & Cronin, 2008). A narrative interviewing approach emphasises the generation of rich, detailed accounts and the exploration of dominant discourses surrounding Irish Travellers' engagement with psychological interventions in prison. This method is well-suited for capturing the complexity of contextual and interpersonal dynamics, as well as the uniqueness of individual experiences. Its exploratory nature is particularly fitting given the limited research in this area. Moreover, Irish Traveller writers have highlighted the significance of storytelling in transmitting history and values across their community and generations (Ó Haodha, 2011).

Reflexivity

All eight interviews were carried out by the author, a white British female who had previously worked in prisons providing psychological intervention. A reflexive journal was maintained throughout the research process. This ensured reflection of the author’s influence on the research process, extracts from which can be seen in Appendix A. The author has taken a social constructionist approach, which emphasises the role of context and culture in the formation of meaning and highlights a lack of objective knowledge. However, this is in the context of being a healthcare professional outside the travelling community, with inherent Eurocentric views. The researcher was sensitive to the relational and dynamic nature of ethnicity

and ensured self-reflexivity throughout the research (Mason, 2003).
Recruitment was extended to include clinicians due to difficulties with initial recruitment. The decision was made not to broaden the inclusion criteria to include other Traveller identities so as not to replicate the historical grouping of distinct and separate Traveller identities. Although the inclusion of clinicians may reduce the space given to Traveller voices, it provided a valuable understanding of the external community stories which impact Irish Traveller narratives.

An expert by experience (EbE) was consulted during project development. After the initial question prompt, they contributed to potential areas for follow-up. For service user interviews, the difference in ethnicity between the interviewer and the participant was named in the hope of minimising the hindrance to discussion. However, it is likely the author's differences in gender, ethnicity, religion and age will have influenced the generation of narratives. In clinician interviews, although ethnicity and gender were shared identities with the participants, there were likely additional intersectional differences which may not have been named. Therefore, the narratives produced in interviews are co-constructed, as the recipient of stories (a white woman associated with psychological services) influences how stories are designed (Riessman, 2008). Member checking was offered to all participants to minimise the influence of researcher bias (Lindheim, 2022).

Ethics

Ethical approval was granted by the Southeast Research Ethics Committee (REC) on 08/06/23 (Appendix H), National Research Council (NRC) on 09/10/23 (Appendix I) and Health Research Authority (HRA) on 30/10/23 (Appendix J). Approval was granted by the NHS trust research and development team on 08/01/24 (Appendix K). An amendment to recruit from additional sites was granted by HRA on 25/01/24 (Appendix L) and NRC on 22/02/24 (Appendix M). A final amendment to expand recruitment to include staff was approved by HRA on 19/08/24 (Appendix N).

Informed consent was acquired from service users and clinician participants following consideration of the information provided in service user participant information sheets (Appendix Q) and clinician participant information sheets (Appendix R). Following in-person interviews, audio recordings of interviews were uploaded to a secure drive prior to leaving the prison, where they were stored until the end of the analysis. Recordings were manually transcribed.

Participants

Narrative analysis does not aim for generalisability and does not prescribe predetermined sample sizes, consequently, sample sizes are often based on opportunistic considerations (Squire et al., 2014). Similar sample sizes can be seen in published narrative papers (Donaghay-Spire et al., 2014). Recruitment within prisons poses additional challenges, which are further exacerbated by the recruitment of a minoritised group within this setting (Randolph et al., 2023). This is also further complicated by the subject matter, psychological distress, in a group where mental health is thought to be highly stigmatised and numerous barriers to help-seeking have been identified (Richardson et al., 2023).

Four male service users aged 21-37 years, and four female clinicians, aged 27 – 38 years, agreed to participate in the study. Purposive sampling was used to select participants who would meet the inclusion criteria (see Table 1). Contact with psychological services in prison includes those who had been assessed and had attended at least one intervention session, including those who had disengaged following the first intervention session. Those who had not engaged in any psychological intervention were not eligible to participate as it was considered that those with previous engagement may be more likely to engage in research and they would be able to speak to their experience of the intervention.

Recruitment took place across two prison sites. Limited details regarding the prison sites are presented to ensure the anonymity of participants. The first recruitment site was a category C prison, of which the population included approximately 30 who had identified as Travellers. The psychology service in the prison worked to a stepped-care model, providing interventions for mental health with no focus on offence-related work.

The second prison site was a Category B prison. The estimation of overall Travellers in the prison is unknown, as recruitment took place via a wing with a mental health provision, on which two prisoners had identified as Travellers. The mental health provision on the wing was provided as part of the offender personality disorder (OPD) pathway, with interventions focused on managing mental health and reduction of violent and sexual offences.

Both services were from within one NHS trust in the Southeast of England (see appendix G for letter of access).

Table 1

Participant inclusion and exclusion criteria

Service user criteria	Inclusion criteria:
	• Male • Self-identified as Irish Traveller • Aged 18 or over • Currently or previously served custodial sentence • Had contact with psychological therapies services in prison • Risk assessed as low risk to self, and staff (if applicable)
	Exclusion criteria:
	• Under the age of 18 • No contact with psychological services • Risk assessed as high risk to self or staff
Clinician criteria	Inclusion criteria:
	• Worked within a prison in a role providing psychological interventions • Engaged in one-to-one work with Irish Traveller men

Service user participants included those who had defined themselves as Irish Traveller upon entry to the prison and had contact with psychological therapies in prison. Potential participants were reviewed by a research supervisor to identify suitability. Initially, recruitment was planned from a three-prison cluster, one of which held a high proportion of Irish Travellers. However, due to changes in contracts for healthcare provision, this was limited to one with few prisoners identifying as Irish Travellers. To aid recruitment, additional prison sites were approached, as well as a third sector organisation with services in prison in the community. One additional prison site consented to support the study. Five potential service user participants were identified, of which one declined as they were due to be released imminently.

Participants completed a brief demographics questionnaire; responses can be seen in Table 2. Length of intervention indicates how many sessions they received, and whether the intervention was completed. All service user participants were currently serving custodial sentences and interviews were conducted in person within a prison.

Table 2

Service user participant demographics

Participant*	**Age****	**Intervention**	**Length of intervention**	**Intervention completed?**	**Length of sentence *** **	**Location of interview**
John	20-29	Counselling	8 sessions	Yes	5 - 10	Prison wing
Billy	20-29	Hearing voices	Unsure	Yes	5 - 10	Prison wing
Edward	20-29	Counselling	1 session	No – declined further sessions	5 -10	Prison healthcare
Michael	30-39	Therapeutic wing	Ongoing weekly sessions	Ongoing	10+	Prison education room

*names have been changed to protect anonymity
** age in years
** Sentence time in years

Clinician participants were recruited via purposive sampling through prison psychology teams, all of whom had worked in prisons in the Southeast of England. The demographics of clinician participants can be seen in Table 3.

Table 3

Clinician participant demographics

Participant*	Age**	Gender	Ethnicity	Profession	Length of time working in prisons***
1. Caroline	30-39	Female	White British	Trainee Psychologist	3
2. Lisa	20-29	Female	White British	Trainee Psychologist	3.5
3. Sally	30-39	Female	White British	Psychologist	2
4. Rachel	30-39	Female	White British	Psychologist	4.5

*names have been changed to protect anonymity
** age in years
*** working time in years

Data Collection

Interview topic guides were developed for service users and clinicians (see Appendix S and Appendix T). A narrative inquiry approach was used, whereby interviews began with a single question (Thornhill, 2004): “For this part, I’m going to ask a question and want you to tell me as much about it as you can. I’m not going to interrupt or ask any other questions, as I would like to hear your story as you want to tell it. Going as far back as you can remember, tell me how you came to (work in) psychology in prison?”. Notes were made during their answer, which were used to inform follow-up questions related to the research area. Interviews with clinicians were conducted via video call to encourage participation, with all service user interviews conducted in person in the prisons. Interviews were only commenced once consent had been given and participants had been given an opportunity to ask any questions. Interview length ranged from 32 min to 60 mins (M = 47.25, SD = 11.49).

Qualitative Validity

Member checking (Carlson, 2010) was offered, with two service user and four clinician participants agreeing. Two participants were unavailable as they had been released from prison. This was conducted during the initial stages of analysis, to ensure that the participant experience was understood before developing emerging narratives. Clarification of language used and meaning intended was key for two participants, regarding their feelings towards professionals and services. A transcript was reviewed and coded by a research supervisor, providing additional perspective and interpretation of the transcript.

Analysis

Narrative analysis encompasses a range of approaches, which can be used to facilitate and understand what is said, and why and how it is said (Riessman, 2008). The methodology in the present study utilised a combination of narrative approaches including Dialogical Analysis (Frank, 2012), Thematic Analysis (Riessman, 2008) and a Three-Tier Model of narratives (Makowski & Rappaport, 2000) which focuses on personal, community and cultural narratives in the data. The use of Thematic

Analysis allows for a focus on the content of shared stories and the identification of common themes across multiple participant experiences. Dialogical/positional analysis moves beyond content to the purpose of the stories shared and with whom they are shared, exploring how power dynamics shape individual stories. Rappaport's Three-Tier Model seeks to consider personal, community and cultural narratives and how these inform the individual's narrative identity. The Three-Tier Model situates these stories within broader cultural and societal contexts, examining how Traveller's identity and societal beliefs may influence their experiences. There can be tensions in integrating these three levels of analysis. Focusing on personal themes might overlook the social and cultural factors that influence them while emphasising the broader context might obscure individual experiences. However, when integrated, they provide a rich, multi-dimensional understanding of the narratives.

Within this study, an analytical approach was applied to each transcript moving from the broad (thematic analysis), to the social context (three-tier model) to the individual context (dialogical analysis). Table 4 presents the stages of the analytical approach used, which although presented as linear steps, the analysis was an iterative process, with movement back and forth through the steps as the analysis was carried out. The stages were modelled on the core principles of each of the three narrative approaches used, as described in Riessman (2008).

Table 4

Step-by-step procedure of analysis

Step	Process
1	Audio recordings of interviews were transcribed, during which preliminary reflections and thoughts were noted.
2	Each participant's transcript was read with a focus on the content. Personal narratives were highlighted and organised using the narrative summary sheet (example sheet in Appendix U). This included the following areas: - At what points do the stories begin? - Are there turning points shared as part of their narrative? - What is the tone of the narratives? - What devices have been used to shape their stories? (metaphors, choice of language etc) - How have they made meaning from their experiences?
3	The transcripts were read again with themes identified and documented on the narrative summary sheet. A synopsis was developed to include: - Where the story began - Community narratives - Key moments in the narrative - Their understanding/experience of mental health
4	The analysis focused on a dialogical approach (Murray, 2000) which focused on the following areas: - What are the central narratives? - How does the narrative serve the participant/what is the function? - How has the participant told the story and how do they want the story to be received? - What voices are present in the stories? - What aspects are missing from the narrative? - What facets of the participants’ identity may have influenced the narrative? - What dominant narratives are used or rejected within the stories?
5	What cultural and community narratives can be heard in the interviews?
6	What narratives of help-seeking and psychological intervention can be observed in the narratives, and how are these linked to cultural narratives?
7	Sharing of synopsis and discussion of the summary sheet was offered to each participant. Feedback on themes highlighted and language used were incorporated and changes were made to the synopsis and summary sheet where needed.
8	Narratives were compared across participants to identify themes in stories of service user participants, and themes in clinician stories, and then comparison of parallels or divergences in themes across service user and clinicians (see Appendix V and Appendix W).
9	Demonstrative quotes were taken from interviews to illustrate findings.

Results

Narrative analysis is concerned with how participants construct meaning through their stories. Researchers often aim to bring forward the voice of the storyteller, allowing the narrative structure and content to speak for itself, avoiding overinterpretation of data (Polkinghorne, 2007). In line with this, results are presented using the language of participants where possible. Table 5 summarises each participant's individual stories to provide context for the analysis.

Table 5

Summary of participants' narratives

Participant	Summary
P1 – John Service user participant	John shared he was unsure of how he came to be in contact with psychology in prison. He also spoke of his experiences with bereavement counselling, revealing his initial reluctance to open up but gradual comfort during sessions. He discussed how he has coped with his emotions in prison and the loss of his nephews, and how counselling has helped him cope. He explored personal growth in prison and developing a greater understanding of what is helpful for him. John discussed his experiences as a Traveller, facing challenges in navigating prison with his cultural identity.
P2 – Billy Service user participant	Billy, a prisoner, discussed his initial contact with psychology due to anger issues and ADHD, which began during his first jail term. He completed an eight-week anger management course but found it challenging to apply strategies in jail. John highlighted inconsistencies in jail, such as unfair treatment and delays in recategorization for Irish Travellers. He contrasted prison life with his community, noting the lack of support and the impact on his mental health. He emphasised the difficulty of reintegrating into society post-release, lacking job opportunities and community support.
P3 – Edward Service user participant	Edward discussed feeling uncertain of the process of seeking support in prison, querying the utility of talking about the past. He spoke about his experiences with ADHD and its impact on focus. He also discussed the importance of trust in relationships, and

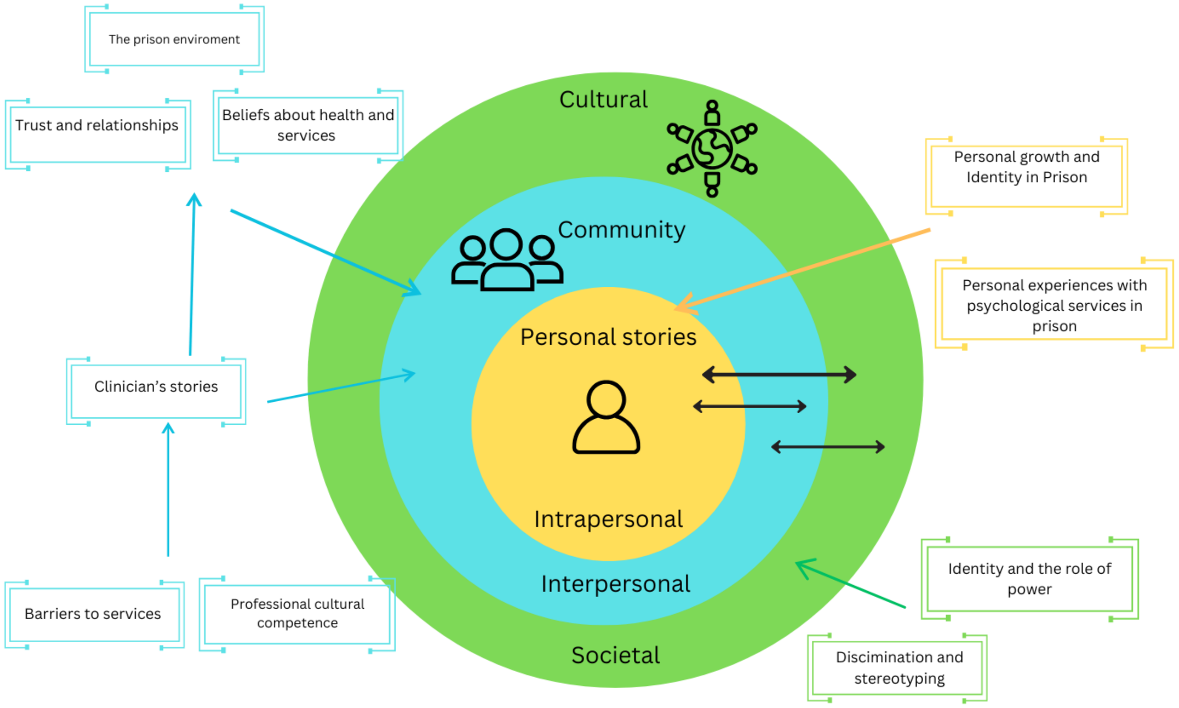
	the challenges of fulfilling family expectation. He discussed the shared community ideas of gender roles and mental health, emphasising the social pressures and privacy concerns that arise in relationships.
P4 – Michael Service user participant	Michael reflected that he was unsure what clinician’s saw in him to suggest he join the mental health wing, however he saw it as an opportunity. He described the psychology intervention he was doing and how it was like clinicians “rewinding a film” to understand him better. There was a lack of certainty over the utility of talking about the past, especially as this is a new experience for him even outside of mental health contexts. He discussed community ideas of mental health and the way he has seen this play out for others he knows. He shared stories of his experiences with professionals, including social services and the power they hold. He reflected on his trial and considered whether certain things were permitted that would not have happened were he not a traveller.
P5 – Caroline Clinician participant	Caroline discussed the challenges of supporting positive mental health of prisoners. She highlighted the importance of building trust and relationships, as well as the need for more training and understanding within the mental health team of different facets of identity. She also discussed the prevalent negative views of Irish Travellers in prisons, rooted in stereotypes and misconceptions, and emphasised the need to challenge these biases to provide adequate support for travellers' mental health. Finally, she touched on the difficulties in establishing trust and addressing sensitive topics in therapeutic work with prisoners.
P6 – Lisa Clinician participant	Lisa shared a sense of mistrust towards psychological therapies among Irish Travellers in prisons, stemming from historical experiences of discrimination and stigma. She highlighted challenges in building trust, managing power dynamics, and addressing disparities in mental health support across different age groups. Lisa discussed the impact of facets of her own identity and the prison environment on the therapeutic work. She also spoke of the impact of isolation and reflection in prison, and the complexities of working with individuals from marginalised groups.
P7 – Sophie Clinician participant	Sophie highlighted the overrepresentation of Irish Travellers in prisons and the challenges they face due to discrimination and harsh environments, affecting their mental health. She also discussed the complex power dynamics within prisons and the need to form meaningful relationships to facilitate psychological change. Sophie emphasised the need for mental health professionals to develop a greater understanding of a range of identities.

P8 – Rachel Clinician participant	Rachel explored her experiences working with Irish travellers in prisons over 10 years ago, and again in the present. She noted that cultural norms, particularly in sexual offending interventions, were frequently discussed but often complicated the process of addressing offence-related beliefs. She highlighted her experiences of the challenges of navigating cultural differences in the context of legal frameworks. She also discussed the impact of systemic biases and the lack of cultural competence in psychological interventions. Rachel emphasised the importance of genuine engagement with cultural diversity and the need for more inclusive and culturally sensitive practices in prisons.

Results are presented by research question. Firstly, themes exclusive to service user narratives, secondly clinician narratives and finally community and cultural narratives, and any parallels and divergences in these. Although presented separately, the overlap between sections is noted, with stories and themes represented in Appendix V and Appendix W. Results are presented thematically, with a dialogical narrative approach and Rappaport's three-model framing additional insights. Figure 1 shows a diagram of the narrative themes from the present study and how they integrate with the service user's narrative identity (McAdams & McLean, 2013). This has been conceptualised using Rappaport's three-tier model (Mankowski & Rappaport, 2000). The model demonstrates the interplay between personal, cultural and cultural narratives and the bidirectional influence they may have on each other.

Figure 1

Model demonstrating narratives of Irish Travellers accessing psychological intervention in prison, in the context of narrative identity theory



What are the Personal Stories of Male Irish Travellers who have Accessed Psychological Intervention in Prisons?

All service user participants initially struggled to answer the opening question, requiring the use of follow-up prompts that facilitated a co-constructed narrative with the researcher. This suggests that participants may have felt unable to speak openly with a new, unknown professional holding keys due to fear of judgement, or due to difficulty viewing psychological distress and help-seeking through a service lens. As a result, analysing the original sequence and structure of their stories was not possible, meaning turning points or causality of events could not be identified

(Riessman, 2008). Two unique themes emerged from the participants' narratives including their Experiences with Psychological Services in Prison, and Personal Growth and Changes in Their Sense of Self.

Personal Experiences with Psychological Services in Prison

This theme explores how the service user participants understood and made sense of their personal experiences with psychology in prison. It is of note that the initial question prompted service user participants to share this. All service user participants identified they were uncertain of how they came to be in contact with psychology, and three service user participants noted a lack of clarity of what others may have seen or reported that led to their psychology referral.

I actually really don't know how the counselling thing come up. I think um, I think it could have been something to do with chaplaincy, something like that. **Michael**

Their experiences tended to involve initial reluctance, challenges with engaging, and eventual emotional benefits from the intervention. All participants also reflected on their perceptions of the intervention, with only Edward stating he was not able to approach the intervention earnestly, dropping out after one session.

Researcher: You spoke a little bit before about like the, the session that you had at the counselling. Can you tell me more about that?

Participant: Miss, to be honest, that was all made up, and there were bits of truth.

There was bits of truth. But I didn't really take serious. **Edward**

All participants expressed doubt or uncertainty prior to starting the intervention and reflected on the challenges with engagement. The eventual benefit of engagement was identified by Michael and John, with Michael describing interpersonal connection as rare within the prison setting.

At first, I had a voice in my head and who was telling me the stuff people would think about [seeing a psychologist]. I didn't know what else to do about it. Like, actually, when I've talked to someone, she was a psychologist, things like understanding what went on there and how to cope. By the end, I used the whole hour session talking though the things that felt hard. **John**

Personal Growth and Identity in Prison

Three service user participants shared stories of their sense of personal development and increased self-awareness. Billy was the only participant not to share stories relating to personal growth, which may be reflective of the early stage of his psychological intervention, and the long period of time ahead of him in prison. All three of the participants who spoke of individual development and insight were due to be released within the next year, with Billy serving a life sentence. This may be due to consideration of their identity when returning to the community.

Michael, Edward, and John shared experiences of identity transformation and self-reflection during their time in prison. Each reported grappling with their sense of identity and change, as a result of the intervention, and time in prison.

Obviously being in prison, like thinking, like decisions that I made, like, and I'm thinking, like, how impulsive my behaviour is, and stuff like that, how I just do things, and put myself in situations. **Michael**

What are the Stories Unique to Clinicians Providing Intervention to Irish Travellers in Prison?

All clinician participants were able to answer the initial question. All narratives began with how their career brought them to work in prisons, moving on to specific work that they had experienced with Irish Traveller prisoners, summarising some of the challenges specific to the population and environment. All participants were tentative in their answers, conscious of grounding them in clinical examples they could recall. This may reflect how they position themselves as psychologists, as reflective, scientist-practitioners, or it may speak to positioning with the author who would likely be positioned as advocating for Irish Travellers, therefore hoping to not be perceived as expressing discriminatory views. The themes unique to their stories included: professional cultural competence and barriers to services.

Professional Cultural Competence

All clinician participants described their perceptions of cultural competence, demonstrated by how diversity is spoken about within teams. They noted a frequent lack of acknowledgement of Irish Traveller culture in conversations around diversity and the importance of nuanced understanding in professional settings, particularly regarding ethnicity and culture.

I noticed more since going on training like about making sure we consider like difference and diversity and culture. But I suppose travellers are never included when you talk about that. **Caroline**

Clinician participants highlighted the need for professionals to develop cultural competence rooted in an accurate, personalised understanding of individuals rather than assumptions or media-influenced stereotypes.

I think that also training that we receive in the NHS and in psychology that talks about identity and intersectionality, from memory doesn't, or what, doesn't have kind of like a specific, a specific focus on the Irish traveller community, either, which, given the prevalence of that group in prison, probably would be helpful. **Lisa**

Barriers to Services

Three clinician participants shared stories regarding barriers to services. Exclusionary services were noted due to logistical, structural and cultural barriers which leave Irish Travellers unable to access services in a way which is equitable to the settled population.

"There's a certain amount of barriers to getting into the service, I think, for travellers, that perhaps aren't there for other people, like most of the time, how you get to the

services is you put in an app so you have to write down what you want. You also have to be able to read all the leaflets you've been given. So, literacy automatically becomes quite a big barrier." **Sophie**

Conversely, Caroline noted how services in prisons may have removed some barriers that might be present in the community as there is clarity as to which service provides which intervention.

Like when you're in prison, you know what's available, you know the services. Whereas outside, like, even, like, I think even for like us, like for me, I sometimes think that the mental health like, where you go, like, it's quite confusing. Like, there's a lot of services around, and people don't really quite know where to go. **Caroline**

What are the Parallels and Diversions in the Community and Cultural Narratives that Featured in Participant Stories?

These narratives are comprised of three primary influences, firstly within the culture and community of prison, and secondly within Irish Traveller culture, and finally in the dominant cultural narratives of society. The interplay between these contexts may have varying levels of influence dependent on the theme discussed, however would be difficult to extrapolate from one another. In addition, three out of four service user participants described Irish Travellers' views as strange in some way. It is curious whether this was shared in anticipation of judgement from the researcher, as someone external to their culture. This positioning is likely to have influenced the narratives that were shared.

In comparing the cultural and community narratives across participants, shared narratives highlighted parallels in clinician and service user stories. Meanwhile, diversions illustrate the differences in participants' perspectives, emphasising how unique backgrounds, contexts, or personal interpretations shape their stories.

Parallels between the service user and clinician stories are highlighted through shared narratives presented below. Diversions, which arise in the differing perceptions of the narratives by the participants, are also noted and discussed below.

Trust and Relationships

A shared narrative relating to trust was described by six participants (three service users and three clinician participants). The concept of cultural distrust was highlighted, underpinned in part by a fear of vulnerability. Billy reported his mistrust of professionals as due to experiencing them as “trying to catch [him] out”. Edward highlighted this concept as relevant to both those external to the community, as well as within.

I keep a lot of people at arm's reach. Even my cousin that’s in my cell now. Like I’m close with him, like closer than a lot of people but I'm closer with him in a way that I'd fight for him, I’d die for him. I mean, I've give him half of what I had do you know what I mean? But when it comes to speaking, talking and telling them stuff, you can't do that. **Edward**

The importance of interpersonal relationships was highlighted by three clinician participants, building on the concept of trust highlighted by service user participants. Clinician participants reflected on their presence in prison allowing for relationship building prior to intervention, perhaps meeting the need for connection many prisoners may have. They also identified that relationship building may be of higher importance within prison settings, due to difficulties with trust in the wider prison population. Clinician participants highlighted the importance of developing relationships with all prisoners, which can facilitate engagement in psychological interventions for those who are referred, particularly those from the Traveller community.

if I went to see like, an Irish traveller who had, like, a family member on the same wing, and I was like, chatting to him, and his like, say, cousin walked past, and he'd be like, "come and talk to miss". He'd be like "she's all right. Like, it's fine". And that's how, like, you would then get somebody else's like, because somebody else has seen you and been like "yeah, she's fine. You can talk to this person". And I think that kind of like, like something about reputation, or something or like, be proving yourself trustworthy to someone, and then like the person that you've proven it to their opinion is trustworthy. So other people would trust that you're trustworthy.
Sophie

Beliefs about Health and Services

Three service user participants shared beliefs about health and services influencing their engagement with help-seeking and psychology in prison. All expressed preconceived ideas regarding psychology which created a reluctance to engage with psychological input. Edward described these ideas as rooted in the stigma attached to attending health and mental health appointments, both in prison and in the community. Edward shared family perceptions that accessing mental health support is to be discouraged.

It’s probably, my family wouldn’t tell me that “It's like, it's not right to go [to counselling].” But I think hearing them talk about other people, I probably, probably wouldn't remember what they said. But subliminally in the back of my mind. It's like “oh, I shouldn't do that.”. **Edward**

Additionally, Billy reflected how the reluctance to engage is due to a sense of privacy and he shared community stories of negative outcomes from stays in mental health hospitals and the belief that prison is a preferable place. Both Billy and Edward spoke of their perception of psychology as focused on the past, which they described as sometimes best forgotten.

In parallel to the service user narratives, all clinicians shared narratives around ideas of health, mental health and psychology in the Irish Traveller and prison community. Three clinicians identified contact with mental health support in prison as often the first contact Irish Traveller prisoners may have had with mental health services, reflecting stories shared by service user participants. Two clinicians described Irish Travellers as underrepresented in psychological interventions, with Lisa understanding this to be due to the emphasis placed on family support in managing mental health rather than professional support. She also described how social exclusion can occur when a prisoner has been identified as having mental health difficulties.

Although a shared narrative, there were some divergences from how this is perceived. Caroline and Sophie reported high enthusiasm and uptake from Irish Traveller service users, both reporting high percentages of their caseloads identifying as Irish Travellers.

There's that stereotype of "they don't talk to anyone like they're not going to talk about their mental health". But I actually found, if I'm thinking about the people that I worked with, were probably the most engaging people I worked with, the people that that really wanted support. **Caroline**

The Prison Environment

Three clinician participants described the influence of the prison environment as a context for mental health and psychology. All three queried whether the environment was suitable for some psychological work, due to the lack of safety and untherapeutic environment.

It's just such a like, unpleasant, over-stimulating environment that then to ask people to really dig deep when the base level of psychological safety, or like physical safety, isn't there. **Sophie**

All service user participants shared narratives of defending against emotions while in prison. The need to avoid internal experiences was highlighted, in addition to reducing emotional expression around others. The need for self-management and suppression of emotions is likely counter to the expectations of engaging with psychology.

I put on a smile for people or whatever, you know, I mean, and I kind of like put myself second in these kinds of situations. But that's just my way of coping innit. Like right now, my mum died two weeks ago, the funerals today, and it's like, I haven't, haven't, showed no emotion like once you know. **Michael**

Paralleling the service user narratives discussed earlier, three clinician participants described emotional avoidance for prisoners. This was attributed to the lack of support from family available while in prison, in addition to cultural differences in expressions of distress which may mean less support is given or is given at a later stage of difficulty.

Discrimination and Stereotyping

Seven participants, three service users and four clinicians described discrimination and stereotyping of Irish Travellers within prison settings, representing a parallel narrative between clinicians and service users. These experiences are likely to influence help-seeking and experiences of psychological distress in prison settings. John and Billy described being treated differently from other prisoners, for example during the trial (Billy) and when awaiting re-categorisation (John).

There's another Irish fella in this jail. He applied for D cat; was told he had no chance of going to a D cat jail. That's not right. Any English or other fella in this jail, wait two weeks and they're going to D cat, with a re-categorisation. **John**

Four participants described discriminatory views and words used concerning Irish Travellers, which would not be deemed acceptable for other ethnicities. Rachel shared that attitudes to Irish Travellers have remained discriminatory although those holding those views express them in different ways now.

*Like for people who've gone telling, making jokes about black people call them bad names. And that's like, simple now, you can't. But people can still say p***ey this and p***ey that. No one says anything about it. It's just seen as normal.* **Billy**

A parallel in narratives, regarding stereotyping of Irish Travellers was highlighted by participants, with a focus on the role of the media and the role of professionals in perpetuating this. Edward highlighted the personal impact of being stereotyped as violent, leading to a self-fulfilling prophecy of fighting to defend himself. Three clinician participants reflected on how these experiences of discrimination and stereotyping influence the experience of services, in addition to contributing to care planning for Irish Travellers. This included the dismissal of Irish Travellers' needs and minimal attempts to engage them due to believing they would not engage. It was also noted that the experience of discrimination within the criminal justice system (CJS) can lead to a sense of injustice at the sentence given, which in turn influences engagement with those seen to represent the CJS.

The wider mental health team, it might not quite feel the same for travellers or people to engage with them, it might not feel the same. So maybe if there was a bit of reluctance, people are like "Oh, they're not going to engage anyway, so that's fine". **Caroline**

Identity and the Role of Power

Seven participants' personal stories reflected narratives regarding power and the influence of different facets of identity, representing a parallel narrative between clinicians and service users.

Four participants reflected on the role of being a professional in a prison on the service user. The power given by "holding all the keys" both literally and metaphorically, was described as creating a power imbalance between professionals and service users, with a perceived sense of obligation to engage with services in prisons.

I realise you can't start an argument with [professionals] because they've got all the control over everything. So, you kind of, have to be nice to them [laughs]. **Billy**

The role of gender identity in power was shared by five participants. Edward and John reflected on this in relation to community expectations of how men must behave, including reducing emotional expression.

You're supposed to basically be a businessman, and a family man, a fighting man.

Er, there’s just loads of different things you’re supposed to be. If you have one, and you don’t have the other, it’s like you have nothing. **Edward**

Diverting from service user narratives, three clinicians described themselves as disempowered in a prison context due to their gender. All described the experience of working with men who have offended against women, and how this can feel conflicting and can trigger strong emotion. They shared how in the provision of psychological interventions in prison settings they can experience a sense of vulnerability, leading to a need to compartmentalise facets of their identity. These feelings of vulnerability are likely to influence the service user experience of the intervention.

In terms of experiences of sexism or discrimination, as a female working in a men's prison, basically, I think it's challenging, because it shakes your moral values about how you work with people who cause you harm, potentially emotional harm or physical harm, or harm on a more broad societal level. **Lisa**

All three clinician participants also discussed the aspects of identity they hold which position them as in power over Irish Travellers accessing psychology in prison, including professional role and ethnicity. The fluidity of power was highlighted, with changing levels of minoritisation depending on context.

Discussion

This study sought to understand the stories of male Irish Travellers who had engaged with psychological interventions, alongside the perspectives of the clinicians who worked with male Irish Travellers. It also aimed to examine how personal, community and cultural narratives intersect and contribute to the formation of narrative identity.

What Were the Personal Stories of Irish Travellers Who Had Accessed Psychological Intervention, and Do Community and Cultural Narratives Feature?

Eight areas emerged from the service user participant narratives: personal experiences with psychological services in prison; personal growth and identity; trust and relationships; beliefs about health and services; the prison environment; identity and the role of power; and discrimination and stereotypes. These include community and cultural narratives shaping personal stories. The complex interplay between these levels of narratives cannot be unteased, with all influencing the individuals' formation of identity.

All shared stories of their experiences of psychology in prison, highlighted a lack of certainty regarding the process of help-seeking, and initial hesitancy to engage with psychology. A reported lack of clarity over initial contact with services is a unique finding from this study and highlights the need to understand the routes into services and consent. These stories were influenced by community and cultural narratives. Previous research highlighted the impact of masculinity on mental health help-seeking (Gonzalez et al., 2005), with this barrier intensified within prison environments due to the expectation of hypermasculinity (Kupers, 2005). This is additionally influenced by community narratives of mental health and psychology, including mental health stigma from within the Irish Traveller community (Villani & Barry, 2021) and the prison population (Byrne et al., 2023). These narratives also contribute to concepts of expression of psychological distress, with Cemlyn et al. (2009) identifying Traveller community responses as using stoicism as a response to experiences of discrimination and stigma.

This experience also connects to community narratives of trust, where three participants shared stories of difficulty trusting those in power and those external to Irish Travellers. Travelling communities' mistrust of outsiders has been found to exist across settings (Cemlyn et al., 2009). The sense of mistrust is likely linked to experiences of discrimination, which was shared by three participants. Discrimination was highlighted in multiple contexts by participants, which have been documented previously, including in prison (Gavin, 2019) and in the courts (Morgan-Williams & Donson, 2023).

The concept of personal development and growth from psychological intervention was highlighted by three participants. In keeping with previous research, the three participants were close to release, which may have encouraged greater self-reflection and greater changes in identity (Khan, 2023).

All of the above stories are influenced by the role of power and the influence of identity. Power can be fluid, depending on whether an individual is minoritised within a setting (Crenshaw, 1991). Power was spoken about in relation to being in prison and gender, with identity as a prisoner removing power in the therapeutic relationship and gender gaining power within the therapeutic relationship. The interaction of power is of note when considering developing professional relationships with Irish Travellers in prison, with therapeutic communities demonstrating the importance of empowering those in custody (Bennet & Shuker, 2010).

What Were the Stories of Clinicians Who Provided Psychological Intervention to Irish Travellers, and Do Community and Cultural Narratives Feature?

There was considerable overlap between the narratives shared by service users and clinicians. Two themes emerged unique to clinicians: professional cultural competence and barriers to services.

The importance of relationship building was identified by three participants, linking with the community narrative of mistrust of others and professionals. Also named were logistical barriers, with one participant noting there may be fewer barriers in prison, which is contrary to previous research identifying increased barriers to mental health support in prisons (Patel et al., 2017; Forrester et al., 2018).

Clinicians identified a lack of cultural competence in practitioners when working with Irish Travellers. A key finding unique to this study was the exclusion of Traveller identities from diversity discussions. This may reflect the relatively recent recognition as an ethnic minority (Cromarty, 2019). It may also be indicative of the aforementioned discrimination and social exclusion that Irish Travellers experience.

All clinicians described Irish Traveller discrimination and stereotyping within the prison system, noting that negative stereotypes can drive formulation and care planning. This is in keeping with past research (Gavin, 2019) and connects with the concept of power raised. All clinicians described identities that give power and those that disempower. Their identity as a woman in prison, often working with men who have offended was raised by three participants. This highlights the dynamic nature of power and how in institutions it can be difficult for professionals to accurately perceive their power (Crenshaw, 1991).

Strengths and Limitations

Narrative research aims to share rich, individual stories rather than seek generalisability (Riessman, 2008). While this study involved a small, geographically limited sample, it highlighted the often excluded experiences of Irish Travellers in prison, a group that faces "double stigma" due to their ethnic and prison identities (Bancroft, 1997).

Clinician narratives of Irish Travellers accessing psychology in prison had not been explored before. Including clinician perspectives was crucial for understanding the experiences of this group, as psychological interventions for them are likely cross-cultural due to their underrepresentation in the field.

Recruitment challenges limited participant diversity, and including individuals from different security levels and stages of their sentences could have provided more insight into how narratives change over time (Haney, 2003).

Service user participants struggled with the narrative inquiry approach, likely due to unfamiliarity with discussing emotions, lack of trust, and the researcher’s gender and ethnicity. This co-construction of narratives may have led to more positive portrayals of psychology, influenced by the researcher’s identity. Future studies may benefit from using semi-structured interviews, particularly when researching high-stigma groups.

Although EbE collaboration was present during the project's development, unfortunately, due to personal circumstances they were unable to provide input to the analysis, and no alternative EbE was able to be sought. It is hoped that the use of member checking mitigates some of this impact, however, a greater inclusion of EbE perspectives would have made for a richer interpretation of the narratives told. Due to the location of the service user interviews (in prison), it was not possible to have an EbE present in the interview process. Previous research has noted how the inclusion of a member of the travelling community in interviews has facilitated greater discussion (Condon et al., 2019). Further research outside of a secure establishment would benefit from this approach.

The interview settings likely influenced the narratives. Two service user interviews on the wing were brief due to the loud, busy environment and the participants' need to return to their cells. The other service user interviews occurred in quieter rooms, and all clinician interviews were conducted via video call, lasting until both researcher and participant reached a natural conclusion.

Implications

Although the narratives explored are individual to those who participated, they may provide insight into those experiences, with clinical implications for those in similar situations.

Clinical Practice

The present study highlights experiences of discrimination experienced by Irish Travellers and stereotypes held by professionals, likely impacting trust and the provision of care when services are accessed. Training programs that aim to increase cultural competence, and awareness can help reduce implicit and explicit biases among staff working with Irish Travellers. Improvements in cultural competence are particularly key when working in institutional settings (Mac Gabhann, 2011). This could be further facilitated through the inclusion of Irish Traveller identity in discussions around diversity, with all clinicians reporting this being excluded from these reflections. Such discussions have been shown to improve clinician cultural competence and thus improve the service user experience of a cross-cultural therapeutic relationship (Hook et al., 2013).

Stories from service users highlight a potential lack of clarity in the process of help-seeking. An unclear process of how participants came into contact with services raises potential questions regarding whether informed consent could be given to engage. Services sharing a clear process of referral and ensuring this is fully understood by service users may improve therapeutic alliance and potential outcomes (Beahrs & Gutheil, 2001).

Trust and relationships were identified as key to the experience of help-seeking and psychology. Research has previously highlighted the importance of developing a therapeutic relationship in a prison population (Denton & Grenade, 2022), however, findings from the present study may shed light on the additional experiences of mistrust for Irish Travellers in prison. This, in conjunction with experiences of discrimination and stereotyping, emphasises the need for clinicians and services to ensure adequate time is given to building rapport and trust with Irish Travellers in prison accessing services.

Clinicians should note potentially higher rates of stigma and greater value placed on privacy regarding healthcare when working with members of the Irish Traveller community. Consideration should be given to ensuring privacy, although this can be a challenge working in prisons where there are few private spaces.

Policy and Research

Further research may benefit from comparing Irish Traveller help-seeking and psychological intervention experiences across their sentence, as previous research has indicated that experiences of distress peak near the start of a sentence (Favril & van Ginneken, 2023). It may be beneficial to understand how the stage in sentence interacts with narratives of psychological intervention and help-seeking.

Although the research sought to give voice to a group often underrepresented in research, there is limited variation within the group. Further research may benefit from focusing on those who have chosen not to engage in psychological intervention to better understand what support is utilised and how this can be bolstered to improve mental health in prisons.

Conclusion

The study explored the narratives of help-seeking and psychological intervention held by Irish Travellers and clinicians providing the interventions. This project provides an initial step towards understanding the meaning made of these experiences and how the narratives are influenced by the cultural and community narratives to which they are exposed. Further research is needed to identify potential barriers to support and ways to develop culturally competent services.

References

Adamson, V., Gibbs, M., & McLaughlin, D. (2014). Evaluation of the improving access to psychological therapies for offenders programme at HMP Lincoln: a three year prospective cohort study. *The Journal of Forensic Psychiatry & Psychology*, *26*(2), 185-201. https://doi.org/10.1080/14789949.2014.985695

Addis, M.E., & Mahalik, J.R. (2003). Men, masculinity, and the contexts of help seeking. *American Psychologist, 58*(1), 5-14. https://doi.org/10.1037/0003-066X.58.1.5

All Ireland Traveller Health Study Research Team. (2012). The health care experiences of Travellers compared to the general population: the All-Ireland Traveller Health Study. *Journal of Health Services Research & Policy, 17*(3), 173-180. https://doi.org/10.1258/JHSRP.2011.011079

Allen, D. (2016). 'It's in their Culture': Working with automatic prejudice towards Gypsies, Roma and Travellers during care proceedings. *Seen and Heard*, *26*(2), 40-52. https://e-space.mmu.ac.uk/623531/8/Seen%20and%20Heard%20Dan%20Allen%20DRAFT%206%20May%202016%5B2%5D.pdf

Andrews, M. (2021). Quality indicators in narrative research. *Qualitative Research in Psychology*, *18*(3), 353-368. https://doi.org/10.1080/14780887.2020.1769241

Bancroft, A. (2005). *Roma and Gypsy-travellers in Europe: Modernity, Race, Space and Exclusion.* Ashgate publishing.

Beahrs, J. O., & Gutheil, T. G. (2001). Informed consent in psychotherapy. *American Journal of Psychiatry*, *158*(1), 4-10. https://psychiatryonline.org/doi/pdf/10.1176/appi.ajp.158.1.4

Bennett, P., & Shuker, R. (2010). Improving prisoner-staff relationships: exporting Grendon's good practice. *The Howard Journal of Criminal Justice*, *49*(5), 491-502. https://doi.org/10.1111/j.1468-2311.2010.00639.x

Binchy, A. (1985). *Shelta: An historical and contemporary Analysis* [Doctoral dissertation, Dublin City University]. DCU Research Repository.

Bouw, N., Huijbregts, S. C., Scholte, E., & Swaab, H. (2019). Mindfulness-based stress reduction in prison: Experiences of inmates, instructors, and prison staff. *International Journal of Offender Therapy and Comparative Criminology*, *63*(15-16), 2550-2571. https://doi.org/10.1177/0306624X19856232

Bradshaw, R., Pordes, B. A., Trippier, H., Kosky, N., Pilling, S., & O'Brien, F. (2017). The health of prisoners: summary of NICE guidance. *British Medical Journal*, *356*. https://discovery.ucl.ac.uk/id/eprint/10042701/1/Pilling_brar130317%20final%20BMJ%20article%202017.03.23%201.1.pdf

British Psychological Society. (2015). *Clinical Psychology Workforce Project.* Division of Clinical Psychology. https://www.bps.org.uk/sites/www.bps.org.uk/files/Page%20-%20Files/Clinical%20Psychology%20Workforce%20Report%20%282015%29.pdf

Burns, D., Murray, C., Ferguson, J., & Moore, L. (2023). The experiences of men in prison who do not receive visits from family or friends: A qualitative systematic review. *Criminal Behaviour and Mental Health*, 1-25. https://doi.org/10.1002/cbm.2332

Burr, V. (2015). *Social constructionism*. Routledge. https://eclass.uowm.gr/modules/document/file.php/NURED260/International%20Encyclopedia%20of%20the%20Social%20%26%20Behavioral%20Sciences%20Burr%20Social%20Constructionism%202015.pdf

Byrne, E., Bradshaw, D., Kerin, M., & Pepe, I. (2023). A social identity approach to mental health help-seeking behaviour in prisoners: A systematic review. *Journal of Community & Applied Social Psychology*, *34*(1), e2727. https:/doi.org/10.1002/casp.2727

Carlson, J. A. (2010). Avoiding traps in member checking. *Qualitative Report*, *15*(5), 1102-1113. http://www.nova.edu/ssss/QR/QR15-5/carlson.pdf

Cemlyn, S., Greenfields, M., Burnett, S., Matthews, Z., & Whitwell, C. (2009). *Inequalities experienced by Gypsy and Traveller communities: A review* (Vol. 12). Manchester: Equality and Human Rights Commission.

Cesaroni, C., Maycock, M., & Vaswani, N. (2023). Incarcerated young men, masculinity, and trauma. *Men and Masculinities*, *26*(2), 188-209. https://doi.org/10.1177/1097184X231166690

Condon, L., Bedford, H., Ireland, L., Kerr, S., Mytton, J., Richardson, Z., & Jackson, C. (2019). Engaging gypsy, Roma, and traveller communities in research: Maximizing opportunities and overcoming challenges. *Qualitative Health Research*, *29*(9), 1324-1333. https://doi.org/10.1177/1049732318813558

Crenshaw, K. (1991). Mapping the margins: Intersectionality, identity politics, and violence against women of color. *Stanford Law Review, 43*(6), 1241–1299.

http://www.jstor.org/stable/1229039?origin=JSTOR-pdf

Cromarty, H. (2019). "Gypsies and Travellers 08083." *House of Commons Library*, London. Available at: http://researchbriefings.files.parliament.uk/documents/CBP-8083/CBP-8083.pdf (Accessed 13 September 2023).

Cullenbrooke, F., & Gupta, S. (2021). Mental Health of Irish Travellers: An East London Perspective. *Mental Health, Mental Illness and Migration*, 261-269.

Dalbir, N., Wright, E. M., & Steiner, B. (2024). Mental illness, substance use, and co-occurring disorders among jail inmates: Prevalence, recidivism, and gender differences. *Corrections*, *9*(2), 264-286. https://doi.org/10.1080/23774657.2022.2090028

Earthy, S. & Cronin, A. (2008). Narrative analysis. In N. Gilbert (Ed.), *Researching Social Life* (pp. 202-221). Sage. https://s3.eu-central-1.amazonaws.com/eu-st01.ext.exlibrisgroup.com/44SUR_INST/storage/alma/AB/88/AF/6C/60/FD/40/78/53/2F/BA/D9/79/C3/DC/9E/narrative%20analysis.pdf?response-content-type=application%2Fpdf&X-Amz-Algorithm=AWS4-HMAC-SHA256&X-Amz-Date=20241031T083004Z&X-Amz-SignedHeaders=host&X-Amz-Expires=119&X-Amz-Credential=AKIAJN6NPMNGJALPPWAQ%2F20241031%2Feu-central-1%2Fs3%2Faws4_request&X-Amz-Signature=4c0f035c428ca2c73ba16ca41b44402eafd0183829703d53dfeadca61c792db0

Every-Palmer, S., Ross, B., Flewett, T., Rutledge, E., Hansby, O., & Bell, E. (2023). Eye movement desensitisation and reprocessing (EMDR) therapy in prison and forensic services: a qualitative study of lived experience. *European*

Journal of Psychotraumatology, *14*(2), 2282029. https://doi.org/10.1080/20008066.2023.2282029

Denton, D., & Grenade, L. (2022). Connecting with clients: Building therapeutic alliances with people who are incarcerated. *Psychotherapy and Counselling Journal of Australia*, *10*(1). https://pacja.org.au/2022/07/connecting-with-clients-building-therapeutic-alliances-with-people-who-are-incarcerated/

Donaghay-Spire, E. G., McGowan, J., Griffiths, K., & Barazzone, N. (2016). Exploring narratives of psychological input in the acute inpatient setting. *Psychology and Psychotherapy: Theory, Research and Practice*, *89*(4), 464-482. https://doi.org/10.1111/papt.12081

Equality Act 2010, c. 15. https://www.legislation.gov.uk/ukpga/2010/15/contents

Favril, L., & van Ginneken, E. F. (2023). Individual and environmental contributors to psychological distress during imprisonment. *European Journal of Criminology*, 14773708231201726. https://doi.org/10.1177/14773708231201726

Fazel, S., & Baillargeon, J. (2011). The health of prisoners. *The Lancet*, *377*(9769), 956-965. https://citeseerx.ist.psu.edu/document?repid=rep1&type=pdf&doi=95cfbc5e8c90d2022231e3bcf5c5c07531fa8e75

Fazel, S., Hayes, A. J., Bartellas, K., Clerici, M., & Trestman, R. (2016). Mental health of prisoners: prevalence, adverse outcomes, and interventions. *The Lancet Psychiatry*, *3*(9), 871-881. https://doi.org/ 10.1016/S2215-0366(16)30142-0

Fazel, S., & Seewald, K. (2012). Severe mental illness in 33 588 prisoners worldwide: systematic review and meta-regression analysis. *The British Journal of Psychiatry*, *200*(5), 364-373. https://doi.org/

10.1192/bjp.bp.111.096370

Fisher, W. R. (1984). Narration as a human communication paradigm: The case of public moral argument. *Communications Monographs*, *51*(1), 1-22. http://redmonky.net/utpa/4324/fischer.pdf

Forrester, A., Till, A., Simpson, A., & Shaw, J. (2018). Mental Illness and the Provision of Mental Health Services in Prisons. *British Medical Bulletin, 127*(1), 101-109. https://doi.org/10.1093/bmb/ldy027

Foster, N. (2019). *Traveller Community and health practitioner stories of self and each other: A poststructural narrative analysis.* [PhD thesis, University of Edinburgh.] University of Edinburgh Research.

Frank, A. (2012). Practicing dialogical narrative analysis. *Varieties of Narrative Analysis*, 33-52.

Gavin, P. (2019). 'Prison is the worst place a Traveller could be': The Experiences of Irish Travellers in Prison in England and Wales. *Irish Probation Journal*, *16*, 135-152. http://researchspace.bathspa.ac.uk/12905/1/12905.pdf

Gavin, P. (2020). Irish ex-prisoner reflections on their psychological wellbeing whilst in prison in England and Wales. *Advancing Corrections Journal*, *9*(1), 101-118. https://researchspace.bathspa.ac.uk/13207/1/13207.pdf

Gonzalez, J. M., Alegria, M., & Prihoda, T. J. (2005). How do attitudes toward mental health treatment vary by age, gender, and ethnicity/race in young adults?. *Journal of Community Psychology*, *33*(5), 611-629. https://doi.org/0.1002/jcop.20071

Greenfields, M. (2017). Good practice in working with Gypsy, Traveller, and Roma communities. *Primary Health Care*, *27*(10), 24-29. http://doi.org/10.7748/phc.2017.e1263

Haney, C. (2003). Mental health issues in long-term solitary and "supermax" confinement. *Crime & Delinquency*, *49*(1), 124-156. https://doi.org/ 10.1177/0011128702239239

Hammack, P. L. (2008). Narrative and the cultural psychology of identity. *Personality and Social Psychology Review*, *12*(3), 222-247. http://doi.org/10.1177/1088868308316892

Harding, S. (2014). Social exclusion: Cultural dissonance between Travellers and non-Travellers in British secondary schools. *Journal of Student Engagement: Education Matters*, *4*(1), 25-34. http://ro.uow.edu.au/jseem/vol4/iss1/4

Her Majesty's Inspectorate of Prisons. (2014). *People in Prison: Gypsies, Romany and Travellers.* London: Her Majesty's Inspectorate of Prisons

Hodgins, M., & Fox, F. (2012). 'Causes of causes': ethnicity and social position as determinants of health inequality in Irish Traveller men. *Health Promotion International*, *29*(2), 223-234. https://doi.org/10.1093/heapro/das066

Hook, J. N., Davis, D. E., Owen, J., Worthington Jr, E. L., & Utsey, S. O. (2013). Cultural humility: measuring openness to culturally diverse clients. *Journal of Counseling Psychology*, *60*(3), 353.https://doi.org/10.1037/a0032595

Ibrahim, F. A. (1985). Effective Cross-cultural Counseling and Psychotherapy: A Framework. *The Counseling Psychologist*, *13*(4), 625-638. https://doi.org/10.1177/0011000085134006

Inside Times. (2022). *Official: Prisoners can no longer be called "residents". Inside Times.* https://insidetime.org/newsround/official-prisoners-can-no-longer-be-called-residents/

Khan, Z. (2023). Experiences of self-reflection as identity reconstruction and adaptation to prison life. *The Howard Journal of Crime and Justice*, *62*(4), 575-589. https://doi.org/10.1111/hojo.12541

Kupers, T. A. (2005). Toxic masculinity as a barrier to mental health treatment in prison. *Journal of Clinical Psychology*, *61*(6), 713-724. https://doi.org/10.1002/jclp.20105

Lindheim, T. (2022). Participant validation: A strategy to strengthen the trustworthiness of your study and address ethical concerns. In G. Espedel, B. Jelstad Lovaas, S. Sirris, & A. Waeraas (Eds.) *Researching Values: Methodological Approaches for Understanding Values Work in Organisations and Leadership* (pp. 225-239). Cham: Springer International Publishing.

McAdams, D. P. (2001). The psychology of life stories. *Review of General Psychology*, *5*(2), 100-122. http://www.selfdefiningmemories.com/McAdams_Life_Stories_2001.pdf

McAdams, D. P. & McLean, K. C. (2013). Narrative Identity Theory. *Current Directions in Psychological Science, 22*(3), 233-238. http://doi.org/10.1177/0963721413475622

McKey, S., Quirke, B., Fitzpatrick, P., Kelleher, C. C., & Malone, K. M. (2020). A Rapid Review of Irish Traveller Mental Health and Suicide: A psychosocial and anthropological perspective. *Irish Journal of Psychological Medicine*, 1-11. http:// doi.org/10.1017/ipm.2020.108

Mac Gabhann, C. (2011). Voices unheard. *A Study of Irish Travellers in Prison. London: Irish Chaplaincy in Britain*. https://www.iprt.ie/site/assets/files/6252/voices_unheard_june_20112.pdf

Maier, K. H., & Ricciardelli, R. (2019). The prisoner’s dilemma: How male prisoners experience and respond to penal threat while incarcerated. *Punishment & Society*, *21*(2), 231-250. https://doi.org/10.1177/1462474518757091

Mankowski, E. S., & Rappaport, J. (2000). Narrative concepts and analysis in Spiritually-based communities. *Journal of Community Psychology*, *28*(5), 479-493. https://doi.org/10.1002/1520-6629(200009)28:5%3C479::AID-JCOP2%3E3.0.CO;2-0

Marziali, E., & Alexander, L. (1991). The Power of the Therapeutic Relationship. *American Journal of Orthopsychiatry*, *61*(3), 383-391. https://www.rotman-baycrest.on.ca/files/publicationmodule/@random45f5724eba2f8/AmerJOrthopsychia91_61_383.pdf

Mason, D. (2003). Changing Ethnic Disadvantage: An Overview in D. Mason (Ed.), *Explaining ethnic differences: changing patterns of disadvantage in Britain* (pp. 9-19). Policy Press.

Mishler, E. G. (1986). *Research Interviewing.* Cambridge: Harvard University Press

Moore, K. E., Stuewig, J. B., & Tangney, J. P. (2016). The effect of stigma on criminal offenders' functioning: A longitudinal mediational model. *Deviant Behavior*, *37*(2), 196-218. https://doi.org/10.1080/01639625.2014.1004035

Morgan-Williams, S. and Donson, F. (2023). 'The court as a site of rediscrimination', in L. Flower & S. Klosterkamp (Eds), *Courtroom Ethnography* (pp. 179-194). Palgrave Macmillan. https://doi-org.ucc.idm.oclc.org/10.1007/978-3-031-37985-7_12

Myers, M. (2019). An inheritance of exclusion: Roma education, genetics, and the turn to biosocial solutions. *Research in Education*, *107*(1), 55-71.

https://doi.org/10.1177/0034523719880205

Nurse, J., Woodcock, P., & Ormsby, J. (2003). Influence of environmental factors on mental health within prisons: focus group study. *British Medical Journal*, *327*(7413), 480. https://doi.org.uk/ 10.1136/bmj.327.7413.480

Office for National Statistics. (2021). Gypsy or Irish Traveller populations, England and Wales: Census 2021. https://www.ons.gov.uk/peoplepopulationandcommunity/culturalidentity/ethnicity/articles/gypsyoririshtravellerpopulationsenglandandwales/census2021

Ó Haodha, M. (2011). Travellers and Communal Identity: Memory, Trauma and the Trope of Cultural Disappearance. *Études Irlandaises*, (36-1), 43-57. https://doi.org/10.4000/etudesirlandaises.2126

Parent, M. C., Hammer, J. H., Bradstreet, T. C., Schwartz, E. N., & Jobe, T. (2018). Men's mental health help-seeking behaviors: An intersectional analysis. *American Journal of Men's Health*, *12*(1), 64-73. https://doi.org/10.1177/1557988315625776

Patel, R., Harvey, J., & Forrester, A. (2018). Systemic limitations in the delivery of mental health care in prisons in England. *International Journal of Law and Psychiatry*, *60*, 17-25. https://doi.org/10.1016/j.ijlp.2018.06.003

Pickering, A., Blagden, N. & Slade, K. (2023) 'You can have a bit of my pain, see how it feels' – understanding male prisoners who engage in dual harm behaviours. *Psychology, Crime & Law, 29*(8), 825-848. https://doi.org/10.1080/1068316X.2022.2037593

Pike, K. L. (1967). *Language in relation to a unified theory of the structures of human behavior* (2nd ed.). Mouton.

Police Act 2022, c. 83. https://www.legislation.gov.uk/ukpga/2022/32/contents

Polkinghorne, D. E. (2007). Validity issues in narrative research. *Qualitative Inquiry*, *13*(4), 471-486. https://doi.org/10.1177/1077800406297670

Pyke, K. D. (1996). Class-based masculinities: The interdependence of gender, class, and interpersonal power. *Gender & Society*, *10*(5), 527-549. https://www.researchgate.net/profile/Karen_Pyke/publication/249667860_Class-Based_Masculinities_The_Interdependence_of_Gender_Class_and_Interpersonal_Power/links/00463527829262d233000000.pdf

Quirke, B., Heinen, M., Fitzpatrick, P., McKey, S., Malone, K. M., & Kelleher, C. (2020). Experience of discrimination and engagement with mental health and other services by Travellers in Ireland: Findings from the all-Ireland Traveller health study (AITHS). *Irish Journal of Psychological Medicine*, 1-11. https://doi.org/10.1017/ipm.2020.90

Race Disparity Unit. (2022). *Gypsy, Roma and Irish Traveller Ethnicity Summary.* UK Government Ethnicity Facts and Figures. https://www.ethnicity-facts- figures.service.gov.uk/summaries/gypsy-roma-irish-traveller

Ramesh, T., Mercieca, M., Curran, H. V., & Cabourne, J. (2023). Exploring masculinity, experience of distress and help-seeking within a UK male prison. *Journal of Men’s Health, 19*(12), 87-98.

https://doi.org/10.22514/jomh.2023.134

Randolph, I., Simonds, R., Sharps, D., Wallace, J., Joseph, H., Ropac, R., & Bergin, T. (2023). Integration of individuals with lived experience to improve recruitment within criminal justice research: ‘experience as the best teacher’. *International Journal of Social Research Methodology*, 1-14. https://doi.org/10.1080/13645579.2023.2276960

Rangiwai, B., Enari, D., Masae, C., Paea, D., Tahilanu-Mapili, L., & Vailahi, V. (2021). Lost in Translation: Reflexive Thematic Analysis in Research with Pacific Peoples. *Te Kaharoa*, *17*(1). https://pdfs.semanticscholar.org/3377/3154082f600c4bd195c04b7c919757936baa.pdf

Ratkalkar, M., & Atkin-Plunk, C. A. (2020). Can I ask for help? The relationship among incarcerated males’ sexual orientation, sexual abuse history, and perceptions of rape in prison. *Journal of Interpersonal Violence*, *35*(19-20), 4117-4140. https://doi.org/10.1177/0886260517714440

Ricciardelli, R. (2015). Establishing and asserting masculinity in Canadian penitentiaries. *Journal of Gender Studies, 24*(2), 170–191. https://doi.org/10.1080/09589236.2013.812513

Richardson, N., McDonnell, K., Carroll, P., & O’Donnell, S. (2023). Using an intersectional approach to explore the lived mental health experiences of Traveller men affected by suicide in Ireland. *American Journal of Men's Health*, *17*(5), 1-16. https://doi.org/15579883231189063.

Riessman, C. (1993). *Narrative Analysis.* London: Sage Publications.

Riessman, C. K. (2008). *Narrative methods for the human sciences*. Sage.

Silver, K.E., Levant, R.F., & Gonzalez, A. (2018). What Does the Psychology of Men and Masculinities Offer the Practitioner? Practical Guidance for the Feminist, Culturally Sensitive Treatment of Traditional Men. *Practice Innovations*, *3*(2), 94. 0 https://doi.org/10.1037/pri0000066

Singleton, N., Gatward, R., & Meltzer, H. (1998). *Psychiatric Morbidity Among Prisoners in England and Wales*. London: Stationery Office.

Squire, C., Andrews, M., Davis, M., Esin, C., Harrison, B., Hydén, L. C., & Hydén, M. (2014). *What is Narrative Research?*. Bloomsbury Academic.

Sturge, G. (2023). UK Prison Statistics. *House of Commons Library. https://researchbriefings.files.parliament.uk/documents/SN04334/SN04334.pdf*

Tanner, B., & Doherty, A. M. (2021). Suicidal Ideation and Behaviors Among Irish Travellers Presenting for Emergency Care: Ethnicity as a Risk Factor. *Crisis: The Journal of Crisis Intervention and Suicide Prevention*. https://doi.org/10.1027/0227-5910/a000769

The Traveller Movement. (n.d.). *Romani (Gypsy), Roma and Irish Traveller History and Culture.* Retrieved October 30, 2024, from https://travellermovement.org.uk/gypsy-roma-and-traveller-history-and-culture

Tyler, N., Miles, H.L., Karadag, B., Karadag, B. & Rogers, G. (2019). An updated picture of the mental health needs of male and female prisoners in the UK: prevalence, comorbidity, and gender differences. *Social Psychiatry and Psychiatric Epidemiology,* 54, 1143–1152. https://doi.org/10.1007/s00127-019-01690-1

UK Ethnicity Facts and Figures. (2022). *Gypsy, Roma and Irish Traveller ethnicity* summary. https://www.ethnicity-facts-figures.service.gov.uk/summaries/gypsy-roma-irish-traveller

Villani, J., & Barry, M. M. (2021). A Qualitative Study of the Perceptions of Mental Health Among the Traveller Community in Ireland. *Health Promotion International*, *36*(5), 1450-1462. https://doi.org/10.1093/heapro/daab009

Wong, P. T. (2016). The Need for Existential Cross-cultural Competency in Therapy and Supervision. *Psych. Critiques.* https://doi.org/10.1037/a0040311

Yousaf, O., Poppat, A., & Hunter, M. S. (2015). An investigation of masculinity attitudes, gender, and attitudes toward psychological help-seeking. *Psychology of Men and Masculinity,* 16(2),234 - 237. https://doi.org/10.1037/a0036241

Appendix A – Excerpts from reflexive journal

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Appendix B - Example quotes for experiences of rejection table

Author	First order constructs	Example of second order constructs	Second order theme	Third order construct
Thompson et al. (2022)	“We face a lot of racism and discrimination in our daily lives which affects our mental health. And also that even with medical professionals that there is internal racism and discrimination” (p. 5)	“Participants were frequent victims of racist behaviour, including from professional organisations such as social services, health care and schools” (p. 5)	Discrimination	Experiences of rejection
Keogh et al. (2020)	No quote	“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	
Smith & Ruston (2013)	“Prejudice has a big impact on your physical health because you withdraw from society. So you won’t go to the doctors and then you withdraw and that’s what’s happening” (p. 9)	“The respondents used social closure as a strategy to minimise the prejudicial attitudes they experienced from the wider society and specifically among health staff. They voiced a widespread reluctance to seek professional advice on heath matters	Discrimination	

		based on previous negative experiences with health professionals and hostile encounters with receptionists and other health staff" (p. 8)		
Treise & Sheperd (2006)	"don't have time for travellers" (p. 2)	"Fears of hostility were fuelled by common experiences of actual discrimination" (p. 2)	Discrimination	
Van Cleemput (2009)	"It is frightening being a Traveller love, because no-one wants you... if they could, they'd build a hole and they'd shove all the Travellers into it and they'd just bury them all there. If there was no law they would do that." (p.185)	"The experience of racism and negative stereotyping is pervasive and automatically anticipated with many examples given from all areas of life" (p. 185)	Discrimination	

Author	First order constructs	Example of second order constructs	Second order theme	Third order construct
Condon et al. (2021)	'that I should not go to the hospital, because there are such doctors which do not want to help' (p. 6)	"Both Roma and Gypsy/Traveller participants gave examples of relatives who had repeatedly attended primary care with symptoms that later proved cancerous; this led to conflict when family members felt they had to pressure doctors to make a referral. Difficulties were exacerbated for non-English speaking Roma, some of whom had used a health insurance system in Slovakia and had little experience of primary care. A woman (who acted as an informal interpreter for friends and family) described dismissive treatment of Roma, which she attributed to discrimination" (p. 6)	Discrimination	

Author	First order constructs	Example of second order constructs	Second order theme	Third order construct
Gilhooley et al. (2019)	“They are very slow to refer, and I hate using the racist card, but there is an awful lot of that type of thing going on” (p. 4)	“Discrimination was also discussed among group members as a possible reason for reported difficulty in accessing secondary care. Participants questioned whether their travelling background influenced the GP’s referral practices.” (p. 4)	Discrimination	
Smith & Newton (2016)	“Most camps are miles away from the shops even now aren’t they? It’s very rare you’ll get one close to shops. Far from doctors, far away from health care, no bus route ... if it’s easy access definitely because like I said we don’t always live on a bus route” (p. 5)	“Geographic and social isolation also excludes people from the social and material resources necessary for planning a course of action on the basis of the best available knowledge” (p. 5)	Isolation	
Thompson et al. (2022)	“Say you’re sort of a gay Irish Traveller man? And you feel like ‘the whole rest of the world doesn’t like me because I’m a Traveller, and now I might get completely isolated from here because, I’ve got a boyfriend.’ You know that feeling of like I’m	“As GRT people feel ostracized from the wider society, close community bonds provide a sense of security and protection. As such, rejection from the GRT community leaves participants feeling isolated. This isolation and lack of belonging strongly and negatively impacted	Isolation	

	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" (p. 5)	participants' MH." (p. 5)		
Smith & Ruston (2013)	"[T]ry to buy their way into housing estates they will knock neighbours and say 'Will you do a swap with me?' Just to move to be close to each other." (p. 8)	The existence and proximity of social bonds played an important function in mitigating the negative psychological impacts of enforced settlement, widespread discrimination and social stigma but also resulted in placing respondents at risk of not accessing effective health care and not knowing what they needed to do to prevent ill health (p. 12)	Isolation	

Author	**First order constructs**	**Example of second order constructs**	**Second order theme**	**Third order construct**
Thompson et al. (2022)	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 p. 7	This stigma causes discomfort when talking about MH issues. Consequently, individuals avoid discussing their MH with others in the community which, in turn, heightens shame and reluctance to access support. P. 7	Shame	
Condon et al. (2021)	A friend, he had it [bowel cancer] and he was very open...I'd be shy to talk about it and be shamed...if it did happen to me, I don't think I could go to the NHS. (p. 5)	Both Roma people and Gypsy/Traveller spoke of cancer as a stigmatised disease, but noted views are changing	Shame	
Reid & Taylor (2006)	We'd been married two years and no child. I was shamed and couldn't talk to anybody. I went secretly for the tests. They wanted him to come for tests as well but to me, as a Traveller, it was a woman's problem. (p. 4)	"Traveller women's perceptions of the stigma associated with remaining single or infertile acted as a strong discouragement to question the status of marriage and motherhood" (p. 4)	Shame	

Van Cleemput (2006)	“Maybe it's just through the way we were brought up, it's our kind of shyness and embarrassment whatever” (p. 191)	Within this context the findings demonstrate the prominence of shame in a devalued identity and how this is a contributory factor in the reinforcing the communication divide (p. 334)	Shame	

Appendix C – Example quotes for communication with healthcare professionals and services

Author	First order constructs	Example of second order constructs	Second order theme	Third order construct
Thompson et al (2022)	"The 'nerves' thing, is like an all-purpose word that is used [by travellers] to describe a huge array of conditions" (p. 7)	"Despite improved awareness amongst the younger generation, miscommunication was deemed responsible for lack of overall knowledge. The use of psychiatric terminology by MH professionals compared to the language used by GRT people increased miscommunication and confusion." (p. 7)	Communication differences	Communication
Condon et al. (2021)	"They talks in a different way, language than what we do and we understand blunt words and they don't want to put them blunt words, but that's better for us if they did." (p. 5)	"This study provided examples of what a good service looks like, mainly from tertiary care, where practitioners (nurses, doctors and third-sector workers) were described as forming relationships of	Communication difference	

		trust with patients and their families and communicating clearly." (p. 7)		
Keogh et al (2020)	No quote available	"During the interviews the service users talked about how the TMHLN helped the Travellers and the type of help that she gave them. Any of the help that was provided was embedded within an interpersonal communication process that was tailored to meet the communication needs of the service users." (p. 7)	Communication differences	
Van Cleemput (2009)	"they told me, but I wouldn't know; they did [explain] but I didn't understand" (p. 219)	"Health staff behaviours and most importantly, communication difficulties, were the factors that most influenced Travellers' impressions of their health care experience" (p. 218)	Communication differences	
Reid & Taylor (2006)	"She didn't say anything but I knew from the look in her eyes that things weren't right" (p. 6)	"Non-verbal messages were crucial to effective communication, with all women included referring	Communication differences	

Author	First order constructs	Example of second order constructs	Second order theme	Third order construct
		to the importance of eye contact, facial expressions, touch and physical distance" (p. 6)		
Gilhooley et al. (2019)	"It's not being explained; it's just give you the cream, and not all travellers are good readers and they may not be able to read the instruction" (p. 3)	"Others reported that their literacy levels were not being assessed before information was imparted, which resulted in some participants receiving incomprehensible information, requiring them to go back to their GP for a simpler version" (p.3)	Dissemination of information	
Jackson et al. (2017)	"I took my son twice [for vaccinations]. I didn't know what they were actually saying, I didn't know what it was for; I didn't understood. If I go somewhere I do manage to make myself understood, that time I didn't" (p.9)	"Literacy was also seen as a barrier among the English speaking communities in York and Bristol; this was not exclusively related to older community members. Of those who discussed literacy, many described people being unable to read immunisation leaflets or letters/texts about	Dissemination of information	

Author	**First order constructs**	**Example of second order constructs**	**Second order theme**	**Third order construct**
		appointments as well as struggling to make sense of conversations with health professionals, particularly if GPs use medical jargon" (p. 9)		
Condon & Salmon (2014)	"She gave me some [leaflets], but I can't read, not unless I ask someone to read it, then I find out what's in it. I'd ask whoever was there but not a lot of people read. It's difficult if you need someone to read. I just looked at the pictures, but I didn't often look in the book." (p. 6)	"Health professionals were described by all groups as relying on written materials to give health promotion information, despite low literacy levels. Although none of the Roma interviewees read English, most mentioned having been given leaflets" (p. 6)	Dissemination of information	
Van Cleemput (2009)	"if you don't read and write it's difficult to get information." (p. 227)	"Health professionals were described by all groups as relying on written materials to give health promotion information, despite low literacy levels. Although none of the Roma interviewees read English,	Dissemination of information	

Author	**First order constructs**	**Example of second order constructs**	**Second order theme**	**Third order construct**
		most mentioned having been given leaflets" (p. 227)		
Reid & Taylor (2006)	No quote	"Attempts to provide information would need to take into account low levels of literacy among gypsy traveller communities, and in fact a recent drug education programme, designed by Gypsy Travellers themselves in collaboration with a loca Drug Action team, had made constructive use of audio cassettes" (p. 3)	Dissemination of information	
Keogh et al. (2020)	No quote	"They also talked about how the TMHLN understood their needs. Important components of this interpersonal relationship were time and being listened to which were valued. Within this	Being heard	

Author	**First order constructs**	**Example of second order constructs**	**Second order theme**	**Third order construct**
		relationship, a number of activities occurred” (p. 6)		
Gilhooley et al. (2019)	“The dermatologist let me tell her everything I had done” (p. 5)	“Participants reported ‘telling my story’ to the dermatologist and discussed their eagerness to tell the dermatologist about the treatments they had trialled.” (p. 5)	Being heard	
Van Cleemput (2009)	“he was very good like that he listened ... he just wanted to listen. I explained all that to him and he examined me...” (p. 222)	“There were numerous examples of health staff, and doctors in particular, who failed to 'listen' or to take them or a family member seriously.” (p. 222)	Being heard	
Reid & Taylor (2006)	“They took your temperature, put a hand on your tummy, looked at the stitches and told you how much milk the child should be taking and then didn’t come back for hours. There was never anyone to ask you what	“Women voiced discontent with a task-oriented system of clinical care that valued identification of underlying pathology (Royal College of Midwives, 2000) but neglected emotional needs” (p. 7)	Being heard	

Author	**First order constructs**	**Example of second order constructs**	**Second order theme**	**Third order construct**
	you thought and felt" (p. 7)			

Appendix D – Example quotes for cultural identity and management of health

Author	First order constructs	Example of second order constructs	Second order theme	Third order construct
Van Cleemput (2009)	“if God borned you to have a short life, you had a short life; if He borned you to have a long life you'd have a long life- nothing you could do to alter it” (p. 208)	“Beliefs about the relevance of screening area major factor in whether preventative measures are seen as a priority” (p. 208)	Fatalism	Cultural Identity and management of health
Thompson et al. (2022)	“I think like telephone support would be helpful [but] I just think there’s other practical things you need to think of as well, like if they are living in a trailer, and there’s loads of siblings running around, it’s just like how can I have this conversation privately?” (p. 6)	“Participants reported a fear and distrust of outsiders which is intertwined with a need to protect their community and maintain a strong sense of privacy” (p. 7)	Privacy	
Keogh et al. (2020)	No quote	“This sense of confidentiality and privacy allowed the service users to feel comfortable with the TMHLN and meant that they were able to talk about the issues that affected them in an open manner.” (p. 7)	Privacy	

Author	First order constructs	Example of second order constructs	Second order theme	Third order construct
Van Cleemput (2009)	“not really to be honest. If it's personal, it's like that's personal, you don't want everybody knowing your business” (p. 194)	“The aspect of the strong cultural belief in privacy is a great fear of other Gypsies and Travellers outside of their own close family 'knowing their business'”(p. 256)	Privacy	
Condon et al. (2021)	“We’ll keep them home...we got daughters, granddaughters [to] look after the person that’s ill.” (p. 6)	“When a family member was terminally ill, there was an expectation among Gypsy/Travellers that they would be cared for within the family” (p. 6)	Network support	
Condon & Salmon (2014)	“I don’t think they need any advice in feeding their children because it’s passed on from their own mums and grandmothers” (p. 5)	“Participants agreed that the family plays a large part in influencing infant feeding choices. Large families are commonplace among Gypsies and Travellers, and there is an expectation that older children help care for younger siblings.” (p. 5)	Network support	
Smith & Ruston (2013)	“The condenseness of the travelling community keeps it alive. Without that we’d disintegrate, which is what the government want, but that’ll never happen even	“The ability to deflect and resist external pressures by maintaining a dense web of social relations was perceived to be essential to collective identity	Network support	

	if they put us all in houses and places we don’t want to be: they’ll always be who they are” (p. 6)	and a sense of individual wellbeing.” (p. 6)		

Van Cleemput (2009)	“"my family is there like, but you've got to help yourself." (p. 189)	“Interviews demonstrated a cultural expectation and desire for the family to give support and care to each other” (p.189)	Network support	
Reid & Taylor (2006)	No quote given	“Postnatal care in hospital, by restricting access to family and friends, was perceived to diminish the social significance and integration of mother and baby into the family and the Traveller community. Existing supportive mechanisms were undermined and isolation enhanced” (p. 7)	Network support	

Treise & Sheperd (2006)	No quote available	“Traditional patterns of help-seeking tended to keep problems with the family or the extended family unit” (p. 2)	Network support	
Condon et al. (2021)	“We wouldn't talk about it to our wives, and they wouldn't talk about women's problems to us” (p. 6)	“Even in illness, privacy between men and women was maintained.” (p. 6)	Gender roles	

Smith & Newton (2016)	“If there was a vehicle and the men needed it well you had no vehicle because if they don’t go to work we don’t eat basically. So if we’re left without a vehicle that’s the way it is isn’t it?” (p. 5)	“Structural constraints are a greater influence on behaviour in poor and excluded groups, as competing and more immediate concerns take priority over the less immediate benefits of immunisation. In the example below, the participant explains how a combination of strictly demarcated gender roles and short-term material needs can preclude attendance at clinics and surgeries” (p. 5)		
Van Cleemput (2009)	“Your work's important... and keeps you going... [bringing up family] that was my work ... look after them and keep them clean and feed them. He was the reins, to put them in their place and what they had to do and what they did and they listened” (p. 189)	“the above references to clear gendered roles are aspects of Gypsy and Traveller culture that are viewed as important to uphold. It is equally important for health staff to be aware of these values” (p. 189)		

Author	First order constructs	Example of second order constructs	Second order theme	Third order construct
Jackson et al. (2017)	No quote	“Only two Traveller participants, one Bristol Roma Father and a York English Gypsy Mother, specifically spoke of how their housing (one on an official site, one in a house) facilitated take up of immunisations because their families are more integrated into society and are located close to the local GP practice.” (p. 10)	Living arrangements	
Smith & Newton (2016)	“A lot of travelling children don’t go to school for as long as other children. I don’t think they are offered the same information and awareness and what have you.” (p. 5)	“A core theme was the incompatibility of living arrangements and their attendant way of life with the provision of immunisation services.” (p. 5)		
Condon & Salmon (2014)	No quote	“For English Gypsy and Irish Traveller, interviewees travelling could lead to disrupted contacts with health professionals due to moving between sites.” (p. 9)		

Author	First order constructs	Example of second order constructs	Second order theme	Third order construct
Van Cleemput (2009)	“You're just as well stay in the one place and just learn to live every day because there literally is nowhere out there that you can stay and have a week or fortnight and move on again” (p. 187)	“Negative aspects of travelling, such as being continually moved on, lack of access to basic facilities and difficulties in accessing services” (p. 187)		
Van Cleemput (2009)	“: You know, my father- in-law, he was very ill and he found the curing people helped a lot ... that's like that's a part of our religion. That's what we believe in” (p. 203)	“Most Irish Travellers spoke of their strong Catholic upbringing and faith. Some also placed great belief and hope in the 'curing people' and of going to great lengths to travel to see 'holy' people for their intercession” (p. 203) “Religious and cultural beliefs dictated that many women kept special prayers or religious items with them” (p. 6)	Religion	

Appendix E- Example quotes for constructs relating to trust

Author	First order constructs	Exmple of second order constructs	Second order theme	Third order construct
Condon et al. (2021)	"Macmillan nurses are a godsend to all families, whether they be Travelling families, or house-dwelling families, because they're there, day and night, for any support that you may need...regardless [of] nationality." (p. 7)	"Specialist cancer services were described as good and healthcare professionals as kind and caring. Participants particularly liked those who built a relationship" (p. 6)	Experiences of HCPs	Trust
Jackson et al. (2017)	"It's the same practice so we know the Doctors and I really wouldn't want to move myself or my kids from them because they know us as if you're equal, if you know what I mean. [I'm] not just a patient, they know our history and get on with them" (p. 11)	"The importance of relationships with health professionals, with GPs and Health Visitors particularly, emerged strongly across all six communities. Many Travellers, predominantly women, described positive relationships based on trust and respect that often developed by attending the same GP practice and seeing the same health professionals over a prolonged period of time"	Experiences of HCPs	

		(p. 11)		

Author	First order constructs	Example of second order constructs	Second order theme	Third order construct
Gilhooley et al (2019)	‘If you don’t have a good relationship with your doctor sometimes you might feel a bit intimidated to say, “look, I’m sorry, I do want this appointment” (p. 4)	“When relationships with healthcare providers deteriorated as a result of bilateral poor health literacy, disillusionment with the medical profession ensued. Participants returned to more familiar forms of management, such as traditional remedies (cures), which were under their control” (p. 4)	Experiences of HCPs	
Smith & Newton (2016)	“They [health professionals] don’t care they don’t really care about this population. If they would care about this population they will make the effort to pop along” (p. 6)	“Negative experiences in health care settings and a perception that their health is afforded a low priority confirmed through the paucity of engagement with this community, played a significant role in some mothers’ refusal to engage with vaccination programmes” (p. 6)	Experiences of HCPs	
Smith & Ruston (2013)	“There’s more that’s frightened of doctors. No that’s right they’re [Gypsies/Travellers] just getting pushed around and	“Negative experiences are communicated and circulate through social networks where they accumulate with similar anecdotes of poor and	Experiences of HCPs	

Author	First order constructs	Example of second order constructs	Second order theme	Third order construct
	it's [health problem] never sorted." (p. 9)	discriminatory treatment and crystallise into a normative consensus" (p. 9)		
Van Cleemput (2009)	"when you find somebody good you appreciate it." (p. 213)	"As with news of 'bad' doctors, news of a good doctor or health worker spreads rapidly" (p.213)	Experiences of HCPs	
Reid & Taylor (2006)	"You didn't ask most of them treated us Travellers like nobodies didn't want to take time to speak to us. The doctors and nurses don't understand and don't want to understand!" (p. 5)	"There are several instances of such behaviour with Traveller women often lacking basic information and made to feel a nuisance when asking questions." (p. 9)	Shared experiences	
Treise & Sheperd (2006)	No quote available	"doctors", * or other workers, who showed an interest and appeared to gace time to listen, were highly valued and families would often travel long distances to consult them (contradicting the notion that Gypsy Travellers are not interested in accessing mainstream services)" (p. 2)	Trusted HCPs	

Author	First order constructs	Example of second order constructs	Second order theme	Third order construct
Keogh et al. (2020)	No quote	"Trust, confidentiality and privacy were repeatedly talked about by the service users as being essential to any relationship that they had with health professionals and from the onset, the service users talked about how they almost instantly developed these with the TMHLN" (p. 7)	Trusted HCPs	
Smith & Ruston (2013)	"Personally, I've done two or three hundred miles to keep a doctor because he's been reliable and he likes you and you like him. Even now I don't have a doctor round here I travel to mine because I've known him 22 years and he's reliable." (p. 10)	"Doctors with good reputations were held in high esteem. Information concerning trusted general practitioners and health professionals circulated widely through networks and respondents recounted examples of Gypsies travelling long distances to maintain continuity of care with a trusted member of health staff" (p. 10)	Trusted HCP	

Author	First order constructs	Example of second order constructs	Second order theme	Third order construct
Condon & Salmon (2014)	"I don't know what decided me to breastfeed, perhaps it was the midwife. With the last one I had the best service from the midwife. The health visitor for Travellers used to visit.... She was very supportive. She prompted me into it, coaxed me into it" (p. 8)	"A warm, trusting relationship which had developed over time appeared a prerequisite for successfully supporting a mother to breast-feed" (p. 8)	Trusted HCP	
Jackson et al. (2017)	No quote	"The other important information source was family and community. Whilst Travellers across all communities spoke of a shift from family towards health professionals as the primary source of health information, the sharing of experiential knowledge and advice was still passed down via 'word of mouth" (p. 6)	Community source of information	

Author	First order constructs	Example of second order constructs	Second order theme	Third order construct
Smith & Newton (2016)	“Jen who has the autistic child she believes it’s that [MMR] so that’s why people will hold back because of that especially everybody who knows her and her child.” (p. 8)	“The structure of social relations in GRT communities also means that gossip and anecdotes circulate widely, and constitute a further dimension of decision- making” (p. 8)	Community as source of information	
Condon & Salmon (2014)	“The Travelling community are reared up with children. I’ve always looked after children. I had younger sisters and always watched them” (p. 5)	“women considered that they had pre-existing knowledge and skills when they became parents. Few participants described themselves as requiring professional support in caring for children irrespective of age or number of children” (p. 5)	Community as source of information	

Appendix F- Example quotes relating to structural barriers and enablers to services

Author	First order constructs	Example of second order constructs	Second order theme	Third order construct
Smith & Newton (2016)	When I was a baby I got school boosters at home, you know into your leg. The health visitor used to come out they came to the camp and gave everybody immunisations. (p. 5)	"In spite of public health concerns over levels of infectious and communicable diseases in GRT communities, participants argued that outreach services were less frequent than during their own childhoods" (p. 5)	Outreach	Structural barriers and enablers to services
Reid & Taylor (2006)	No Quote	"Early discharge was not complemented by increased home visits from the public health nurse. These visits were nonetheless viewed positively as an opportunity" (p. 7)	Outreach	
Treise & Sheperd (2006)	No Quote	"They would need to be flexible in terms of delivery, with options for home visits, appointments at local surgeries and telephone contact" (p. 3)	Outreach	

Thompson et al. (2022)	“I think like telephone support would be helpful [but] I just think there’s other practical things you need to think of as well, like if they are living in a trailer, and there’s loads of siblings running around, it’s just like how can I have this conversation privately?” (p. 6)	“Participants faced practical difficulties when accessing MH services, including time, transport and privacy issues.” (p. 6)	Incompatible services	

Condon et al. (2021)	‘lack of access to services for a lot of people...and uneducated on the flipside as well’ (p. 6)	“However, a Traveller man argued that fatalism was justified because ‘lack of access to services for a lot of people...and uneducated on the flipside as well’ led to poorer health outcomes for Gypsy/Travellers than the majority population” (p. 6)	Incompatible services	
Jackson et al. (2017)	“Yeah, it is hard. They might give you an appointment for 2 weeks’ time, by 2 weeks’ time I’m forgetting about it anyway” (p. 11)	“Issues raised included the difficulty of registering with a GP practice without a fixed address or living on an unofficial site, frustration in getting through to the GP practice by phone to book an appointment, and being unable to get an appointment quickly” (p. 10)	Incompatible services	

Author	First order constructs	Example of second order constructs	Second order theme	Third order construct
Van Cleemput (2009)	"I just kept away until I was perhaps six months. They'd say where have you been" (p. 229)	"Unsolicited appointments for cervical smears or other undesirable procedures are less likely to be kept. This would be a particular concern for GPs, conscious of needing to meet Government targets." (p. 229)	Incompatible services	
Reid & Taylor (2006)	"The appointment was for 10 and I waited till 1 o'clock to see the doctor. You went in for 2 minutes and he told you nothing, and that was it. I usually didn't bother going." (p. 5)	"Stories of the organisation of care and the attitudes of health-care professionals reflected well-documented themes concerning protracted waiting times, inadequate information and impersonal treatment, and a general lack of consideration for other aspects of the women's lives aside from their pregnancy" (p. 5)	Incompatible services	

Author	First order constructs	Example of second order constructs	Second order theme	Third order construct
Condon et al. (2021)	“I think Billy was losing blood a long time ago...because I found it in the toilet. And I wondered where'd that blood come from because I never had no periods. But he had polyps” (p. 6)	“Women described men as reluctant to attend the doctors and attempted to encourage them to seek health care when necessary (see Table 3, Fatalism). Reluctance to engage with health services was often ascribed to men's breadwinner role, but many Gypsy/Traveller men referred to shame as the primary deterrent.” (p.6)	Late attendance at services	
Gilhooley et al. (2019)	“I have had psoriasis since I was 11 and I had very little knowledge about it. It’s only since we started working that I have learned a bit more about health and everything; I was getting no real information” (p. 4)	“Issues surrounding health literacy were prominent in relation to participants’ relationships with their GPs. Some participants felt that they were receiving insufficient information about the management of their personal skin disease or that of their child.” (p. 3)	Lack of information	

Author	First order constructs	Example of second order constructs	Second order theme	Third order construct
Reid & Taylor (2006)	No quote	"Attendance for 6-week postnatal check and cervical screening was very poor. Women viewed these preventive interventions as unimportant and embarrassing, yet often lacked basic information" (p. 7)	Lack of information	
Van Cleemput (2009)	"I just learnt it for myself, picked it up from the old people, from me great grandparents and me own mother and father" (p. 227)	"Much information about health and health services is readily available to a literate population in the form of leaflets, notices and posters, articles in popular magazines and in newspapers and increasingly via the internet. None of these routes are available to large numbers of Gypsies and Travellers who were unable to avail of a formal education. Instead, there were two main sources of information: information handed down or deliberately sought from family or peers in the	Lack of information	

		community, and the television" (p. 227)		

Appendix G – letter of access

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Appendix H – REC favourable outcome letter

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Appendix I – NRC approval letter

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Appendix J – HRA Approval

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Appendix K – Trust research and development approval email

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Appendix L – HRA approval to recruit from additional sites

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Appendix M – NRC approval to recruit from additional sites

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Appendix N – HRA approval of amendment to recruit staff

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Appendix O – Service user participant information sheet

Salomons Institute of Applied Psychology
One Meadow Road, Tunbridge Wells, Kent TN1 2YG
www.canterbury.ac.uk/appliedpsychology

Participant information about the research

Irish Travellers' experience of psychology in prisons

Hello. My name is Sarah Smith, 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.

It is important to understand why the project is being done and what will be done. Please take time to read the following information carefully before deciding whether to take part and discuss it with others if you wish. Please ask if there is anything that is not clear or if you would like more information.

What is the purpose of the study?

The Mental Health Inreach Team (Inreach) provides mental health support for residents in the prison, this includes support from psychology. In prisons, we know that people can have different mental health needs than when they are in the community so it's important to check whether the support being given is helpful. We also know that people from travelling communities can find it harder to get support, in ways that other people might not. This means that the process of getting support from psychology might be different for Irish Travellers who are in prison than it is for other residents. This study hopes to find out what it is like for Irish Travellers to seek help and what things may make this easier or harder.

Why have I been invited?

You have been invited as you stated you are an Irish Traveller and you have had support from psychology while in prison.

Do I have to take part?

It is up to you to decide whether to join the study. If you agree to take part, I will then ask you to sign a consent form. You are free to change your mind and say you want to leave the study, without giving a reason. This can only be done until the content of the interviews is anonymised. This means the information you gave us will be changed so no one will know it is you. Once this is done, we won't be able to remove your information. This would not affect any support you get from Inreach. Your decision to take part in this study will have no consequences, positive or negative, on your sentence.

What will happen to me if I take part?

If you choose to take part, you will meet with the researcher twice for an interview where you will be asked to share your experiences. There will be a series of questions so the researcher can hear as much about your views as possible. You will meet with the researcher again after the interview to talk about what was discussed in the first interview, to make sure you've been fully understood.

All interviews will be audio recorded.

Expenses and payments

As interviews will take place within the prison, it is not expected for there to be any expense for you. You will be paid the usual session amount you would have earned were you not taking part in the research. The amount will vary depending on what job or role you have in the prison. If you are unsure how much this is, please ask a member of the research team to check for you.

What will I be asked to do?

You will be contacted by the researcher who will check if you can take part by asking you some short questions. At this point you can ask more questions you might have about the study. You do not have to take part unless you feel completely happy with the study.

If you are happy to take part, we will invite you to take part in an interview that will take up to an hour. This will be in the prison, at a time that works best for you and the researcher. This interview will be audio-recorded and later typed up into written words.

Before the interview the researcher will ask you to fill in a consent form and will ask you some basic questions about your background (gender, age, prison status, religion, housing status in community). We are collecting this information so we can be sure we have spoken to people with a range of different experiences.

The interview will ask about how you came to get support from psychology and how you found the support. It will also involve some questions about your culture, and how you feel support from psychology might fit with this.

What are the possible disadvantages and risks of taking part?

Discussing your experience of mental health can sometimes be tricky. This is especially true while being in prison. The interviews will be carried out in a supportive way and can be stopped at any time. After the interview, you will have time to talk to the researcher about anything difficult which may have come up for you during the interview. Together you and the interviewer will both think of sources of support and what may be helpful for you. Please tell the researcher if you feel upset during the interview. Details of sources of support will be given after the interview.

What are the possible benefits of taking part?

We cannot promise that this study will help you, but we hope that the information we get from this study will help improve mental health support for Irish Travellers in prison in future.

What if there is a problem?

f you have any complaints about the way, you have been treated during this study, or any possible harm you might come to, these will be taken seriously and addressed. The detailed information on this is given in Part 2.

Will information from or about me from taking part in the study be kept confidential?

In this study we will use the information you give us. We will only use information that we need for the research. We will let very few people know your name or contact details, and only if they really need it for this study.

Everyone involved in this study will keep your data safe and secure. We will also follow all privacy rules.

At the end of the study, we will save some of the data for future research. This means some of the results from the study might be used by other research in future, but you won't need to do anything else in this situation. We will make sure no-one can work out who you are from the reports we write.

Part 2 tells you more about this.

This completes Part 1. If you are interested in taking part, please read the information in Part 2 before making a decision.

Part 2 of the information sheet

What will happen if I don't want to carry on with the study?

It is up to you to decide whether or not to take part. If you do decide to take part, you will be given this information sheet and will be asked to sign a consent form. If you decide not to take part, you do not need to do anything further and do not need to give a reason. Once your interview has been written up and details have been changed to keep your identity private, you won't be able to withdraw from the study. This is because we would have started comparing the interviews and won't be able to separate your interview from the others. This will happen two months after your interview. This means you won't be able to withdraw after two months after your interview.

The interview will be audio-recorded so it can be written up for the study. If you do not wish to be audio recorded, you will not be able to take part in the study.

Those taking part should always be comfortable with the recording process, and you are free to as for the recording to be stopped at any time.

If you lose capacity to consent to this study and we have not changed your details to be anonymous, we won't include your information in the study and will delete any information we have. If we have changed your details, we won't be able to withdraw your information as we won't be able to separate it from the other participants' information. This means your information will continue to be included in the study.

What if there is a problem?

If there is a problem at all during the study, you are encouraged to raise this. You can contact the researcher, speak to a member of inreach or contact a member of the team at Salomons. Any concerns raised will not affect the support you receive from Inreach.

Concerns and Complaints

If you have a concern about any part of this study, you should ask to speak to the researcher and can talk about what's worrying you. You can contact the researcher by submitting an application to the Mental Health Inreach Team, addressed to Sarah Smith, and you will get a response as soon as possible. If you still have concerns and want to complain formally, you can do this by submitting an application the Mental Health Inreach Team. Inreach will respond to you and help you to raise the complaint with Canterbury Christ Church University.

Will information from or about me from taking part in the study be kept confidential?

The information you share during the study will be recorded using an audio recorder, which will then be written up. Your data will be given a code number, so your name will not be connected with the interview outside of the research team. Any information that might mean people would know it is you, like where you live, will be changed so you can't be identified. Only members of the research team will listen to the recordings and once your interview has been written up, the audio recording will be deleted. We will keep all information about you safe and secure and will not share what is said with the prison or anyone else unless absolutely necessary.

Once we have finished the study, we will keep some of the data so we can check the results. We will write our reports in a way that no-one can identify you as someone who took part in the study. We might include exact phrases you have said when we write up the results of this study, however any information which could possibly be used to identify you will be removed.

Sometimes people will use this information to do research or to check your records to make sure that the research is being done properly. People who do not need to know who you are will not be able to see your name or contact details. This information will be kept for 10 years and then will be disposed of securely after this time.

During the interview, if a risk of harm to yourself, others or security is shared, this means we might have to break confidentiality. This means we might not be able to keep some of the information you have told us to ourselves. This is usually when there is an immediate risk of harm to you, someone else, or prison security. We would always try to talk to you first if we needed to share information about you to keep people safe. This includes behaviour that is against prison rules and can result in an adjudication (known as a “nicking”).

- If you were to share details of any illegal acts that have not been reported before, in some cases we may need to break confidentiality and report it. This applies to the following offences:

- offences against children
- money laundering
- terrorism related offences
- abuse of vulnerable adults
- any offence that may continue to pose harm to yourself or others

How will we use information about you?

We will need to use information from you for this research project.
This information will include your:

- initials
- Prison site

People will use this information to do the research or to check your records to make sure that the research is being done properly. People who do not need to know who you are will not be able to see your name or contact details. Your data will have a code number instead.

We will keep all information about you safe and secure. Once we have finished the study, we will keep some of the data so we can check the results. We will write our reports in a way that no-one can work out that you took part in the study.

What are your choices about how your information is used?

- You can stop being part of the study at any time, without giving a reason. If the information we have has not been made anonymous, we will delete information we hold on you.
- We need to manage your records in specific ways for the research to be reliable. This means once it has been made anonymous, we won’t be able to let you see or change the data we hold about you.

- If you agree to take part in this study, the data from this study may be used in future research. This will not require you to do anything, and all information used will be anonymous. This will be stored by Canterbury Christ Church University research repository.

Where can you find out more about how your information is used?

You can find out more about how we use your information:

- by asking one of the research team
- by contacting the Head of Data Protection at Canterbury Christ Church University. Their contact details are below:

Myriam Tavernier
Head of Data Protection
myriam.tavernier@canterbury.ac.uk
01227 925405

Please ask your keyworker or a member of the research team to support you in making contact if needed.

What will happen to the results of the research study?

When the study is completed, the results will be written into a report which will be handed in to Canterbury Christ Church University and will hopefully be published in a scientific journal so other healthcare professionals can see the results. Your identity and personal details will be kept confidential and no named information about you will be published in any reports. We will send you a copy of the published report if you wish before destroying your contact details. A summary of the results can be provided, and you will be sent a copy if you would like one.

Who is sponsoring and funding the research?

This study is being funded by 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 given favourable opinion by South East Research Ethics Committee. It has additionally been approved by The Salomons Ethics Panel, Salomons Institute for Applied Psychology, Canterbury Christ Church University. Approval for this study has also been agreed by HMPPS National Research Council.

Appendix P – clinician participant information sheet

Salomons Institute of Applied Psychology
One Meadow Road, Tunbridge Wells, Kent TN1 2YG
www.canterbury.ac.uk/appliedpsychology

Participant information about the research

Exploring narratives of psychological intervention and help seeking for Irish Travellers in prisons: staff and service user perspectives

Hello. My name is Sarah Smith, 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.

It is important to understand why the project is being done and what will be done. Please take time to read the following information carefully before deciding whether to take part and discuss it with others if you wish. Please ask if there is anything that is not clear or if you would like more information.

What is the purpose of the study?

The Mental Health Inreach Team (Inreach) provides mental health support for residents in the prison, this includes support from psychology. In prisons, we know that people can have different mental health needs than when they are in the community so it’s important to check whether the support being given is helpful. We also know that people from travelling communities can find it harder to get support, in ways that other people might not. This means that the process of getting support from psychology might be different for Irish Travellers who are in prison than it is for other residents. This study hopes to find out what it is like for Irish Travellers to seek help and what things may make this easier or harder, in addition to the experience of staff in providing these interventions.

Why have I been invited?

You have been invited as you have previously worked in prisons, providing psychological intervention, working with Irish Traveller residents.

Do I have to take part?

It is up to you to decide whether to join the study. If you agree to take part, I will then ask you to sign a consent form. You are free to change your mind and say you want to leave the study, without giving a reason. This can only be done until the content of the interviews is anonymised. This means the information you gave us will be changed so no one will know it is you. Once this is done, we won’t be able to remove your information.

What will happen to me if I take part?

If you choose to take part, you will meet with the researcher twice for an interview where you will be asked to share your experiences. There will be a series of questions so the researcher can hear as much about your views as possible. You will meet with the researcher again after the interview to talk about what was discussed in the first interview, to make sure you’ve been fully understood.

All interviews will be audio recorded.

Expenses and payments

Interviews will be carried out in a location that is convenient for you or can take place via videocall. It is not expected for there to be any expense for you, however as a reimbursement for your time, £10 electronic vouchers will be emailed to you within two weeks of your interview.

What will I be asked to do?

You will be contacted by the researcher who will check if you can take part by asking you some short questions. At this point you can ask more questions you might have about the study. You do not have to take part unless you feel completely happy with the study.

If you are happy to take part, we will invite you to take part in an interview that will take up to an hour. This will be via videocall, at a time that works best for you and the researcher. This interview will be audio-recorded and later typed up into written words.

Before the interview the researcher will ask you to fill in a consent form and will ask you some basic questions about your background. We are collecting this information so we can be sure we have spoken to people with a range of different experiences.

The interview will ask about your experience providing psychological interventions in prison. It will also involve some questions about your culture, and how you feel this impacts psychological interventions.

What are the possible disadvantages and risks of taking part?

The interviews will be carried out in a supportive way and can be stopped at any time. After the interview, you will have time to talk to the researcher about anything difficult which may have come up for you during the interview.

What are the possible benefits of taking part?

We cannot promise that this study will help you or current service users, but we hope that the information we get from this study will help improve mental health support for Irish Travellers in prison in future.

What if there is a problem?

If you have any complaints about the way, you have been treated during this study, or any possible harm you might come to, these will be taken seriously and addressed. The detailed information on this is given in Part 2*.*

Will information from or about me from taking part in the study be kept confidential?

In this study we will use the information you give us. We will only use information that we need for the research. We will let very few people know your name or contact details, and only if they really need it for this study.

Everyone involved in this study will keep your data safe and secure. We will also follow all privacy rules.

At the end of the study, we will save some of the data for future research. This means some of the results from the study might be used by other research in future, but you won't need to do anything else in this situation. We will make sure no-one can work out who you are from the reports we write.

Part 2 tells you more about this.

This completes Part 1. If you are interested in taking part, please read the information in Part 2 before making a decision.

Part 2 of the information sheet

What will happen if I don't want to carry on with the study?

It is up to you to decide whether or not to take part. If you do decide to take part, you will be given this information sheet and will be asked to sign a consent form. If you decide not to take part, you do not need to do anything further and do not need to give a reason. Once your interview has been written up and details have been changed to keep your identity private, you won't be able to withdraw from the study. This is because we would have started comparing the interviews and won't be able to separate your interview from the others. This will happen two weeks after your interview. This means you won't be able to withdraw after two weeks after your interview.

The interview will be audio-recorded so it can be written up for the study. If you do not wish to be audio recorded, you will not be able to take part in the study.

Those taking part should always be comfortable with the recording process, and you are free to as for the recording to be stopped at any time.

If you lose capacity to consent to this study and we have not changed your details to be anonymous, we won't include your information in the study and will delete any information we have. If we have changed your details, we won't be able to withdraw your information as we won't be able to separate it from the other participants' information. This means your information will continue to be included in the study.

What if there is a problem?

If there is a problem at all during the study, you are encouraged to raise this. You can contact the researcher or contact a member of the team at Salomons.

Concerns and Complaints

If you have a concern about any part of this study, you should ask to speak to the researcher and can talk about what's worrying you. You can contact the researcher via email on ss575@canterbury.ac.uk .

If you still have concerns and want to complain formally, you can do this by contacting the research lead Canterbury Christ Church University on Fergal.jones@canterbury.ac.uk.

Will information from or about me from taking part in the study be kept confidential?

The information you share during the study will be recorded using an audio recorder, which will then be written up. Your data will be given a code number, so your name will not be connected with the interview outside of the research team. Any information that might mean people would know it is you, like where you live, will be changed so you can't be identified. Only members of the research team will listen to the recordings and once your interview has been written up, the audio recording will be deleted. We will keep all information about you safe and secure and will not share what is said with anyone else unless absolutely necessary.

Once we have finished the study, we will keep some of the data so we can check the results. We will write our reports in a way that no-one can identify you as someone who took part in the study. We might include exact phrases you have said when we write up the results of this study, however any information which could possibly be used to identify you will be removed.

Sometimes people will use this information to do research or to check your records to make sure that the research is being done properly. People who do not need to know who you are will not be able to see your name or contact details. This information will be kept for 10 years and then will be disposed of securely after this time.

How will we use information about you?

We will need to use information from you for this research project.
This information will include your:

- Age
- Gender
- Ethnicity
- Profession
- Length of time working in prison

People will use this information to do the research or to check your records to make sure that the research is being done properly. People who do not need to know who you are will not be able to see your name or contact details. Your data will have a code number instead.

We will keep all information about you safe and secure. Once we have finished the study, we will keep some of the data so we can check the results. We will write our reports in a way that no-one can work out that you took part in the study.

What are your choices about how your information is used?

- You can stop being part of the study at any time, without giving a reason. If the information we have has not been made anonymous, we will delete information we hold on you.
- We need to manage your records in specific ways for the research to be reliable. This means once it has been made anonymous, we won't be able to let you see or change the data we hold about you.
- If you agree to take part in this study, the data from this study may be used in future research. This will not require you to do anything, and all information used will be anonymous. This will be stored by Canterbury Christ Church University research repository.

Where can you find out more about how your information is used?

You can find out more about how we use your information:

- by asking one of the research team
- by contacting the Head of Data Protection at Canterbury Christ Church University. Their contact details are below:

Myriam Tavernier
Head of Data Protection
myriam.tavernier@canterbury.ac.uk
01227 925405

What will happen to the results of the research study?

When the study is completed, the results will be written into a report which will be handed in to Canterbury Christ Church University and will hopefully be published in a scientific journal so other healthcare professionals can see the results. Your identity and personal details will be kept confidential and no named information about you will be published in any reports. We will send you a copy of the published report if you wish before destroying your contact details. A summary of the results can be provided, and you will be sent a copy if you would like one.

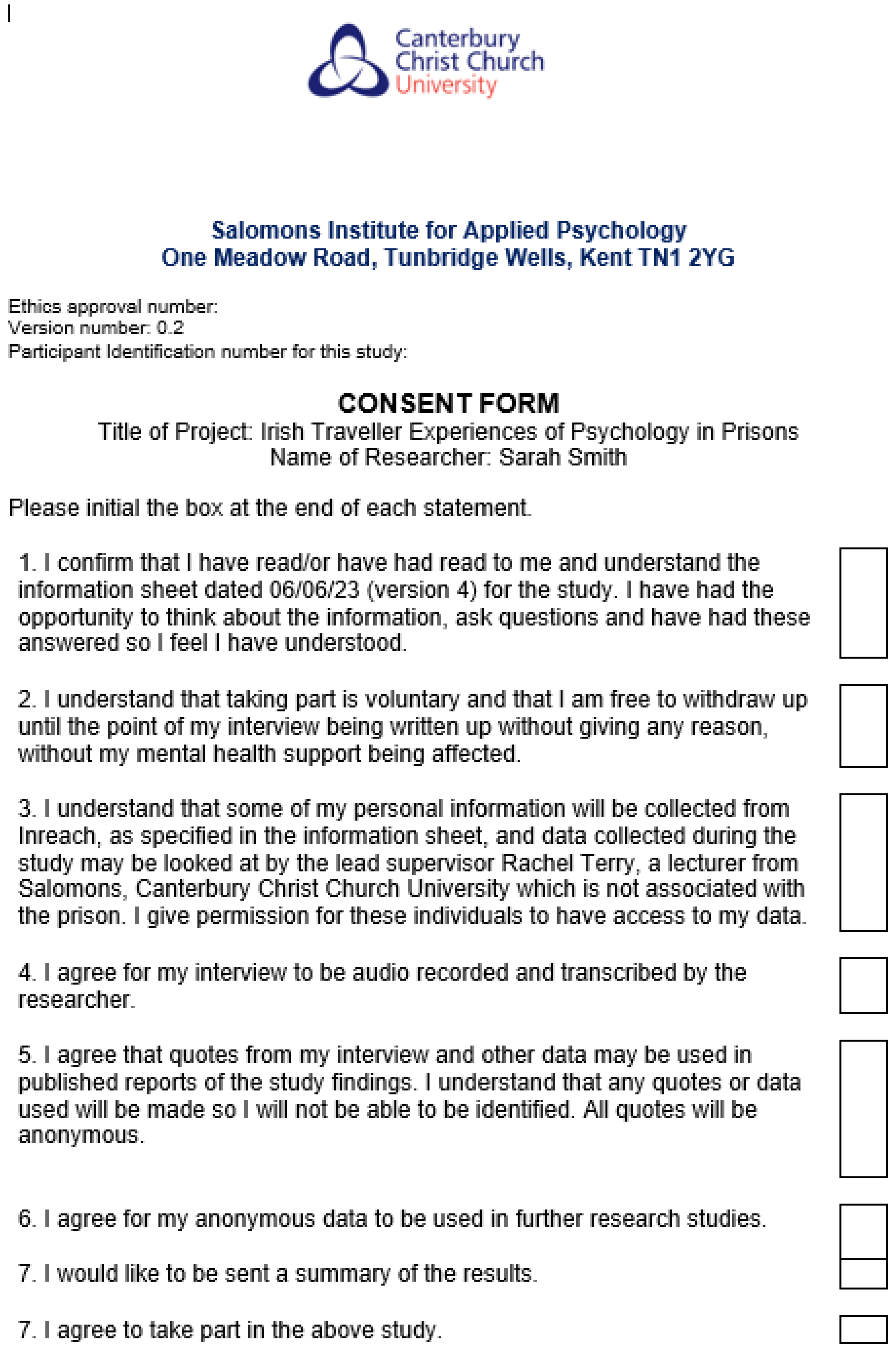
Who is sponsoring and funding the research?

This study is being funded by 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 given favourable opinion by South East Research Ethics Committee. Approval for this study has also been agreed by HMPPS National Research Council.

Appendix Q – Service user participant consent form



Canterbury Christ Church University

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

Ethics approval number:
Version number: 0.2
Participant Identification number for this study:

CONSENT FORM

Title of Project: Irish Traveller Experiences of Psychology in Prisons
Name of Researcher: Sarah Smith

Please initial the box at the end of each statement.

1. I confirm that I have read/or have had read to me and understand the information sheet dated 06/06/23 (version 4) for the study. I have had the opportunity to think about the information, ask questions and have had these answered so I feel I have understood. ☐

2. I understand that taking part is voluntary and that I am free to withdraw up until the point of my interview being written up without giving any reason, without my mental health support being affected. ☐

3. I understand that some of my personal information will be collected from Inreach, as specified in the information sheet, and data collected during the study may be looked at by the lead supervisor Rachel Terry, a lecturer from Salomons, Canterbury Christ Church University which is not associated with the prison. I give permission for these individuals to have access to my data. ☐

4. I agree for my interview to be audio recorded and transcribed by the researcher. ☐

5. I agree that quotes from my interview and other data may be used in published reports of the study findings. I understand that any quotes or data used will be made so I will not be able to be identified. All quotes will be anonymous. ☐

6. I agree for my anonymous data to be used in further research studies. ☐

7. I would like to be sent a summary of the results. ☐

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

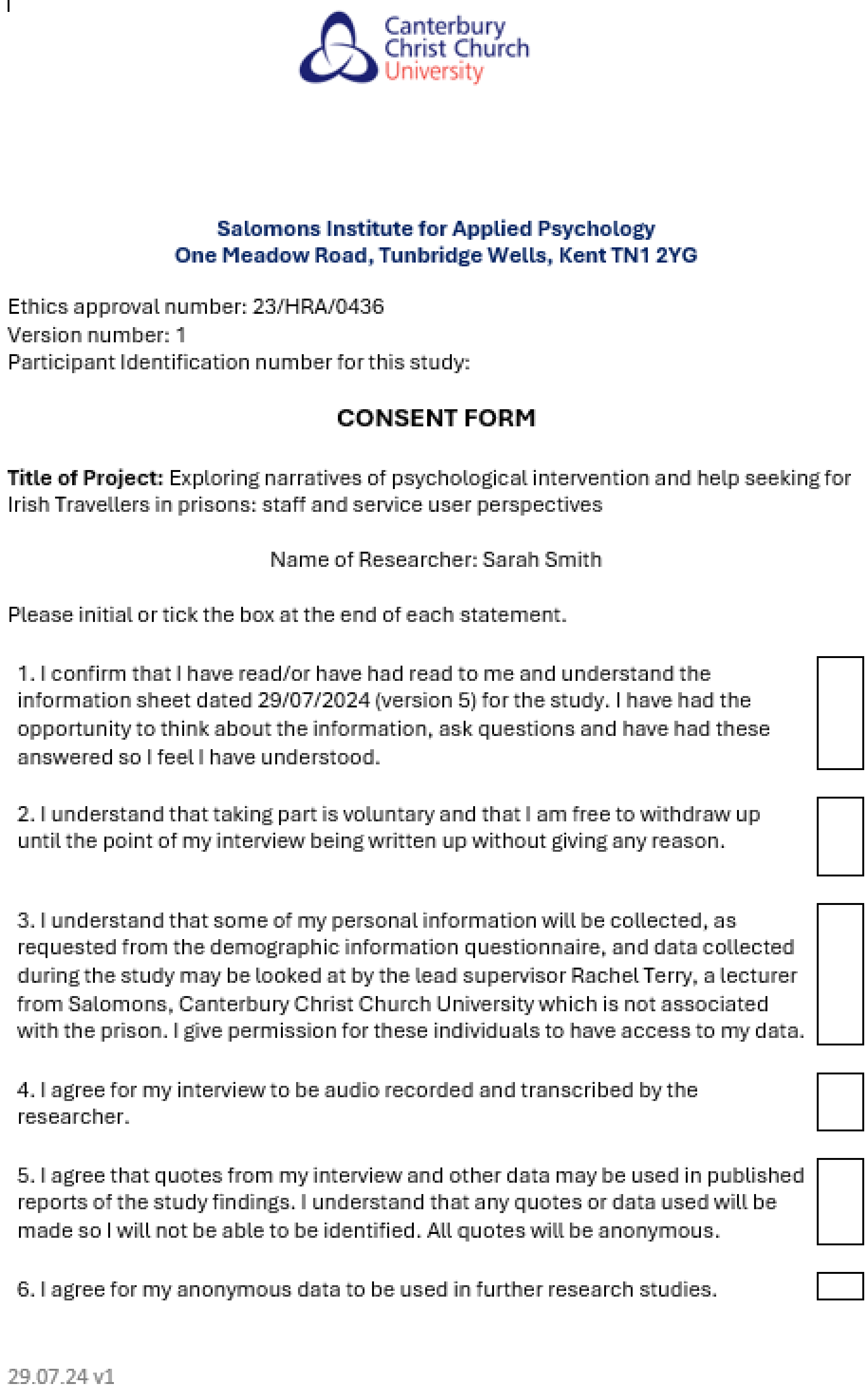
Name of Participant____________________ Date________________

Signature ___________________

Name of Person taking consent ______________ Date_____________

Signature ____________________

Appendix R – Clinician participant consent forms



Canterbury Christ Church University

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

Ethics approval number: 23/HRA/0436
Version number: 1
Participant Identification number for this study:

CONSENT FORM

Title of Project: Exploring narratives of psychological intervention and help seeking for Irish Travellers in prisons: staff and service user perspectives

Name of Researcher: Sarah Smith

Please initial or tick the box at the end of each statement.

1. I confirm that I have read/or have had read to me and understand the information sheet dated 29/07/2024 (version 5) for the study. I have had the opportunity to think about the information, ask questions and have had these answered so I feel I have understood. ☐

2. I understand that taking part is voluntary and that I am free to withdraw up until the point of my interview being written up without giving any reason. ☐

3. I understand that some of my personal information will be collected, as requested from the demographic information questionnaire, and data collected during the study may be looked at by the lead supervisor Rachel Terry, a lecturer from Salomons, Canterbury Christ Church University which is not associated with the prison. I give permission for these individuals to have access to my data. ☐

4. I agree for my interview to be audio recorded and transcribed by the researcher. ☐

5. I agree that quotes from my interview and other data may be used in published reports of the study findings. I understand that any quotes or data used will be made so I will not be able to be identified. All quotes will be anonymous. ☐

6. I agree for my anonymous data to be used in further research studies. ☐

29.07.24 v1

☐

7. I would like to be sent a summary of the results. ☐

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

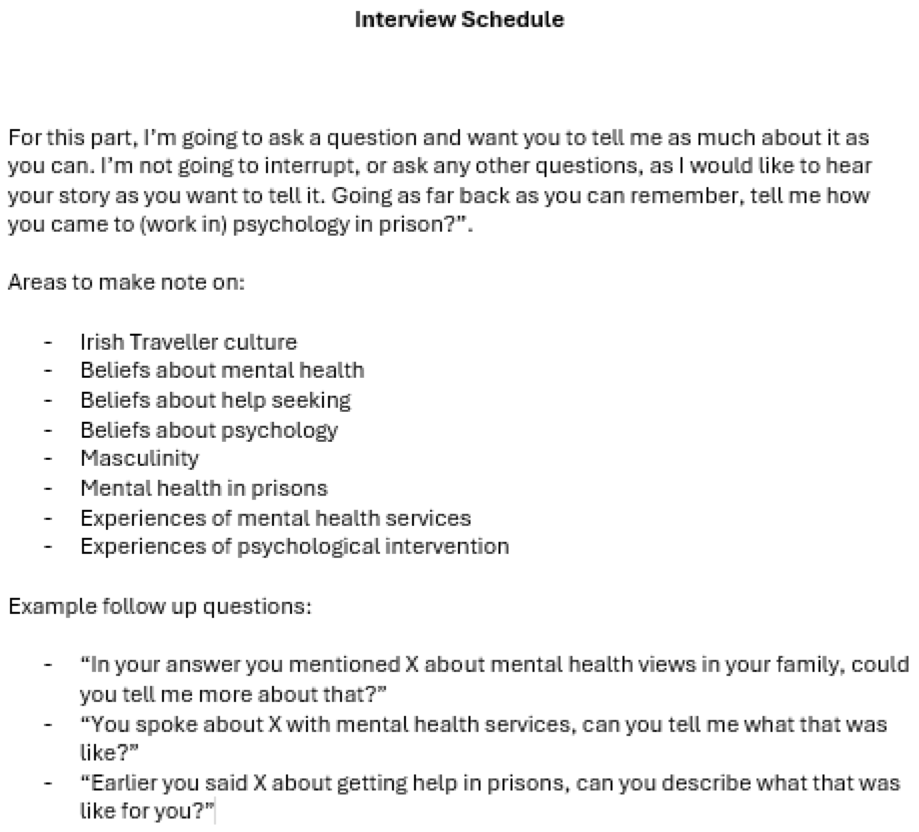
Name of Participant___________________ Date_______________

Signature __________________

Name of Person taking consent _____________ Date____________

Signature ___________________

Appendix S – Service user participant topic guide



Interview Schedule

For this part, I'm going to ask a question and want you to tell me as much about it as you can. I'm not going to interrupt, or ask any other questions, as I would like to hear your story as you want to tell it. Going as far back as you can remember, tell me how you came to (work in) psychology in prison?".

Areas to make note on:

- Irish Traveller culture
- Beliefs about mental health
- Beliefs about help seeking
- Beliefs about psychology
- Masculinity
- Mental health in prisons
- Experiences of mental health services
- Experiences of psychological intervention

Example follow up questions:

- "In your answer you mentioned X about mental health views in your family, could you tell me more about that?"
- "You spoke about X with mental health services, can you tell me what that was like?"
- "Earlier you said X about getting help in prisons, can you describe what that was like for you?"

Appendix T – Clinician participant topic guide

Interview Schedule

Question 1:

To start off, I'm going to ask a question and want you to tell me as much about it as you can. I'm not going to interrupt, or ask any other questions, as I would like to hear your story as you want to tell it. Including as much detail as you feel is relevant, can you tell me about your experiences of working with Irish Travellers in prisons?

The next part of the interview will include follow up questions regarding parts of the narrative provided by the participant that are pertinent to the research questions.

Areas for follow up:

- Clinicians understanding of narratives around mental health in prison
- Specific stories about working with Irish Travellers in prison
- Experiences of providing psychological intervention to Irish Travellers
- Narratives around being masculinity and mental health – within themselves and within the people they work with
- Narratives around help seeking – in prison and in the community
- Narratives around help seeking and masculinity
- Mental health stories in their family/community

Example questions:

- "you mentioned that Irish Travellers would often engage better in interventions. Could you tell me more about that"
- "you described a difference in relationship between the officers and clinicians, can you tell me more about that"
- "you said that cross cultural therapy is common in prisons, can you say more about that"
- "when things went into lockdown in the prison, what happened next"
- "you mentioned that it might be different to how it would be in the community, can you tell me more"

Appendix U – Example narrative summary sheet

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Appendix V – Table of narrative themes for service user participants

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Appendix W - Table of narrative themes clinician participants

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Appendix X – Example transcript with coding

THIS HAS BEEN REMOVED FROM THE ELECTRONIC COPY

Appendix Y: Feedback to the ethics panel

Dear Ethics Panel,

I am writing regarding the following research project, which has now been completed:

Exploring Narratives of Psychological Intervention and Help-seeking for Irish Travellers in Prisons: Staff and Service User Perspectives

Introduction

Male Irish Travellers are over six times more likely to take their life by suicide, with those in prison facing greater pressures on their mental health. Intersecting identities and the prison environment may pose additional barriers to seeking help for psychological distress and access to psychological therapies. This study aimed to understand Irish Traveller and clinicians' narratives of help-seeking for psychological distress and psychological intervention in prison, exploring cultural narratives and the influence of narratives on identity development.

Aims

To address these gaps in the literature, the current study had the following research questions:

1. What are the personal stories of male Irish Travellers who have accessed psychological intervention in prisons?
2. Do community and cultural narratives of help-seeking and psychological intervention feature in their personal stories?
3. What are the stories of clinicians providing interventions to Irish Travellers in prison?
4. What are the parallels and divergences in the stories told?

Method

Narrative inquiry was used and analysed using a combination of three narrative analytical approaches. Eight interviews were completed, four service users and four clinicians. Participants narrative summary sheets were shared with an opportunity to feedback.

Results

Findings highlighted the personal stories of Irish Travellers who have accessed psychological intervention in prison, which were contributed to by cultural and community narratives. Of particular note were identity and the role of power, experiences of discrimination and stereotyping, trust and relationships, prison as a context for mental health and psychology, and beliefs about health and services. Implications are discussed for developing cultural competence in professionals, development of therapeutic relationships and areas for future research.

Best wishes,

Trainee Clinical Psychologist