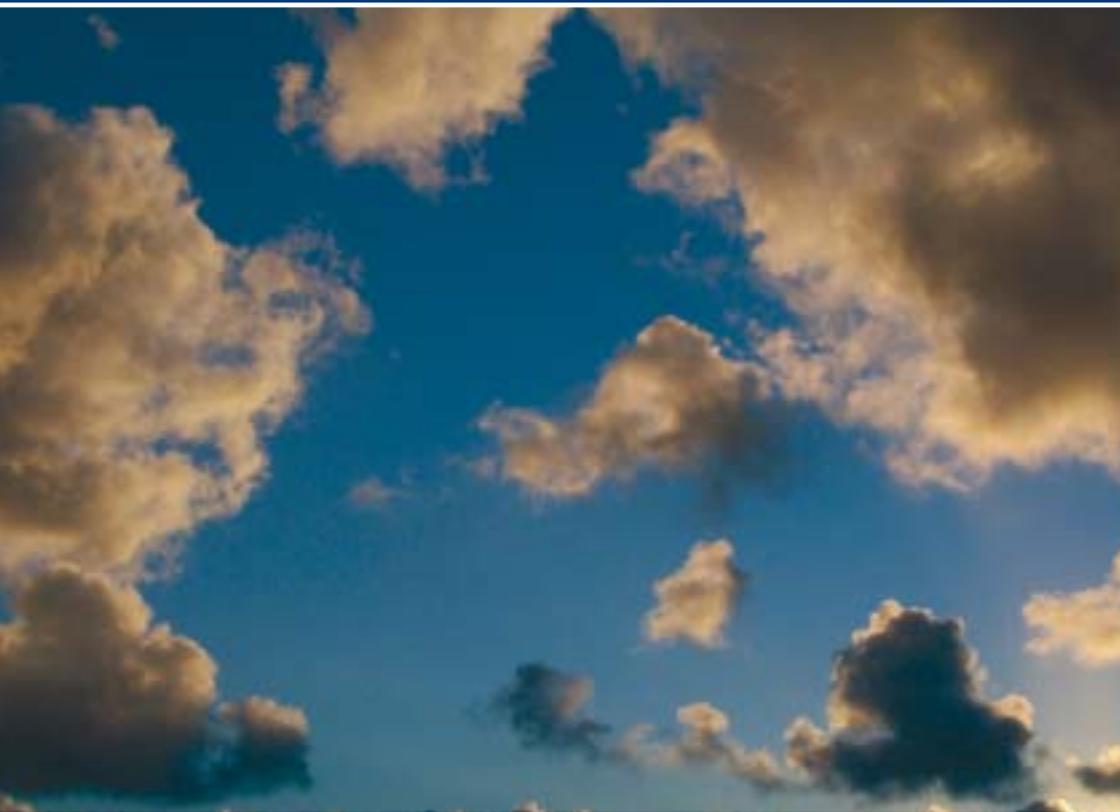


# SUICIDE AMONG THE IRISH TRAVELLER COMMUNITY 2000–2006

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## ACRONYMS

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<b>AI/AN</b>	American Indians/Alaskan Natives
<b>ASIST</b>	Applied Suicide Intervention Skills Training
<b>CSO</b>	Central Statistics Office
<b>DOE</b>	Department of the Environment
<b>DES</b>	Department of Education and Science
<b>DJELR</b>	Department of Justice, Equality and Law Reform
<b>DOHC</b>	Department of Health and Children
<b>DSW</b>	Department of Social Welfare
<b>HSE</b>	Health Services Executive
<b>IAS</b>	Irish Association of Suicidology
<b>ITM</b>	Irish Traveller Movement
<b>WHO</b>	World Health Organisation

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## EXECUTIVE SUMMARY

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The author has kept a nationwide annual account of suicide among Travellers in Ireland from 2000-2006. It is the first research that has been carried out with the purpose of documenting the incidence of suicide among Travellers. It is unique in that it covers the whole Traveller population over a seven year period, and information has been gathered regarding the family circumstances and underlying issues concerning the subjects of the research. The sources of data include Local Authority social workers for Travellers, the Department of Environment and Local Government annual statistics of the National Traveller population and CSO data.

### MAIN FINDINGS

Between 2000 and 2006 the rate of suicide among Irish Travellers at 3.70:10,000 was over three times that of the total population, peaking in 2005 when it was over five times the national rate. The actual number of deaths by suicide among Travellers in this period was 74.

Suicide is predominantly a male issue. For the total population, male suicide is four times as common as female suicide. For Travellers the male suicide rate is 91%, over nine times as common as female suicide.

52% of those who died by suicide had never married, with a further 15% being separated or widowed.

Over 65% of Traveller suicides occurred among those aged under 30. (National figures over the same period showed almost 34% of all suicides since 2000 occurred among the under 30's).

The age group most at risk for Travellers is 25-29, which accounts for 26% of Traveller suicides.

Suicide amongst Travellers aged 40 and over at 12% is relatively infrequent compared with the total population, where over 46% of all suicides occur amongst those aged over 40.

80% die by hanging, with poisoning being the second most used method at 9%.

Accommodation type does not seem to be a significant factor, except that roadside families are at greater risk of suicide, while rates are lower for those in houses, particularly group housing and privately owned or rented housing.

In almost 70% of instances it was the person's first attempt at suicide, a fact which is of significant concern to service providers.

Traveller suicides classified according to the patterns which have emerged from the findings.

### Troubled suicides

This refers to cases where the informant described a background of major social problems; lives characterised by alcohol or substance abuse and violent behaviour, and a history of self-harm or suicide attempts. These people found themselves in a situation where there was no future. The question here is not why they died, but how they had managed to stay alive for so long.

It also refers to people who had suffered a considerable degree of hardship and tragedy in a short space of time, which would render even the most resilient of characters vulnerable to suicide.

### Motiveless suicides

At the other end of the spectrum were those who came from very secure backgrounds. These individuals showed no sign of suicidal ideation; they had none of the risk factors typically associated with suicide, such as depression, alcohol or substance abuse. Respondents said that there appeared to be no reason for the decision and spoke of the incredible anguish experienced by those left behind, unable to understand why these people had actually chosen to end their lives.

While both of the above categories could be found in any group in society, the following three categories closely linked to Traveller culture, and as such are Traveller specific suicides.

## Bereavement suicides

The most common pattern that has emerged throughout this research is that of the Traveller, who, following the death of somebody close, takes his own life, usually by hanging. What is of major concern is that in 40% of cases where a Traveller took his/her life following the death of somebody close, that death itself was also a suicide.

## Violence suicides

Violence, whether domestic or feuding, was reported as a contributory factor in 20 cases of suicide. Eight of these occurred following a violent episode. Four were victims, four were perpetrators.

## Shamed suicides

These suicides, seven in total, took place following disclosure of an alleged criminal act or awaiting trial for a criminal act. In general, the older the individual the more serious the act was likely to be. The view of the respondents was that the pressure of this shame motivated these people to kill themselves.

## Why now?

Today, young Travellers have a lot more in common with their settled peers than their parents' generation did, and to a certain extent, there has been a loss of cultural traditions as they take on the values of mainstream society. However, public opinion of Travellers as inferior and as a threat has not changed, and Travellers face huge rejection from the settled population. Some attempt to conceal their Traveller identity completely. They are not fully accepted as part of settled society, they may no longer be firmly rooted in their own cultural and social traditions, and they have lost pride in their own ethnic identity.

Legal restrictions and economic reasons have made it increasingly difficult for Travellers to travel and to keep horses, both activities being central to Traveller culture. For those without work, who have lost the traditions of

travelling and keeping horses, there is nothing to do. Particularly vulnerable are single young men. To alleviate boredom they may drink, take drugs, joy-ride, and engage in other forms of anti-social behaviour. All of these risk-taking behaviours are associated with suicide, and it takes little to persuade somebody for whom life holds no interest to end theirs.

With recent changes in society, Travellers have had to learn to cope with increased hostility, difficulty with identity, loss of culture and traditions and lack of purpose in life. Given the existing vulnerabilities of Travellers today, factors such as alcohol or substance abuse, economic insecurity, violence, depression assume an additional risk level. It may therefore not be so surprising that an immediate crisis, such as death or marital conflict, can act as a trigger factor for suicide.

## Towards prevention

If those more vulnerable to suicide are those who lack self-esteem and experience cultural anomie, and those who have lost hope in a better future, it must follow that those most likely to be survivors are those who are proud of their Traveller identity, and who feel that there can be a better future for their children whether they choose to retain a separate identity or to integrate. The challenge for service providers is to encourage that which gives dignity and a purpose in life (improved living conditions, access to further education and employment), while at the same time to avoid isolating Travellers from their community.

For an approach towards suicide prevention to be successful, it must involve building on the strengths within the Traveller community; strengths such as strong family and kinship ties, religious beliefs, and a high tolerance for troubled members, which can be developed to protect high-risk individuals against suicide. Travellers need to be informed of the incidence of suicide and areas of risk, and given the necessary supports, so that they can be involved in the delivery of suicide prevention strategies.

# INTRODUCTION

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Ireland experienced one of the fastest growing rates of suicide in the world in the 1980s and 1990s (Health Services Executive [HSE], 2005:12), with the highest number of deaths by suicide ever in this state reaching 519 in 2001. Between 2000 and 2006, a yearly average of 473 people have been recorded as dying by suicide in Ireland, and each year since the millennium, the number of recorded deaths by suicide has exceeded the number of recorded deaths from road traffic accidents. It is over four times as common among men as among women. Between 2000 and 2006 those under 30 years accounted for almost 34% of all suicides, the age at greatest risk being 20-24 years, and the most frequently used method being hanging, which accounted for 57% of all deaths by suicide. Suicide in Ireland is an issue of enormous public and political concern. The President of Ireland, Mary McAleese, addressing the 24th World Congress of the International Association for Suicide Prevention in Killarney, August 2007, referred to the "considerable media interest and public debate" generated by the conference in an area which affects every element of Irish society.

Nothing has ever been documented on the rate of suicide among Travellers. The Central Statistics Office (CSO) does not categorise rates of suicide according to ethnic group. Working with Travellers as social worker for Wicklow Co. Council in the late 1990s, I was concerned by what I perceived as a high incidence of suicide among Travellers, especially young Traveller men. When I embarked upon this project in 2000, no literature on Travellers and no study on Traveller health referred to suicide, and the then recently published *Report of the National Task Force on Suicide* (Department of Health and Children [DOHC], 1998) did not mention Travellers. With the purpose of gaining additional knowledge of the extent and nature of this issue, I set out to discover the number of Traveller deaths by suicide that year and to compare the result to National figures. The year was 2000, the 'millennium year', the economy was booming, jobs were plentiful, Irish people had a lot to look forward to in the new century, and that year, nine Travellers took their own lives.

The result of the 2000 study showed that the rate of suicide among Travellers that year was over three times the national rate. However, many respondents believed suicide to be a very rare occurrence among Travellers. One respondent had worked with Travellers for over twenty years and had

never heard of a suicide within the Traveller community. I decided to continue to gather data for a minimum of five years, in order to discover whether the number of suicides in 2000 had been exceptionally high or whether they were more indicative of a very disturbing trend. Over this period, I believed I could establish a more accurate rate of suicide within the Traveller community and provide a means for Travellers to publicise their cause, and bring out into the open things that may otherwise remain hidden. Once information became available regarding the extent of this issue, the representation of Travellers as a group specifically affected by suicide should be ensured in any National strategy regarding suicide intervention or prevention.

Furthermore, by applying current theories regarding suicide to the Traveller community, and by examining recurring patterns among those Travellers who had died by suicide, I aimed to identify those most at risk of suicide. In so doing, it is hoped that it would assist Travellers in providing the necessary supports within the community itself. Raised awareness of this group should also assist anybody working with Travellers in the delivery of their service, and may identify new areas for policy intervention.

I aimed to focus on three questions, namely:

1. What is the incidence of suicide among Travellers?
2. Who is at risk of suicide in the Traveller population?
3. How can the incidence and profiles be understood?

## OVERVIEW

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Chapter one contains a historical view of suicide in Western Europe, from Ancient Greek and Roman times until the 20th century. This is followed by a summary of developments in Ireland since the decriminalisation of suicide in 1993, and of suicide rates in the 21st century.

Durkheim's theory of suicide is outlined, and both sociological and psychological hypotheses regarding the causes of suicide are examined in the light of modern Ireland, including social change, alcohol abuse and mental illness.

This chapter concludes with a look at literature on suicide among African Americans, and three indigenous minority cultures: American Indians/Alaskan Natives (AI/AN), Inuit and Australian Aboriginal peoples.

In chapter two, issues concerning the Irish Traveller community are examined in the areas of health, accommodation, education and access to employment. Following from the causes of suicide as outlined in chapter one, social change, alcohol/substance abuse and mental illness are looked at in relation to the Traveller community. From literature regarding cultural factors which have a bearing upon suicide rates in African American, AI/AN, Inuit and Australian Aboriginal peoples, cultural issues relevant to the Traveller community are examined. Issues which protect against suicide include family ties and religion, while facilitating factors include bereavement, exclusion, poor coping strategies and domestic violence.

Chapter three describes the methodological framework adopted for this research, the criteria used for identifying the research population, selecting sources of information, the research instruments used, and methods of data collection and analysis, as well as limitations and ethical issues.

In chapter four, the results of the findings of this research are analysed. A tentative rate of suicide is established, and compared to the national rate. There is a demographic profile of those who died, and an analysis of pathological indicators and common precipitating events. Suicides have been categorised into five general types as have emerged from the qualitative data.

Chapter five draws together the findings of the research, literature on suicide and Travellers, and the respondents' experience working with Travellers, in order to understand the present incidence and profile of suicide among Travellers. It looks at the family, and situations where it fails as a protective factor. It also looks at wider social factors affecting suicide which have emerged as particularly relevant to Travellers today, including accommodation, bereavement, suicide contagion, psychiatric issues, alcohol and drugs, violence, lack of purpose, membership of a minority indigenous group. It then looks at how social change has impacted upon the Traveller community in such a way that cultural erosion and identity issues are at a critical stage at present.

This study concludes with some recommendations for future study, and an approach for tackling the issue of suicide among Travellers.

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**CHAPTER 1**  
LITERATURE ON SUICIDE

## HISTORICAL OVERVIEW

Suicide is defined in the Oxford English Dictionary as the action or an act of intentionally killing oneself. For a death to be classified as suicide, a court must decide whether the person actually killed himself (*actus reus*) and whether it was his/her intention to do so (*mens reus*) (Pritchard, 1995:4). The problem for coroners is that they cannot ask the deceased if death was intentional, so they can only guess at the truth by looking for clues in the circumstances surrounding death, e.g. the method, the place and the life history and mental state of the person (Browne, 1992). Two people who agree on what the term suicide means may disagree completely on whether a specific case should be categorised as such (Douglas, 1967:184).

First coined in England during the 17th century from the Latin *sui* of oneself and *caedes* murder, by the 18th century it was commonly used throughout Europe. Although the word is relatively modern, there have always been people who decide that life is no longer worth living and prefer to depart voluntarily. Today suicide is seen as an act representative of the furthest extreme of human misery, an isolated act which expresses a sense of personal alienation so complete that others cannot conceptualise it (Hill, 2004:1-2). It is defined in Ireland's national strategy on suicide prevention as *a conscious or deliberate act that ends one's life when an individual is attempting to solve a problem that is perceived as unsolvable by any other means* (HSE, 2005:9). This definition is taken from the Australian Department of Health and Aging LIFE Strategy (1999), and does not take into account suicide motivated by vengeance, or suicide when one is tired of life.

In this section on the history of suicide, I rely heavily on the work of Georges Minois (1999). Ancient suicide was viewed with a certain dignity, as a deed of someone hoping to preserve his honour (Van Hooff, 1990:131). For the Ancient Romans suicide was only rarely associated with anything even broadly recognisable as "depression". It was dramatically public in character, and noted for the dispassion with which it was attempted (Hill, 2004:2). However for economic and patriotic reasons suicide was forbidden to slaves and soldiers. The Ancient Greeks varied in their opinions regarding suicide. While the Epicureans and Stoics held that the individual had the liberty to choose whether to live or die, Aristotle and Plato were opposed to suicide, as individuals had a duty to the gods and society. Plato made exceptions in cases of painful and incurable illness, condemnation and the miseries of fate.

Nonetheless in Athens, the bodies of suicide victims were buried outside the city walls, the right hand cut off and buried separately (Fahy, 1991:19).

With the dawn of Christianity, the prohibition of killing became absolute apart from certain strictly defined instances, and it extended to killing oneself. St. Augustine strengthened Christian condemnation of suicide stating that life is a sacred gift from God, and God alone can take it away. The death of Judas was seen as a more serious crime than the betrayal of Christ, as it removed all chance of repentance.

In Western society, the strict Christian approach continued throughout the middle ages and was incorporated in civil legislation. The bodies of those unfortunates who died by suicide were severely punished. Their corpses were in some places dragged through towns and then hung upside-down, or pinned to crossroads by a stake through the chest. The goods of the individuals were confiscated. The next of kin were forced to watch the spectacles which brought dishonour to the entire family, as well as throwing them into poverty.

In 1621, Robert Burton wrote *The Anatomy of Melancholy*, in which melancholia was seen as a disease causing suicide. He suggested that melancholia could worsen under certain circumstances, poverty, sickness, death of a loved one, loss of liberty, amorous jealousy, religious terror. This work marked a turning point on how suicide was viewed, as an illness rather than a sin. This view was not shared by the churches.

The late 17th and early 18th centuries saw a great rise in number of suicides in England. Newspapers printed articles on some of the more interesting cases, inquiring into their circumstances and causes. Readers grew accustomed to seeing suicide as the result of social or psychological circumstances, and to view those affected as victims rather than criminals. Public opinion became increasingly hostile to the confiscation of property of a suicide victim. To a certain extent suicide verdicts were avoided in clear cases of suicide, and even where a suicide verdict was reached the coroners' juries undervalued their wealth to avoid plunging the family into poverty.

Characteristic of the late 18th century was the suicide note, which was often published. These presented the act as rational and explicable in human terms, and gave readers insight into the mind of those who died by suicide. Motives included marital discord and family problems, death of a child or

loved one, poverty, debt, shame, remorse and humiliation. At the end of the 18th century suicide was being decriminalised nearly everywhere in Europe, although the UK and Ireland would have to wait until the late 20th century to follow suit.

From the late 19th century and throughout the 20th century numerous theories on the causes of suicide were put forward. These focussed on social and cultural factors associated with a higher rate of suicide, and on individual characteristics or psychological traits of those most at risk of suicide. Suicide was considered a crime in the UK until 1961. The last charge in an Irish court of attempted suicide was in 1967 (Neville, 2006), and it was decriminalised in Ireland in 1993.

## DURKHEIM'S THEORY OF SUICIDE

In 1897, Emile Durkheim published his most influential work on suicide, based on the suicide rate statistics of several European nations at that time (Durkheim, 1952). It is of great importance because he explained suicide in terms of social causes, and transformed the way in which suicide was understood. Rather than examining the personal factors which led to an individual taking his own life, he looked at the social factors which underlie suicide. The key factors were integration and regulation. Durkheim categorised suicide under four headings according to the degree of integration and regulation: *egoistic suicide* resulting from lack of integration, *altruistic suicide* resulting from excessive integration, *anomic suicide* resulting from lack of regulation, and *fatalistic suicide* resulting from excessive regulation.

*Egoistic suicide* is most likely to occur where ties uniting individual with others are slackened or broken. People most likely to be at risk include those living alone, separated from family ties, without support of group membership.

*Altruistic suicide* results from excessive integration and group control, where the death of the individual is justified for the common good. For Durkheim, this active suicide contrasts with depressed egoistic suicide, and ranges from the religious fervour of a fanatic, to the remorse of criminal who wishes to expiate his crime.

*Anomic suicide* is most likely to occur when traditional beliefs, morals and practices break down as a consequence of rapid social change. This may occur during periods of great economic prosperity or economic slumps. According to Durkheim, in a regulated society, there is a limited degree of freedom, and people are taught to control desires and goals within limited attainable boundaries. An abrupt growth of wealth leads to increased desires, and without restraint upon aspirations, goals become infinite in scope and nothing gives satisfaction. It is in these circumstances that the conditions for anomic suicide are at a maximum. To pursue a goal which by definition is unattainable is to condemn oneself to a state of perpetual unhappiness, and one cannot survive repeated disappointments of experience indefinitely. The result is similar when there is a sudden downturn in an economy. *Anomie* begets a state of exasperation and irritated weariness which may turn a person against oneself or another

according to circumstance. Also included as a type of anomic suicide is when a person kills him/herself after killing the person he/she accuses of having ruined his/her life. It is anomic because the individual's emotions are without regulation. In an exasperated state his/her anger is taken out on the cause of this frustration, by suicide if the individual sees him/herself as the one to blame, or homicide or other violent act before suicide if he/she sees another is to blame.

*Fatalistic suicide* occurs when there is excessive regulation, e.g. the suicide of slaves. Durkheim included this type of suicide for completeness rather than for its contemporary importance, referring to it only in a footnote.

Suicide can result from a combination of the above. Durkheim refers to mixed suicides where there is depression (egoism) and agitation (anomie). He also cites the example of the bankrupt man who kills himself to spare family disgrace (altruism) and because he cannot cope with lifestyle change (anomie).

Referring to the rapid increase in suicide rates in the period before his writing, Durkheim commented that our social organisation, must have changed profoundly in the course of this century, to have been able to cause such a growth in the suicide-rate. Durkheim's great insight that a nation's suicide rate is indicative of the cohesiveness of that society is borne out by modern international research (Pritchard, 1995:6). To a modern reader it is remarkable that Durkheim's writings of the late 19th century remain relevant and valid in the 21st century.

Durkheim's theory that integration is a protective force against suicide, and that there is a correlation between rapid social change and suicide continues to have a major impact on the study of suicide. While social factors have an important influence on suicide rates, so too do cultural, psychological and biological factors. These, the various life situations a person may find himself in, and the meaning they hold for him, converge to actually prompt individuals to take the final decision to end their lives. "If we could recognise the individual likely to commit such acts, we might be successful in suicide prevention" (DOHC, 1998:44).

## DEVELOPMENTS IN IRELAND SINCE 1993

In 1993, Ireland became the last country in western Europe to decriminalise suicide. It was intended to remove the stigma attached to suicide and bring the law into conformity with the views of the Irish people (Parliamentary Debates, 28th April, 1993), while at the same time forbidding the aiding and abetting, counselling and procuring the suicide of another. Since its decriminalisation, there have been a number of developments in Ireland to promote public awareness of suicide, and suicide prevention.

The end of the 20th century saw the establishment of the National Suicide Research Foundation and the Irish Association of Suicidology (IAS), as well as the publication of the final report of the National Task Force on Suicide (DOHC, 1998). As a direct recommendation of this report, the National Suicide Review Group was set up, and the Health Boards created the position of Suicide Resource Officer (eleven in total), to coordinate suicide prevention services and provide information on local support services.

The new century saw the training of 24 ASIST (Applied Suicide Intervention Skills Training) officers, and the running of the first workshops in 2004. Developed in Canada in 1982, these two-day workshops aim to prepare participants to do emergency suicide intervention until the immediate danger is resolved or further support resources can be activated. Between August 2004 and August 2006, 160 workshops were held in Ireland with 3,000 participants in attendance.

In 2005, *Reach Out, the National Strategy for Action on Suicide Prevention* was published (HSE, 2005). Building on the National Task Force on Suicide Report, *Reach Out* is action focussed with both a general and a targeted approach. Following the publication of *Reach Out*, the National Suicide Review Group was absorbed into the National Office for Suicide Prevention. This body aims to ensure the implementation of the actions set out in *Reach Out*, and to coordinate suicide prevention initiatives across the country.

## SUICIDE IN IRELAND IN THE 21ST CENTURY

Even with the aforementioned developments, the rate of suicide has continued to rise, and between 2000 and 2006, an average of 473 people died by suicide each year. (Note that the CSO figures for 2005 and 2006 refer to deaths by suicide registered in those years. There may be some discrepancy between the number of deaths registered in a given year and the actual occurrence of such deaths, therefore the 2005 and 2006 figures are provisional.) Having experienced one of the fastest growing rates of suicide in the world in the 1980s and 1990s (HSE, 2005:12), the numbers for both men and women have levelled out since the start of the new millennium. However, 2001 saw the highest number of recorded deaths by suicide ever in this state when they reached a total of 519. It is also noteworthy that each year from 2000 to 2006, the number of recorded deaths by suicide has exceeded the number of recorded deaths from road traffic accidents. The average annual total of deaths on the road being 335 compared to 473 by suicide.

Suicide is most common among men, the male to female ratio from 2000 to 2006 being 4.2:1. In particular young men are at risk, with men under 30 years accounting for almost 29% of all suicides in that period (male and female suicides under 30 account for 34% of the total), the age bracket at greatest risk being 20-24.

The most frequently used method is hanging which, during this period, accounted for 57% of all deaths by suicide. This method of death is not judicial hanging, which was used in executions as a relatively humane and swift form of death, involving breakage of the neck. Hanging as a method of suicide is asphyxiation by self-strangulation, a slow mode of dying. There has been an increase in the percentage of suicide by hanging in recent years, both by men and women. Between 2000 and 2006, 62% of men and 36% of women used this means of death. Drowning accounted for 17% of deaths and poisoning for 14%. Among women poisoning accounted for almost 28% of deaths followed by drowning 26%.

Suicide in Ireland is more of a rural than an urban phenomenon. This is not only the case in Ireland but reflects patterns in the rest of Europe (Cox, 2006:7) and in the United States (LivingWorks, 2005). This could be explained by easier access to mental health services in urban areas, as well as by the increased risk of isolation in rural areas (Cox, 2006:7), or that the anonymity of urban areas reduces the stigma associated with seeking treatment.

## CAUSES OF SUICIDE

Suicide is a complex problem for which there is no single cause. It results from the complex interaction of biological, genetic, psychological, sociological and environmental factors (WHO, 2000:5). It is widely recognised that hopelessness is central to many suicidal acts, where suicide is seen as the only solution to life's problems.

Aware (a voluntary organisation comprising patients, relatives and mental health professionals, established to assist people affected by depression) has suggested (1998:12) that the causes of suicide can be best explained by a domino effect of three components, psychiatric illness (mainly depression), traumatic losses in life (including bereavement, marital breakdown and unemployment), and finally the added depressing effect of alcohol abuse or illicit drug use. The sequence need not occur in this order. In the young it can begin with the third, restricting their thinking, and their ability to visualise solutions to problems. It is at this end stage that suicide becomes a meaningful alternative (Aware, 1998:2).

The Oireachtas Report (Houses of the Oireachtas, 2006) identifies those most at risk as having socio demographic vulnerabilities, interfacing with lifelong susceptibilities that are then usually subject to a precipitating event with catastrophic consequences. Socio-demographic vulnerabilities include being male, under 35 years, unemployed, single, separated or divorced. Specific susceptibilities include a psychiatric illness, alcohol and substance misuse, gambling problems and other debts, poor physical health, history of deliberate self harm, family history of suicide. Common precipitating events include rejection, interpersonal problems, a recent humiliating event, loss or bereavement, work difficulties (Houses of the Oireachtas, 2006:11).

Not everybody in these situations will go on to end their own lives. It is not the problems that lead the person to commit suicide, it is the effect those problems have on them, on their self-esteem and the way they view their future; the key factor is hopelessness (Glynn, 1995 cited in McElwee, 1997:104).

Quite apart from suicide resulting from depression and a feeling of hopelessness, some resulting from anger, are motivated by thoughts of punishing oneself or others. Durkheim (1952:285) referred to the anger and frustration caused by unregulated emotions as leading to anomic suicide. Halbwachs (1978:301) said that youth suicide is frequently inspired by

thoughts of vengeance, to compel people to recognise the wrong done to the victim. The individual imagines the shock, regrets, remorse and grief of those responsible. He also referred to suicide as a form of self punishment, and questioned why society on one hand condemns suicide, yet on the other hand orders the guilty to atone for their crimes (Halbwachs, 1978:299).

Suicide may be seen as the only way of ending an unbearable sense of pain brought about by depression and hopelessness, or as a way of punishing oneself or others, brought about by extreme anger. What needs to be examined are the settings and conditions that make the occurrence of proximate causes of suicide (depression, hopelessness, anger) more likely (Smyth, MacLachlan and Clare, 2003:108).

## 1 Suicide contagion

An initial suicide can lead to further deaths by suicide, known as suicide contagion, cluster suicide or copy cat suicide. It can occur through direct exposure where victims were known to each other, and indirect exposure where victims knew the initial suicide in the cluster through media exposure or word of mouth (Neville, 2006). Research indicates that knowing how a person, particularly a family member, killed themselves, substantially increases the risk of suicide in somebody with severe depression (McKeon, 1991:96). The person who finds the body of someone who has taken his/her own life needs to be watched for suicide risk (Cox, 2006:10).

Durkheim (1952:97-98) stated that family members often die by the same method at the same age. However he did not feel that it was necessarily genetic and gave the example of a 19-year-old girl with very suicidal tendencies whose father and uncle had died by suicide. She was preoccupied with idea that she too must follow suit, until she learned from her mother that the man she believed was her father was not. The suicidal tendencies subsequently disappeared.

Whether suicidal tendencies are inherited or not, having a family history of suicide increases one's risk of suicide. It may be that those who are bereaved by suicide are so overwhelmed by the stigma, guilt and anger which complicates their grieving that they in turn are at risk of suicide themselves. Jackson (2004) cites John D. Weaver, who suggests that in some families suicide becomes a learned violent behaviour for coping with stress. He also says that suicide contagion is especially likely to happen in schools where a

very popular person dies by suicide. The IAS and the Samaritans have developed media guidelines regarding the reporting of suicide to reduce the level of suicide contagion (IAS, 2006).

## 2 Social change

The late 20th century saw a huge growth in the Irish economy. Increased prosperity led to a greater urbanisation of the population, a new immigrant population and a change in social values. During this period Ireland underwent such social change that today it is in many ways unrecognisable from the Ireland of twenty years ago. There have been major increases in the rates of marital breakdown, single parent families, alcohol consumption and crime, all of which correlate with higher suicide rates (Neville, 2006). The role of the Church has diminished considerably and 21st century Ireland is replete with images of distrust – clergy abuse, doctors kill, politicians are corrupt (Smyth et al., 2003:59). Better living conditions do not necessarily constitute better mental health (Lester, 1993:82) and there is a price to be paid for a consumer driven society. The division between rich and poor is increasing, and as a person's success is measured by his spending power, there is increased pressure on the individual to earn more and more. In many cases both parents work leading to a reduction in the amount of time families spend together. In addition long commuting distances means that community ties and supports are weakened.

With a greater emphasis on the individual rather than the family or community, on material achievement and on occupation, Smyth et al. (2003:111-112) point out that the great downside to this focus on individual success is the consequence of individual failure. With less diffusion of responsibility there may be fewer to share the burden with. Of particular concern would be those who are unemployed. Irish society awards status and prestige according to the person's position and contribution to work (Neville, 2006). When a person is unemployed it can diminish their own self-image and self-worth, and financial problems, which result from unemployment, are associated with hopelessness (Cox, 2006:8). Where there is forced unemployment, suicide can occur at the time of job loss because of the stress of shame and adjustment, or at a much later stage when financial resources are exhausted and hope is diminished (LivingWorks, 2005:9).

The National Strategy on Suicide (HSE, 2005:14) also refers to the impact of social change on the rate of suicide in Ireland, stating that young men in rural areas no longer have a clear pathway into farming due to the modernisation of agriculture; an increasing number of single parent families leaves fathers more isolated; teenage girls struggle with burden of unrealistic expectations about physical appearance and achievement, propagated by popular culture and the media; older people no longer have support of an integrated and extended family and community network to turn to. In particular the role of men has changed. Women have entered the workforce in great numbers but have retained their role within the family, while in recent times, the male has become very marginalized (Fitzgerald, 2004). Public perception of the traditional macho image has become increasingly negative. When it comes to work, procreation, family and so many areas of life, it seems that women can perform as well as men, even in the absence of men (Smyth et al., 2003:88).

Smyth et al. (2003:46) also note that adapting to a changing cultural context can be extremely demanding for an individual. This is particularly so in Ireland where there has been an abandonment of traditional values and eager adoption of new ideals. It is perhaps not so surprising that Ireland experienced one of the fastest growing suicide rates in the world with the increased prosperity of the 1980s and 1990s.

### 3 Stigma

For all the modernisation and liberalisation of social attitude that has taken place in Ireland in recent years, there is still a huge stigma associated with suicide, although Spellissy (1996:108) notes that the emphasis has shifted to one of concern, rather than censure. Organisations, such as Aware have campaigned to promote positive mental health and to raise awareness of depression and suicidal ideation. However there is still the perception that something was not quite right in the family of a person who died by suicide, and friends and neighbours often at a loss to know what to say when faced with suicide, leaving bereaved families isolated in their grief (Cox, 2006:10). In an interview with journalist Emily Cox, (2006:147) the Governor of Mountjoy Prison (the main committal prison in the State for males aged 18 years and over), John Lonergan, stated that "A prisoner's suicide is a failure on behalf of the prison service – it's important to recognise that we failed to protect that person's life." Lonergan's statement echoes the feeling of

failure, coupled with shame and guilt, which are very closely associated with suicide. Unfortunately, this sense of stigma associated with mental health and suicidal behaviour is one of the biggest obstacles to a person who is depressed or indeed suicidal seeking treatment. It is ultimately one of the greatest challenges to suicide prevention (HSE, 2005:30).

## 4 Alcohol abuse

Alcohol and substance abuse are strongly related to suicide (HSE, 2005:36). There is a certain similarity between alcohol/substance abuse and suicide, in that people in crisis turn to both to ease pain (Connolly, cited in Cox 2006:98). Smyth et al. (2003:113) note the huge increase in Ireland's consumption of alcohol and drugs with our increased prosperity: "Now, wealthy as we are, we are all the better positioned to do to excess just about everything". While the increase in all kinds of substance abuse presents a worrying trend, it is alcohol abuse that I focus on here. Alcohol consumption and pub culture are a major part of the Irish identity. An Irish Times youth poll indicated that while young people are aware of the dangers of heroin and cocaine, they seem to think that alcohol poses no health risk (National Youth Council of Ireland, 2006). Smyth et al. note that with economic growth, alcohol consumption has become increasingly harmful and increasingly intolerable: "The culture of conviviality that once imbued Irish pubs is being replaced by a more frenetic, almost chaotic and certainly public self-destruction" (Smyth et al., 2003:113).

According to the WHO (2000:7), alcoholism (both alcohol abuse and dependence on alcohol) is a frequent diagnosis in those who have died by suicide, especially young people. The Department of Health and Children Report (DOHC, 2001:7) states that the important role that alcohol plays in suicide needs to be recognised and addressed at both local and national level. According to Connolly (2004), there is a direct relationship between levels of alcohol consumption and rates of completed suicide. In Ireland during 1990s alcohol consumption rose by 41% and suicide rates rose by 44% (Houses of the Oireachtas, 2006:41). Ireland is amongst the highest consumers of alcohol in the world, ranking second in the European Union (after Luxembourg) for alcohol consumption (DOHC, 2004:6). Research shows that in comparison to adults in other European countries, adults in Ireland have the highest reported consumption per drinker and the highest level of binge drinking (Ramstedt, M. and Hope, A. (in press) cited in DOHC, 2004:8).

The long-term effects of excessive alcohol consumption have an impact on suicide as do the immediate effects of binge drinking. Prolonged abuse of alcohol is in itself a major contributory factor in depression and suicidal behaviour (HSE, 2005:36). Chronic alcohol abuse and alcoholism are associated with domestic violence, family dysfunction and marital breakdown, all of which in turn are associated with increased suicide risk. Furthermore, the health consequences of alcohol abuse, e.g. liver cirrhosis, place individuals into another group at risk of suicide (Connolly cited in Cox, 2006:98).

In an interview with Emily Cox, Dr. J. Brophy, stated that the immediate effects of alcohol such as reduced inhibition, increased aggression, change in behaviour, emotional and perceptual distortion and exacerbated lowered mood are significant factors in facilitating suicidal acts (Cox, 2006:97). Alcohol can lead to increased impulsiveness and can be used to provide false courage before a suicidal act (HSE, 2005:36).

According to Smyth et al. (2003:34), alcohol does not cause people to have suicidal thoughts or behave in suicidal manner, but for those who already hold such thoughts, the consumption of alcohol may reduce their inhibition, making them more likely to act. Lester (1997:139), on the other hand argues that people who have been drinking without serious suicidal intent might impulsively kill themselves while intoxicated.

While we cannot be sure whether the close relationship between alcohol and suicide is causal or not, it remains clear that a society which has rapidly increasing alcohol consumption levels and suicide rates needs to address both issues with urgency.

## 5 Mental illness

Suicide is in itself not a disease, nor necessarily the manifestation of a disease, but mental disorders are a major factor associated with suicide (WHO, 2000:5). Although depression is the most common condition to be associated with suicide, only a low proportion of those suffering from deep depression go on to die by suicide (Charlton et al., 1994, cited in Kelleher, 1996:51). Schizophrenia Ireland has produced more disturbing statistics. They say it is estimated that 10-13% of all those diagnosed with schizophrenia die by suicide and that suicide is the primary cause of premature death in this group (Nangle, 2005:13).

It is felt that victims are caught in the crossfire between serious mental illness on one hand and extreme personal vulnerability at a point of time on the other hand (Fahy, 1991:23). Co-morbidity of a psychiatric disorder and alcohol or substance abuse greatly increase the risk of suicide (HSE, 2005:34). Psychiatric disorders, usually depression, or an intoxicant problem are present in 90% of people who take their own lives (Aware, 1998:2).

It is recognised that patients attending mental health services are at increased risk of suicide in the period of discharge from psychiatric care (Goldacre et al., 1993 cited in DOHC, 2001:60). In the study *Suicide in Ireland* (DOHC, 2001:60), it was found that almost one third of those who had died by suicide and who had also been treated for a psychiatric illness as in-patients, took their lives within three months of discharge from a psychiatric hospital.

According to Pritchard (1995:33), depending on which studies one looks at, between 40% and 80% of suicides are carried out by people suffering from depression. Fahy (1991:23) points out that not all suicides have a major depressive illness; suicides, motivated by thoughts of punishing another are most common among the young, and this, he notes, is the area of most rapid increase. Baechler (1975, cited Bailey, 1998) states that suicide is neither a force nor a sickness; it is quite simply a logical solution to a real or imaginary problem.

While it is very difficult to ascertain the precise connection between suicide and depression, the correlation between mental health issues and suicide cannot be ignored, and more input into the mental health services is necessary. Smyth et al. (2003:117) warn that while the expertise of mental health practitioners is a valuable resource with regard to suicide, a society that is content simply to refer potentially suicidal people to specialists is one that fails to locate the problem in itself. The site for prevention of suicide must be ordinary life, not life in crisis, when one is least able to take on board that which one most needs to know.

## SUICIDE AND MINORITY ETHNIC GROUPS

According to Durkheim individual circumstances do not explain changes in the rate of suicide (Durkheim 1952:297). The cultural context one belongs to is seen as of primary importance in explaining these fluctuations. Smyth et al. (2003:29) citing Gergen and Gergen (1996), argue that culture, that which organises and shapes our understanding of reality, the way we interact with the world and those in it, and that which gives meaning to our lives, is a central facet of suicide. They also point out that when multicultural perspectives on suicide are examined it becomes clear that culture may act as a protective factor, or as one that increases risk in already vulnerable groups – a facilitating factor (Smyth et al., 2003:30).

No statistical information is available on Traveller suicide, nor has any research been carried out on possible risk and protective elements of Traveller culture in relation to suicide; however, there is considerable data on the practice of suicide in other minority cultures. Here I shall briefly look at research that has already been carried out into some of these cultures. Those examined include African Americans, whose rates of suicide are low compared to rates for the majority population. Like Travellers, they tend to have strong family and religious ties. I have also chosen to examine research which has been carried out into the indigenous peoples of North America, Greenland and Australia, who show very high rates of suicide. There are many similarities between these groups and Travellers in that they are all indigenous populations which share common issues such as poverty, and loss of culture and traditions.

### 1 African Americans

When compared to other racial and ethnic populations in the US, African Americans fall into the category of the relatively poor, being over represented in high need groups that are particularly at risk for mental illness (homeless, in prison, in foster care, exposed to violence). Yet their suicide rate is about half that of non-Hispanic whites (SMHAI, 2004), Black females having lowest suicide rate of any cultural/gender group (American Association of Suicidology, 2007). From this it would appear that African-American culture seems to protect against suicide. A study by Cook et al. (2002) revealed that among older African Americans, those with strong religious ties were least likely to have suicidal thoughts, although 60% of

those interviewed were living below poverty line. They suggest that strong religious faith and social supports may be key factors as to why they are less likely to die by suicide. Smyth et al. (2003:32) note that African-Americans are more likely than those of European extraction to live in multigenerational groups, offering the possibility of elderly suicide being reduced, as they can feel they can continue to make a valuable and meaningful contribution to their family and community.

That religion is a protective factor against suicide where it allows increased integration was highlighted in Durkheim's *Le Suicide* (1952). Dervic et al. (2004) found that regardless of denomination, religious affiliation reduces the risk of suicide. They suggest that in addition to promoting social ties and reducing alienation, religious beliefs may assist people coping with stress, hopelessness and anger, all of which help prevent suicide. Kelleher (1996:24) suggests that the negative association between suicide and religion may be due in part to the condemnatory attitudes of some religions to suicide.

## 2 Indigenous minorities

### *(i) American Indians and Alaska Natives*

The situation for indigenous populations in North America is quite different with the rate of suicide among American Indians and Alaska Natives (AI/AN) being considerably higher than National U.S. rates. While research findings on the rate of suicide among these groups varies, it is accepted that the rate is higher for indigenous people than for any other group in North America (Smyth et al., 2003:33, Living Works 12-13). Issues with this group are loss of their land, poverty, poor education, forced geographical relocation and cultural assimilation (Gary et al., 2005). Smyth et al. (2003:33) note that striking levels of alcohol dependence and poverty can be observed within Native American culture, both problems being recognised as independent risk factors for suicide. Phenomena used to explain suicide among American Indians and Alaska Natives include social disintegration and acculturation. Cultural conflict and identity formation problems are thought to help create chronic dysphoria and anomie which influence vulnerability to suicide (Gary et al., 2005). The American Psychological Association Congressional Testimony on Suicide (1999) notes that conditions (such as substandard living conditions, devastating health conditions, unemployment, alcohol and substance abuse) which confront

the AI/AN population pose significant health and mental health risks that test resilience. Some find the inner resources to cope, while others do not. The report also suggests suicide is often the result of failure to deal with problems such as depression, alcoholism and domestic violence all of which are pervasive among the AI/AN population.

### *(ii) Inuit*

Suicide was accepted in traditional Inuit societies, but probably limited to situations where the survival of the group was endangered by the infirmity of a group member (Leineweber, 2000:9). Apparently the only suicides were the elderly or the infirm, with youth suicide unthinkable in traditional society (Brooke, 2000). The strategic location of Greenland during World War 2 and the Cold War, led to new economic, social and political structures (Leineweber, 2000:3). The break from traditional hunting, especially with the decline of the fur industry forced the indigenous population to adapt to modern society, leading to social pathologies and public health problems. The most alarming being the increase in suicide rates which rose in the 1970s, peaking in the mid-1980s at five times the European average (Leineweber, 2000:10).

The rate of suicide among Canada's Inuit population is also very high. The 1995 Report of the Royal Commission on Aboriginal Peoples (Miller Chenier, 1995) found that the suicide rate was placed at 3.3 times the national average for registered Indians and at 3.9 times the national rate for Inuit.

For Leineweber (2000:25), rapid and profound social change gives the most tangible explanation of the recent explosion of suicide rates. Colonial stresses such as isolation, definition and transition, as well as a negative perception of traditional Inuit ways are also cited as problems associated with an increased suicide rate. Such problems are exacerbated with drinking, shame, low self esteem and anger, the latter often turned inward resulting in suicide (Peaceful Societies, 2005).

### *(iii) Australian Aboriginals*

Suicide was virtually unknown in traditional Australian Aboriginal societies until the 1970's, when the incidence rates of suicide and suicidal behaviours began to increase (Tatz, 1999:23, Elliott-Farrelly, 2004:2). While recognising that enumeration of Indigenous populations is problematic as is the

collection of reliable suicide statistics, researchers estimate that Aboriginal suicide is at least 1.5 times to twice the national rate (Elliott-Farrelly, 2004:2; Hunter, 2001; Tatz, 1999:10). Elliott-Farrelly (2004) states that poverty, state dependence, racism and moving between two (sometimes conflicting) cultures are all factors facing Australian Aboriginal peoples and are relevant to increased rates of suicide. Reser (2002:39) feels that similar to Native American suicide, Aboriginal suicide is often an impulsive act, with binge drinking playing an important role.

Hunter (2001) points out that in the 1960s the strict controls on Indigenous communities (which he describes as draconian and racist) were lifted without planning or preparation, leading to a period of 'deregulation' in the 1970s. This was characterised by social instability, with increased alcohol consumption, increased rates of violence and incarceration, and it was against this background that suicide began to be recognised as an issue.

According to Tatz (1999), the link between mental illness and suicide is not applicable in the case of Aboriginal suicide. Policies of exclusion and administrative arrangements established to target an entire people as being in need of care and protection have resulted in this group being designated a separate legal class of person. The Aboriginal community have suffered great losses: their land and their traditional economy, while cultural practices are found to be abhorrent to white society. The result is disordered communities, and the disorder has come to the surface as violence; domestic, interpersonal and now suicidal.

## Summary (i) – (iii)

Research into the aforementioned indigenous populations has emphasised the impact of acculturation and cultural stress on the rate of suicide. Acculturation refers to the way in which individuals or groups adapt to a cultural context which is different to the one they were brought up in. Ways of relating to and interacting with the new culture include assimilation, separation, marginalisation and integration (Berry, 2000:298). In these traditional populations, exposure to rapid social change may lead to alienation from traditional values and social instability (Leineweber, 2000:35). If culture orders and gives meaning to life experiences, the dismantling of one's culture may result in a disordered and personally meaningless world; traditional safeguards (interdependence, clear role-orientation and traditional tribal structure) that protected against suicide, are no longer typical (Smyth et al., 2003:35).

Tatz (1999) refers to a perpetual cycle of grief as a major factor in Aboriginal life. This grief is for relatives who die in infancy or who die young from diseases, accidents or violence, and grief for losses of their land and traditional culture. Miller Chenier (1995), referring to the indigenous peoples of Canada, suggests that unresolved grief may be a widespread psychological problem associated with suicide.

Although these communities are very different from one another and have diverse and complex histories, they share common features such as high levels of poverty, low levels of health and education, inadequate accommodation and limited employment opportunities, as well as poor coping strategies such as high levels of alcohol abuse and violence. In conditions such as these people are more likely to develop feelings of helplessness and hopelessness that can lead to suicide (Miller Chenier, 1995).

Like the aforementioned indigenous populations, Travellers experience high levels of disadvantage and negative perception of their culture and traditions by the majority population (Mac Gréil, 1996; Curry, 2000; Pavee Point, 2006a). However, the strength of family and religious ties may serve to protect Travellers from suicide, as it appears to have done for the African-American peoples. The next chapter looks at issues affecting the Traveller community, and discusses to what extent Traveller culture acts as a protective factor or a facilitating factor regarding suicide.

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## CHAPTER 2

### LITERATURE ON TRAVELLERS

## INTRODUCTION

Irish Travellers are an indigenous minority group making up almost 1% of the total population of Ireland. Travellers have their own language, customs and traditions, and (McCarthy, 1994:124; Mac Laughlin, 1995:14) rarely marry outside the Traveller community. Nomadism, the importance of the extended family, the Traveller language and the organisation of the Traveller economy all provide visible and tangible markers of the distinct Traveller culture (DOE, 1995:75, Binchy, 1994). Legally, Travellers are defined as follows:

Traveller community means the community of people who are commonly called Travellers and who are identified (both by themselves and others) as people with a shared history, culture and traditions including, historically a nomadic way of life on the island of Ireland. (Equal Status Act 2000, Section 2).

According to Ní Shúinéir (2004), there is a lack of detailed historical research regarding the origins of the Irish Traveller community, although popular culture suggests several theories: these include theories that Travellers are the direct descendants of the Irish nobility, descendants of Irish peasants from the time of the Great Famine of the 1840s, or that they are dropouts of society, none of which it would seem, has any foundation. Historical sources would suggest that Travellers have been part of Irish society for centuries (Ní Shúinéir, 1994: 60-66, Okely, 1983:13-15).

Traditionally Travellers were commercial nomads who traded in the rural agricultural economy (Donahue, McVeigh and Ward, 2005:18). Travelling is a fundamental part of Traveller identity (McDonagh, 1994:98). It has not only an economic function, but also a social function in that it permits people to meet and be together, yet facilitates separation in cases of conflict (Liégeois, 1994:78). Today 77% of Travellers live in houses, however, nomadism remains an important part of cultural identity to all Irish Travellers whether they are nomadic or not (Donahue et al., 2005:66). McDonagh (1994:95) points out that while some settled people may in fact travel more than some Travellers, it does not make them nomadic. Similarly, Belton (2005:68-69) states that settled people may live in caravans but are not Travellers. According to Liégeois (1994:79), a settled person retains a sedentary mindset when travelling, Travellers, even when not travelling, remain nomadic; nomadism is more a state of mind than a state of fact.

At the moment there is no precise figure on the number of Travellers in Ireland. The 2002 and 2006 CSO national census forms included a question as to whether the respondent was a member of the Traveller community. According to the 2006 national census, the number of Travellers in Ireland is 22,369. According to Liégeois (1994:29), census figures on Gypsies/Travellers in any European country have always been imprecise as there is a reluctance for them to declare themselves as such on census forms. Pavee Point (2004a) deems the CSO figure to be an underestimate for the same reason.

Since the early 1970s, the Local Authorities have carried out an annual count of Traveller families, which is collated by the DOE. In order to be included in the annual count, the same criteria are used to define a Traveller as were used for the Travellers' Health Status Study, where the enumerators were mainly Local Authority social workers; namely that the social worker has to believe that a person is a Traveller, and the person has to agree with this assessment (Barry and Daly, 1988:9-10). The DOE annual count takes place on the final Friday in November each year. It could happen that some families may be counted twice if on the day of the annual count they are in a different county from that in which they are normally resident. Similarly, although it is expected that all Traveller families will be known to the social worker, there may be gaps in this knowledge, and those families will not be included in the annual count. The Irish Traveller Movement (ITM) states that while the Local Authority annual count is flawed, it is still considered as having the potential to offer the most comprehensive method of data collection if modified (ITM, 2005:12). The most recent figures, taken in November 2006, show that there were 7,691 Traveller families in Ireland. According to the CSO, the average Traveller family size is 4.22, indicating the number of Travellers in Ireland is approximately 32,456. Pavee Point (website date 2005-06), calculating on the basis of CSO and Local Authority population data, estimates the number of Travellers at 30,000.

The increase in the Traveller population is extraordinarily high compared with that of settled population, significant factors for such an increase in the Traveller population including early age of marriage, rarity of spinsterhood, and large family size (DOE, 1983:8). The DOE annual count has shown an increase in the number of Traveller families from 4,898 in 2000, to 7,691 in 2006. This represents an increase of 57% in the number of families. The increase in the number of Travellers from 23,119 in 2000, to 32,456 in 2006 was 40% compared to an increase of 12% in the general population over the same period. (The reason for the disparity between the increase in the

number of families and the number of Travellers is due to a reduction in the average Traveller family size as indicated by the CSO over the same period.)

## TRAVELLERS IN IRISH SOCIETY AND IN OFFICIAL SOCIAL POLICY

Mac Laughlin (1995:1-3) identifies three important watersheds in the evolution of the position of Irish Travellers in society since the mid-19th century. The first occurred during the building of the Irish nation. Values of property owners were hegemonic and it was considered that Travellers had no place in modern Ireland. In 1922 the newly formed Irish state inherited anti-nomadic legislation such as the 1824 Vagrancy Act, which included in its definition of a vagrant, any person wandering and lodging under a tent, or in any cart or wagon, not having a visible means of subsistence. This section was only removed from Irish legislation by the Housing Act of 1988 (Lentin and McVeigh, 2006:133). The second watershed began in the 1960s, with the movement towards urban centres. Many shifted into new niches in the urban economy, as their traditional occupations became increasingly redundant. According to Mac Laughlin (1995:50), the move to urban centres gave rise to large Traveller encampments, which contributed to a build up of tension and antagonism between the Traveller and settled communities. Travellers faced a high degree of discrimination, coupled with a growing despondency and overdependence on the welfare state. The third watershed began in the late 1980s and continues to date. This period witnessed the then President of Ireland Mary Robinson encourage a greater awareness of Traveller culture, the setting up of a Task Force on the Travelling Community calling for the prioritisation of Traveller needs and interests, and new legislation on equality. More importantly this period saw the emergence of Traveller support groups at both a local and national level, raising Traveller political consciousness, and allowing Travellers themselves to articulate their own concerns. As Travellers have grown in their understanding of the root causes of their social exclusion, there has also been a strengthening in their awareness of their ethnicity (O'Connell, 1994:118).

Mac Laughlin (1995:3) feels that this third stage has also been marked by worrying set-backs, namely the rise of a virulent anti-Traveller racism, and the internalisation of feelings of social inferiority amongst Travellers themselves. Travellers today experience a high level of prejudice and

hostility, and many are extremely poor. The Traveller Health Strategy (DOHC, 2002:4) identifies Travellers as a particularly disadvantaged group, stating that social exclusion, racism and the influence of a harsh living environment are the main contributory causes of this.

Sedentary people frequently acknowledge that Travellers have a different way of life solely in terms of poverty and deprivation, implying that the Traveller way of life would disappear if the problems of poverty were solved (O'Connell, 1994:116). Okely (1994:6) notes that while "Gypsy" is seen as a positive, exotic label, Travellers are not viewed as such, but tend to be dismissed as drop-outs. She emphasises (Okely, 1983:18) that the term Traveller implies a travelling, nomadic identity as well as full membership of an ethnic group. Much of our thinking about ethnic minority groups is a product of socialisation that implies that these groups come from elsewhere (Mac Lachlan and O'Connell, 2000:10). Rigal (1989, cited in Kenny, 1997:38) states that the debate on Traveller ethnicity remains polemic because of the national origin shared by settled and Travellers. Kenny (1997:28) argues that if the definition of "ethnic group" includes a nationality requirement, it implies that Travellers, or indeed any other indigenous minority, are precluded from being identified as such. While the Irish Traveller community is specifically identified in the Northern Ireland Race Relations Order 1997, as a racial group, the Irish Government has not accorded Travellers the status of an ethnic group. Ireland's report to the Convention on the Elimination of All Forms of Racial Discrimination (CERD) 2004, stated that:

"The Government's view is that Travellers do not constitute a distinct group from the population as a whole in terms of race, colour, descent or national or ethnic origin. However, the Government of Ireland accepts the right of Travellers to their cultural identity, regardless of whether the Traveller community may be properly described as an ethnic group" (CERD, cited by the Equality Authority, 2006:38).

Farrell (Farrell and Watt, 2001:25) distinguishes between "race" which has a perceived biological basis, and "ethnicity" which relates to the sharing of a collective identity based on a sense of common history and ancestry. Ethnic groups possess their own culture, customs, norms, beliefs and traditions, which are passed on from one generation to another, and may also share language, geographical origin, literature or religion. The UK Office for

National Statistics (2003:7) argues that it is not practical to base ethnic identification upon an objective and rigid classification, as membership of an ethnic group is something that can be based on a combination of categories and is subjectively meaningful to the person concerned. The fact that Travellers are perceived by the sedentary population, and identify themselves as a distinct group (DOE, 1983:6; Equal Status Act, 2000) would support the position that they are an ethnic group. The Equality Authority states that:

This acknowledgement of Traveller ethnicity is not only a matter of academic importance. It has significant practical implications in the promotion of equality of opportunity for Travellers and in the elimination of discrimination experienced by Travellers. (Equality Authority, 2006:8)

There have been three government-convened bodies who reviewed and reported on the situation of Travellers and proposed interventions to meet their needs. These documents – *The Report of the Commission of Itinerancy* (Department of Social Welfare [DSW], 1963); *Report of the Travelling People Review Body* (DOE, 1983), and the *Report of the Task Force on the Travelling Community* (DOE, 1995) – formed the framework for state social policy.

All three Reports recognised that the Traveller community in Ireland experiences high levels of social exclusion and disadvantage. Travellers have not always been recognised as having a distinct culture. Fanning (2002:154) notes that in the 1960s, the implication was that Travellers' lifestyle was inferior, making assimilation a legitimate policy goal. By the 1980s, Travellers were recognised as an identifiable group, but distinctiveness was regarded as expression of individual choice. It was in 1995 that the Report of the Task Force (DOE, 1995), recognising Traveller cultural distinctiveness, recommended that it should be supported by public policy.

In the sections that follow I shall review literature on the following four issues which pose serious difficulties for Travellers: accommodation and living conditions, health, education, and access to employment.

## ACCOMMODATION AND LIVING CONDITIONS

### *(i) The Report of the Commission of Itinerancy (DSW, 1963)*

At the time of the establishment of the Commission on Itinerancy, approximately 1,150 Traveller families were living on the roadside. The aim of the Commission was to provide opportunities for a better way of life for Travellers. However, the report made several references to the lifestyle of Travellers as a problem. It recommended housing Travellers with a view to integration and absorbing them into the community. "All efforts directed at improving the lot of itinerants and at dealing with the problems created by them.... should always have as their aim the eventual absorption of the itinerants into the general community" (DSW, 1963:106). The recommendations of the Commission led to what was known as the "settlement" project, which has been widely criticised as being based on a rejection of nomadism (O'Connell, 2002:58). The report was also criticised for its implication that Travellers were deviant and their lifestyle inferior (Fanning, 2002:153).

### *(ii) Report of the Travelling People Review Body (DOE, 1983)*

Over the twenty years which followed the Report of the Commission of Itinerancy, 1,150 families were housed or accommodated on serviced sites, but the Traveller population doubled and the number of families on the roadside was still 1,150 (DOE, 1995:100). The Report of the Travelling People Review Body acknowledged the inappropriateness of earlier assimilation policies, stating that

...the concept of absorption is unacceptable, implying as it does the swallowing up of the minority Traveller group by the dominant settled community, and the subsequent loss of Traveller identity. (DOE, 1983:6)

The report (DOE, 1983:15) recognised that the wishes of Travellers who choose to remain on the road must be respected and serviced sites must be provided to allow them to continue that form of life with such dignity and comfort as it allows. However, it recommended housing as the best accommodation for Travellers. It also recommended that newly-wed couples should be considered extra sympathetically for housing "to lessen the risks of regression to a travelling way of life" (DOE, 1983:45).

### *(iii) Report of the Task Force on the Travelling Community (DOE, 1995)*

The Report of the Task Force represented a shift in focus from the previous reports in that it recommended that Traveller cultural distinctiveness should be supported by public policy (Fanning, 2002:154). It recommended that accommodation which is provided to Traveller families must be appropriate to their needs and met through a range of accommodation types (DOE, 1995:101), and that the design of Traveller specific accommodation should reflect the distinct culture and identity of Travellers (DOE, 1995:115). The Report of the Task Force (DOE, 1995:102) looked at the concept of "indigenous" families, noting that Local Authorities had focused on accommodating the families who lived in their areas, thereby leading to the exclusion of "other" families, for which it recommended the provision of a network of transient halting sites. It also placed strong emphasis on addressing inequalities encountered by Travellers (Fanning, 2002:154).

Following from the Recommendations of the Task Force Report, there has been a great deal of progress putting in place the administrative, legislative and financial framework for the provision of Traveller accommodation; a framework which is underpinned by mechanisms at national and local level for consultation with Travellers and Traveller representatives (Department of Justice, Equality and Law Reform [DJELR], 2000:13). The National Traveller Accommodation Consultative Committee was set up with representation from Traveller Support Groups and members of the Traveller community. In 1996 the Traveller Accommodation Unit was established to oversee the implementation of the National Strategy for Traveller Accommodation. The Housing (Traveller Accommodation) Act was passed in 1998, requiring Local Authorities, in consultation with Travellers, to prepare five year programmes to meet the existing and projected accommodation needs of Travellers and to take necessary steps to ensure their implementation. That year the number of Traveller families living on the roadside was still approximately 1,150, the same as the number of roadside families when both the 1963 and 1983 reports were written. However it should be noted that while the number is the same it represents a far smaller proportion of the total population.

The dawn of the 21st century saw the adoption of the five-year Local Traveller Accommodation Plans by all Local Authorities in 2000, additional funding from the Traveller Accommodation Unit for building and refurbishment of Traveller specific accommodation, and a scheme of loans and grants for the replacement of caravans for Travellers. The quality of

Traveller accommodation has improved greatly. Citizen Traveller (2001, cited in Brack and Monaghan, 2007) found that Travellers expressed higher levels of satisfaction with group housing than with any other type of accommodation. Group houses are generally built for a family group or a group of compatible families. When vacancies arise, families are usually consulted before an offer of accommodation is made by the Local Authority. Furthermore, if a family turns down an offer of accommodation in a group housing scheme, it is not viewed negatively by the Local Authority. This type of housing is usually occupied by families who want to live in close proximity to one another. There are times when group housing is not successful (e.g. if there is a vacancy and no compatible family is available to take it, or if there is a rift between families), which can result in strained relationships exacerbated by the fact that families are in such close proximity to one another. However, generally speaking, it works well, and many extended families express a preference for accommodation together. There has been an increase in recent years in the number of Travellers who independently source private rented accommodation through an estate agency, funded by the HSE Supplementary Welfare Allowance. Being "indigenous" to an area is not a requirement to avail of Supplementary Welfare Allowance, which allows for freedom of movement from one area to another, and a greater degree of choice of accommodation.

However, according to the DOE figures for 2006, there are 629 Traveller families living on unauthorised sites, frequently located in unsafe areas and lacking basic services such as running water, toilets and electricity. Local Authorities still face a constant struggle with the provision of halting sites and group housing. Residents claim that the price of their houses will fall if Travellers move into their area (Fanning, 2002:145), and can be quite vocal in their objections to a proposed halting site or group housing scheme. This, coupled with lengthy delays in identifying sites, securing planning permission, etc. means that standard housing is a much more easily available option. Travellers, who may have waited a considerable length of time, often in deplorable conditions, for an offer of accommodation, are sometimes faced with the choice of accepting an offer of a house in a Local Authority estate, available immediately, or to continue to wait on the roadside until such time as a halting site or group housing scheme may be built. Families sometimes experience considerable difficulty adjusting to standard housing, and see it as a loss of freedom and a hindrance to their occupations and source of livelihood, while others cannot manage the additional expenses that are associated with being housed (Gmelch,

1985:143). There is often friction with neighbours, particularly if the Traveller family has a large number of visitors (DSW, 1963:37). Living in a house may even cause adverse psychological effects, including isolation, loneliness, loss of identity and feelings of being closed in (Ginnety, 1993 cited in Heron et al., 2000:109). Once in standard housing there is little hope of their being accommodated on a halting site (ITM, 2002a:10) or elsewhere. Faced with these difficulties, many Traveller families leave standard housing and return to the roadside, some after a few months, others after several years. Having already been housed, they are considered as having lower priority than families who have not been accommodated, both by the Local Authority and by other Travellers. Accommodation issues are a major source of stress to Travellers.

## HEALTH

The largest investigation of Travellers' health status in Ireland was conducted by Joseph Barry in 1986-87, and published by the Health Research Board (Barry et al., 1989). Of major concern was the lower life expectancy of Travellers, and in particular that of Traveller women, compared with their settled peers. Still births and infant mortality were over double that of the settled population. Travellers also had higher death rates for metabolic disorders, congenital problems, accidents, respiratory ailments. There has been no significant statistical analysis of Travellers' health since then, nor is there a systematic or regular gathering of data relating to Traveller health issues (DOHC, 2002:32). In relation to the provision of health services, the Task Force Report stated that all eight Health Boards had reported that they had experienced particular difficulties regarding Travellers, including poor take up of services, failure to keep recall appointments, problems renewing medical cards and the reluctance of GP's to take Travellers onto their lists (DOE, 1995:149-150). The 2002 Health Strategy recognises that Travellers are particularly disadvantaged in terms of health status and access to health services, and that they suffer poor health on a level which compares so unfavourably with the settled community that it would probably be unacceptable to any section thereof (DOHC, 2002:4). The Primary Health Care for Travellers Project identified poverty, poor accommodation and cultural stress resulting from discrimination and exclusion as causes of health inequalities experienced by Travellers (Fanning, 2002:162).

## EDUCATION

In the early 1960s, the Commission on Itinerancy (DSW, 1963:64) noted that almost all Travellers were illiterate and almost no Traveller children attended school. The situation has changed completely since then and in 2004-2005 virtually 100% of Traveller children of primary school-going age were enrolled in schools (Department of Education and Science [DES], 2006:36). With regard to second level education, approximately 50% of Traveller children remain in school until 3rd year, although the majority of Traveller children leave mainstream schooling prior to completing Junior Cycle, with only a small percentage transferring to Senior Cycle (DJELR, 2005:28). Nonetheless, literacy levels have increased among Travellers, which, according to Liégeois (1994:247) will change their relation with their surroundings, facilitating participation in political issues and asserting their wishes.

There have been many positive developments in education for Travellers in recent years. The Education Act 1998 obliged schools to ensure that the education system respects diversity of values and traditions in Irish society. In 2002 the DES published Guidelines on Traveller Education in Primary (2002a) and Second Level Schools (2002b). In 2005, the National Council for Curriculum and Assessment published Intercultural Education in the Primary School: Guidelines for Schools, which named Travellers as a minority ethnic group (2005:12).

Despite these significant improvements in recent years, irregular school attendance and absenteeism, especially at post-primary levels, are still a problem within the Traveller community. The ITM note the lack of positive experience for Traveller children in education. Evidence of bullying and its link to discrimination is of particular concern as is the low level of interaction between Traveller and settled children (ITM, 2004:13). According to Liégeois (1994:87), parents whose own memories of school are negative, hesitate to entrust children to it. He also refers to the perception of many Travellers and Gypsies is that there has been no connection between scholastic success and success in economic and social fields (Liégeois, 1994:87). There is little incentive for a young Traveller to remain at school and complete formal education when there is little hope of it leading to a well paid job, and the time spent at school could be spent earning a living elsewhere.

The Chief Inspector's Report (DES, 2005:20) showed that the levels of achievement of Traveller pupils were not on a par with their non-Traveller

peers, and that Traveller parents expressed their deep concerns about the low attainment of their children, particularly in relation to reading standards. While there has been no research carried out on attainment levels of Traveller children leaving primary school, teacher opinion is that many Traveller children under-achieve and are three years behind the norm in core subjects (Kenny, 1997:48). Pavee Point argues that a contributing factor to the low levels of attainment of Travellers in education is the lack of visibility of Traveller culture within the school system, which may contribute to feelings of isolation experienced by Traveller children. It is very important for all children to feel confident and positive in their own identity in school. Unfortunately many Traveller children are aware that their identity will pose a problem for them in school (Pavee Point, 2005c). The recent DES Report for a Traveller Education Strategy in its policy of inclusion addresses issues of racism and discrimination, and seeks to create a positive environment for Traveller children by respecting their cultural identity (DES, 2006:9).

## ACCESS TO EMPLOYMENT

Travellers are frequently associated with going from door to door selling objects, or collecting items which can be traded at markets. They deal in a broad range of items such as antiques, carpets, gates, and scrap metal (DOE, 1995:244). Work areas also associated with Travellers include recycling and waste disposal (DJELR, 2006:33). Horse dealing is an economic activity of great importance both financially and culturally for Travellers, many of whom could not envisage bringing children up in a childhood without horses (DOE, 1995:264). The high percentage of Travellers who live in standard housing and continue to keep horses reveals that even if not in Traveller specific accommodation, the economic necessity and traditions of keeping horses do not disappear (ITM, 2002b:13).

Traditionally Travellers retained a distinct economic role within rural society until at least the 1950s when some of their skills and trades became obsolete (Fanning, 2002:49). Having traditionally adapted their services to the needs of individual farmers and the agricultural cycle, they then moved on to adapt to the needs of the urban house-dwelling population (Gmelch, 1985:5). The transformation of some in the 1960s to scrap dealing, including car dismantling, provided a lucrative income (Mac Laughlin, 1995:39).

Despite the disjointed nature in the list of Traveller occupations, there is an underlying commonality that all working Travellers prefer to be self employed than in paid employment, and to have flexibility of occupation rather than job security (Hickland, 1994 cited in Mac Laughlin, 1995:41). Self employment allows Travellers to engage in economic activity in a flexible manner while avoiding the potentially discriminatory employee-manager-other employee relationship (Cossée, 2005:11). Moreover, self employment provides the independence to fully pursue family obligations such as participation in social affairs, as well as keeping up social relations (Liégeois, 1994:95).

The Report of the Task Force (DOE, 1995:246-247) identifies five features in addition to self employment, which stand out as central to the Traveller economy regardless of which economic activity is engaged, and which have remained constant over the years.

- Nomadism, whereby mobility enables Travellers to access a broad range of markets, engage in a broader range of economic activities and so make marginal activities viable.
- Income generation rather than job creation, with a particular focus on immediate payment in cash for services provided.
- The family is the basis of the work unit, with older family members passing on skills and knowledge to younger members.
- Home space and workspace are often the same, the home being used as a base from which to work and store materials.
- Flexibility, the ability to respond to market demand by adapting to new activities as trades lose markets and new ones open up.

While there is a significant and distinct work ethic within the Traveller economy, it does not always yield a profitable income. Gmelch (1985:156) found that the economic niche of Travellers was almost identical to that of the past, subsistence activities still being marginal ones requiring flexibility and mobility. At around the same time the Report of the Travelling People Review Body (DOE, 1983:3) observed a decline in traditional forms of employment, with more and more relying on state assistance. More recently Heron et al. (2000:107) found that some Travellers have viable economic activities but the majority live in relative poverty, with a high level of state

dependence, which in turn increases negative settled attitudes towards Travellers. They are often depicted as an underclass and referred to as welfare scroungers (Fanning, 2002:136).

A significant amount of the Traveller economy takes place within the informal economy, which is a source of tension between Travellers and settled people (DOE, 1995:249). Many are reluctant to participate in the formal economy due to the perceived financial and social risk, the complexity of formalisation and the fear of losing secondary benefits such as medical cards (Cossée, 2005:18-19). This in turn creates situations which are in conflict with the law, further confining Travellers to the margins of society (DOE, 1995:249).

Increasing regulation in work areas associated with Travellers, means that opportunities to continue self employment become more difficult (DJELR, 2006:33). An example of this is horse dealing. The Report of the Task Force (DOE, 1995:264) identified two main constraints for Travellers in keeping horses; lack of facilities and harassment which arises from this. Traveller organisations view the present control of horses act and by-laws as having a detrimental impact on their economic security, and as a further erosion of their culture and heritage (ITM, 2002b:7). Within the framework of the encountered difficulties, Cossée (2005:34) has observed a decrease in handing down skills from one generation to the next, which may be because of difficulties faced by Traveller economy, non-recognition of economic practices by mainstream society or because formal education offers new outlooks.

Modern Ireland has witnessed a lengthy economic boom, with low unemployment rates. In the early 1960s the Commission on Itinerancy (DSW, 1963:102) made the following observation: "Itinerants find it difficult to obtain many forms of employment because of their background and the unwillingness of some employees to associate with them." Although the Employment Equality Act (1998) promotes equality of opportunity, and the Traveller community is specifically named in the Equal Status Act (2000), there are still huge barriers to Travellers seeking mainstream employment. The unemployment level, according to 2002 census, was 9% for the total male population, while for Traveller men, it was 73%. For the total female population, the level of unemployment was 8%, but for Traveller women, it was 63% (DJELR, 2006:19). Low educational standard is a major barrier to employment and so too is the lack of role models (DJELR, 2006:34). One can imagine that it would be extremely difficult to be the only Traveller

employed in an organisation, particularly if no other family member has ever embarked on this type of work. Some of younger generation are in salaried employment, which Cossée (2005:13) suggests may be because they are less recognisable as Travellers as they wear same clothes and listen to same music as settled peers. She goes on to say that Traveller organisations would like to see them get salaried work without having to hide their identity, and so challenge the popularly held idea that Travellers do not want to work (Cossée, 2005:14).

## SUICIDE RISK FACTORS APPLIED TO IRISH TRAVELLERS

Until recently, in research and policy literature focussing on Travellers, there was practically no mention of suicide occurring among this group. The 1987 Traveller Health Research (Barry et al., 1989) made no reference to suicide, and the Report of the National Task Force on Suicide (DOHC, 1998) did not mention Travellers. In *Reach Out*, the Irish strategy on suicide the HSE authors included a paragraph about Travellers:

At present there is a lack of research on mental health and suicide among the Traveller community but anecdotally, service providers are expressing concern about an apparent increase in suicide risk and suicidal ideation among this group, especially among young Traveller men. (HSE, 2005:37)

In response to a growing concern about a perceived increase in suicides within the Traveller community the Traveller Suicide Working Group was established by Pavee Point in 2004 (Pavee Point, 2005c). They made a submission to the National Suicide Prevention Strategy expressing their concern regarding the lack of statistical information on the growing phenomenon of suicide within the Traveller community (Pavee Point, 2005b).

In terms of suicide risk, Travellers would already be deemed vulnerable due to their low socio-economic status and poor health. In this section I shall look at social change, alcohol/substance abuse and mental illness, issues associated with increased risk of suicide, in the context of Travellers. The extent to which these impact on Travellers would perhaps indicate whether they are in fact a high risk group.

## 1 Social change

Ireland underwent huge social change in the latter part of the 20th century. The Irish Traveller population too has undergone profound and traumatic transformation because of the decline of rural based economic activities and the related decline in economic function of nomadism; the two definitive changes being urbanisation and sedentarisation (Donahue et al., 2005:9). For Gmelch there were economic incentives for both urbanisation and sedentarisation. Urban migration followed from the availability of social welfare which had to be collected in person each week, forcing those without motor transport to remain close to towns. Furthermore, larger towns had a degree of anonymity, allowing Travellers earn an income from scrap collecting without the labour exchange finding out (Gmelch, 1985:47-48). The tendency towards sedentarisation was rewarded in part by the fact that both charities and householders regarded newcomers with extra caution and mistrust, while they preferred to help those who have been in their area longest (Gmelch, 1985:105).

Possibly the most striking change has been in the area of Traveller accommodation. At the time of the Commission (DSW, 1963:40), 90% of Traveller families lived in horse-drawn caravans or tents, with fewer than 5% living in houses. At the end of 2006 the number of Traveller families in houses was over 77%. In recent years private rented accommodation is an option considered by an increasing number of young couples who do not wish to live in a caravan on an unauthorised site. Currently over 12% of Traveller families are in this type of accommodation.

Another important change has been the raised awareness of Traveller culture and Travellers' rights. A major contributory factor to this has been the growth in the number of Traveller organisations both at national and local level. They take on an advocacy role representing Travellers in the public forum and highlighting issues relating to Travellers, and following the recommendation of the Task Force (DOE, 1995:69), they are involved in drawing up policy documents concerning the needs of Travellers. Legislation places both institutions and individuals under a legal obligation not to discriminate against Travellers, and there is an increasing acceptance of the reality that Travellers have rights now, not just as citizens, but as Travellers (Donahue et al., 2005:10). With improved literacy levels and active involvement in Traveller organisations, Travellers have become more politically aware, and better able to articulate their requirements and concerns.

However, this period of change, beginning in the 1960s with the movement of Travellers from rural society to the margins of urban and suburban Ireland generated new forms of conflict between Travellers and settled. Faced with deepening hostility from settled communities opposed to the presence of Travellers, the policy of assimilation was sanctioned by the state (Fanning, 2002:5). This approach, which tended to assume that minority groups were deficient, deprived and lacking in cultural capital, promoted the absorption of Travellers into the dominant culture in the belief that the socialisation of all into a shared value system was the only way forward (Farrell and Watt, 2001:27). It sought to achieve this through housing Travellers among the settled population, a policy fraught with difficulty given the public opposition to living in close proximity to Travellers. A specific anti-Traveller racism developed, which was more widespread and focused than any of the tensions involved in rural nomadism (Donahue et al., 2005:9), and although assimilation has since been rejected as a policy by the state (DOE, 1983:6), public opinion of Travellers as inferior and a threat has not changed. Travellers have had to manage their everyday lives under settled society's hostile gaze, and have been forced to develop strategies and alter their life plans to cope with this (Pavee Point, 2006a:27).

Of major concern is the impact of social change upon Travellers, and how they have adapted to a new cultural context. Young Travellers in particular, have a lot more in common with their settled peers than their parents' generation did. They live in the same estates, attend the same schools, listen to the same music and watch the same television programmes. Older Travellers are concerned about the implications of such contact with young settled people, and many fear that their children will adopt bad habits and poor morals, particularly in relation to drugs and sexual activity, (OFSTED [UK Office for Standards in Education], 1999, cited in Fountain, 2006:47). Others fear the loss of cultural traditions as they feel their children are taking on the values of mainstream society. Indeed, for some Travellers, nomadism has become synonymous with exclusion, poverty and the past (Pavee Point, 2006a:40). According to De Vos (1995:25), the fear of some ethnic minorities that more successful members may leave them is justified to an extent when the capacity to interact with individuals of higher status produces emotional and material rewards that are impossible to gain through association with a subordinate group lacking such opportunities. Those that receive some acceptance from the settled population are judged by their Traveller peers. They face issues of belonging: not fully tolerated by the settled residents, they also face rejection from other Travellers, who feel

that they must fully commit to the Traveller identity in order to be recognised as a member of the group (Pavee Point, 2006a:34). Unable to integrate into mainstream society, but no longer firmly rooted in their own cultural and social traditions, such youths exist in a type of “nowhere land” where the search for identity may be overwhelming (Kirk, 1993:132). Travellers in this situation are forced to choose to which community they will belong, while facing ostracisation from each (Pavee Point, 2006a:32). It is understandable but extremely worrying that some may adopt maladaptive coping strategies such as alcohol or substance dependence, or anti-social behaviour.

## 2 Alcohol/substance abuse

According to the Traveller Health Strategy (DOHC, 2002:92), there is little objective research pointing to the pattern of drug or alcohol abuse among Travellers. However, research indicates that social deprivation, and problems in the areas of education, employment, health and accommodation, are all risk factors which can lead to the development of problematic alcohol or substance abuse (Fountain, 2006:45). Following from this, it would appear that Travellers as a group are particularly vulnerable in this respect.

Gmelch (1985:102) noted that from the perspective of the settled community drinking among Travellers constitutes a major social problem, waste of money and social nuisance. He suggested that Travellers, aware that they are viewed at best as objects of charity or pity, at worst as a noxious social problem, may drink excessively as a reaction to insecurity and low self esteem (Gmelch, 1985:103). He drew attention to the fact that drinking is one of the few recreational activities open to Travellers and is an important remedy for boredom, and that it also serves to promote communication and expression of grievances impossible to reveal in other social contexts (Gmelch, 1985:104).

Until the Equal Status Act (2000), Travellers were regularly refused service in pubs and it was extremely difficult to book a hotel reception following a Traveller wedding. The Report of the Travelling People Review Body (DOE, 1983:24) stated that while Travellers were criticised for a high level of drunkenness, two surveys indicated that alcoholism or continued excessive indulgence in alcohol is not widespread amongst Travellers. There is no evidence that excessive drinking is significantly worse than, or even as great as among settled people. More recently concern has been expressed that Traveller women and young Travellers are increasingly using alcohol (Pavee

Point, 2004b:6). Fountain (2006:33) has found that there is widespread alcohol use amongst Travellers, especially males, although she does not state whether this is any different from the non-Traveller population. Given that Ireland is the second highest consumer of alcohol in the European Union (DOHC, 2004:6), it is quite possible that the incidence of alcohol abuse amongst Travellers is an issue of concern, without it being any higher than that of the general population.

The extent of drug use among Travellers is not known, but there is a growing awareness that it is an issue, and both Travellers and those working with Travellers have reported that illicit drug use has increased over the last few years (Fountain, 2006:31-32). Increased risk factors include drug use by another family member: the close living situation of many Travellers suggests that drug use by a member of a family could not be hidden from other members, and that shared activities could include using drugs (Fountain, 2006:61). Hurley (1999, cited in Kenny, 2003:18) suggests that the close uncritical mutual support strategies in Traveller culture that help maintain the solidarity of the group might also militate against Travellers confronting drug dealing within families and sites.

On the other hand the closeness of the extended family can act as a protective factor against drug usage. According to Fountain, (2006:61) there are indications that in certain situations, the Traveller family may be becoming increasingly vulnerable to disruption, breakdown and conflict, and that the influence of these protective factors in some cases may be eroded. Some adult Travellers feel that mixing with settled people and loss of the old traditions are factors pushing young people towards drugs (Hurley, 1999, cited in Kenny, 2003:45). Fountain (2006:61) suggests that extending social networks to include members of the settled community is a risk factor for problematic drug use only if those networks include drug users.

### 3 Mental illness

The Report of the Commission of Itinerancy (DSW, 1963:47) found that the number of Travellers in psychiatric hospitals was relatively small, and came to the conclusion that the incidence of mental ill-health amongst the Traveller population was not as high as in the settled population. Thirty years later the Report of the Task Force (DOE, 1995:145) recognised that the many pressures Travellers face affect their mental health, the main stressors being change of lifestyle, current living environment, worry and bereavement.

Poor living conditions appear to be significantly associated not just with poor physical health, but also with poor psychological health (Heron et al., 2000:112). Living on the roadside without basic sanitation is a major source of stress for Travellers, especially at times of illness or the birth of a new baby. A number of Travellers find the move to standard housing extremely stressful. Some experience a sense of overwhelming isolation, especially if they are the only Traveller family in the area, others find the additional expense of living in a house too difficult to handle, while others worry that their children may become involved in drugs or sexual activity by mixing with the wrong type of people. Their anxiety is exacerbated by the knowledge that if they return to the roadside it could be years before they are considered for accommodation again.

In the submission to the Expert Group on Mental Health Policy, it was stated that Travellers' experience of racism and discrimination can lead to feeling of being a social outcast, having low self-esteem, having lack of pride in one's ethnic identity as well as introducing a stress and a crisis into the lives of Travellers that is detrimental to their health and sense of well being (Pavee Point, 2006c:5,6). Van Cleemput (2000, cited in Kenny, 2003:16) saw the reduced opportunity for Travellers to live their traditional lifestyle as a major cause of increased physical and mental ill health.

Pavee Point conducted a survey on the Health of Traveller women in 1997 (unpublished). In that study 34% of Traveller women interviewed suffered from long term depression compared with a finding of an approximately 9% amongst their settled peers (Pavee Point, 2006c:6). A study by Heron et al. (2000:110) of the psychosocial health of Irish Traveller mothers, showed that 46% of mothers were psychologically distressed at the time of interview. They suggested that the figure could be reduced if women felt they could be relieved of some of the burdens of being primary caretaker of often very large and demanding families (Heron et al., 2000:112).

Statistical information on the use of mental health services by Travellers is scarce, but it is believed that the uptake of these services is low (DOHC, 2002:85). There is a strong stigma attached to having mental health problems within the community, which restricts Travellers seeking or availing of any form of mental service (Pavee Point, 2006c:7). Going to outsiders for "counselling", particularly when the counsellor is a settled person who may not be aware of Traveller culture, is not an option first considered by most Travellers and so service uptake may be low (Pavee Point, 2006c:7). During the course of my work, Travellers have expressed a distrust of the psychiatric

services and a fear that their children may be taken into care if they access the service of a psychiatric hospital. On the other hand, there does not appear to be the same stigma attached to the usage of anti-depressants. Concern has been expressed that prescription drug use is an issue among Traveller women (Pavee Point, 2004b:6). Fountain found high levels of prescribed sedative, tranquilliser, and antidepressant use by female Travellers (2006c:34), and that the practice of sharing prescription drugs with others was common (2006c:67). The Traveller Health Strategy (DOHC, 2002:4) has indicated that Travellers may not have the literacy skills to follow instructions on prescribed medicines, which renders the sharing of prescription drugs especially dangerous. The high level of prescription drug use indicates that underlying issues are not being tackled at source, and that the level of psychological distress among Travellers is of major concern.

## CULTURAL ISSUES AND SUICIDE RISK

Theories regarding suicide would indicate that Travellers are a vulnerable group. They have a low socio-economic status, fare poorly in terms of health, accommodation and living conditions, education and access to employment (O'Connell, 2002:49). Their way of life has undergone profound social change, and alcohol/substance abuse and mental illness are growing concerns. I would like to examine aspects of Traveller culture which may act as a protective factor regarding suicide, namely family ties and religion. Certain issues affecting Travellers may render them more vulnerable to suicide. Apart from those already discussed in the previous section, I would like to consider the following issues which may act as a facilitating factor regarding suicide: bereavement and grief, exclusion, coping strategies and domestic violence.

### 1 Family ties

Halbwachs (1978:32) identified collective living, where customs derive influence simultaneously from sentiments of kinship and common occupations, as protecting against suicide. He believed that two great collective powers are more intact in these cultural contexts than elsewhere: family and religion. For Travellers, every aspect of life gravitates around the family, which is a permanent feature synonymous with stability. In the relative absence of other attachments (geographical, professional) on which

to base identity, the significance of the family is extreme (Liégeois, 1994:83). The importance of the family to the Traveller community should not be underestimated (Heron et al., 2000:107), and ties of kinship, even the most removed type, are strong (DSW, 1963:37). The child is secure within the community: tradition gives security against the future, and group cohesion protects from the unknown (Liégeois, 1994:87). Individuals are not left alone, but tied up in a network of intense emotional relations: multi-generational groups live and work together, unmarried adults, orphans, the sick and aged remain with the family (Liégeois, 1994:83-84). Travellers hold dysfunctional members within their group to a point well beyond where majority populations give up (Kenny, 2003:14). The closeness of family ties is also apparent when Travellers, living on the roadside, opt to remain in deplorable conditions until such time that they can be accommodated with family members in a group scheme, rather than be separated from one another in different housing estates.

The family provides a huge social support for Travellers. This support is emotional, practical and offers security throughout life. Older Travellers in turn, have an important role to play with the younger generation, and their contribution to Traveller society is valued. If, for any reason, a family member is excluded from this group, the consequences for the individual are extremely serious. According to Liégeois (1994:84), it constitutes social death, as there is no place for the individual but in his family.

## 2 Religion

Nearly all Irish Travellers are Catholics. Travellers believe strongly in saints, relics and holy places. Even children wear scapulars, crosses and holy medals. They go to a priest for blessings, or to take the pledge for a period to control drinking habits. Travellers have huge rituals surrounding the sacraments, especially First Communion and weddings which are very elaborate events. Marriage almost always takes place in the Catholic Church, and double or even triple weddings are not infrequent. Funerals bring together all family members, and Travellers show respect to their dead with expensive headstones. Travellers make pilgrimages to holy places such as Knock, Our Lady's Island or even Lourdes and Fatima, and they attend patronal festivals 'patterns'.

Kenny (2003:57) observed that Travellers in her study did not refer to religion in relation to the question as to what had helped generations of

Travellers to survive their historic poverty and oppression; she notes that faith may be an unquestioned and private matter. Durkheim (1952) did not refer to whether one had a personal relationship with God, but indicated that religion protects against suicide where it allows for increased integration. Travellers' religious rituals would indicate that their religious practices should protect against suicide.

### 3 Bereavement/grief

Death is an all too frequent occurrence for Travellers. Tatz' comment about Aboriginal people applies to Travellers also – much of their life is spent grieving for relatives who die in infancy, or who die young from accidents, illness or various types of violence (Tatz, 1999:76). Around the time of the funeral, there are a number of mourning rituals to be observed, such as the wake, the ninth day after the burial and the month's mind, sometimes held each month for the first year after death. Traditionally, the deceased's home and belongings were burnt, as they evoked painful memories. This practice is not so common now, but possessions are destroyed or given away, the caravan is sold or the family may leave their accommodation. On the first anniversary of the death, the headstone is erected on the grave. A great deal of money is spent on headstones, adornment, statues and what are effectively shrines to honour the dead. Like the Aboriginal people, with Travellers there is little time to complete the grieving before another death ensues, and there is almost no grief counselling available (Tatz, 1999:91).

Older Travellers also feel a sense of grief for their traditions, which many feel have been lost through the adoption of mainstream cultural values by their youth. Those who dismiss the traditional way of life as one of poverty and hardship are also perceived as losing their heritage; nomadism, campfire stories.

### 4 Exclusion

There have been improvements in government policy regarding Travellers. Equality legislation has named Travellers in the Equal Status Act (2000), as a group which cannot be discriminated against. Government policy recommends that their cultural requirements be recognised and that they be consulted in drawing up policies which affect them.

While government policy advocates integration, this is strongly resisted by the settled population (Pavee Point, 2006a:31). The Report of the Commission noted that in nearly all areas Travellers were despised as inferior beings and were regarded as the dregs of society, their presence being considered as lowering the tone of an area (DSW, 1963:102). Public hostility towards Travellers is still very prevalent. Mac Gréil (1996) considers the position of Travellers as like a lower caste status and notes the substantial deterioration in public attitude since the 1970s. Curry (2000) conducted a similar survey of attitudes to refugees in Dublin in 1998; he measured hostility using the concept of social distance. Respondents were asked, regarding members of named target groups, whether they would: marry or welcome into their family; have as close friend; have as next door neighbour; work in the same workplace; welcome as an Irish citizen; only allow as visitors to Ireland; deport or debar from Ireland. Of the target groups used, (Africans, Arabs, Bosnians, Romanians, Spaniards and Travellers) the group perceived to be at the greatest social distance was Travellers (Curry, 2000).

Terms like "knackers" and "tinkers" are in everyday use, and serve to debase Travellers (Mac Laughlin, 1995:69). Labelling attributes a set of perceived characteristics to an identifiable group: this process demonises and dehumanises people and can create conditions that make discrimination and even violence against minority groups more acceptable (Farrell and Watt, 2001:26). Instead of seeing the individual, the prejudiced characterisations that accompany this label are projected onto the Traveller, who is penalised on the basis of identity (Pavee Point, 2006a:23).

Citing Fanon (1952), Belton writes that the oppressed perceive themselves in terms of how oppressors portray them, and as such the oppressed is not considered as fully human. He goes on to say that with a label such as Traveller, identity as human takes on second status. One is first a Traveller, different and alien from the whole, and the only way out of the situation is to cross over to the mainstream through social compliance and conformity to norms (Belton, 2005:56). According to research carried out for Pavee Point (2006a:59), those who have made this choice have found their way blocked or at least made difficult by the same racist forces that inspired them to try to cross over. It is not uncommon for Travellers to end up in a sort of identity 'limbo'; not recognised as settled by the settled population, they may also be rejected by other Travellers for 'selling out' (Pavee Point, 2006a:31).

It bears emphasising that anti-Travellerism in Ireland is not restricted to incitement to hatred; it also pervades the logic of those who want to 'help' Travellers (Lentin and McVeigh, 2006:132). In a similar fashion to other indigenous peoples, administrative arrangements have been established to target the entire Traveller population, who are regarded as being in need of care and protection. That the protection is in their "best interests" does not alter the reality that they are designated as a separate class of persons with all the negative connotations associated with that status (Tatz, 1999:Executive Summary). Travellers find it obtrusive and burdensome to be universally defined as poor inadequates in need of assistance in every regard (Liégeois, 1994:182). Where Travellers are segregated in the provision of various services it is seen as an imposed setting apart of a group (DJELR, 2000:32).

Almost every Local Authority in Ireland employs a social worker for Travellers. It is clear that Travellers have very distinct accommodation requirements, and where families choose accommodation on a halting site or group housing, compatibility with other families is essential. Knowledge of Traveller culture and sensitivity in dealing with potential conflictual issues is necessary, as is an understanding of the difficulties that may be faced by Travellers who choose to accept standard housing. However, the fact that every Traveller family has been assigned a social worker is questionable, particularly as many Local Authorities do not offer a social work service to settled tenants or foreign nationals. The DES has also developed separate Traveller targeted services (e.g. the current Visiting Teacher service), intended to promote effective integrated education schooling for Travellers. These services for Travellers, are none the less segregated and reinforce the notion that Travellers are a problematic group, or somehow inferior.

Mac Laughlin (1995:3) suggests that the demoralisation of Travellers has led to a gradual internalisation of feelings of social and racial inferiority. Their experience of low social status and exclusion is mostly due to the widespread hostility of settled people towards them; hostility based on prejudice which in turn gives rise to discrimination and affects Travellers in all aspects of their lives (Pavee Point, 2005a:6). In addition to the factors described above, the experience and the fear of discrimination dominate the lives of many Travellers. These add a significant level of stress to many aspects of their lives and particularly to their relations with the majority population (DES, 2006:5).

## 5 Coping strategies

Mac Laughlin (1995:79) warns that the isolation of Travellers and the fragmentation of their world is reducing Travellers to the status of social outcasts in contemporary Ireland. Travellers have had to learn to cope with exclusion, with changes in Traveller society and difficulties with identity, and with the real hardships they experience in their lives. Coping strategies which may be adaptive in one dimension, may be maladaptive in another, for example drinking (Gmelch, 1985:6). Pavee Point (2006a:33-34) identifies four responses used by Travellers to deal with the problem of exclusion:

- Passing – where Travellers attempt to conceal their Traveller identity completely.
- Tackling the system – through the media or the courts, a struggle which few have the know-how or energy to carry through.
- Group solidarity – faced with discrimination and an often hostile reception, Travellers retreat into their own social networks, further compounding their segregation within society.
- Self-levelling – exclusion exacerbates anti-social behaviour, creating a vicious cycle whereby the prejudices of settled people are justified by the actions of some Travellers.

Condra (2000)<sup>1</sup> stated that egression, namely walking away from problems, is a poor coping strategy. Travellers frequently leave an area to avoid conflict, or to escape interpersonal tension. The long term cost of this solution may well be an inability to deal with issues which cannot be left behind. On the other hand, “shifting” (gathering one’s belongings and leaving an area) is no longer as easy as it once was. Families in Local Authority housing, are aware that if they leave their house, they may not be considered for accommodation for years. Having perhaps got used to the comforts of a water supply and electricity this is not a decision to be taken lightly. Even if a family decides to move, there are few places for them to

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<sup>1</sup>Personal communication. Point made by Dr. Michael Condra (Assistant Professor Psychology and Psychiatry, Queen's University Kingston, Ontario, Canada) in discussion with the researcher during a training workshop, “The Assessment of Suicide Risk in Adolescents and Adults”, conducted by him in Mary Immaculate College, NUI Limerick, 18th November, 2000.

go. Rather than viewing “shifting” as a poor coping strategy, I believe it is a traditional coping strategy that no longer is a viable option for many Travellers, and therefore an alternative must be sought.

Most Travellers find appropriate coping strategies, however some take to alcohol, drugs, anti-social behaviour and violence as outlets for their frustration. Violence can be directed towards another or turned inwards towards oneself. Suicide is an expression of extreme violence turned inwards. For the moment I shall look at one form of violence directed towards another: domestic violence.

## 6 Domestic violence

In 2005 the National Crime Council (NCC), in association with the Economic and Social Research Institute (ESRI), published the first ever large scale study undertaken to give an overview of the nature, extent and impact of domestic abuse against women and men in intimate partner relationships. They found that 49% of admissions to women's refuges are Travellers (Watson and Parsons, 2005:99). These statistics are alarming and further research is required into this issue. Because Traveller communities are close knit, a violent domestic situation between a husband and wife can turn into an interfamily dispute (Pavee Point, 2000). For Traveller women experiencing domestic violence, the difficulties are exacerbated by the attitudes and perceptions of people outside their community, and the attitudes within their own community towards marriage and the issue of domestic violence. Traveller women experiencing domestic abuse are often caught between the violent behaviour they experience from Traveller men and the experience of racism they share with Traveller men (Greenwich Domestic Violence Forum, 2003).

Once a Traveller woman makes the decision to go to a refuge, accessible and appropriate responses such as viable alternative accommodation are virtually non-existent due to the exclusion, discrimination and prejudice experienced by Travellers (Barnardos, 2003:14). Furthermore, strong community connections and communication can mean that a woman who decides to leave her husband virtually has to lose contact with the whole community, her culture and her way of life, and face the prejudice of the settled population alone (Greenwich Domestic Violence Forum, 2003).

Women in domestic violence situations do their utmost to protect their children from abuse (Kelly, 1996 cited in Barnardos, 2003:6), however it leaves scars on children. Where abuse of a woman is taking place within the family, her parenting capacity may be severely affected (Barnardos, 2003:4). The negative effects of overhearing or directly witnessing such violence are similar to symptoms of children who have been abused (DJELR 1997:30). The cumulative effects of living in poverty, isolation and poor environmental conditions in themselves damage women's health. When these difficulties are combined with physical, mental and emotional abuse, the effects are enormous (DJELR 1997:31). The consequences of violence against women go far beyond immediate physical damage to the victim; long-term effects include abuse of alcohol and drugs, depression, and suicide (Amnesty International website, no date).

While I do not under any circumstance condone domestic violence, in certain instances for the perpetrator it is the only way he may have learned to deal with frustration. Following an incident of violence, he may then experience a huge sense of remorse, which serves to exacerbate an already negative self-image. The associated depression and guilt may lead to the perpetrator also being at risk of self-harm or suicide.

## 7 Summary

The Task Force report recognised that Travellers cannot give up their values, customs and beliefs totally and adopt others, and recommended that the distinct culture and identity of the Traveller community be recognised and taken into account (DOE, 1995:80). Nomadism has moved from being defined as a problem, to being identified as a core tradition, constitutive of Travellers' ethnic identity (Kenny, 1997:40). Travellers and Traveller organisations, as with other sectors of the community, are represented in local and national consultative bodies to Local and national authorities that make decisions regarding Travellers' lives. Anti-Traveller racism has been prioritised and is central to the whole development of Irish anti-racism (McVeigh, 2002:220). Materially Travellers are better off than they were, and unlike much of settled society they have retained their faith and above all their strong family ties. Lifestyle improvements coupled with the security that comes with the attachment to the extended family should all serve to protect Travellers from suicide.

However, some families are still living on the roadside, without water, basic sanitation and under threat of eviction. They still have a lower life-expectancy than their settled peers, a lower level of educational attainment and little access to employment. Public attitude towards Travellers is still very negative regardless of whether they are on the roadside or in houses. Travellers experience widespread hostility from settled society, which constantly and negatively reminds them of their social identity (Pavee Point, 2006a:60). Some internalise feelings of social inferiority, and reject their Traveller identity, but are still not accepted by settled society. The prosperity of the "celtic tiger" has passed many Travellers by, but the impact of Ireland's changing society has not. Barber (2001, cited in Smyth et al., 2003:38) argues that with societal development and increased prosperity and success, people make upward social comparisons with their counterparts, thus magnifying their relative unhappiness, and making an already vulnerable group more susceptible to suicidal behaviours. The question is whether the protective factors are strong enough to counteract the negative forces.

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## CHAPTER 3

### METHODOLOGY

## METHODOLOGICAL FRAMEWORK

The methodological framework used involved a combination of quantitative and qualitative research methods. It included both the systematic collection and profiling of quantitative data as well as the collection of biographical information, which by its nature required a qualitative analysis. All those involved in the research had worked with Travellers for some time, and were familiar with Traveller culture, having had extensive contact with Travellers in both formal and informal settings. In turn, I had huge access to rich data because of my immersion in this field of work and because of the established network of Local Authority social work colleagues. The research project recognised the importance of culture in shaping not just life experience, but also its meaning for the individual, and it aimed to provide a cultural interpretation of the problem of suicide.

## RESEARCH PROCEDURE

I aimed to highlight the incidence of suicide among Travellers in order to identify an area for policy intervention. I also hoped to increase awareness among Local Authority social workers of the issue and to help identification of clients at risk. At the Traveller Suicide Prevention Seminar organised by Pavee Point in 2005, a need for research into this issue was identified. Concern regarding the lack of statistical information on the occurrence of suicide within the Travellers was raised in their submission to the National Suicide Prevention Strategy (Pavee Point, 2005b). While there are limitations to the findings of this research, I would hope that it can form a basis, or a starting point, for further research into the issue of suicide among Travellers.

In this chapter the method of research is dealt with. This includes the identification of the research population, the sources of information, the method of collection data, how records were kept, and it outlines the methods used to analyse the data. It also looks at the limitations of the project and ethical issues.

## 1 Identification and profile of Traveller population

As noted in Chapter 2 of this study, there are two official sets of figures regarding the number of Travellers in Ireland: CSO national census data, and DOE annual counts. The national census for 2006 shows a Traveller population of 22,369 persons. The second is the annual count of Traveller families, which is carried out by Local Authorities and collated by the DOE. While this only looks at the number of families, rather than the number of Travellers, it has the advantage of being updated on a yearly basis. According to the 2006 annual count there were 7,691 Traveller families in Ireland. With the average Traveller family size at 4.22 according to the 2006 census, this would lead to an approximate number of 32,456 Travellers in Ireland today.

As discussed in chapter two of this study, national census data on Travellers are contested; DOE data are also queried but are accepted by Traveller action groups and others as more reliable. For the purpose of my research I shall use the DOE statistics to determine the number of Travellers in Ireland, because examination of data from all sources suggests that they are the most accurate, and they provide for fluctuation of numbers on a yearly basis. Furthermore, these figures are supplied mainly by Local Authority social workers, who are also the sources of information for this research. Therefore any Traveller who has been included in this research, has been accounted for in the DOE statistics. It is possible that some Traveller families will not be known to the social worker, and therefore will not be included in the annual count, or that there may be duplication. The implications of these inaccuracies for this research are discussed in the section on limitations below.

In order to obtain an approximate number of Travellers for each year, the number of Traveller families for that year is multiplied by the average Traveller family size as published by the CSO; as the CSO figures are collected every four years, a sliding scale is used to estimate the average Traveller family size during the intervening years. Details of the calculation of the approximate number of Travellers in Ireland on a yearly basis from 2000-2006 are included in Appendix Table 1a. The Traveller population will be profiled in the data analysis chapter.

## 2 Data collection: scope and sources

While we may work as individual researchers, we can only do so within a complex network of social connections (Dunne, Pryor and Yates, 2005:22). I wished to identify gatekeepers, who would either be able to supply the data I required, or refer me to somebody with access to this information. I sought respondents who would have an interest in understanding the problem of suicide among Travellers and whose experience and involvement with Travellers would be similar to my own. As the actual number of Travellers is quite low, I aimed to cover 100% of the population rather than taking a sample. For this reason I decided to contact the social worker in each Local Authority. Being part of this group myself I had easy access to its members. Practically every Local Authority employs at least one social worker specifically for Travellers, there being approximately 55 such positions, and they have been used to compile many official statistics on Travellers such as the DOE Annual Count. Each social worker has very clear-cut geographical boundaries to their area of work, and with the exceptions of Co. Westmeath (until 2005) and Co. Cavan, all of Ireland is covered. In those Local Authorities where there is no social worker employed or where there may be an unfilled position, I contacted the member of staff responsible for implementing the Traveller Accommodation Programme. In these cases I was referred to other persons working directly with Travellers. Similarly in cases where a social worker may have been new to the position, had been absent for a significant part of the year (e.g. study leave) or may not have had much contact with a person who died by suicide I was referred by the social worker, to somebody with more contact with Travellers in that area. Apart from Local Authority social workers I interviewed Local Authority personnel such as Traveller liaison officers, housing officers, caretakers, and other statutory and community workers such as public health nurses for Travellers, local Traveller support groups, and Primary Health Care Project workers. In Local Authorities which employ more than one social worker, I interviewed each one. Occasionally, in an area with two social workers one may have said that having discussed the matter with his/her colleague, there was no incidence of suicide in their county in the year in question. In such cases I did not interview the second colleague.

### 3 Research instrument

Having decided to use Local Authority social workers as my sources of information, I chose to contact each one by telephone to gather data. It would have been less expensive and less time consuming to write to or e-mail them to ascertain the number of suicides in a given year, and to follow up only those in whose areas a suicide had occurred. However this may not have yielded such a high response rate, and in any case I felt it was important to speak directly with each one. In this way I was able to raise their awareness of suicide as a serious issue among Travellers and to consult with them regarding issues that should be covered, whether they had been affected or not. Frequently the social worker was able to tell me of an occurrence of suicide in another locality, which proved a useful test of the reliability of my information. It was important for me to develop my contacts with this group as I could not have carried out this work without their support and co-operation.

My first contacts regarding this research took place early in 2001. Each subsequent year I contacted all Local Authority social workers with the same questions. Calls were usually made in February or March, and data was collected regarding the previous calendar year. The duration of calls ranged from as short as one minute to calls of approximately 30 minutes. Although considerably more time consuming and expensive than e-mail, I found this method of data collection to be very beneficial. I had already known several of my colleagues prior to carrying out the research, but in this way I was able to build up a relationship with all of them.

The data collection instrument used in these telephone interviews was a semi-structured questionnaire. In each telephone call I explained the purpose of my research and asked if there had been any suicides among the Traveller community in their area the previous year. In cases where there had been a death by suicide I asked the age, sex, marital status, housing circumstances and method used. I also asked a final question inviting an open-ended response, namely whether the respondent felt that there were any other information relevant to this study. As the research progressed, and colleagues expected my calls, information gathering took a much less structured, and informal format. Respondents were encouraged to raise their own issues and suggest areas to be explored.

A question frequently asked regarding suicide is why it happened, although in many cases this question cannot be answered by those closest to the

person who died, let alone by a social worker from the Local Authority. Yet in certain cases there are factors which those involved feel are significant. Working with Travellers I find accommodation type (or lack of accommodation) to be a huge source of discontent, which could be a significant contributory factor. I had included a question on this point from the start; other factors emerged over the years of consultations.

After five years I looked at the responses to the open-ended questions and noticed certain patterns emerging. There was also a growing concern among my colleagues/respondents about what appeared to be an increase in suicides among Travellers, and they began to question whether certain factors were relevant to Traveller suicide. Based upon the findings emerging from data collected in the first five years of research, I returned to the respondents who had supplied data regarding suicides from 2000 to 2004, and asked six additional questions. Was there a family history of suicide? Was there a recent bereavement? Had there been previous suicide attempts? Did the individual have a diagnosed mental illness? Was there alcohol or substance abuse? Was the individual drinking heavily immediately before the suicide? I also asked these questions when gathering data for 2005 and 2006. Predictably these questions did not yield the same response rate as in some cases I was unable to contact the original respondent, and in others, the respondent may not have had access to this information.

I cannot overstate the degree of support and cooperation I have received from everybody I interviewed. Initially many social workers were surprised at my interest in this topic as they believed suicide to be extremely rare among Travellers, while others were concerned about the high level of suicide among Travellers in their counties. Over the course of the research, the quality of data increased as colleagues became more interested and involved in the project. I was regularly asked for feedback, additional questions were suggested by colleagues and some went to great lengths to provide as much data as possible for me. In some cases they spoke to relatives of the deceased, or to people who worked with the family, although most could answer the questions without consulting another person. I was frequently told of suicides from outside a respondent's own area. Given the nomadic nature of Travellers, this was particularly useful to me. It has also helped me to double-check my information. Every year since I began my research, all social workers responded positively to my request for data.

## VALIDITY OF RESEARCH PROCESS

All Local Authority social workers were contacted each year, and consulted about all known Travellers in their area. As there are clearly defined geographical areas to each social worker's area of work, all Travellers in Ireland were included in the research. Data were collected from professional records, over a seven-year period. During this time, respondents grew in their understanding and appreciation of the project, giving careful and considered responses to annual data requests. While the reliability of these sources is respected, the significance of the respondents' and the researcher's perspectives is registered in the presentation and analysis of data. The validity of the findings was tested in the light of literature on suicide, and of the respondents' experiences working with Travellers. It should also be noted that the findings are not presented as a statistical analysis, but themes and issues have been highlighted, which from the perspective of the informants, were of relevance to those who died by suicide.

### 1 Limitations

As with any piece of research a certain degree of inaccuracy can be expected. It is possible that information may be exaggerated, or that the respondent simply does not accurately remember events to give a true picture. In the case of this research, one can question whether the respondents are in a position to know all of the Traveller families in their areas, and whether they can state that a death was in fact suicide rather than accidental. Establishing the rate of suicide among Travellers presents a further difficulty as there are conflicting theories as to the actual number of Travellers in Ireland. Looking at these issues individually I shall examine the limitations of my research and how they have been dealt with.

### 2 Accuracy

Denscombe (2002:117) recommends that the climate and circumstances of research should encourage honest, full and accurate answers. My respondents are primarily Local Authority social workers. While they have shown great interest in my research, they have no vested interest whatsoever in the outcome. There is nothing to be gained by their exaggerating data or giving false information.

Bearing in mind that human memories do not always store accurate records of the past, I contacted each Local Authority on an annual basis so that data would be fresh in people's minds. Frequently suicides were reported to me which had not taken place in the respondent's area, but which they had heard about from Travellers who knew or were related to the person involved. These reports have been very useful to me as a form of cross reference and have helped me in testing the accuracy of my respondents. Having established the number of people who died by suicide, I also kept questions to basic facts (age, accommodation type) which would be on file anyway. However with the second phase when in 2006 I returned to respondents with additional questions regarding those who died by suicide 2000 – 2004, memories were challenged. Predictably I was unable to get responses in every case. Sometimes it was because the respondent never had access to the extra information. In other cases I was unable to contact the original respondent, and their replacements would not have access to this data.

### 3 Number of Traveller families in a given area

Local Authority social workers are expected to know all Traveller families in the area in which they work. In turn, they are known to Travellers, and regardless of individual relationships, like the doctor, teacher or public health nurse, they are part of normal life. However, there are three areas where there may be gaps in this knowledge.

- a. People newly arrived into an area. Usually if somebody from this category has died by suicide, it is brought to my attention by the social worker in their county of origin, who will specify the county in which the suicide occurred. In many cases the information has also been supplied by the social worker in the county where the suicide took place. In such cases, they stated that the person had originally come from another county, and that the social worker in that area may have further information regarding their background.
- b. Families who have been in an area for generations, requiring neither the services of a social worker nor the Local Authority, or families not known to the social worker as Travellers. In such cases families are so long established in the community that it may come to the social worker's attention via a third party, e.g. another professional or local knowledge.

- c. Nomadic families who do not wish to apply to the Local Authority for accommodation and who do not wish to be known to the social worker. Again a suicide from this group may come to the attention of a social worker through relatives accommodated in their area discussing it. In such cases the information received will be very basic.

In cases where families are not known to the social worker, they may be known to the public health nurse, visiting teacher, community welfare officer and certainly to the local Traveller support group. As suicide is such a devastating issue, which can shock a community, it is quite likely that a death by suicide from one of these families will be brought to the attention of the social worker. However we can assume for a margin of error in under-estimation of the number of deaths by suicide.

## 4 Reporting of suicides

As has been stated above, classification of death as suicide is open to challenge, and may be based on various issues such as the method of death and extenuating circumstances. Only in cases where the respondent felt certain that a Traveller had died by suicide did I actually use the information. Because of the caution exercised in classifying a death as suicide, the actual number of Traveller deaths by suicide may be under-represented in this study.

## 5 Establishing a rate of suicide

Although the number of Travellers in Ireland is not known, as discussed above, the DOE annual count is generally considered to have the most reliable figures at present. It is appropriate that these figures should be used for this research, as they are mainly supplied by Local Authority social workers. It ensures that any Traveller included in this research has been included in the annual count. Based on the approximate number of Travellers calculated on an annual basis (see Appendix Table 1a) and the number of Traveller deaths by suicide reported each year, a tentative rate of suicide has been identified.

## ETHICS

Much research involves looking into people's private lives. If this is not handled sensitively and in an ethical manner it may cause unnecessary stress to the subjects, it may raise false hopes or lower self-esteem. Classification of death as suicide is an ethical issue in all suicide research, while particular to this research are further ethical concerns regarding culturally sensitive issues related to the Traveller population. While carrying out this research I sought to be open and transparent, and to respect the feelings and confidentiality of all those involved. I also sought to gather and collate only information which I believed could contribute to a greater understanding of suicide among the Traveller population.

### 1 Classification of death as suicide

It is difficult to say with absolute certainty that a person has intentionally killed him/herself. Even our official statistics are open to challenge as they measure the number of suicide verdicts reached by coroners. In a study by Atkinson et al. (cited in Gomm, 2004:54) four English coroners and five Danish counterparts were presented with the same 40 cases, yet the verdicts of each decision maker on the cause of death were quite different. The English coroners concluded that between 16 and 23 deaths were caused by suicide, while the Danish coroners concluded that between 27 and 32 deaths were in fact suicides.

The method of death, previous attempts and threats of suicide, extenuating circumstances, and especially a general acceptance by family and friends that a person had in fact died by suicide assisted respondents in deciding whether or not to report a death as a suicide.

### 2 Anonymity and confidentiality

This research is completely anonymous. I have chosen not to give any examples of individual situations using false names as practice reveals that pseudonyms and other disguises can fail: people can recognise themselves as subjects, and people who were never involved can resemble the fictionalised characters (Herrera, 1999). The project deals with a very small group of people, therefore, in the findings, no reference has been made to

the counties in which suicides have taken place, as it may not protect the identities of those concerned. Similarly, if someone has died in an unusual manner, this information has not been included. In some cases, very detailed accounts of the circumstances surrounding a person prior to their death have been supplied, which have been omitted from the written analysis. All of these decisions have been taken to protect the anonymity of the subjects of the research.

### 3 Those affected by the findings

Participants should not be adversely affected as a consequence of engaging in the research (Denscombe, 2002:179). There are two groups who could be affected by my research, the suppliers of data and subject group. Regarding those who have supplied data, generally social workers, I have taken measures to maintain confidentiality and protect the anonymity of their client group, to avoid any negative consequences.

Clearly it is the subject group, Travellers, who are more likely to be upset by the research. The findings have been analysed in general terms, rather including detailed information about individual cases, in order to protect privacy. Suicide has been examined in the context of Traveller culture and issues which may negatively impact upon the Traveller community. The strengths of Traveller culture are looked at in order to identify ways of reducing the level of suicide within their community.

### 4 Informed consent

Regarding those from whom data was gathered, it was explained from the beginning the purpose of the research, how the data would be used, and that it would ultimately be published. Local Authority social workers are frequently called upon to supply data regarding Travellers (e.g. the DOE annual count). It was felt that the data I was looking for was to an extent common knowledge, that someone working in that geographical location could gather from a number of sources. In cases where additional information was given to me, it was from one professional to another with the reassurance on my part that this information would be kept strictly confidential.

Informed consent is generally taken to mean that those who are researched should have the right to know that they are being researched, and that in some sense they should have actively given their consent (Bulmer, 2001:49). In this case, as the subjects of the research had all died by suicide, consent was not possible. The next of kin of Travellers who died by suicide were not approached, nor was their consent sought. The reason for this was to avoid any additional distress to those families, especially as data was gathered on a yearly basis, frequently only a few months after a bereavement. For me to obtain their consent would require the building of a relationship with people in a very vulnerable situation; and some may feel let down if having discussed the conditions surrounding the suicide of a close family member, it is merely presented as statistical information rather than as a case study. It should be noted that some social workers did speak to relatives of the deceased and obtained their consent before passing information to me.

Sieber (1992:18, cited in Miles and Huberman, 1994:289-90) identifies three core principles to guide ethical choices.

- 1 Beneficence – maximising good outcomes for science, humanity and the individual research participants while avoiding or minimizing unnecessary harm, risk or wrong. The problem of suicide among Travellers is very serious, and ought to be looked into. It is hoped that this project would pave the way for further research. At the same time precautions have been taken to ensure privacy and protect the anonymity of all those involved.
- 2 Respect – protecting the autonomy of persons with courtesy and respect for individuals as persons, including those who are not autonomous. By definition the subjects of this research would be considered as 'not autonomous'. Out of respect for them and those bereaved by their deaths, undue intrusion into their situations has been avoided, and only findings which are believed to be relevant, rather than interesting or curious, have been included.
- 3 Justice – ensuring reasonable, non exploitative and carefully considered procedures and their fair administration; fair distribution of costs and benefits among persons and groups. Those who bear the risk of research should be those who benefit from it. I have informed participants clearly of the purpose of my research, consulted with them as to what information they felt should be included, and kept them informed of my findings.

Ethical approval for this research was sought and obtained from the Ethics Committee of NUI Maynooth. Also consulted regarding ethical issues which may have arisen during the course of the research were Wicklow Co. Council, the DOE Traveller Accommodation Unit, the local Traveller primary health care project, and Traveller support groups. An outline of this project has been presented at the Local Authority social workers annual conference in Cork, November 2005, and at the 24th World Congress of the International Association for Suicide Prevention in Killarney, August 2007.

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# CHAPTER 4

## DATA ANALYSIS

## INTRODUCTION

In this chapter, the data, showing the overall profile of the incidence of suicide among Travellers is presented and compared with the incidence in the national population. Traveller specific data have been disaggregated under the range of recognised factors commonly associated with increased risk of suicide as outlined by the Oireachtas Report on Suicide (Houses of the Oireachtas, 2006). This report identifies those most at risk as having demographic vulnerabilities, interfacing with lifelong susceptibilities that are then subject to a precipitating event (2006:11).

- Demographic vulnerabilities: gender, age, marital status, accommodation type.
- Specific susceptibilities: previous attempts, family history of suicide, psychiatric illness, and alcohol or substance misuse.
- Common precipitating events: bereavement, violent episode, marital problems, trouble with the law, serious illness.

Demographic factors, gender and age are compared with national figures as is method of suicide. Marital status is not compared with national rates as within the Traveller community, marriage has a specific and distinct cultural context which is not comparable to that of the total population. Similarly Traveller accommodation type is not comparable to that of the total population. Information on suicide on the basis of county has not been included. As the topic is such a sensitive issue, and the actual numbers are very low, naming counties may render it possible to identify individuals. Suffice to say that between 2000 and 2006, Traveller suicide has affected almost every county in Ireland.

The national figures are taken from the CSO, *Vital Statistics*, Yearly Summary for each year from 2000 to 2006. CSO figures for 2005 and 2006 refer to deaths by suicide registered in those years. There may be discrepancies between dates of death and dates of registration which have not yet been updated. As such the figures for 2005 and 2006 are provisional. In all cases of death that occur in a 'violent or unnatural manner' or 'suddenly from unknown causes', coroners are obliged to hold inquests (DOHC, 2001:16). Following the inquest, information recorded on the confidential form 104 by an Garda Síochána is sent to the CSO, which is the basis for national data on suicide. Based on the number of deaths classified

as 'undetermined' the Report of the National Task Force on Suicide estimated a margin of error in terms of the understatement of suicide as less than 5% (DOHC, 1998:23), while the HSE suggests that this margin of error could be as high as 18% (HSE, 2005:10).

The number of Travellers is also estimated. The figures concerning Traveller population are taken from the DOE annual count of Traveller families, multiplied by the average Traveller family size as published by the CSO (see Chapter 3 of this study). It is presumed that the average Traveller family size of those who registered as Travellers does not differ significantly from those who did not register as Travellers for the 1996, 2002 and 2006 census enumerations.

As the total population of Travellers is c.30,000 persons, the suicide incidence rates are cited per 10,000 rather than per 100,000 persons (the norm for suicide reports). All data concerning Traveller suicide have been collected during the course of this research. To avoid the possibility of over-reporting, in each case, unless the informant could state that beyond all reasonable doubt death was the result of suicide, it was not included in this study. How this degree of certainty is reached varies from case to case, depending on the circumstances surrounding death. In some cases the person may have threatened suicide or made previous attempts, in others the method of death together with the family's discussing the death as suicide may have influenced the decision to name it as such. If the respondent indicated any doubt that death may not have been intended, it was not considered as suicide.

Two points require comment: whether deaths by suicide among Travellers, reported by informants in this study, were also registered in the national statistics on suicide; and whether all deaths by suicide among Travellers were registered as such by the informants. No definite answer can be given on either count, but an attempt was made to ascertain if there were obvious gaps. CSO tables are classified according to sex, five-year age band and method, so it is possible to see in a given year, for example, the number of males aged between 25 and 29 who died by hanging. Every instance of reported suicide in this study was checked with the CSO tables to ensure that there was at least one occurrence of death by that gender, age band and method in the given year – i.e. that there is a possibility that the death in question was registered in the CSO data. Although it cannot be said with certainty that the actual cases were included, there was no case of a reported suicide in this study which was outside the frame of data in CSO tables.

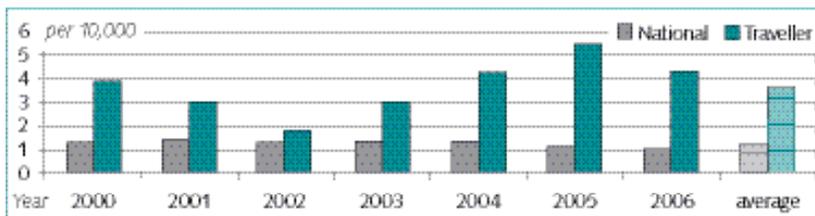
As discussed in the section on limitations, it is possible that some Travellers who died by suicide were not known to the informants, and thus have not been included in this research. In relation to the accuracy of suicide deaths, it can be presumed that there is a margin of error in terms of underreporting both in this record of suicide for the Traveller population and in the CSO records of suicide for the national population.

The key informants were mainly Local Authority social workers. In this way the entire Traveller population could be included in the research, and there was a 100% response rate in each year of data collection. All questions seeking quantitative data were answered. Regarding the qualitative data, there are certain issues which respondents were unable to answer.

Much of the work of the Local Authority social worker is with adults, especially women, regarding accommodation or specific social issues. While in theory, all Travellers in an area should be known to the social worker, there would be families who require little if any social work contact, and others who do not wish to have such contact. Thus, in some instances of suicide the informant was able to provide very detailed information of the circumstances surrounding death, while in others there are gaps in the information. It should also be noted that some of the questions asked were by their very nature subjective. The question on alcohol and substance misuse can be interpreted differently depending on the respondent. Some did not consider "recreational use of cannabis" as substance abuse, while others did. Similarly, there are no clear indications to tell at what stage a person's drinking is deemed an abuse of alcohol. Again, many of the precipitating events are subject to interpretation. To decide that an event is relevant is subjective. Indeed it could be argued that nobody, apart from the deceased, can state with certainty which events were significant. Furthermore, in cases where a risk factor or an event has not been mentioned, it cannot be assumed that it did not occur, or that it did not have significance for the individual. For these reasons, extra care is required in interpreting the qualitative data.

## PROFILES OF SUICIDE INCIDENCE NATIONALLY AND AMONG TRAVELLERS

In this section, demographic profiles, namely sex and marital status and age are covered, as well as method of death. The Appendix to this thesis provides tables of primary data on which elements in the Figures presented in this chapter are based.



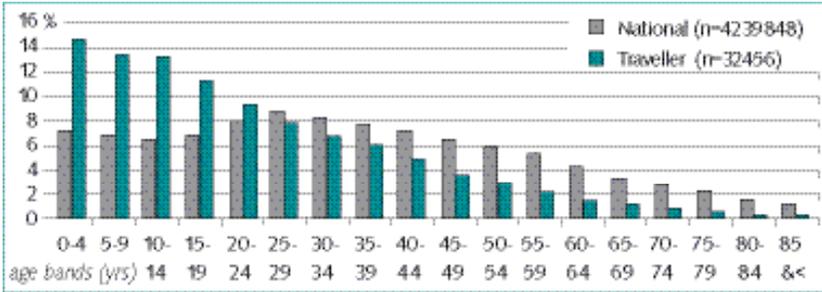
**Figure 1.** Suicide rates per 10,000 persons, national and Traveller populations, 2000-2006.

Sources: Traveller population: DOE annual counts, 2000-2006. National suicide rates: CSO Vital Statistics, 2000-2006. On suicide incidence among Travellers: primary data.

Between 2000 and 2006 inclusive, there was a reported total of 74 suicides among Travellers in Ireland. Given that the Traveller population is small, and the incidence of suicide among Travellers from a statistical point of view is low, even a variation of one or two incidences in a year will show a considerable variation in the annual rate. The average annual rate of suicide among Travellers between 2000 and 2006 inclusive was 3.7 per 10,000. This is over three times the average rate of suicide of the total population of Ireland during the same period which was 1.2 per 10,000. For Travellers, the annual rate peaked at 5.44 per 10,000 in 2005, which was more than five times the 2005 national rate. While there has been a gradual reduction in the national rate, among Travellers this has not been the case.

# 1 Age, sex and marital status

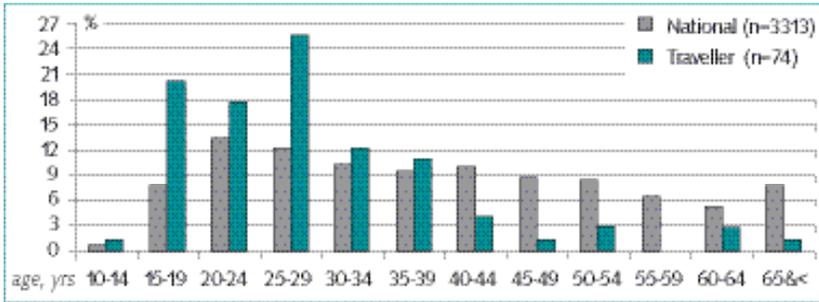
## Age



**Figure 2.** Percentage distribution of total national population and of Traveller population by age band, 2006

Sources: Traveller population: DOE count, 2006. National population figures and all age band profiling: CSO (2007) 2006 Census: Principal Demographic Results, Table 5; Vol. 5 Table 28.

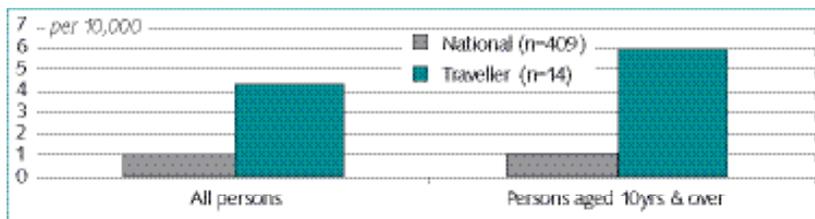
The distribution of Irish Travellers by age band is quite different from that of the total Irish population; Irish Travellers being considerably younger. 53% of Travellers are aged under 20 compared to 28% of the national population. At the other end of the spectrum, 4% of Travellers are aged over 60 compared to over 15% of the total Irish population.



**Figure 3.** Percentage distribution of suicide incidence, 2000-06, by age band, National and Traveller populations

Sources: National data: furnished by CSO (August 2007). Data on Travellers: Primary data.

Suicide is an issue which predominantly affects the young in Ireland, with almost 34% of all suicides since 2000 being of those under 30 years of age. For young Travellers the risk factor is higher, with over 65% of Traveller suicides occurring among the under 30s. The age group most at risk for Travellers is 25-29, which accounts for 26% of Traveller suicides, more than twice the national rate for the same age band. The second highest risk group is 15-19. The rate of suicide in this age band, at 20% is over 2.5 times that of the total population. Suicide amongst Travellers aged 40 and over, at 12%, is relatively infrequent compared with the total population, where over 46% of all suicides occur amongst those aged over 40. That the Traveller population is younger than the total population could be used to explain in part the lower incidence of suicide among the elderly, or the higher incidence among teenagers.



**Figure 4.** Suicide rates in 2006, per 10,000 of all persons and per 10,000 persons aged 10 years and over: national and Traveller populations

Sources: National data: CSO Vital Statistics, 2006. Data on Travellers: primary data.

Figure 4 demonstrates how rates can vary if those aged under 10 are omitted. It should be noted that 14% of the national population but 28% of the Traveller population are less than 10 years of age. When calculated on the base of the total populations, in 2006 the rate of suicide among Travellers, at 4.31 per 10,000, was 4.5 times the national rate of 0.91 per 10,000. However, if the rate is calculated for persons aged 10 years and over, the rate for Travellers rises to 6.01 per 10,000, which is 5.4 times the national rate of 1.12 per 10,000.

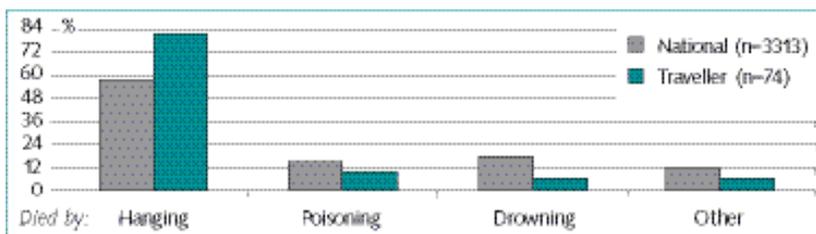
### *Sex and marital status*

Suicide is predominantly a male issue. For the total population, male suicide is four times as common as female suicide. In this study, of 74 Travellers, 67 were male and 7 were female. This yields a male suicide rate of 91%, over nine times as common as female suicide.

Of those who died by suicide, 38 (52%) had never married, 25 (34%) were married, with a further 15% being separated (n=9) or widowed (n=2). Given that 39% of all Travellers aged over 15 are single, and 50% are married, this further confirms the higher risk factor of being single upon suicide rates. Of note is the fact that only one person was reported as being in a same sex relationship. In one other case, it was suggested that sexual ambiguity may have been an issue of concern. Sexual orientation is discussed further in chapter 5.

Regarding Traveller women who have died by suicide, the numbers are low, there being seven in total. Between 2000 and 2003 there was one occurrence of female suicide, followed by one in 2004, two in 2005 and three in 2006. It appears from this that suicide among Traveller women is a more recent phenomenon. Six were under 30 years of age, while five were single women without children. In both instances where the woman was married, there were very significant precipitating events, described by the respondents as trigger factors, which would have reduced the protective factor of family ties.

## 2 Method of suicide



**Figure 5.** Percentage profiles of suicide methods, National and Traveller populations, 2000-06.

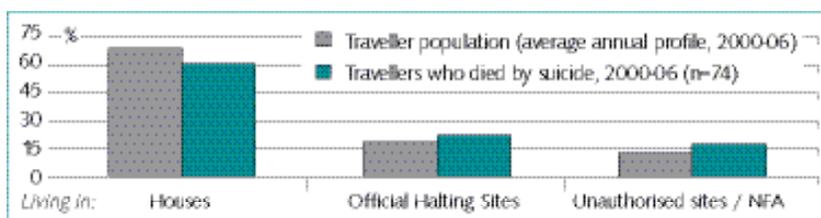
Sources: National data: CSO Vital Statistics, 2000-2006. Data on Travellers: primary data

By far the most frequent method used is hanging, which accounts for almost 57% of all suicides since 2000. 59 Travellers used this means of death, which accounts for 80% of Traveller suicides. While for the total population the second most used method is drowning, followed by poisoning, the second most used method by Travellers is poisoning at 9% (n=7). Poisoning refers to any death caused by consuming, inhaling or injecting a toxic substance, and includes death by drug overdose. For Travellers, most cases of poisoning, were in fact drug (or drink and drug) overdoses. 4 died by drowning, which accounts for 5% of Traveller suicides, compared to 17% for the total population.

## PROFILE OF TRAVELLER-SPECIFIC FACTORS

In this section, detailed profiles of factors with specific relevance to Travellers and suicide risk are drawn from the data. Accommodation is a basic factor; others fall under the general heading of pathological indicators. These include ongoing and immediate risk factors. For numerical data on which Figures in this section are based, see tables in Appendix.

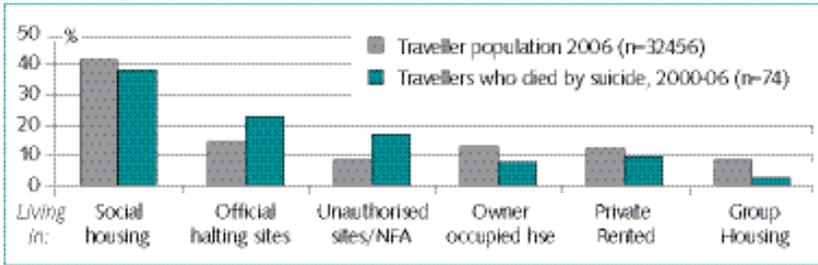
### 1 Accommodation



**Figure 6.** Accommodation profiles: total Traveller population, and Travellers who died by suicide, 2000-06

Sources: DOE counts and primary data

Here, the accommodation type of Travellers who have died by suicide is compared with the accommodation situation of Traveller families according to the DOE annual counts from 2000 to 2006. A total of 59% of those who died were living in houses, whether rented, or owned. However, over the seven-year period, an average total of 68% of all Travellers live in houses. As the percentage of Travellers in houses who died by suicide is slightly lower than the percentage of all Travellers living in houses, it can be presumed that living in a house is not a contributory factor to Traveller suicide. It appears from Figure 6 that those living on halting sites, and those without accommodation (unauthorised sites or homeless), have a higher risk of suicide. This will be discussed in the next chapter. There is not a significant difference between the percentage living in any type of accommodation and percentage of those who died by suicide, therefore conclusions cannot be drawn from these quantitative data alone although they suggest lines for further observation and enquiry.



**Figure 7.** Detailed accommodation profiles: total Traveller population in November 2006, and Travellers who died by suicide, 2000-06

Sources: DOE count 2006 and primary data

The accommodation type of Travellers who have died by suicide is compared with the accommodation type of Travellers today, based upon the DOE annual count in November 2006. The DOE figures include a category of "Sharing Housing". In Figure 7 the details of this category are distributed across the type of accommodation shared, e.g. "Social housing" includes tenants, their families and others sharing this accommodation. Overall, accommodation in houses appears to be a factor protecting against suicide, especially group housing, followed by private accommodation, be it rented or owned. Almost 35% of Travellers live in these types of housing, compared to just over 20% of occurrences of suicide. The reason for this may be connected to the fact that in most cases Travellers would exercise a greater degree of personal choice in taking these types of accommodation.

Those on unauthorised sites or homeless are the group at greatest risk of suicide, accounting for 9% of Traveller families, but almost 18% of suicides. Accommodation issues are discussed further in the next chapter.

## 2 Pathological indicators

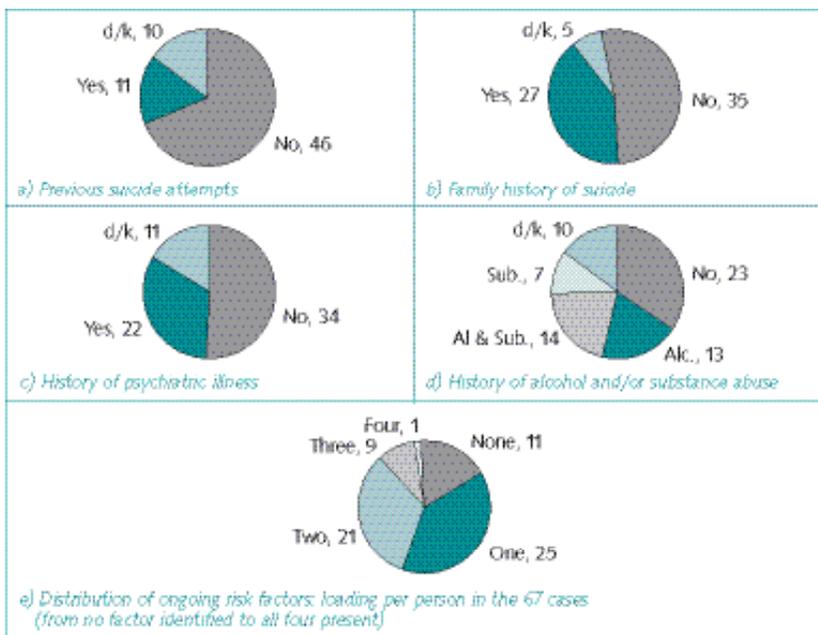
In the initial years of research, data were gathered concerning the incidence of suicide among Travellers, and a demographic profile of those who had died by suicide. Respondents were also asked whether they felt there was any other relevant information concerning each case. Based on the responses to this question over the period 2000-2004, a further six questions were added to my interviews, whether the person had previous suicide attempts, a family history of suicide, a diagnosed psychiatric illness, a history of alcohol or substance abuse, a recent bereavement or had been drinking immediately prior to death. Where possible, the original sources of information were returned to with those additional questions. In seven instances (9% of all cases), the original respondent was not contacted. Furthermore, in some cases the respondents did not know the answers to these questions. Although the numbers of 'don't know' answers plus not contacted respondents is unfortunately high, much can be learned from on the information that was furnished.

The data have been broken into two categories. Ongoing risk factor profiles refer to specific susceptibilities commonly associated with increased risk of suicide. Immediate risk factor profiles refer to precipitating events which may have motivated the individual to take his/her own life.

*(a) Ongoing risk factor profiles*

In Figures 8a-e below, the seven cases where respondents were not contacted have been omitted so the total number of reported cases (n) is 67 persons (data label d/k = don't know).

- a) Previous suicide attempts
- b) Family history of suicide
- c) History of psychiatric illness
- d) History of alcohol and/or substance abuse
- e) Distribution of ongoing risk factors: loading per person in the 67 cases (from no factor identified to all four present)



**Figures 8a-e.** Ongoing risk factor profiles of 67 of the Travellers who died by suicide, 2000-06: (a) previous attempts, (b) family history, (c) history of psychiatric illness, (d) history of alcohol or substance abuse, and (e) distribution of intersecting factors.

Source: Primary data

In 11 cases, the individual had a history of suicidal behaviour. In each of those cases, it was reported that there had been a number of previous attempts. However, 46 Travellers died on their first attempt at suicide, 33 of whom had at least one of the above-named on-going risk factors.

A family history of suicide refers to a sibling, parent or grandparent, first cousin, uncle or aunt, spouse or child. The suicide may have occurred in the recent or distant past. 27 of the total were reported to have had a family history of suicide while 35 were reported not to have. Of the 27 with a family history of suicide, for 17, it was their first suicide attempt, while 5 were reported as having made previous attempts. Although those five who had both a family history of suicide and previous suicide attempts would be considered as having a high risk of suicide, three of the five had not received any psychiatric intervention. Of those with no family history of suicide (n=35), 28 died on their first attempt. This figure is high and renders identification of those at risk of suicide difficult.

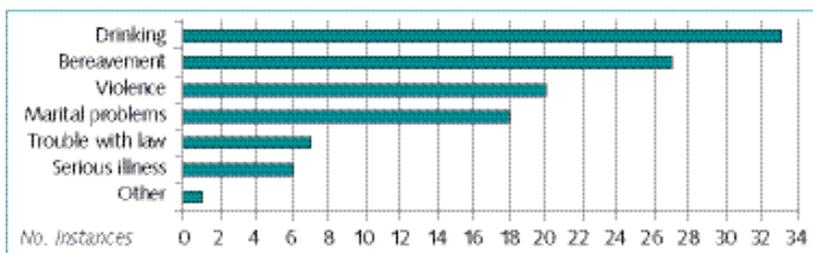
Almost one third of all cases (n=22) were on record as having a history of psychiatric illness. They had been treated by either a psychiatrist or G.P. for a psychiatric illness, usually depression. This category also includes individuals who were reported as not continuing to avail of psychiatric services, as previous experiences had been negative. In some instances, classified as "no psychiatric history", the respondent stated that the individual had been very depressed or agitated, and may have had a psychiatric illness, but that it had never been treated. Psychiatric issues are discussed further in the next chapter.

Alcohol abuse and/or substance abuse were reported as issues in 34 instances. However, it is difficult to assess the reliability of these answers. For one respondent, "substance abuse" may refer to any use of illicit drugs, while for another, it may refer to an addiction, casual use not being recorded as "abuse". Where respondents asked for clarification on the question, they were informed that the question referred to "abuse" rather than usage. In all cases respondents spoke of illicit drug use, not abuse of prescription drugs. Similarly, different respondents will have different opinions as to what is classified as "alcohol abuse". Some referred to "problematic" drinking, where family members may have discussed the social consequences of the person's drinking with the respondent, or the HSE may have had concerns regarding the children's welfare because of their parents' drinking habits. Some gave concrete examples of individual's drinking inappropriately, or of medical intervention for alcoholism.

There was only one case where the individual was reported to have had all of the four risk factors. 25 were reported as having one, while 11 individuals were not reported as having any. This has serious implications for Travellers and service providers alike in that 11 did not demonstrate any of the above signs of suicidal risk. Of particular concern is the high number for whom this was their first attempt at suicide. With no family history of suicide, no previous attempts, no psychiatric history, no abuse of alcohol or drugs, there is little to identify those at risk of suicide.

*(b) Immediate risk factor profiles*

Many of those who die by suicide come from secure family backgrounds, and lead normal lives, showing none of the afore-mentioned risk factors. However, sometimes a precipitating event may bring about suicidal tendencies. In 57 cases (77% of the total), events were reported, which the informant believed were of significant importance and which may have motivated the individual to take his/her life. More than one significant event was reported in several cases; in 18 cases the individual had been affected by three or more events. Informants were asked whether those who died had been drinking prior to death and whether they had experienced a recent bereavement. They were not asked questions concerning violence, marital problems, legal conflict or serious illness. These four issues may therefore be under-reported.



**Figure 9.** Significant events occurring in 57 cases immediately prior to death

Source: Primary data

Alcohol plays a significant role in deaths by suicide. In 33 cases it was reported that the person had been drinking immediately before death, with many respondents describing a situation in which a large amount of alcohol had been consumed. All of these individuals had at least one other named precipitating event, or one of the ongoing risk factors (Figures 8a-e and 9). The role of alcohol is discussed further in the next chapter.

In the case of Traveller suicides the second most common significant event was bereavement. In 27 instances (over one third of the total), one or more persons close to the individual had died. Eleven of those deaths were also suicides. In some circumstances, the bereavement was one of several issues, any of which could have led to suicide. However, in 20 instances the recent death of somebody close was cited as a very significant factor, probably motivating the person to take his/her own life. Sometimes the suicide took place within the month following the bereavement. In 10 of these 20 cases, the individual was reported to have been drinking immediately prior to death, frequently with others as part of the grieving ritual.

Violence, whether within marriage or not, has been cited as significant in 20 cases. In eight of these, suicide was reported to have followed a violent episode. In all eight cases, the respondent indicated that the episode prior to suicide was one of many serious assaults involving the person who died. In four cases it was the victim who died by suicide, and in four it was the perpetrator.

Marital conflict was named as significant in 18 instances, 12 where the couple was still married, and six where the separation was very recent. In 11 of these cases, domestic violence was reported as an issue. In some extreme situations, suicide followed a barring order or a partner's taking refuge from a violent situation. Separation is infrequent among Travellers and issues such as lack of access to one's children and having to leave the family home were reported as causes of distress.

Conflict with the law is another factor which was reported as relevant in cases of suicide. Seven Traveller suicides, all male, were reported as taking place following disclosure of an alleged criminal act or awaiting trial for a criminal act. In each of these cases, the informant had no doubt that this was a major (if not the sole) contributory factor to the individual's suicide. Generally speaking, the older the individual the more serious the criminal act. However, the perceived shame it would bring upon the individual and the family was considered by respondents as more significant than the nature of the act itself.

Serious illness was named as a contributory factor in six cases, usually life-threatening, and involving major medical intervention. In three cases it was a personal illness, and in three, the illness was that of a close family member.

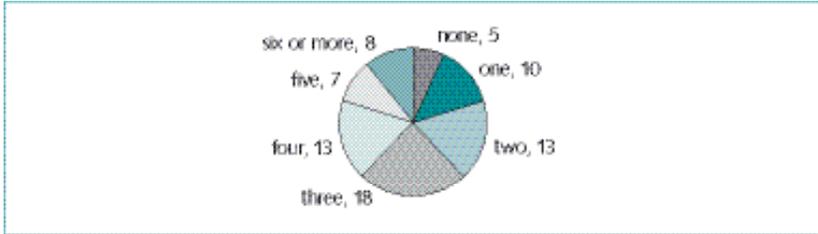
### *(c) Troubled family background*

Questions were not asked regarding the family background of those who died by suicide. Information of this nature would be more appropriate for an in-depth study of sample cases rather than for this research which aimed to gather more easily accessible and quantifiable information. However, there were 12 noteworthy cases, where the informant described a horrific life history, which may lead one to question not why the person had died by suicide, but how they had survived for so long. At time of death four of this group were between 15 and 24 years old, five were between 25 and 29, and the remaining three were between 35 and 44 years old. In these cases the individual had to contend with a range of social issues including a childhood of abuse or neglect, mainly due to violence and/or alcohol abuse in the family home. In over half of these cases, siblings had died by suicide or other violent means. Most of these individuals had a history of self-harm or previous suicide attempts, of violent behaviour, and of alcohol and/or substance abuse. All of these people had found themselves in a downward spiral with a bleak future.

In a further eight cases, respondents described a chaotic family situation where the mother of the person who died had issues, either of a psychiatric nature (n=5) or involving alcohol abuse (n=3). This research did not look into the issue of family dysfunction and its connection with Traveller suicide. However it has emerged from the qualitative data as being an area which needs to be examined in greater depth.

### *(d) Simple and complex risk factor profiles*

According to the WHO (2005:5), there is no single cause of suicide, but it is the result of a complex interaction of various risk factors. In this section the total number of ongoing risk factors (fig 8a-8e) and immediate risk factors (fig 9) which affected those who died by suicide between 2000 and 2006 are looked at. Included as a risk factor is a troubled or dysfunctional family background as outlined in the section above.



**Figure 10.** Distribution of ongoing and immediate risk factors: loadings per person (n=74), from none identified, to six or more factors identified.

Source: Primary data

In 15 cases (21%), either none or one of the ongoing and immediate risk factors was mentioned as relevant to the person who died. It is possible that a risk factor was not mentioned because the relevant question was not asked, or because the informant was not aware of it. However, in seven cases, the respondent described the individual as coming from a stable background, in which there were no underlying social issues. They were involved in education, sport or work, and were not considered by the respondent as being at risk of suicide. In two instances their deaths may have been the consequence of a precipitating event, but in five the respondent stated that there appeared to be no motive for the death.

At the other end of the spectrum were those with several risk factors: eight people had 6 or more risk factors. Six of the eight were reported as having a family history of suicide. In all eight cases, alcohol and/or substance abuse were said to have been issues of concern. Five came from very troubled family backgrounds, while seven were affected by at least three precipitating events.

Of those eight who demonstrated at least 6 risk factors, it was reported that four had not been in contact with psychiatric services, nor had they been treated by their GP for depression. All four had a family history of suicide, three having recently lost a member of their immediate family to suicide. All four were reported as having a history of both alcohol and substance abuse, and were drinking at the time of death. In all four instances violence was named as an issue of concern, while three were described as having a very troubled family background. Psychiatric issues are discussed further in the next chapter.

## TYPES OF SUICIDE

In this section suicide is classified according to the patterns which have emerged from the findings of the qualitative data. This is largely based on issues that the respondents reported as significant in specific cases, and also on their observations regarding the issue of suicide among Travellers in general. It should be noted that most respondents have had several years experience working with Travellers, and would have known those who died and their families quite well. Furthermore, contact between the researcher and respondents in certain cases involved detailed and exhaustive discussions on the topic of suicide among Travellers, and feedback on the progress and findings of this research, over a seven-year period.

### 1 Troubled suicides

This refers to 12 cases where the informant described a background of major social problems. In each case there had been a childhood of abuse or neglect. Problems in the family home included violence, both domestic and feuding, alcohol abuse, conflict with the law, and a family history of suicide. In over half of these cases, siblings had died by suicide or other violent means. Of those who reached adulthood, most went on to have relationship difficulties, lives characterised by alcohol or substance abuse and violent behaviour, and a history of self-harm or suicide attempts. From the time they were children these people found themselves in a situation where there was no future.

It also refers to those who had been affected by multiple crises. Eighteen individuals had been affected by three or more precipitating events. Eight had suffered two recent significant bereavements. In six of those eight cases, one if not both of the recent bereavements had been by suicide. Of the eight one had been treated by a GP for depression, while the remaining seven were reported as not having received any psychiatric treatment.

### 2 No known motive suicides

Many who died by suicide were described as coming from loving and secure families, and were frequently involved in sport, education or were working. According to respondents, they appeared to have everything going for them. While some died following a significant event such as death or legal

conflict, five appeared to have no motive for doing so. Speaking at the 24th World Congress of the International Association for Suicide Prevention in Killarney, August 2007, Mishara stated that “relatively minor precipitating events can have tremendous effects at crucial moments”, which it is not always possible for another to recognise. These individuals showed no sign of suicidal ideation, they had none of the risk factors typically associated with suicide, such as depression, alcohol or substance abuse. Respondents said that there appeared to be no reason for the decision and spoke of the anguish experienced by those left behind, unable to understand why these people had actually chosen to end their lives.

### 3 Bereavement suicides

The most common pattern that has emerged throughout this research is that of the Traveller, who, following the death of somebody close, takes his own life, usually by hanging. This appears to be a time of extreme vulnerability for Travellers. In addition to the loss, they may have to shoulder the organisation and the financial burden of an elaborate funeral. Respondents have reported drinking sessions, or binges, frequently with others following one of the grieving rituals, where large quantities of alcohol and possibly drugs have been taken, during or after which a Traveller has taken his/her life.

Not all bereavement suicides follow this pattern. Some have taken their lives following a death, without any ‘assistance’ from alcohol or drugs.

Included under the heading of bereavement suicides are three which very closely followed the news that a relative was seriously ill and may be about to die. The view of the respondent was that the anticipation of the death so greatly disturbed these individuals that they took their own lives.

### 4 Violence suicides

Domestic violence, not limited to conflict between couples, but among other family members, and feuding were reported as contributory factors in 20 cases of suicide. Eight of these occurred following a violent episode. Four were victims, four were perpetrators. In all but one case, a large quantity of alcohol was reported to have been consumed at the time. All eight died by hanging, a violent means of suicide in itself.

Respondents have observed the difficulties facing a Traveller woman who wishes to escape from a violent domestic situation. In some cases, violence has always been an issue, while in others it began as isolated episodes, followed by great demonstrations of remorse, and it took some time before it came to be recognised as a frequent pattern of behaviour. Where there are children, reasons cited for a mother's reluctance to leave home include the emotional attachment the children have to their father, or her own fear of financial insecurity. In some situations there have been ties of friendship and kinship between her own family and that of her husband's, making separation more difficult. For some, escaping from a violent situation would mean severing links not just with her husband's family but also with her own, and for a Traveller woman, this is not a realistic option. Respondents spoke of women who endured lives of cruelty and oppression, occasionally taking temporary shelter with their parents or in a women's refuge. It was their opinion that some perceived death as the only way to end the violence.

The perpetrator is also at risk of suicide. Some grew up in families where conflict was resolved using violence. Respondents suggested that it may be the only way the perpetrator has known of asserting his authority as head of the household, either within the family or as protector of the family. Episodes were referred to, especially with drink or drugs involved, where violence escalated out of control. In some cases following one such episode, perhaps when the wife had taken shelter elsewhere, the perpetrator took his life. Some respondents have expressed the opinion that this form of suicide is one final act of vengeance, to punish his wife for leaving the situation. Others have said that it may be the consequence of an overwhelming sense of guilt and remorse as the anger subsides, and that by this form of self punishment he hopes to be released from all blame.

## 5 Shamed suicides

These suicides, seven in total, took place following disclosure of an alleged criminal act or awaiting trial for a criminal act. In general, the older the individual the more serious the act was likely to be. In all cases it was perceived by respondents that the act, or its disclosure would bring shame upon the individual and dishonour to the family. The consequence of this could be that the individual and the family would be marginalized and ostracised from the whole community. The view of the respondents was that the pressure of this shame motivated these people to kill themselves.

Of the above classifications, the first two (troubled suicides and no known motive suicides) could be applied to any sector of the community. The other three classifications (bereavement, violence and shamed suicides) concern issues which may be of greater relevance to Travellers. The key elements of this chapter are discussed further in the next chapter.

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## **CHAPTER 5**

### **DISCUSSIONS, CONCLUSIONS AND RECOMMENDATIONS**

## INTRODUCTION

Until relatively recently, there has been a reluctance to discuss suicide among Travellers. It was not referred to in either the Traveller Health Research Report (Barry et al., 1989) or the Report of the National Task Force on Suicide (DOHC, 1998). It was briefly mentioned in *Reach Out* (HSE, 2005:37), where it was noted that there were concerns regarding an apparent increase in suicide risk, although there was a lack of research into this area. This project is intended as a starting point for future research into this topic. It is the first research that has been carried out with the purpose of seeking to document the incidence of suicide among Travellers, and to comparing rates of suicide among Travellers to that of the general population. In terms of suicide research it is unique in that it is a nationwide study, covering the whole Traveller population rather than a sample, and information has been gathered regarding the family circumstances and underlying issues concerning the subjects of the research. Although there are gaps in this information, certain issues have come to light here. That is not to say that these are the only, or even the most relevant issues concerning Travellers who die by suicide. On the basis of the data obtained, of the literature on suicide and on Travellers, and of my knowledge of the experience of social workers for Travellers over the past twelve years, this section is a summary of what I believe are key issues regarding the suicide in the Traveller community today.

## THE FAMILY

In "Le suicide" Durkheim (1952) stated that integration, in particular family ties and group membership, protected against suicide. For Travellers, all of life centres around the family, which offers social and emotional support to its members. Living in multigenerational groups, children and adults work side by side, the aged, the unmarried and the sick remain with the family, all members contributing to family life (Liégeois, 1994:83-88). In times of difficulty the extended family and community offers complete support to its members. Visible manifestations of this are funerals, and when a family member is in hospital (DOHC, 2002:99; DOE, 1995:150). However, there are times when family ties are not enough to protect the individual from suicide. Outlined below are three situations where the family can not offer its members protection from suicide.

1. Although rare, it sometimes happens that a member is ostracised from the family, or indeed a family may be ostracised from the extended family or community network. The consequences of exclusion for the individual are extremely serious as it results in a total breakdown of social supports. I would suggest that this is a factor in some suicides, especially those where there has been a legal conflict which may bring shame upon the family. According to Liégeois (1994:83) the individual acts not as an individual, but as a member of the family, and it follows that the misdeed of an individual is felt to be that of the family. Similarly, Fountain (2006:65) quotes a Traveller, who states that not only heroin users, but often their families, are marginalized and ostracised from the whole community. It is possible that the perceived shame these criminal acts would bring upon their families was more than the individuals could bear. Respondents have spoken of rifts occurring among families, and apportioning of blame, following such cases of suicide.
2. Domestic breakdown occurs in families where there are so many issues such as poverty and overcrowding, domestic violence, addiction and depression, that they are no longer stable. Parents may be so overwhelmed by and totally absorbed with their own problems, that they neglect their children. Although there are strong emotional bonds, they are not able to give their children the discipline and guidance that is essential for their development. Having learned not turn to their parents for support, these children are at risk of growing up to be angry and frustrated teenagers, engaging in anti-social behaviour, violence (sometimes directed at their parents) and excessive alcohol or drug use. In the case of Australian Aboriginal peoples, Tatz (1999) refers to young people at risk of suicide, because they have nobody to turn to, should they wish to change their present circumstances. The home is filled with family members in a similar hopeless situation, and there is nobody to act as a guide or mentor in a transition to betterment (Tatz, 1999:79). In seven cases the respondent mentioned that the mother of the deceased had mental health problems or alcohol related problems. Questions regarding parents or family background were not asked, and I would suggest that this be an area which would warrant further research.
3. When a death occurs, Travellers will travel great distances to attend a funeral and be with the bereaved. There are a number of grieving rituals

such as the 9th day and month's mind masses, sometimes held every month for the first year, which offer ongoing support for families. However, without the loved one (or ones), the family is no longer the same as it once was. Unlike the situation above where family members are so absorbed in their own problems that they cannot offer support, in this situation the individual views the family, and indeed life, as no longer complete. So great is the desire to be with the deceased, they may not allow the other family members to give the support which is vital as protection against suicide.

## OTHER FACTORS AFFECTING SUICIDE

### 1 Demographic factors

At the outset of this research in early 2001, a number of respondents were of the opinion that suicide was an extremely rare occurrence within the Traveller community. These generally came from rural Local Authorities. Those in the city councils or in counties to the east of the country were all aware that suicide was an issue. Although information on suicide on the basis of county has not been included, as doing so may render it possible to identify individuals, it can be said that between 2000 and 2006, a Traveller suicide has occurred in almost every county in Ireland, including those of the afore-mentioned respondents.

Suicide is most common among men, the male to female ratio among Travellers from 2000 to 2006 being 9.6:1, the male to female ratio for the total population being 4.2:1. In particular young single men are at risk, with men under 30 years accounting for almost 65% of all suicides. There is a considerable difference between this and the national rates where those under 30 years of age account for 34% of the total number of suicides. For Travellers, the age bracket at greatest risk is 25-29, which accounts for 26% of all suicides. It is slightly older than age group at greatest risk for the total population, which is 20-24. 20% of Traveller suicides are in the 15-19 age group, which is the second highest risk group. 52% of the Travellers who died by suicide were single, while 66% were either single, separated or widowed.

The most frequently used method is hanging which accounts for 80% of suicides among Travellers. This is significantly higher than the national rate, which is 57%. It is a particularly lethal method, leaving little possibility for

rescue. Fewer than 15% (n=11) were reported to have made previous suicide attempts, a disturbing statistic for service providers and families alike. Poisoning follows at 9% with 4% of deaths by drowning. For the total population deaths by drowning exceed deaths by poisoning, 17% compared to 14%.

The typical profile of the Traveller who dies by suicide is similar to that of the typical Irish person who dies by suicide; young, single, male and death by hanging. However in the case of Travellers, the figures of those falling into the typical profile are significantly higher.

Few Traveller women have died by suicide, and it appears to be a more recent phenomenon. Generally speaking they have been single women, in their 20s and without children. However, in every instance where the woman was married, very definite issues were related to me, which would have left those women in a state of utter hopelessness and isolation, from which the very strong attachment to their children could not rescue them.

## 2 Accommodation

The results of the quantitative data suggest a link between accommodation type and instance of suicide, with Travellers in housing at slightly lower risk of suicide. However, the numbers may be too low to base any inferences on them on their own. Citizen Traveller (2001, cited in Brack and Monaghan, 2007) found a marked disparity in Travellers' satisfaction with life depending on the type of accommodation they lived in. This concern would be confirmed by both the respondents' and my own experience working in accommodation services. What emerges as more significant is not the type of accommodation, but how the individual feels about where he/she lives. A couple, both having grown up in a house, might find it extremely difficult to adjust to married life on the roadside, without water or basic sanitation, especially with the arrival of a first-born infant. Similarly, a family on a housing estate, might find the tenancy agreement which forbids the accumulation of scrap and only allows for one domestic animal, very restrictive. Coupled with the awareness that their neighbours do not wish to have Travellers living among them, they may feel isolated yet trapped as there is nowhere else to go.

The types of accommodation that appear to offer most protection against suicide are owner-occupied, private rented and group houses. All three

involve choice on the part of the Traveller. Clearly with owner-occupied houses, a Traveller chooses whether to purchase a house or not, and the capital resource facilitates movement. Private rented housing requires the Traveller to source accommodation independently through an estate agency. The Traveller exercises choice over which house to rent and in which area to live. Group houses are generally built for a family group or a group of compatible families, who have chosen to live in close proximity to one another. This type of accommodation is usually designed and built in consultation with the families who are to occupy it. It would appear that the level of satisfaction experienced living in specific accommodation is directly related to the degree of choice involved in obtaining the accommodation.

Those at greater risk of suicide according to the findings are those living on unauthorised sites or the homeless. Homeless refers to those who sleep in hostels or in the streets. An unauthorised site refers to any unofficial or illegal site, from roadside encampments to single caravans in yards behind houses. Although living in appalling conditions, the majority of these Travellers are with their extended family network, and this constitutes "home" (AHBV, 2001, cited in Kenny, 2003:12). Many families, while unhappy with the lack of facilities, would prefer to remain together in inadequate conditions than separated in houses. These families tend to "hold out" for the type of accommodation they want, usually a site only for their family, or a group housing scheme. Although in unofficial accommodation these families still exercise a degree of control and intentionality with regard to their family integrity and future accommodation. However, for many on the roadside, their living conditions are a source of considerable stress. This applies not only to those for whom it is their first experience of life in a caravan, but also those who have left, or been evicted from standard housing, and know that they may have to wait years before they are considered for accommodation again. Like the homeless, these families have little or no control over their situation.

Halting sites, like group housing, are a form of Traveller specific accommodation. Ideally, they are designed and built in consultation with the families who are to occupy them, and existing residents are generally consulted before allocating vacant bays. However, the quality of Local Authority halting sites can vary considerably from those that provide basic facilities for families which it is presumed are awaiting standard housing, to those which provide 'day houses' (houses without bedrooms), ample space for trailers and carrying out work, and are intended as permanent homes.

The data gathered in this study suggests that families on halting sites appear to be at greater risk of suicide than families in social housing. This is an area which requires further research.

### 3 Bereavement

The most common pattern that has emerged throughout this research is that of the Traveller, who, following the death of somebody close, takes his own life, usually by hanging. Frequently, a large quantity of alcohol is consumed, possibly with others who are also grieving. This appears to be a time of extreme vulnerability for Travellers, for whom early or tragic death is an all too common occurrence (Brack and Monaghan, 2007:16). Travellers are extremely supportive of one another in times of bereavement, and will travel great distances to attend funerals and month's mind or anniversary masses. Young death is frequent among Travellers, some families experiencing several tragic deaths within a relatively short space of time (Brack and Monaghan, 2007:16). For Travellers, an elaborate funeral is indicative of the degree of affection and respect held for the deceased (Brack and Monaghan, 2007:19). There are month's minds masses to organise (sometimes each month for the first year) and an ornate headstone to be provided for the grave one year later, all of which can place families under considerable financial strain, particularly if there is more than one death. Travellers are openly emotional in their response to death, and at times, after funerals or other mourning rituals, (like most Irish people) they may gather in large groups and a lot of alcohol is consumed. It has emerged as a pattern throughout this research that in this situation Travellers have taken their lives. Respondents have reported drinking sessions, or binges, sometimes over a number of days, with large quantities of alcohol and possibly drugs being consumed. It is as if the group is drinking to escape from their grief, and one member takes it to the next stage by suicide.

### 4 Suicide contagion

Having a family history of suicide increases one's risk of dying by suicide (IAS website, no date); 36% of Travellers who died by suicide between 2000 and 2006 had a family history of suicide.

Eleven of those who died, had recently lost somebody close to them by

suicide. In eight cases it was a sibling. Families have had to cope with the suicide of one member, followed closely by a second or third or even more – in some instances by the same means and in the same place. In the first years of data collection, some Local Authority areas had not experienced suicide among Travellers, not just in the course of this research but for several years prior to it. Subsequently the same areas reported two or even three suicides over an eighteen month period.

While suicide contagion is well recognised, opinion differs as to why it occurs. Durkheim (1952:97-98) believed it unlikely to be genetic. Environmental factors for siblings may be very similar, each choosing to escape from the same issues. However, the second person to consider suicide has the additional problem of having to cope with the suicide of the first, and the guilt, stigma and anger that comes with it. It is also possible that in families where a number of members have died by suicide, it has become a learned response for dealing with stress.

According to Tatz (1999:76) some, especially teenagers, may take their own lives in order to gain "respect". Having witnessed the funeral and grieving over one suicide, they imagine what it would be like if they were to die. He suggests that they believe they will be there in spirit to witness the sorrow, remorse, regret and respect created by their final act. This has similarities with Halbwachs' (1978:301) description of youths imagining the grief of others following their own suicides. However, it differs in that Halbwachs referred to youth inspired by thoughts of vengeance and punishment, while Tatz refers to those whose lives were 'insignificant' and whose deaths are inspired by thoughts of self esteem. Tatz (1999:76) states that much of this kind of suicide occurs in small communities.

## 5 Psychiatric issues

It is generally agreed that psychiatric disorders are a major factor associated with suicide (WHO, 2000:5), although studies vary regarding the exact correlation between the two. While 32% of those studied had been treated for a diagnosed psychiatric condition, over 40% had not. In some cases where the individual had not been treated for a psychiatric illness, the respondents felt that there were psychiatric issues, usually depression. The findings also show that a number of those who died had several social problems, some from the time of their childhoods, and were in situations from which they were unlikely ever to escape. Suicide may not have been

an indication of a mental disorder, but a means of leaving an intolerable situation.

There appears to be a distrust of the psychiatric services by Travellers. The DOHC (2002:85) has noted that the uptake of these services is low, while Traveller organisations suggest that the stigma attached to having mental health problems restricts Travellers availing of mental services (Pavee Point, 2006c:7). In one situation, it was only after three siblings had died by suicide that the other family members became involved with the psychiatric services, none of the three deceased siblings ever having received psychiatric treatment. Of the eight Travellers in this project who demonstrated six or more risk factors associated with increased risk of suicide, four had never attended psychiatric services. Informants also referred to some cases where the individual had availed of psychiatric assistance but had not continued to do so because of negative experiences associated with the service. In fact, three suicides took place very shortly, sometimes within hours, after leaving a psychiatric hospital. Although the DOHC (2001:60) recognises that suicide risk increases during the period following discharge from psychiatric care, these suicides would not increase Travellers' confidence or trust in the psychiatric services.

It has been reported that some families were concerned that a member was depressed and feared that the individual was suicidal, but felt that they were powerless to assist. Almost 60% of those surveyed had no history of previous suicide attempts. This appears to be very high, and is extremely worrying where a Traveller demonstrates suicidal tendencies. At present, suicidal ideation is dealt with through the psychiatric services. Concern has been expressed that families who wish to have a member committed to a psychiatric hospital may be refused, if the person concerned is unwilling to avail of psychiatric help. It is felt that there may not be enough time to source other channels to obtain help where an individual is suicidal.

This is not intended as a criticism of mental health workers, many of whom are extremely sensitive to Traveller culture. However, current practice is not always suitable for Travellers, and an approach which involves the extended family in intervention, may be more appropriate.

## 6 Alcohol and drugs

There is a strong relationship between alcohol/substance abuse and suicide (HSE, 2005:36), with alcohol abuse or dependence on alcohol being a frequent diagnosis in those who have died by suicide (WHO, 2000:7). In this research study, alcohol and/or substance abuse were reported as issues in 46% of cases where Travellers died by suicide. Gmelch (1985:104) states that drinking offers Travellers a temporary escape from feelings of inadequacy. However long term, excessive reliance on drinking as a coping response constitutes a vicious circle in which the original conditions are worsened. Prolonged abuse of alcohol or drugs is associated with poverty, domestic violence, family breakdown, and suicide.

The strategies Travellers engage in regarding alcohol and substance management are identified by Fountain (2006). For illicit drug users, the family is likely to encourage any effort to control their usage, be it uptake of service or direct parental control. Traveller parents sometimes leave houses where they have lived for many years and return to the roadside, to sever all contact between a son or daughter and the "bad company" they associate with his/her introduction to drugs. On the other hand, there does not appear to be the same awareness that addiction to prescription drugs is also an issue of concern, although this problem is increasingly being addressed in primary health care programmes.

Regarding alcohol abuse, while Travellers will attend psychiatric institutions to be "dried out", anecdotally it appears that they rarely avail of long-term supports and counselling, or attend the more readily available Alcoholics Anonymous (AA) meetings. Supports such as AA are designed for and attended by the majority population, and they emphasise total abstinence and the individual's avoidance of circles and situations where he/she used to drink. Given the closeness of Traveller family ties, this separation from the family circle realistically speaking, is not culturally achievable. Alati, Peterson and Liamputtong Rice (2000, cited in Kenny, 2003) in their review of abstentionist approaches to the treatment of alcoholism among Aboriginal people, found that the AA's emphasis upon the powerlessness of the alcoholic and on personal/familial deficits or pathology as causes of addiction as culturally inappropriate. Traditionally, Travellers who have felt that their drinking is becoming problematic, go to the priest and take the pledge for a period (Fountain, 2006). Although not ideal, periods of abstinence are more likely to be achievable than total abstinence.

The immediate effects of alcohol are associated with the increased impulsiveness and false courage before a suicidal act (HSE, 2005:36). In 45% of cases in this study (n=33) the individual was reported to have been drinking immediately before death. In over half of the 33 cases the respondent reported triggers which were considered to be of significant importance and which may have motivated the individual to take his/her life. The most frequently cited trigger factor being a bereavement. In some situations vast quantities of alcohol had been consumed. It is noteworthy that seven of the 33 were not reported as having an ongoing problem with alcohol or drugs. It is possible that while the individual turned to drink, with the intention of easing pain, it clouded perception of the situation, magnifying the problem out of all proportion and leading to suicide. On the other hand it may have given the person the courage to do what they had intended to do anyway.

## 7 Violence

Aggression broadly falls into two types, predatory (controlled or goal-oriented) and affective (impulsive or hostile) (Vitiello et al., 1990). There are socially acceptable ways of channelling aggression, and dealing with conflict in the worlds of sport and business. It is not so long ago that corporal punishment was seen as an acceptable way of maintaining class control.

Not everybody succeeds in controlling feelings of anger. Some may lack the communication skills to articulate their dissatisfaction or frustration, and resort to angry outbursts or threatening behaviour. For others, violence is a learned response, and may be the only means they have of dealing with situations of conflict. Many public bodies have had to adopt policies for staff dealing with aggressive clients.

Travellers have much to feel angry about. The knowledge that most of Irish society has great disrespect for Traveller culture is difficult for the individual to deal with. Added to this is the fact that membership of the Traveller community means poorer health, a lower life expectancy, lower educational attainment and poorer living conditions. If the frustration and anger is not controlled or channelled elsewhere, there is a chance that it will result in violence directed towards others or towards oneself.

For some Travellers, violence and anger management are major issues. As has already been stated, research carried out for the National Crime Council

in association with Economic and Social Research Institute showed that in 2003, 49% of admissions to women's refuges were Travellers (Watson and Parsons, 2005:99), an extraordinarily high statistic for a group that makes up less than 1% of the total population of Ireland, and one that warrants further investigation. In some parts of Ireland, conflict among Traveller families has attracted media attention. Liégeois (1994:83) states that conflict is expressed collectively, with relations between individuals simultaneously being relations between family groups. Tatz (1999:20) has observed the following pattern in many Aboriginal societies of frustration, followed by alienation from society, then withdrawal from society, no longer caring about law-abidingness, and finally violence. His observation was that violence was directed against the immediate family or social group, or against oneself, not against society.

In 27% of the total number of Traveller suicides, violence was mentioned as an issue, although at no stage was a question asked regarding violence. I was informed of eight suicides which occurred following a violent episode, four of whom were victims and four perpetrators, all of whom died by hanging. For Durkheim, the suicide of a perpetrator following the assault of a victim is a form of anomic suicide. It is anomic because his emotions are without regulation. In an exasperated state he takes his anger out on the cause of his frustration, by homicide or other violent act, and follows it by killing himself (Durkheim, 1952:285).

## 8 Lack of purpose

Many Travellers, even those on the roadside, no longer travel. This is partly because the economic reasons for doing so are no longer viable for them, but also because finding a place to move to has become increasingly difficult. While some choose not to travel, others feel that they have lost a form of social integration and miss the very activity of gathering belongings and moving to a new place. Similarly, Travellers view the Control of Horses Act (1996) and by-laws as having taken away something which gives men a purpose in life. Looking after horses is time consuming, it involves handing down skills from one generation to the next, and there are fairs to look forward to, which in themselves are major social events. For those without work, who have lost the traditions of travelling and keeping horses, there is nothing to do. They lack purpose in life, they have no reason to get up in the morning and nothing to look forward to. Particularly vulnerable are single young men. To alleviate boredom they may drink, take drugs, joy-ride,

and engage in other forms of anti-social behaviour. All of these risk-taking behaviours are associated with suicide, and it takes little to persuade somebody for whom life holds no interest to end theirs.

Rising expectations, marginalisation and lack of purpose combined with increased prosperity also means that today's youth can afford to engage in risk-taking behaviour such as binge drinking, drug taking and dangerous driving, all associated with early death and suicide.

## 9 Membership of an indigenous minority group

Having looked at the AI/AN, Inuit and Australian Aboriginal communities, there are many similarities between these and Travellers in Ireland. All are indigenous minority groups and all have rates of suicide considerably higher than the national population. They share common features such as high levels of poverty, poor accommodation, low levels of education and health, including mental health. In their countries, their traditions and customs are viewed negatively by the majority population. All have endured policies of assimilation and a high level of monitoring from social services, the consequences of which, cultural identity conflict and low self esteem, are prevalent.

On the other hand, research into the AI/AN, Inuit and Australian Aboriginals shows an alarming level of cultural disintegration, including high levels of alcoholism, chaotic family structures and child neglect. Tatz (1999:67-73) cites numerous examples of horrific cases of self-harm and suicide, which involve self-torture. Research literature and reports from Traveller organisations do not reveal any evidence that the Traveller community has anything like the levels of social disintegration which have been reported for these groups.

## 10 Sexual Orientation

The almost complete absence of sexual orientation as an issue of concern, is in itself noteworthy. Although it has been identified in the submission to the National Strategy for Suicide Prevention (Pavee Point, 2005b) as a contributory factor leading to Traveller suicide, only one person who died by suicide between 2000 and 2006 was reported to have been in a same-sex relationship. In one other case, it was suggested that there may have been

some ambiguity regarding sexual orientation. Marriage and extended family networks are of fundamental importance to Travellers, unmarried adults are a rare phenomenon, and the role of the individual within the family is gender-based (Liégeois, 1994). Travellers who are homosexual may be perceived as rejecting traditional Traveller values, and may find that they are doubly discriminated against, because of both their Traveller and sexual identity.

## WHY NOW?

The current rates of suicide among Travellers indicate that there is a serious problem regarding suicide levels within the Traveller community at the moment, which is proving in certain instances to be too strong for traditional safeguards to protect. Suicidal ideation is increasing as are comments such as "I'm either going to do harm to myself or somebody else" or "I feel like giving up altogether" or "The only thing keeping me alive is the kids". Both Travellers and service providers feel that this is a recent phenomenon. Assuming that this is so, there is a need to understand why suicide levels are so high now, rather than at any other time.

Travellers' lifestyle has improved greatly in recent years, and materially they are better off than ever before. Much progress has been made in the provision of Traveller accommodation, health service and in their participation in the school system. Travellers and Traveller organisations are consulted at local and national level, in relation to decisions and policies which affect them directly. Travellers are specifically named in the Equal Status Act (2000), and following from a number of successful and well publicised court cases, there is a growing awareness that they have rights. There is now policy commitment to respect for Traveller identity but research literature (see chapter 2) and reports from Traveller agencies indicate that application at national and local levels is uneven.

In spite of the administrative, legislative and financial provisions for Travellers, they still experience high levels of poverty and social disadvantage. However, Travellers have always been an impoverished and marginalized group, and this alone cannot explain why suicide rates have increased to such an extent in recent years. Paradoxically, it appears that improvements in the quality of their lives and increased integration with the settled population, have coincided with Traveller society reaching its current problem with regard to suicide.

Travellers have always been able to adapt to change. Traditionally they made changes to their economic practices to suit demand (Liégeois, 1994; Okely, 1983). Throughout the 1960s and 70s they adjusted to urban life and to housing in estates where they were not welcomed, and where the majority population rejected their culture. This did not, as far as we know, lead to an increase in suicides at that time. A consequence of increased integration is that today young Travellers dress like, and share the same interests as their settled peers. Even those living on the roadside or in Traveller specific accommodation (halting sites or group housing) have more in common with their settled counterparts than their parents did. Negative attitudes towards Travellers are still an issue today (Mac Gréil, 1996; Curry, 2000; Pavee Point, 2006a). Young Travellers are more openly questioning why their culture is held in disregard, or what it is about the name 'Traveller' that evokes such hostility from others. Some take the course of having as little to do with the society that rejects them as possible. As Travellers have traditionally lived separate identity, this is unlikely to be associated with the current rise in suicide rates. What is of greater concern are those who react by rejecting their culture and traditions in order to fit in. They may associate their parents' ways with poverty and backwardness, thereby internalising racist attitudes and feelings of social inferiority. This reaction is not limited to the youth. Older Travellers may try to conceal their Traveller identity in order that their children might avoid the hostility they have had to endure. In rejecting or trying to conceal their Traveller heritage they face issues of not belonging anywhere. They are not fully accepted as part of settled society, they may no longer be accepted by Travellers, and they have lost pride in their own ethnic identity. The resulting social isolation and cultural ambiguity are factors which Durkheim (1952) identified as increasing a society's risk of suicide. There is no easy solution, and some find it more difficult to cope than others.

Legislation and policies that aim to ensure that Travellers are treated equally can in turn exacerbate hostility. The 'quota system' adopted by many Local Authorities to ensure that a minimum number of Travellers are accommodated in each scheme, is a source of tension in areas where it is perceived that Travellers are accommodated sooner than the settled. It is also seen as introducing Travellers into areas where they never lived before, and occupying houses which would otherwise have gone to local families. Anecdotal evidence in Local Authority accommodation services would indicate that service users from the majority community feel that Travellers are in a privileged position regarding housing allocations, in times of acute

housing shortage such as today. Anecdotal evidence would also indicate that there is a mistaken perception that under current equality legislation no action can be taken against Travellers for anti-social behaviour lest it be interpreted as discriminatory. The truth or otherwise of these perceptions is not the issue as regards this study: the issue is that for Travellers in integrated housing, it is difficult to escape from such hostility.

An unforeseen outcome of improved policies regarding Travellers has been with the Traveller Accommodation Programme. Travellers have been involved at local and at national level in drawing up accommodation plans, designed to provide accommodation suited to Travellers cultural requirements. This has led to raised and sometimes unrealistic expectations regarding Traveller accommodation. Some Travellers have voiced a sense of disillusionment with the implementation of the Traveller Accommodation Programme (National Traveller Accommodation Consultative Committee [NTACC], 2004). In particular, Travellers and allied organisations have expressed reservations regarding the 'quota system' (ITM, 2001; National Consultative Committee on Racism and Interculturalism, no date), as it can be interpreted as the maximum permitted number of Travellers accommodated in an area, rather than the minimum provision that must be made.

The sense of disillusionment is not limited to accommodation issues. Travellers question the purpose of remaining at school to complete formal education as they do not perceive any connection between school completion and access to paid employment. Similarly, equality legislation protects Travellers from being discriminated against, however, in cases of discrimination it is not every Traveller that is willing to take legal action. Some have stated that there is no point in doing so. Feelings of inadequacy, particularly regarding their lower level of education and limited vocabulary, and the fear that the bad blood generated by the court case will be held against them, are frequently cited as reasons for not pursuing cases of discrimination through the courts. In any case, there are many instances of subtle discrimination such as a tone of voice, a look of contempt, unwillingness to engage in conversation, which are extremely difficult to define or prove, but contribute to lowering a person's self esteem. Travellers do not see equality legislation as protecting them in such situations.

Major changes in society, leading to identity conflict, cultural anomie, and a general sense of dissatisfaction and disillusionment, have resulted in Travellers today being highly vulnerable to suicide. In addition to this are the socio-economic issues, namely that Travellers continue to be a marginalized group,

with (although there have been improvements) poorer levels of health, life expectancy, living conditions, and education than the majority population. Given the existing vulnerabilities of Travellers today, factors such as alcohol or substance abuse, economic insecurity, violence, depression assume an additional risk level. It is in this context that an immediate crisis situation, such as death, marital conflict, etc, can act as a trigger factor for suicide.

## CONCLUSIONS

This research has looked at those who have died by suicide over a seven-year period, with the aim of gaining insight into the factors contributing to suicide levels among Travellers in Ireland today. It is acknowledged that factors which contribute to suicide are varied and complex (WHO, 2000:5), and that the uniqueness of each person means that individual risk cannot be accurately predicted. However, a greater knowledge of the incidence of suicide among Travellers, together with an increased understanding of issues concerning both individuals who have died by suicide and the wider Traveller population, should serve to raise awareness of Traveller suicide, and assist Travellers and service providers in developing strategies to deal with this problem.

The questions set out at the beginning of the research are as follows:

1. What is the incidence of suicide among Travellers?
2. Who is at risk of suicide in the Traveller population?
3. How can the incidence and profiles be understood?

### 1 What is the incidence of suicide among Travellers?

Between 2000 and 2006 inclusive, respondents in this study reported a total of 74 Travellers to have died by suicide. There are limitations in calculating the rate of suicide among Travellers, (discussed in the chapter on methodology), as CSO statistics on suicide and data on the Traveller population are both contested. However, the average rate of suicide among Travellers over the seven-year period is 3.65:10,000. This is more than three times the national rate which over the same period averaged at 1.19:10,000. The national rate has shown a slight annual reduction since 2001 when it

peaked at 1.37:10,000. This is not the case with Traveller suicide which peaked in 2005 with a rate of 5.44:10,000.

There is not always a one-to-one comparison between Travellers and the total Irish population. Travellers are considerably younger than the total population, with 53% aged under 20 and 4% over 60, compared to 28% aged under 20 and 15% over 60 for the national population. Marital status and accommodation type both have a specific cultural context and are not comparable with national figures. Bearing such differences in mind, some comparisons can be made between the profiles of Travellers who have died by suicide and national statistics.

Regarding gender, nationally male suicide is four times as common as female suicide, the male:female ratio being 4.2:1 while for Travellers male suicide is over nine times as common as female suicide, the male:female ratio being 9.6:1. Almost 34% of suicides in Ireland between 2000 and 2006 occurred among those aged under 30, for Travellers it was 65%. For the total population the highest incidence of suicide occurs among the 20-24 age group, and this accounts for 13% of all suicides, for Travellers it is the 25-29 age group, accounting for 26% of suicides. The second highest incidence category for Travellers is 15-19, which accounts for 20% of suicides, compared to 8% of suicides for the total population. For both Travellers and the total population the most frequently used method of death is hanging. 59% of all suicides, and 80% of Traveller suicides used this means of death. The typical profile of the young male who has died by hanging applies to the total population and Travellers alike. However, in the case of Travellers, a greater proportion fall into this category.

## 2 Who is at risk of suicide in the Traveller population?

To address this question, data was gathered on standard relevant census categories, pathological indicators and precipitating events, all associated with increased risk of suicide (Houses of the Oireachtas, 2006:11).

*(a) Standard demographic categories (age, sex, marital status, accommodation type, method of suicide).*

As stated above, most Travellers who died by suicide were men aged under 30, and as such, this group could be deemed as at risk of suicide. In addition the data suggests that being single, separated or widowed increases such

risk. Those of no fixed abode or roadside Travellers appear to be more vulnerable to suicide, while those demonstrating lower risk are those in group housing or in private housing be it owned or rented.

*(b) Pathological indicators (family history of suicide, history of suicide attempts, substance/alcohol abuse, diagnosed mental illness).*

Information was only available in 67 of the 74 cases, as these questions were added after 2004, and in seven cases the original respondent could not be contacted. In addition to this, some respondents were unable to answer these questions. Of concern is the high number (n=46) for which it was the individual's first attempt at suicide. While it is recognised that previous suicide attempts indicate that an individual may be at risk of completed suicide, in only eleven cases were previous suicide attempts reported. It suggests that for Travellers, suicide may be an impulsive act, which occurs before there is an awareness among family or friends that the individual has contemplated such an act.

A family history of suicide was identified in 27 cases. During the course of this research some families have lost two or three members to suicide.

Of those who died by suicide, 30% had been treated for a diagnosed psychiatric condition. What emerges from this research is that there is a general distrust of the psychiatric services among Travellers, and uptake of these services is low, even in cases where Travellers demonstrated several factors associated with increased risk of suicide.

In Chapter 2 of this study, it is suggested that while it appears to be generally believed that alcohol abuse is a major issue concerning Travellers, there is no evidence to support such a claim. However, regarding Travellers who have died by suicide, alcohol and/or substance abuse were reported in 46% of cases. Although one respondent's opinion of what constitutes such abuse may vary from another's, and the figure is open to question, the evidence suggests a very serious level of presence of alcohol and drug misuse in Traveller suicides.

It can be presumed that Travellers who have one or more of the aforementioned pathological indicators are at greater risk of suicide. However, it must also be noted that in eleven cases, none of the above indicators were present.

*(c) Precipitating events (bereavement, conflict, alcohol consumption immediately prior to suicide).*

In 77% of all cases, a precipitating event was reported, which the respondent felt was of major significance. In all but 15 of these cases, more than one significant event, and in 18 cases three or more precipitating events, were reported.

The most frequently reported precipitating event was alcohol consumption, and in each of those cases, at least one other precipitating event or pathological indicator was also reported. The second most reported event was bereavement. 27 Travellers died by suicide following the death or deaths of somebody close to them. In 11 instances those deaths were also suicides. This appears to be a time of great vulnerability for Travellers, especially if large quantities of alcohol are consumed to obliterate grief.

In 20 cases violence was cited as significant. Both the perpetrator and the victim are at risk in such cases. This was followed by marital conflict. Separation is infrequent among Travellers, and a cause of shame to those affected.

In 7 cases, suicide followed an alleged criminal act. While the gravity of these acts varied, the degree of seriousness being generally linked to the age of the perpetrator, in all cases it was the perceived shame that was considered to be the factor most relevant to the suicide.

The final event which was named more than once was serious illness, usually life-threatening, which was reported in six cases. In three of these cases it was a close family member whose life was at risk.

To summarise, it would appear from the findings that Travellers most at risk of suicide have demographic vulnerabilities (such as being male, aged under 30, single, separated or widowed, living on the roadside or of no fixed abode), specific susceptibilities (including alcohol and substance misuse, a family history of suicide, a psychiatric illness) who have then experienced a precipitating event, the most significant being bereavement, violence and shame.

### 3 How can the incidence and profiles be understood?

In the past Travellers had completely separate lives with the minimum of contact with the settled population. Today, young Travellers have a lot in common with their settled peers, and to a certain extent, there has been a loss of cultural traditions as they take on the values of mainstream society. However, public opinion of Travellers as inferior and as a threat has not changed, and Travellers face huge rejection from the settled population. Some attempt to conceal their Traveller identity. They are not fully accepted as part of settled society, and having lost many of their own cultural and social traditions they may no longer be fully accepted as Travellers. Having lost their sense of integration with their social group, the cultural-identity limbo renders them vulnerable to suicide.

Many Travellers, have found that it has become increasingly difficult to travel. It is not easy to find a place to camp, the economic reasons for travelling are not viable, and they have become accustomed to the comforts of permanent accommodation. Traditions such as horse breeding and dealing are also difficult to maintain and pass on to the next generation due to tighter restrictions and legislation on the keeping of horses. For those without work, who have lost the traditions of travelling and looking after horses, there is nothing to do. Particularly vulnerable are single young men, who may resort to alcohol or substance misuse, joy-riding, and other forms of anti-social behaviour in order to alleviate boredom. Aspects of culture which allowed for increased integration have been lost. The resulting situation is that individuals left with nothing to occupy them may opt to break from the regulating aspects of society. If life has no purpose, it can take little to persuade somebody to end it.

With recent changes in society, Travellers have had to learn to cope with increased hostility, difficulty with identity, loss of culture and traditions and lack of purpose in life. All of these have also been cited as contributory factors to the high rates of suicide among the AI/AN, Inuit and Australian Aboriginal peoples. Smyth et al. (2003:35) warn that the dismantling of culture can result in a personally meaningless world, where traditional safeguards no longer protect against suicide. Given the existing vulnerabilities of Travellers today, factors such as alcohol or substance abuse, economic insecurity, violence, depression assume an additional risk level. It may therefore not be so surprising that an immediate crisis, such as death or marital conflict, can act as a trigger factor for suicide.

## RECOMMENDATIONS

### 1 Future research

At the moment the CSO does not classify deaths by suicide according to ethnicity. It would be useful to do so, not just for Travellers but for every ethnic minority group in the state, and would facilitate future research projects such as this. Moreover, further research could be carried out comparing suicide among Travellers with suicide among other ethnic groups within Irish society.

Anecdotal information from respondents would suggest that deliberate self harm is increasing among Travellers. Deliberate self harm and attempted suicide are both considered as indicators of increased suicide risk. In terms of suicide prevention, this is an area which warrants further research.

There is a need for research, which compares Travellers with other groups in similar socio-economic situations in order to get further insight into the factors at work. It would be appropriate to compare the incidence of suicide among Travellers with other disadvantaged sectors of Irish society.

What would be of great benefit would be a comparative study of suicide among the peoples of nomadic origin within the European Union. In this way the policies of the various member states for the integration of these peoples could be examined to identify whether there is a correlation between provisions for these groups and suicide rates.

Research is needed as to why Travellers living on halting sites are at greater risk of suicide than Travellers in social housing, and whether there is a correlation between suicide incidence and the quality of the halting site facilities or the compatibility of families living there.

According to Douglas (1967:284) a descriptive analysis is required in order to understand the meaning suicide holds for individual. In this research project, questions were not asked regarding parents or family background of those who had died by suicide. A huge amount of detail can be gathered, from which much insight can be gained, by focussing on individual case studies. Apart from information regarding upbringing, this would include details of significant life-events and the individual's satisfaction or dissatisfaction with various aspects of life. It was beyond the scope of this project. Nonetheless, some of the families of the subjects of this research

have indicated that they would be eager to participate in future research into suicide among Travellers. I would recommend that such a project be carried out in partnership with Traveller organisations, ideally with Travellers collecting data.

## 2 An approach to suicide prevention

In this section I would like to focus on how to build upon those factors which will lead to increased resilience. If those more vulnerable to suicide are those who lack self-esteem and experience cultural anomie, and those who have lost hope in a better future, it must follow that those most likely to be survivors are those who are happy with or proud of their Traveller identity, whether housed, in sites or on the roadside, and who feel that there can be a better future for their children whether they choose to remain separate or to integrate.

De Vos (1995) refers to situations whereby an ethnic minority group may find that forms of integration are withheld on the basis of ethnicity, stating that the group is forced to accept one of three alternatives: it can accept inferior status as part of a collective self identity, or it can define the situation as one of direct political oppression, or it can define itself symbolically creating positive view of its heritage, thereby establishing sense of collective dignity. While peoples with nomadic traditions are united by a common feeling of oppression and injustice (Belton 2005:19), the challenge facing Travellers and service providers is to encourage a sense of pride. In order to foster this, one needs to have a purpose in life, something that makes the day worth living. A purpose can be found through sport or work, or through providing for or parenting one's children. As service providers, access to further education and employment needs to be encouraged and facilitated. Role models are required to give other Travellers something that they can realistically aim towards. Already there are of Traveller spokes persons who have attained national recognition, but there is also a need for Travellers in the medical, education and legal spheres. Liégeois has pointed out that increased literacy levels among Travellers will change their relation with their surroundings. Through Traveller organisations they are consolidating their position and asserting their wishes, while participation in political activity is becoming more and more significant (Liégeois, 1994:247). Support and resources for initiatives in the areas of education, employment and sport are required to build up resilience, and provide Travellers with a purpose in life.

The importance of the family must not be underestimated. This is particularly so when Travellers are allocated social housing. Social workers report that it is very difficult for a Traveller family to cope in an estate or an area if they do not have family members close by. Accommodation policies must be mindful of the importance of family ties to Travellers, and how isolation from family networks can be detrimental to a Traveller's mental well-being. Similarly, initiatives in the area of main-stream employment are more likely to succeed if they involve a number of Travellers rather than one in isolation.

The Australian national framework for suicide prevention (Australian Department of Health and Ageing, 2000), recommends assisting communities develop their own solutions for preventing suicide, building on the strengths that already exist in the community. According to Tatz (1999:93) Aboriginal youth has neither confidence nor trust in helping agencies. He goes on to state that only the Aboriginal community can address and redress some of the causal factors of suicide. In terms of tackling the causes of suicide in Traveller society, there are certain recognisable risks. One is following bereavement especially where there is binge drinking. Another is where there is violence, particularly of a domestic nature. Service providers may advise of the risks of excessive drinking. They may encourage anger management, and try to advise a woman how to stay safe in the home. However, ultimately it is only Travellers themselves who can deal with these issues. The Irish strategy for suicide prevention, *Reach Out*, recognises that when a particular community has been affected by suicide, the immediate supportive responses are often strongest from within the community itself (HSE, 2005:27). Following from the recommendations of Tatz regarding Aboriginal society, (Tatz, 1999:93), it is only Travellers who can handle the alcohol issues, the parenting problems: only they who can find mentors for their young within their own society. Kenny (2003:47) recommends that the extended family and general Traveller community should be engaged in delivering health services. This is especially so regarding the delivery of suicide prevention strategies.

*Reach Out* also recommends developing partnerships between community organisations and the statutory sector to support and strengthen community based suicide prevention (HSE, 2005:27). As has been seen from the data, many Travellers have died by suicide on their first attempt, where there has been no family history or warning signs. There is no point in waiting for people to say or to indicate that they need help. There is a need

to inform Travellers, where possible through the network of Traveller support groups and the Primary Health Care programmes, of the incidence of suicide and the areas of risk. Traveller participation is essential to the delivery of a culturally appropriate response or action plan (Pavee Point, 2006b). Already since the establishment of the Traveller Suicide Working Group in 2004, there has been a submission to the National Strategy for Suicide Prevention, some Primary Health Care groups have begun to deliver the ASIST programme (which trains people in emergency suicide intervention techniques) to Travellers, and a suicide officer specifically for Travellers has recently been appointed.

## FINAL COMMENT

In 1897, Émile Durkheim put forward the theory that societies with a relatively low level of social integration, and societies in a state of anomie, (where traditional rules guiding society are absent or weakened), are most vulnerable to suicide. This theory is still valid in understanding how the rate of suicide is increasing among groups such as Travellers who have experienced profound changes in their culture and lifestyle in recent years. While Durkheim identified rapid social change as a contributory factor towards an increase in suicide rates, he did not suggest returning to the past in an attempt to artificially restore social forms which he considered outworn: he believed that the only way to check this current of collective sadness is to seek in the past germs of new life which it contained and hasten their development (Durkheim, 1952:391). There is a need to resource initiatives that support present day Travellers integrate themselves within their own history. This may involve recording the past through music, literature, or heritage centres. These will be a tangible evidence of their history of survival, resilience and adaptation to present times. The present generation can continue their history into the future. Traveller society has experienced many changes in recent years. However there remain core values and traditions, such as strong family and community ties, and religious beliefs, and their high tolerance for troubled members, which can be developed to protect high-risk individuals against suicide. Given the appropriate information and training, and above all the necessary supports, there exist within the Traveller community the necessary strengths to develop their resilience to suicide.

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## APPENDIX: DATA TABLES

**Table 1.** Suicide rates per 10,000 persons, National population, 2000-2006

Year	National population	No. suicides	Incidence per 10,000 persons
2000	3789500	486	1.28
2001	3847200	519	1.35
2002	3917200	478	1.22
2003	3978900	497	1.25
2004	4043800	493	1.22
2005	4130700	431	1.04
2006	4239800	409	0.96

Source: CSO, *Vital Statistics (for listed years)*.

**Table 1a.** Suicide rates per 10,000 persons, Traveller population, 2000-2006

Year	No. families	Average family size	Total persons*	No. suicides	Incidence per 10,000 persons
2000	4898	4.72	23119	9	3.89
2001	5150	4.63	23845	7	2.94
2002	6289	4.54	28552	5	1.75
2003	6799	4.46	30324	9	2.97
2004	6991	4.38	30621	13	4.25
2005	7266	4.3	31244	17	5.44
2006	7691	4.22	32456	14	4.31

Sources: Annual DOE counts. Primary data.

\*No. persons = No. families x average family size.

**Table 1b.** Gender profiles of incidence, National and Traveller populations, 2000-2006

Year	National		Travellers	
	Male	Female	Male	Female
2000	395	91	8	1
2001	429	90	7	0
2002	387	91	5	0
2003	386	111	9	0
2004	406	87	12	1
2005	353	78	15	2
2006	318	91	11	3
Total	2356	548	67	7

Source: National data: CSO annual *Vital Statistics*; Travellers: Primary data.

**Table 2.** Percentage distribution of total national population and of Traveller population by age band, 2006

Year	National (n=4239848)	Traveller (n=22369*)
0-4 years	7.21	14.74
5-9 years	6.89	13.50
10-14 years	6.53	13.21
15-19 years	6.88	11.31
20-24 years	7.94	9.21
25-29 years	8.71	7.77
30-34 years	8.22	6.68
35-39 years	7.60	5.98
40-44 years	7.12	4.86
45-49 years	6.48	3.62
50-54 years	5.83	2.90
55-59 years	5.30	2.13
60-64 years	4.26	1.45
65-69 years	3.36	1.08
70-74 years	2.80	0.73
75-79 years	2.19	0.48
80-84 years	1.54	0.23
85 years and over	1.14	0.11
<i>Total</i>	100	100

Source: CSO (2006) *Principal Demographic Results, Table 5; Vol. 5 Table 28.*

\*The total as per the DOE Count for 2006 is 32456.

**Table 3.** Percentage distribution of suicide incidence, 2000-06, by age band, National and Traveller populations

Age bands	Incidence		% distribution by age bands	
	National	Travellers	National	Travellers
10-14 years	16	1	0.48	1.35
15-19 years	256	15	7.73	20.27
20-24 years	446	13	13.46	17.57
25-29 years	408	19	12.32	25.68
30-34 years	342	9	10.32	12.16
35-39 years	313	8	9.45	10.81
40-44 years	329	3	9.93	4.05
45-49 years	287	1	8.66	1.35
50-54 years	282	2	8.51	2.70
55-59 years	207	0	6.25	0.00
60-64 years	171	2	5.16	2.70
65 years and over	256	1	7.73	1.35
<i>Total</i>	3313	74	100	100

Source: National: CSO furnished data; Travellers: Primary data.

**Table 4.** Suicide rates in 2006, per 10,000 of all persons and per 10,000 persons aged 10 years and over: national and Traveller populations

Age bands	Population		Suicide incidence		Rate per 10,000	
	National	Travellers	National	Travellers	National	Travellers
All ages	4239848	32456	409	14	0.96	4.31
Aged 10yrs & over	3649271	23290	409	14	1.12	6.01

Source: National data: CSO annual Vital Statistics; Travellers: Primary data.

**Table 5.** Profiles of suicide methods, National and Traveller populations, 2000-06

Method	Incidence		Percentage profile	
	National	Travellers	National	Travellers
Hanging	1874	59	56.57	79.73
Poisoning	464	7	14.01	9.46
Drowning	570	4	17.20	5.41
Other	405	4	12.22	5.41
Total	3313	74	100.00	100.00

Source: National data: CSO annual Vital Statistics; Travellers: Primary data.

**Table 6.** Accommodation profiles: total Traveller population, and Travellers who died by suicide, 2000-06

Accommodation	Family population by accommodation type		Suicide incidence by accommodation type	
	No. families	%	No. persons	%
Houses	4388	68.13	44	59.46
Halting Sites	1244	19.32	17	22.97
Unauthorised Sites/NFA	808	12.54	13	17.57
Total	6441	99.99	74	100.00

Source: DOE annual counts. Primary data.

**Table 7.** Detailed accommodation profiles: total Traveller population in November 2006, and Travellers who died by suicide, 2000-06

Accommodation	Traveller population, November 2006		Travellers who died by suicide, 2000-2006	
	No. families	%	No. persons	%
Social housing	3202	41.63	29	39.19
Official halting sites	1131	14.71	17	22.97
Unauthorised sites/NFA	696	9.05	13	17.57
Owner occupied housing	1004	13.05	6	8.11
Private Rented	954	12.40	7	9.46
Group Housing	704	9.15	2	2.70
<i>Total</i>	7691	100.00	74	100.00

Sources: DOE 2006 count. Primary data.

**Table 8.** Ongoing risk factor profiles of 67 Travellers who died by suicide, 2000-2006

Factors	No	Yes			Don't know
Previous attempts	46	11			10
Family history	35	27			5
Psychiatric	34	22			11
Alcohol/substance misuse		Alc.	Sub.	Sub. & alc.	
	23	13	7	14	10

Source: Primary data.

**Table 9.** Significant events occurring in 57 cases immediately prior to death

Risk factors	No. persons experiencing this factor
Drinking	33
Bereavement	27
Violence	20
Marital problems	18
Trouble with law	7
Serious illness	6
Other	1

Source: Primary data.

**Table 10.** Distribution of ongoing and immediate risk factors: loadings per person (n=74), from none identified, to six or more factors identified

Number of risk factors	none	one	two	three	four	five	six or more
Number of persons	5	10	13	18	13	7	8

Source: Primary data.

The author has kept an annual account of suicide among Travellers in Ireland from 2000 to 2006, an issue which until then had been largely unrecognised. This is the first research to be carried out with the purpose of documenting the incidence of suicide among Travellers.

Issues concerning the Irish Traveller community are examined, such as health, accommodation, education and access to employment. Theories regarding the causes of suicide are also examined in the light of cultural issues relevant to the Traveller community.

Certain behavioural patterns of those who have completed suicide can be identified. These account for only a fraction of total deaths and indeed they are not causative factors. However the information may assist service providers and Travellers alike in recognising those at risk in an already vulnerable group.



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