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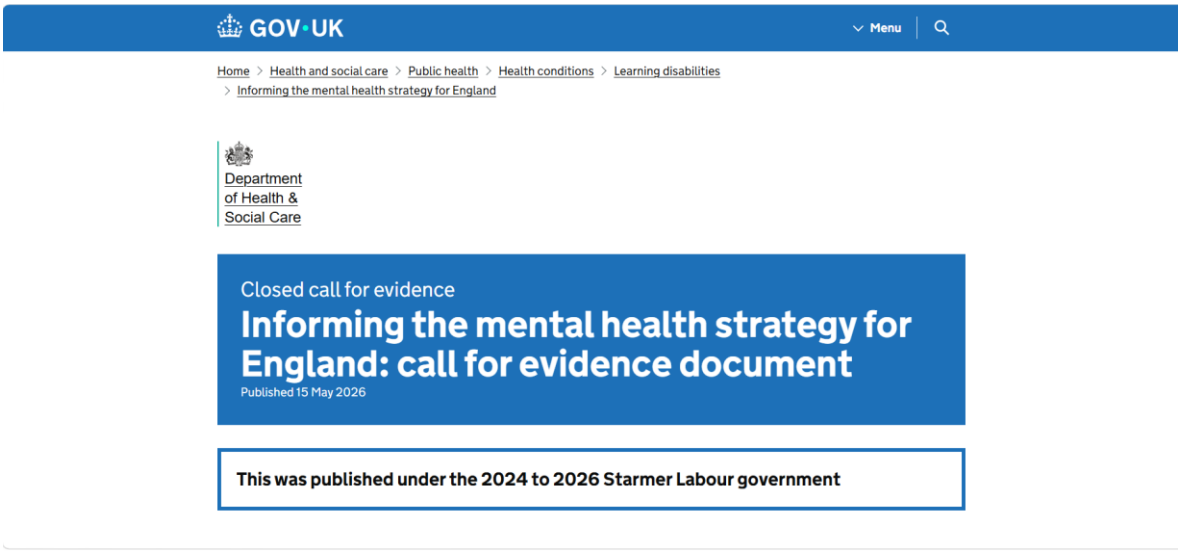
Mental Health Consultation

Informing the mental health strategy for England: call for evidence document



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About TM: The Traveller Movement (TM) was established in 1999 and is a leading national policy and voice charity, working to raise the capacity and social inclusion of the Romani (Gypsy), Roma and Irish, Scottish and Welsh Traveller communities in Britain. TM act as a bridge builder bringing the communities, service providers and policy makers together, stimulating debate and promoting forward-looking strategies to promote increased race equality, civic engagement, inclusion, service provision and community cohesion. For further information about TM visit www.travellermovement.org.uk

About The Traveller Movement

The Traveller Movement (TM) is a national charity and community organisation committed to promoting the inclusion of Romani (Gypsy), Roma and Irish, Scottish and Welsh Traveller communities within UK society. Registered Charity No. 1107113, we work to challenge discrimination, improve access to services, and amplify the voices of these communities in policy and practice.

Our work spans health, education, economic inclusion and social justice. We have a proven track record of co-producing research and interventions with Romani (Gypsy), Roma and Irish, Scottish and Welsh Traveller communities, including Health Needs Assessments. We are a trusted intermediary between statutory services and communities that have historically been marginalised by those very systems.

This submission draws on:

- Primary qualitative research: the Brent Health Needs Assessment (May 2026), comprising in-depth interviews with 17 Irish Traveller residents of the London Borough of Brent, conducted by The Traveller Movement in partnership with Brent Council.
- National evidence: including the All-Ireland Traveller Health Study (2010), the NHS Race and Health Observatory report on Inequalities in Mental Health Care for 'Gypsy, Roma and Traveller' Communities (2023), Friends Families and Travellers' briefings, and academic research from the University of Sheffield, UCL Institute of Health Equity, and others.
- Sector expertise: our direct experience of delivering mental health advocacy, support, and community engagement across England.
- Lived experience: the voices of community members who have generously shared their experiences of mental health, help-seeking, and service engagement.

SUBMISSION: Traveller Movement promotes inclusion for Romani (Gypsy), Roma and Traveller communities. TM has co-produced mental health resources for Mind and developed lived-experience-led CPD, creating culturally responsive models ready to scale through the Strategy. We challenge discrimination, improve service access, and co-produce research and interventions with these communities.

Response to Consultation Questions

Hospital to Community: Whole-System Approaches

Question: How can mental health services work more effectively across the wider NHS, neighbourhood health centres, services for co-occurring conditions, and different sectors including education, employers, local authorities and the VCSE sector?

For Romani (Gypsy), Roma and Irish, Scottish and Welsh Traveller communities, the shift from hospital to community-based care is not merely a matter of service relocation, it is an opportunity to fundamentally redesign how mental health support is conceived, delivered, and experienced. The

current system, centred on clinical environments and formal referral pathways, fails these communities at every turn. A whole-system approach must begin with an honest recognition of why existing services are not accessed and build from there.

The Brent Health Needs Assessment reveals a community with profound mental health needs and near-universal awareness of those needs, yet profound barriers to seeking professional support. All seventeen participants identified mental health as a significant issue in their community. Depression, anxiety, post-natal depression, suicidal ideation, and completed suicides were all reported. Local general practice data shows depression at 32% and anxiety at 28% among Irish Travellers in Brent, three times the level seen in the rest of the borough. Yet accessing support remains extraordinarily difficult.

The stigma and taboo surrounding mental health in Irish Traveller communities is perhaps the single greatest barrier to engagement. As one Brent participant explained:

> *Mental Health is an increasing issue in the community. As everyone knows everyone in the community, things can spread so people may not want to talk about something that's harming them, even though they may need to talk.*

This quote captures the double bind faced by community members: they live in close-knit environments where social proximity is a source of strength and protection, yet that same proximity creates an atmosphere where disclosure of mental health difficulties carries real social risk. Confidentiality is not merely a preference, it is a prerequisite for engagement.

For this reason, The Traveller Movement strongly advocates that community-based mental health support for Gypsy, Roma and Traveller communities must be:

- Off-site and discrete: All twelve women who responded to the Brent assessment felt the community would benefit from mental health support, but consistently requested that it be delivered off-site and confidentially. One participant noted: 'Someone to speak with in confidence. Probably best based off-site as don't want everyone knowing your business.' Another agreed: 'Any mental health support should be off site.' This is not resistance to help, it is a rational, culturally informed assessment of what would make help acceptable.
- Co-produced with communities: Services designed without genuine community input will perpetuate the cultural mismatch that currently prevents engagement. The Brent HNA found that participants had clear preferences for how services should be designed and were willing to engage provided that services were designed and delivered with the community, rather than simply for it.
- Delivered by culturally competent practitioners: Participants in the Brent HNA reported catastrophic failures when services lacked cultural understanding. In one devastating case, a mental health team visited a Traveller site, saw that it was a caravan site, and turned away. The individual concerned was subsequently sectioned, placed inappropriately in a room with women, discharged too early because staff misinterpreted his stress-management exercise as evidence of wellness, and took his own life shortly afterwards. Cultural incompetence in this instance was not merely poor practice, it was fatal.

The government's pilot of six community-based mental health centres offers a valuable opportunity to test new models of care. For these pilots to be relevant to Romani (Gypsy), Roma and Irish Traveller communities, they must include explicit provision for inclusion health groups. This means

appointing dedicated inclusion health workers, ensuring physical accessibility (including for those on authorised sites), and building relationships with communities over time rather than expecting immediate engagement.

The voluntary, community, faith and social enterprise (VCSE) sector is absolutely critical to this agenda. Organisations such as The Traveller Movement, Friends Families and Travellers, London Gypsies and Travellers, GATE Herts, Leeds GATE, and the Roma Support Group already hold the trust of communities that statutory services have historically alienated. We are the most equipped to provide the culturally competent care needed, but this requires, in addition to an invitation to contribute to a consultation, genuine power-sharing across decision-making, design, implementation and evaluation. It also requires providing these organisations, which are critical to community infrastructure, with multi-year, sustainable investment.

The Race Equality Foundation, in their response to this consultation announcement, made this point powerfully: 'For success, the Government needs to go further and ensure VCSEs who are the most equipped to provide the culturally competent care needed, are empowered to do so.' The Traveller Movement endorses this position entirely. The government's ambition for community-based care will fail Traveller communities unless VCSE allies are brought in as genuine care partners, not merely consulted as an afterthought.

Young Futures Hubs and Early Support

The government's commitment to Early Support and Young Futures hubs is welcome, particularly given the devastating mental health needs of young Irish Traveller people. In the Brent HNA, two-thirds of women respondents knew children who had needed mental health support. Concerns included social media pressures, bullying, autism, and ADHD. One participant spoke with particular poignancy about the long-term consequences of unmet childhood needs: 'Well over the years yes, because we've had so far, well, they're older now. Some of them are dead, actually, so if they had to get maybe the proper mental health support maybe they would have been alive.'

However, The Traveller Movement urges a critical design consideration: because of the profound stigma surrounding mental health in these communities, labelling services as 'mental health support hubs' will actively deter engagement. As one Brent participant noted, 'For men to go to a mental health place is taboo.' The very language of 'mental health' carries such weight that services using it become effectively inaccessible.

Instead, we strongly recommend that Young Futures hubs and Early Support provision serving Traveller communities be framed as whole-health or community wellbeing spaces, offering physical health checks, healthy lifestyle advice, youth activities, and family support alongside, but not foregrounding, mental health provision. This approach has been shown to work in other marginalised communities where stigma prevents direct engagement with mental health services. It respects the community's cultural framework while ensuring that mental health needs are addressed through the back door of general wellbeing support.

Within these hubs, staff must be trained in cultural competence and humility specific to Romani (Gypsy), Roma and Irish, Scottish and Welsh Traveller communities. They must understand the specific pressures facing young people from the communities: racism and bullying in school, the pressure of maintaining cultural identity in hostile environments, the impact of social media, and the

particular challenges for those with neurodevelopmental conditions. The Brent HNA found that many children on one site were autistic or had ADHD, yet parents feared the consequences of labelling: 'Once child is labelled with disability there is no going back from it in the community. They can be treated differently.' Services must be designed to support neurodivergent young people without stigmatising them.

SUBMISSION: The shift to community-based mental health care must fundamentally redesign how support reaches Romani (Gypsy), Roma and Irish, Scottish and Welsh Traveller communities. The current system fails them entirely.

Research reveals profound mental health need, depression and anxiety rates significantly above national averages, yet stigma and cultural barriers block access. One community member explained: "Everyone knows everyone... people may not want to talk about something harming them, even though they need to."

The Traveller Movement advocates three essential principles: off-site, confidential support, community members consistently request this, noting: "Someone to speak with in confidence. Probably best based off-site as don't want everyone knowing your business"; co-production with communities, not services designed merely for them; and culturally competent practitioners. A fatal case illustrates why: a mental health team visited a Traveller site, saw caravans, and turned away. The individual was sectioned, placed inappropriately, discharged too early, and died by suicide.

Cross-sector partnership is critical. Traveller Movement has co-produced mental health resources with MIND and developed lived-experience-led CPD training. Government pilots must include dedicated inclusion health workers, physical accessibility, and relationship-building over time. The government's ambition for community-based care will fail these communities unless VCSE allies are brought in as genuine care partners with multi-year funding, not merely consulted as an afterthought.

For Young Futures Hubs, TM recommends whole-health wellbeing spaces rather than "mental health hubs," since stigma deters engagement: "For men to go to a mental health place is taboo." Crucially, these hubs must integrate education inequality and school-based trauma into their model. Bullying, exclusion, and racism in schools are root causes of poor mental health. One community member reflected: "Some of them are dead, actually, so if they had to get maybe the proper mental health support maybe they would have been alive." Staff must be trained in cultural competence, supporting neurodivergent young people.

Severe and Enduring Mental Illness

Question: What further support, in addition to NHS services, should be provided for people with severe and enduring mental illness to help them stay well, maintain participation in education, work and community life, avoid crisis and/or hospital admission, and reduce length of stay in inpatient units?

For Romani (Gypsy), Roma and Traveller communities, severe and enduring mental illness exists within a context of multiple intersecting disadvantages: poor accommodation, educational exclusion, unemployment, discrimination, and social isolation. Addressing mental health in isolation from these

wider determinants is doomed to fail. The Marmot Review established that health inequalities result from social inequalities, and that action is required across the social determinants, including early years, education, employment, housing, and communities, to reduce health inequalities.

The Traveller Movement recommends a model of support that integrates mental health care with practical assistance across the wider determinants of health. This means:

- Housing-first approaches: The Brent HNA documented how poor site conditions, damp, mould, rat infestations, delayed repairs, contribute directly to both physical and mental ill health. The cement factory adjacent to Lynton Close site was identified by 82% of respondents as a cause of respiratory problems, with dust deposition a daily reality. No mental health intervention can succeed while people live in conditions that actively undermine their wellbeing. Support for people with severe mental illness must include advocacy for decent accommodation.
- Employment and education pathways: Chronic unemployment is a major driver of poor mental health among Irish Traveller men in particular. The decline of traditional economic activities, combined with discrimination in the labour market, has left many without meaningful occupation. Support must include tailored employment programmes that respect cultural skills and preferences, and educational advocacy for young people who experience exclusion from mainstream schooling.
- Peer support and community navigation: The Traveller Movement has observed that peer support workers from within Romani (Gypsy), Roma and Irish Traveller communities can achieve engagement that professional services cannot. A community member who has lived experience of mental health challenges, trained in basic support skills, and able to navigate both the community and statutory systems, represents a powerful bridge. The NHS England National Framework for NHS Action on Inclusion Health identifies 'developing the workforce' as one of its five principles, this must include investment in community-based peer navigators.
- Advocacy to prevent inappropriate admission and reduce length of stay: The Brent HNA documented a case where a man with depression was sectioned, placed inappropriately, and discharged prematurely with fatal consequences. Independent mental health advocates with cultural competence in Romani (Gypsy), Roma and Irish, Scottish and Welsh Traveller communities could prevent such tragedies by ensuring that cultural needs are understood and respected within inpatient settings, and that discharge planning addresses the specific challenges of returning to a community where mental health remains taboo.

The NHS Race and Health Observatory has called for 'long-term investment in co-production in the planning, design and delivery of mental health services' for ‘Gypsy, Roma and Traveller communities’. This co-production must extend to services for severe and enduring mental illness, ensuring that inpatient environments, community mental health teams, and crisis services all understand and can respond to the specific cultural contexts of these communities.

SUBMISSION: For Romani (Gypsy), Roma and Irish, Scottish and Welsh Traveller communities, severe mental illness intersects with poor housing, educational exclusion, unemployment, and discrimination. The Marmot Review confirms health inequalities stem from social inequalities, requiring action across housing, education, employment, and communities.

Traveller Movement recommends integrated support across four pillars:

1.Housing-first advocacy: Poor site conditions, damp, mould, infestations, and environmental hazards, directly undermine mental health. No intervention succeeds while accommodation actively harms wellbeing. Support must include advocacy for decent, safe housing.

2.Employment and education pathways: Chronic unemployment, driven by declining traditional trades and labour market discrimination, particularly affects Irish Traveller men. Tailored employment programmes respecting cultural skills, alongside educational advocacy for young people experiencing school exclusion, are essential.

3.Peer support and community navigation: Peer workers from within these communities achieve engagement statutory services cannot. Lived-experience navigators, trained in basic support skills and able to bridge community and statutory systems, represent a powerful intervention. NHS England's National Framework for Inclusion Health identifies workforce development as a core principle; this must include investment in community-based peer navigators.

4. Culturally competent advocacy to prevent inappropriate admission and reduce length of stay: ensuring cultural needs are respected in inpatient settings and discharge planning addresses the taboo surrounding mental health in these communities.

The NHS Race and Health Observatory calls for long-term investment in co-production for Gypsy, Roma and Traveller communities. This must extend to severe and enduring mental illness, ensuring inpatient environments, community teams, and crisis services are competent in responding to the specific cultural contexts of these communities.

Continuity of Care Across Transitions

Question: What are the main barriers to continuity of care across transitions between hospital and community services, and between different levels of care, including child to adult services?

For Romani (Gypsy), Roma and Irish, Scottish and Welsh Traveller communities, barriers to continuity of care are magnified by cultural misunderstanding, discrimination, and the lack of culturally competent practitioners at every level of the system. The transition from child to adult mental health services is particularly fraught, occurring at a life stage when young people are also navigating the pressures of cultural identity, family expectations, and the transition to adulthood within a community that may have different timelines and markers of maturity than the mainstream population. Every point of transition, from community to hospital, between wards, and from hospital back to community, carries the risk of catastrophic failure when cultural competence is absent.

Key barriers to continuity of care for Traveller communities include:

- Loss of trusted relationships: Traveller community members often build trust slowly with individual practitioners. When services transition, whether from CAMHS to adult services, from inpatient to community care, or between different teams, that trust is broken and must be rebuilt from scratch. For a community with deep-seated mistrust of statutory services, this is a significant barrier.

- Lack of culturally competent handover: Standard care transition processes assume a shared understanding of health, help-seeking, and service engagement. For Romani (Gypsy), Roma and Irish Traveller communities, these assumptions do not necessarily hold. A handover that notes 'patient engages well' may mean something entirely different when the patient is an Irish Traveller who has learned to appear compliant while remaining deeply distrustful. Transitions must include cultural context as a standard component of handover documentation.
- Inappropriate placements: The Brent case of a man placed in a ward with women demonstrates how cultural needs, in this case, gender-appropriate placement, are overlooked during transitions. For a community where gender roles are traditionally defined and privacy between men and women is highly valued, such placements are not merely uncomfortable, they are culturally offensive and actively harmful to recovery.
- Discharge to nowhere: When Traveller patients are discharged from inpatient care, they often return to environments, poor accommodation, social isolation, unemployment, that directly undermine their mental health. Without practical support for housing, employment, and social connection, discharge becomes a revolving door. The All-Ireland Traveller Health Study found that 56% of Irish Travellers reported that poor physical and mental health restricted normal daily activities, compared to 24% of the general population, indicating that the gap between clinical intervention and functional recovery is particularly wide for these communities.

The Traveller Movement recommends that continuity of care for Romani (Gypsy), Roma and Irish Traveller communities be strengthened through:

- Dedicated Traveller mental health navigators who span transitions, maintaining relationship continuity across service boundaries.
- Cultural competence requirements in all transition protocols, ensuring that cultural context is documented and communicated at every handover point.
- Pre-discharge planning that addresses the wider determinants of health, accommodation, employment, social support, rather than focusing narrowly on clinical stability.
- Community-based follow-up that is discrete, confidential, and delivered by trusted workers who understand both the clinical and cultural dimensions of recovery.

SUMMISSION: For Romani (Gypsy), Roma and Traveller communities, barriers to continuity of care are magnified by cultural misunderstanding, discrimination, and absent culturally competent practitioners. Transition from child to adult services is particularly fraught, occurring when young people navigate cultural identity and differing markers of maturity. Every transition carries catastrophic risk when cultural competence is absent.

Key barriers include:

Loss of trusted relationships: Trust is built slowly with individual practitioners. When services transition, that trust is broken and must be rebuilt. For a community with deep-seated mistrust of statutory services, this is a significant barrier.

Lack of culturally competent handover: Standard processes assume shared understanding of health and engagement. For these communities, assumptions do not hold. A handover noting 'patient engages well' may mean something entirely different when the patient has learned to appear

compliant while remaining deeply distrustful. Cultural context must be standard in handover documentation.

Inappropriate placements: A documented case of a man placed in a ward with women demonstrates how cultural needs are overlooked. For a community where gender privacy is highly valued, such placements are culturally offensive and actively harmful to recovery.

Discharge to nowhere: Patients often return to environments, poor accommodation, social isolation, unemployment, that directly undermine mental health. Without practical support for housing, employment, and social connection, discharge becomes a revolving door. Research indicates 56% of Irish Travellers report poor health restricting daily activities, compared to 24% of the general population, revealing a wide gap between clinical intervention and functional recovery.

The Traveller Movement recommends: dedicated Traveller mental health navigators spanning transitions; cultural competence requirements in all transition protocols; pre-discharge planning addressing wider determinants of health; and community-based follow-up that is discrete, confidential, and delivered by trusted workers who understand both clinical and cultural dimensions of recovery.

Analogue to Digital

Question: What evidence and innovative examples are there of digital and AI tools being used to improve mental health outcomes, support access to effective mental health support, and complement relational care?

The Traveller Movement approaches the digital agenda with caution, recognising that for many Romani (Gypsy), Roma and Irish Traveller community members, digital exclusion is a significant and often overlooked barrier. The Brent HNA found that while some participants used online searching for health information, nearly a quarter (24%) relied on family members to assist with online searches, indicating that digital access is often mediated through informal support networks rather than exercised independently. One participant accessed the NHS App successfully, but noted that 'it's not great for people who aren't good with computers.'

Friends Families and Travellers report that over 45% of service users accessing their national services present with low or no literacy, creating substantial difficulty in engaging with standard digital health formats. Digital tools, whether apps, online therapy platforms, or AI chatbots, assume a level of digital literacy, language proficiency, and comfort with technology that cannot be taken for granted. A 2024 systematic review on literacy and health in ‘Gypsy, Roma and Traveller communities’ found that 'public health information is often provided through text-based media and... campaigns planned at the commissioning level often did not consider patients with low literacy.'

That said, The Traveller Movement does not oppose digital innovation. Where digital tools are designed with accessibility and cultural relevance in mind, they can complement, but never replace, relational care. Potential applications include:

- Audio and video-based health information: Given low literacy rates and the finding that 88% of Brent HNA participants felt health information materials were not designed for people like them, video and audio content, delivered in accessible language and featuring Irish Traveller

voices, could overcome some barriers. Such materials must be co-produced with communities and distributed through trusted channels rather than left on websites that community members may never visit.

- Telephone-based support: The Brent HNA found that telephone access to mental health support was often inadequate, participants described being told to speak to someone on a one-off basis, only to be placed on a waiting list where the promised call-back never came. However, telephone contact has potential if it is consistent, culturally competent, and delivered by workers who understand the community. A regular check-in call from a trusted worker may be more acceptable than an appointment at a formal service.
- Digital tools for practitioners, not patients: The most promising digital application may be tools that help practitioners provide better care, for example, cultural competence training delivered through digital platforms, decision-support tools that prompt practitioners to consider cultural factors, or electronic health records that flag a patient's Traveller ethnicity and link to relevant cultural guidance.

The Traveller Movement's position is clear: digital tools should complement, not substitute for, the face-to-face, relationship-based care that Traveller communities need and request. AI chatbots and automated support systems carry particular risks for these communities, where the nuances of cultural expression, indirect communication, and coded language may be completely lost on non-human interfaces. The government must ensure that digital innovation does not become a new form of exclusion for communities that are already digitally marginalised.

SUBMISSION: The Traveller Movement approaches digital innovation broadly, recognising that for Romani (Gypsy), Roma and Traveller communities, the most promising digital approaches improve access to trusted, culturally competent support rather than replacing relational care. Digital exclusion remains significant: nearly a quarter rely on family members for online assistance, and over 45% of service users present with low or no literacy, creating substantial barriers to standard digital health formats.

The Traveller Movement's own work demonstrates how digital materials can be culturally adapted and grounded in lived experience. TM has co-produced mental health resources with MIND and developed a new CPD mental health resource, showing how digital tools can be designed with, not for, communities.

Potential applications include: audio and video-based health information in accessible language featuring community voices, overcoming literacy barriers; opt-in text or WhatsApp signposting shared through trusted VCSE organisations; digital CPD training for GPs, CAMHS staff, crisis teams and mental health practitioners to improve cultural competence; supported online referrals through community navigators; and service-level data tools identifying unequal access, waiting times and dropout rates by ethnicity.

Telephone-based support also holds potential if consistent and culturally competent, though current provision is often inadequate, with promised callbacks failing to materialise. AI chatbots and automated systems carry particular risks where cultural nuances, indirect communication and coded language may be lost on non-human interfaces.

The Traveller Movement's position is clear: digital tools should complement, not substitute for, face-to-face, relationship-based care. The government must ensure digital innovation does not become a new form of exclusion for communities already digitally marginalised. Investment must prioritise co-produced, culturally responsive digital resources that bridge communities to trusted practitioners.

Data and Innovation

Question: How can data be used more innovatively to improve mental health and wider societal outcomes?

The central importance of disaggregated data cannot be overstated. The Traveller Movement has long campaigned for systematic collection of ethnicity data that accurately captures Romani (Gypsy), Roma and Irish, Scottish and Welsh Traveller identities across all NHS systems. Currently, the lack of routine ethnic monitoring means that health data for these communities remains incomplete, rendering systematic outcome monitoring and inequality tracking impossible. The NHS Race and Health Observatory has identified this 'data desert' as a fundamental barrier to addressing mental health inequalities.

The 2021 Census represented a significant step forward by including 'Gypsy or Irish Traveller' and 'Roma' as distinct ethnic categories. The data revealed stark inequalities: 12.7% of 'Gypsy/Traveller' respondents reported bad or very bad general health, more than double the White British rate of 5.3%. However, census data alone is insufficient. NHS systems must now ensure that these categories are consistently and accurately recorded across all health records, including mental health datasets.

The Traveller Movement has worked with NHS England to revise the NHS Data Dictionary to include Romani (Gypsy), Roma and Irish, Scottish and Welsh Traveller ethnicities, but implementation at local level remains inconsistent. The Mental Health Strategy must mandate consistent ethnic monitoring across all mental health services, with specific requirements for capturing these communities' identity. Without this data, the strategy cannot track whether its ambitions are being realised for these communities.

Innovative uses of data should include:

- Real-time inequality monitoring: Mental health services should be required to report on access, waiting times, and outcomes by ethnicity, including Romani (Gypsy), Roma and Irish, Scottish and Welsh Traveller categories. This would enable rapid identification of disparities and prompt corrective action.
- Community-level health needs mapping: Data should be used to identify areas with significant Romani (Gypsy), Roma and Irish, Scottish or Welsh Traveller populations and map the availability of culturally competent mental health services against need. This would highlight gaps in provision and guide targeted investment.
- Predictive analytics for early intervention: Where data systems can identify Romani (Gypsy), Roma and Irish, Scottish or Welsh Traveller individuals at elevated risk of mental health crisis, for example, those with multiple A&E attendances, housing instability, or recent bereavement, this information should trigger proactive outreach rather than waiting for individuals to seek help.

The Race Equality Foundation's call for 'systematic collection of disaggregated ethnicity data so we can identify structural racism and racial disparities, and design data-informed solutions to ensure equitable mental health care' is one we endorse wholeheartedly. Structural racism cannot be addressed if left unseen.

SUBMISSION: The central importance of disaggregated data cannot be overstated. The Traveller Movement has long campaigned for systematic collection of ethnicity data that accurately captures Romani (Gypsy), Roma and Irish, Scottish and Welsh Traveller identities across all NHS systems. Currently, the lack of routine ethnic monitoring means health data for these communities remains incomplete, rendering systematic outcome monitoring and inequality tracking impossible. The NHS Race and Health Observatory has identified this 'data desert' as a fundamental barrier to addressing mental health inequalities.

However, data must be collected safely and sensitively. Many community members avoid self-identifying due to fear of discrimination, stigma, or historical mistrust of statutory services. Data collection must therefore be optional, confidential, and clearly explained, with assurances that disclosure will not trigger prejudice or adverse treatment. Staff must be trained to ask ethnicity questions respectfully and record responses accurately without assumption or pressure.

The 2021 Census represented a significant step forward by including 'Gypsy or Irish Traveller' and 'Roma' as distinct ethnic categories, revealing stark inequalities: 12.7% reported bad or very bad general health, more than double the White British rate of 5.3%. TM has worked with NHS England to revise the NHS Data Dictionary, but local implementation remains inconsistent.

Innovative uses of data should include: real-time inequality monitoring of access, waiting times and outcomes by ethnicity; community-level health needs mapping to highlight gaps in culturally competent provision; and predictive analytics for early intervention, triggering proactive outreach for individuals at elevated risk. The Race Equality Foundation's call for 'systematic collection of disaggregated ethnicity data so we can identify structural racism and design data-informed solutions' is one we endorse wholeheartedly. Structural racism cannot be addressed if left unseen.

Sickness to Prevention

Question: Which preventative approaches have the strongest evidence for reducing incidence or severity of mental health problems and promoting good mental health?

For Romani (Gypsy), Roma and Irish, Scottish and Welsh Traveller communities, prevention must be understood within a life-course framework that recognises the cumulative impact of discrimination, exclusion, and trauma from early childhood through to older age. The NHS Long Term Plan identified these communities as experiencing 'some of the most significant barriers to accessing health care and poor health outcomes.' Prevention cannot be achieved through clinical interventions alone, it requires action across the social determinants of mental health.

The evidence base for effective prevention in these communities points to several key approaches:

- Primary prevention - addressing the root causes: The most powerful preventative approach is to tackle the structural conditions that produce mental distress. This means addressing racism and discrimination in education, employment, housing, and public services. It means

ensuring that Romani (Gypsy), Roma and Irish, Scottish and Welsh Traveller children are not bullied out of school, that their families are not denied decent accommodation, and that adults in the communities are not excluded from employment. The House of Commons Women and Equalities Committee concluded that 'tackling inequalities faced by 'Gypsy, Roma and Traveller communities'' requires cross-government action, not just health service intervention. Mental health prevention is, fundamentally, a social justice issue.

- Secondary prevention - early identification and support: For those at higher risk, early intervention can prevent the escalation of mental health problems. The Brent HNA revealed devastating accounts of unmet childhood mental health needs leading to suicide in adulthood. One participant reflected: 'Well over the years yes, because we've had so far, well, they're older now. Some of them are dead, actually, so if they had to get maybe the proper mental health support maybe they would have been alive.' School-based mental health support, perinatal mental health services, and outreach to new mothers all represent opportunities for early intervention that could save lives.
- Tertiary prevention - supporting recovery and preventing relapse: For those already living with mental health challenges, staying well requires ongoing support that addresses both clinical and social needs. The Brent HNA found that participants who had positive experiences of support, such as one man who received counselling in prison and found it transformative, were often encountering support outside traditional NHS pathways. Community-based, culturally appropriate ongoing support is essential for preventing relapse and crisis.

The Traveller Movement emphasises that prevention strategies must be culturally grounded. Generic prevention programmes, however well-intentioned, will not reach these communities if they are delivered through channels that communities do not access, in formats they cannot engage with, and by workers they do not trust. The 88% of Brent HNA participants who felt health information materials were not designed for people like them is a powerful indicator of how far prevention approaches currently fall short.

SUBMISSION: For Romani (Gypsy), Roma and Traveller communities, prevention must be understood within a life-course framework recognising the cumulative impact of discrimination, exclusion, and trauma. The NHS Long Term Plan identifies these communities as experiencing some of the most significant barriers to accessing healthcare and poor health outcomes. Prevention requires action across the social determinants of mental health, not clinical interventions alone.

Primary prevention - addressing root causes: The most powerful approach tackles structural conditions producing mental distress. This means addressing racism and discrimination in education, employment, housing, and public services. The House of Commons Women and Equalities Committee concluded that tackling inequalities faced by these communities requires cross-government action, not just health service intervention. Mental health prevention is fundamentally a social justice issue.

Secondary prevention - early identification and support: For those at higher risk, early intervention prevents escalation. National research reveals devastating accounts of unmet childhood mental health needs leading to suicide in adulthood. One community member reflected: "Some of them are dead, actually, so if they had to get maybe the proper mental health support maybe they would have

been alive." School-based mental health support, perinatal services, and outreach to new mothers represent opportunities for early intervention that could save lives.

Tertiary prevention - supporting recovery and preventing relapse: For those already living with mental health challenges, staying well requires ongoing support addressing both clinical and social needs. Community-based, culturally appropriate ongoing support is essential for preventing relapse and crisis.

Prevention strategies must be culturally grounded. Generic programmes will not reach these communities if delivered through inaccessible channels, in formats they cannot engage with, and by workers they do not trust. National research finds that health information materials are not designed for people from these communities, a powerful indicator of how far prevention approaches fall short.

Question: How can services better support the 'missing middle' - those with sustained needs who may not meet the criteria for NHS mental health services?

The 'missing middle' is a concept that resonates powerfully with the Traveller Movement's experience. Many Romani (Gypsy), Roma and Irish, Scottish and Welsh Traveller community members with significant mental health needs fall into a gap where their distress is too severe to be addressed by self-help or informal support, yet not severe enough to meet the threshold for NHS mental health services. This group includes people with anxiety, depression, grief, trauma, and chronic stress related to discrimination and social exclusion.

The Brent assessment revealed a community where mental health needs are ubiquitous but professional support is largely absent. Participants described how 'we can get medication from the GP though sometimes you want to talk and that type of support is hard to find.' Talking therapies, the very support that many community members want, are oversubscribed and culturally inappropriate. One woman described her experience:

> *With the doctor it's straightforward to get medication though with the talking therapies I am really struggling arranging a repeat appointment and follow up... It's a difficult process.*

For the 'missing middle' in Romani (Gypsy), Roma and Irish, Scottish and Welsh Traveller communities, The Traveller Movement recommends:

- Community-based counselling and talking therapies: Delivered off-site, confidentially, and by culturally competent practitioners. The demand for talking therapies is clear from the Brent HNA, what is lacking is supply that is accessible and acceptable to these communities.
- Peer support networks: Trained community members who can provide initial emotional support, signpost to services, and accompany individuals to appointments. Peer support has the advantage of being immediately available, culturally grounded, and free from the stigma of formal mental health services.
- Group-based support: Some participants in the Brent HNA suggested that group activities, youth clubs, women's groups, men's sheds, could provide informal mental health support without the stigma of formal intervention. One participant praised the Brent Youth Centre, describing staff as 'very good, discrete and do stuff.' Such settings offer natural opportunities for connection, activity, and mutual support.

- Practical advocacy: Many people in the 'missing middle' are overwhelmed by practical challenges, housing problems, benefit issues, school exclusions, employment discrimination, that exacerbate mental distress. Practical advocacy that addresses these underlying issues can be as effective as clinical intervention in improving mental health.

SUBMISSION: The 'missing middle' resonates powerfully with the Traveller Movement's experience. Many Romani (Gypsy), Roma and Irish, Scottish and Welsh Traveller community members with significant mental health needs fall into a gap where their distress is too severe for self-help, yet not severe enough to meet NHS thresholds. This group includes people with anxiety, depression, grief, trauma, and chronic stress related to discrimination and social exclusion.

National research consistently reveals communities where mental health needs are ubiquitous but professional support is largely absent. Participants describe how "we can get medication from the GP though sometimes you want to talk and that type of support is hard to find." Talking therapies are oversubscribed and culturally inappropriate. One woman explained: "With the doctor it's straightforward to get medication though with the talking therapies I am really struggling arranging a repeat appointment and follow up... It's a difficult process."

For the 'missing middle', The Traveller Movement recommends:

1. Community-based counselling and talking therapies: Delivered off-site, confidentially, and by culturally competent practitioners. Demand for talking therapies is clear; what is lacking is supply that is accessible and acceptable to these communities.

2. Peer support networks: Trained community members providing initial emotional support, signposting, and accompaniment to appointments. Peer support is immediately available, culturally grounded, and free from the stigma of formal services.

3. Group-based support: Youth clubs, women's groups, men's sheds, praised by one participant as "very good, discrete and do stuff", provide informal mental health support without formal intervention stigma, offering natural opportunities for connection and mutual support.

4. Practical advocacy: Many are overwhelmed by housing problems, benefit issues, school exclusions, and employment discrimination that exacerbate mental distress. Addressing these underlying issues can be as effective as clinical intervention.

Suicide Prevention

Question: Which preventative approaches have the strongest evidence for reducing the numbers of lives lost to suicide?

Suicide is the most devastating mental health issue affecting Romani (Gypsy), and Irish Traveller communities. The All-Ireland Traveller Health Study found that suicide accounts for approximately 11% of all Traveller deaths, a figure that dwarfs the general population rate. The suicide rate for Irish Traveller men is 6.6 times higher than the general population, and five times higher for women. In the Brent HNA, three participants reported knowing male family members who had died by suicide, and two described community members experiencing suicidal ideation.

The gendered dimension of suicide in these communities is particularly stark. Men face extreme barriers to seeking help, driven by cultural expectations of strength and self-reliance. As one male participant explained:

> *Why? It's about not losing face, particularly for the men. Need to seek help early and not let the male image stop them.*

Another man addressed the cultural dimensions directly:

> *Individual men should talk more and access support where they need it. Need to lose this macho image and ask for help.*

And a woman spoke with raw honesty about the hidden nature of male suffering:

> *With suicide men tend to hide struggles more than women. They can find it hard to ask for help... men in the community don't want to be a burden on others.*

These testimonies reveal a profound crisis that demands urgent, gender-specific intervention. The Traveller Movement recommends:

- Male-specific mental health services: Dedicated support for men that understands and works within, rather than against, cultural norms around masculinity. This means framing help-seeking as consistent with strength and family protection, rather than as weakness. It means providing male practitioners where possible, and delivering support in settings that men find acceptable, for example, through sporting activities, practical projects, or informal social settings rather than clinical environments.
- Community-wide stigma reduction: The 'air of secrecy' and taboo around mental health must be gradually dismantled through community-led conversations. The man in the Brent HNA who found counselling transformative in prison and now encourages young men to seek similar support represents a powerful model of peer influence. Community leaders, including religious leaders, elders, and respected figures, must be engaged as allies in normalising help-seeking.
- Crisis intervention that understands the community: The Brent case of a man who died by suicide after being failed by multiple services demonstrates how crisis intervention can go catastrophically wrong when cultural competence is absent. Crisis teams must be trained to engage with these communities, including visiting sites without prejudice, understanding the significance of family involvement, and recognising that apparent compliance may mask deep distress.
- Post-suicide support for families: The impact of suicide reverberates through close-knit communities. Families bereaved by suicide need culturally appropriate support that acknowledges the specific grief, guilt, and stigma that accompany suicide in these communities. Without such support, the risk of further suicide is elevated.

The Traveller Movement's 2019 submission to the Women and Equalities Committee Inquiry into the Mental Health of Men and Boys highlighted that drinking patterns can aggravate mental health problems among Irish Traveller men, as binge drinking is associated with impulsivity and compounds clinical depression. The disintegration of traditional family structures, decline of religious certainty,

chronic unemployment, and difficult daily relations with the general population all create poor self-esteem and self-efficacy in an unsupportive environment. Suicide prevention must address these wider social determinants, not just the individual's mental state.

SUBMISSION:
Suicide is the most devastating mental health issue affecting Romani (Gypsy) and Irish Traveller communities. The All-Ireland Traveller Health Study found suicide accounts for approximately 11% of all Traveller deaths, Irish Traveller men face rates 6.6 times higher than the general population, and women five times higher. National research reveals multiple participants reporting male family members lost to suicide and community members experiencing suicidal ideation.

The gendered dimension is stark. Men face extreme barriers driven by cultural expectations of strength. One male participant explained: "It's about not losing face, particularly for the men. Need to seek help early and not let the male image stop them." Another urged: "Individual men should talk more... Need to lose this macho image and ask for help." A woman noted: "With suicide men tend to hide struggles more than women... men in the community don't want to be a burden on others."

The Traveller Movement recommends:

1. Male-specific mental health services: Framing help-seeking as consistent with strength and family protection, providing male practitioners where possible, and delivering support through sporting activities, practical projects, or informal settings rather than clinical environments.

2. Community-wide stigma reduction: Dismantling the 'air of secrecy' through community-led conversations. Peer influence models, where men who found support transformative encourage others, are powerful. Community leaders, including religious figures and elders, must be engaged as allies.

3. Culturally competent crisis intervention: Crisis teams must be trained to engage without prejudice, visit sites, understand family involvement, and recognise that apparent compliance may mask deep distress.

4. Post-suicide support for families: Culturally appropriate support acknowledging specific grief, guilt, and stigma is essential, as the risk of further suicide is elevated without it.

Suicide prevention must address wider social determinants, drinking patterns, family structure disintegration, chronic unemployment, and poor daily relations, not just individual mental states.

Factors Enabling Good Practice

Question: What commissioning, funding and oversight or accountability arrangements best support safe and integrated mental health services that improve outcomes?

The Traveller Movement's experience, supported by extensive national evidence, demonstrates that good practice in mental health care for Romani (Gypsy), Roma and Irish, Scottish and Welsh Traveller communities requires fundamental reform of commissioning, funding, and accountability arrangements. The current system, built on assumptions of universal access and cultural homogeneity, systematically excludes these communities. Reform must address three levels:

Commissioning must move from generic to targeted. Integrated Care Boards (ICBs) and local authorities must be required to assess the mental health needs of Romani (Gypsy), Roma and Irish , Scottish and Welsh Traveller communities in their areas and commission services specifically designed to meet those needs. This means moving beyond the passive expectation that universal services will reach everyone, to active commissioning of culturally specific provision. The Core20PLUS5 framework, which identifies 'Gypsy, Roma and Traveller communities' as a priority group, provides a starting point, but it must be backed by ring-fenced funding and clear accountability for outcomes.

Funding must be long-term and sustainable. VCSE organisations that deliver mental health support to these communities operate on short-term, project-based funding that prevents strategic planning, workforce development, and sustained relationship-building with communities. The government must provide multi-year, core funding to organisations that have demonstrated effectiveness in reaching and supporting Romani (Gypsy), Roma and Irish, Scottish and Welsh Traveller communities. This funding should not be tied to outputs that prioritise volume over quality, for these communities, a small number of deeply engaged relationships is more valuable than a large number of brief contacts.

Accountability must be meaningful and community-informed. The current accountability framework for mental health services focuses on clinical outcomes and waiting times that may be irrelevant or misleading for these communities. A service that reports short waiting times but has never been accessed by an Irish Traveller community member is not succeeding. Accountability must include measures of equity, access rates by ethnicity, satisfaction among minority communities, and outcomes for inclusion health groups. The Patient and Carer Race Equality Framework (PCREF), which is mandatory for all NHS mental health trusts, must be extended to specifically address Romani (Gypsy), Roma and Irish, Scottish and Welsh Traveller communities and include meaningful community involvement in monitoring and evaluation.

Cultural competence training must be mandated, not optional. The Traveller Movement joins the NHS Race and Health Observatory in calling for 'mandated anti-racist training relating to Gypsies, Roma and Travellers in all health and care training.' This training must move beyond generic equality and diversity programmes to confront the specific prejudices that these communities face, including challenging the stereotypical assumptions that continue to shape clinical encounters. The House of Commons Women and Equalities Committee concluded that 'disparities in health care reflect both structural barriers within the healthcare system and the cumulative impact of discriminatory attitudes and practices.' Training must address both dimensions.

The Equality and Human Rights Commission has described prejudice against 'Gypsy, Roma and Traveller communities' as the last 'respectable' form of racism in Britain, overt, common, and frequently unchallenged. This racism permeates health services, from reception staff who judge Traveller patients to dentists who belittle and bar them, to mental health teams who turn away from caravan sites. Addressing this requires not just training but active accountability, clear pathways for raising concerns, transparent investigation of discriminatory practice, and consequences for individuals and organisations that fail to meet standards of cultural competence.

Finally, the Mental Health Strategy must ensure that national and local mental health and suicide prevention policies take specific account of the needs of Romani (Gypsy), Roma and Irish, Scottish and Welsh Traveller communities. Too often, these communities are omitted entirely from policy

documents or subsumed within broad categories such as 'ethnic minorities' that mask their specific experiences and needs. The strategy must name these communities explicitly, set specific targets for reducing inequalities, and report progress transparently.

SUBMISSION: The Traveller Movement's experience demonstrates that good mental health care for Romani (Gypsy), Roma and Traveller communities requires fundamental reform of commissioning, funding, and accountability.

Commissioning must move from generic to targeted. ICBs and local authorities must actively assess community needs and commission culturally specific provision, moving beyond the assumption that universal services reach everyone. The Core20PLUS5 framework identifies these communities as a priority, but must be backed by ring-fenced funding and clear accountability.

Funding must be long-term and sustainable. VCSEs operate on short-term, project-based funding that prevents strategic planning and sustained relationship-building. Multi-year, core funding is essential for organisations demonstrating effectiveness. For these communities, a small number of deeply engaged relationships is more valuable than large volumes of brief contacts.

Accountability must be meaningful and community-informed. Current frameworks focus on clinical outcomes and waiting times that may mislead—a service reporting short waits but never accessed by Traveller community members is not succeeding. Accountability must include equity measures, access rates by ethnicity, and outcomes for inclusion health groups. The Patient and Carer Race Equality Framework must specifically address these communities with meaningful community involvement in monitoring.

Cultural competence training must be mandated, not optional. The NHS Race and Health Observatory calls for mandated anti-racist training in all health and care settings, confronting specific prejudices these communities face. The Equality and Human Rights Commission describes prejudice against them as the last 'respectable' form of racism in Britain - overt, common, and frequently unchallenged. This permeates health services from reception staff to mental health teams. Addressing it requires active accountability, transparent investigation of discriminatory practice, and consequences for failure.

The Mental Health Strategy must explicitly name these communities, set specific targets for reducing inequalities, and report progress transparently

Summary of Priority Recommendations

The table below summarises the priority actions that should be taken forward in the Mental Health Strategy to improve outcomes for Romani (Gypsy), Roma and Irish, Scottish and Welsh Traveller communities.

Priority area	Recommended action	Lead responsibility
Ethnicity data and accountability	Mandate accurate recording of Romani (Gypsy), Roma and Irish, Scottish and Welsh Traveller ethnicity across NHS	DHSC, NHS England, ICBs and mental health trusts

	mental health datasets, with public reporting on access, waiting times, experience and outcomes.	
Anti-racist and culturally competent practice	Require anti-racist cultural competence and humility training for all mental health practitioners, including crisis teams, inpatient staff, primary care and community mental health services.	NHS England, professional regulators, mental health trusts and training providers
Trusted community provision	Fund trusted VCSE organisations through multi-year core investment to deliver confidential, culturally competent, community-based support and act as genuine partners in service design and evaluation.	DHSC, NHS England, ICBs and local authorities
Access to talking therapies and early support	Commission off-site counselling, talking therapies, peer navigation and whole-health or community wellbeing spaces that avoid stigmatising mental health labels while enabling early intervention.	ICBs, local authorities, NHS Talking Therapies providers and VCSE partners
Suicide prevention	Develop gender-specific suicide prevention work, particularly for men, alongside clear safeguarding, crisis escalation and post-suicide bereavement support for families and communities.	DHSC, local suicide prevention partnerships, mental health trusts, ICBs and VCSE partners

Conclusion

The Traveller Movement welcomes the government's ambition to create a once-in-a-generation Mental Health Strategy. For this ambition to be realised for Romani (Gypsy), Roma and Irish, Scottish and Welsh Traveller communities, the strategy must be explicitly anti-racist, culturally competent, and grounded in the lived experience of the communities it seeks to serve.

The evidence is clear and compelling. These communities experience the worst mental health outcomes of any ethnic group in the UK. Suicide rates are six to seven times higher than the general population. Anxiety and depression are two to three times more prevalent. Access to culturally appropriate support is grossly inadequate. Stigma, taboo, discrimination, and cultural incompetence combine to create a system that fails these communities at every turn.

Yet the evidence also reveals hope. The Brent HNA found a community that is not passive in the face of these challenges. Participants spoke with openness and honesty about mental health. A man who found counselling transformative now encourages young men to seek support. Women called for confidential, off-site talking therapies. The community demonstrated clear preferences for how services should be designed and a willingness to engage, provided that services are designed and delivered in genuine partnership.

The Mental Health Strategy must seize this moment to do something genuinely different. It must mandate disaggregated data collection so that inequalities can be tracked and addressed. It must invest in VCSE partners who hold the trust of communities. It must require cultural competence training for all practitioners. It must design community-based services that respect stigma and taboo. It must address the gendered dimensions of mental health, particularly the crisis of male suicide. It must prioritise early intervention and talking therapies over medication. And it must never be 'race-blind', because for these communities, mental health and racism are inseparable.

The time for action is now. The health and wellbeing of one of the most disadvantaged communities in England depends upon it.

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