



An overview of the nature and extent
of illicit drug use amongst the Traveller
community: an exploratory study

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An overview of the nature and extent of illicit drug use amongst the Traveller community:

an exploratory study

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Centre for Ethnicity and Health
Faculty of Health
University of Central Lancashire

2006

The National Advisory Committee on Drugs (NACD) was established in July 2000 to advise the Government in relation to the prevalence, prevention, treatment, rehabilitation, and consequences of problem drug use in Ireland, based on the analysis of research findings and information. The NACD has overseen the delivery of a three-year work programme on the extent, nature, causes and effects of drug use in Ireland and comprises representatives nominated from relevant agencies and sectors, both statutory and non-statutory, and reports to the Minister of State responsible for the National Drugs Strategy.

<http://www.nacd.ie>

Professor Jane Fountain is lead on research at the **Centre for Ethnicity and Health** in the Faculty of Health, University of Central Lancashire, Preston, UK. Since its inception in the late 1990s, the Centre for Ethnicity and Health, headed by Professor Lord Kamlesh Patel OBE, has overseen the development of a series of flagship projects and partnerships pursuing high- quality, innovative, community-based research and development initiatives focusing particularly upon the health and social care of Black and minority ethnic communities.

To compliment the Centre's research portfolio, teaching and learning activities are in continual development, with the aim of contributing to knowledge, expertise, and good practice in the fields of ethnicity and health. A wide-ranging and dynamic educational portfolio has been developed, including suites of courses ranging from one-day workshops through to Master's level study on equality, diversity and community engagement.

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Foreword – Minister

I welcome this report from the National Advisory Committee on Drugs (NACD). As Minister of State with responsibility for the National Drugs Strategy, I am conscious that drug use amongst the Traveller community has to an extent been a hidden phenomenon and that people who are drug dependent in this community can be particularly vulnerable.

In commissioning the report the NACD had as its overall aim to assess the nature, extent and context of drug use amongst the Traveller community in this State. The report is timely and provides us with useful information on Travellers' drug service needs and, indeed, any barriers that they face in accessing these services. I was pleased to note that Travellers were involved from the beginning in the research that fed into this report as there is real value in involving Travellers in planning appropriate responses to their own needs.

Finally, I would like to express my thanks to all who were involved in the compilation of the report, particularly Dr Jane Fountain, the members of the Research Advisory Group of the NACD as well as the Chairperson, Dr Des Corrigan, and staff of the NACD.

Noel Ahern TD

Minister of State with responsibility for the National Drugs Strategy

Foreword – Chairperson NACD

The NACD is pleased to present to this report as part fulfilment of its responsibilities under Action 98 of the National Drugs Strategy where the NACD is required to investigate the nature and extent of drug use amongst vulnerable groups.

This important study aimed to provide an overview of the nature and extent of illicit drug use among the Traveller Community. Overall, it is clear from the research that Travellers are indeed a vulnerable group for whom the considerable impact of drug use and its consequent problems is now emerging. Traveller groups and drug services reported increasing drug use, problematic use, anti-social behaviour, frustration by Travellers trying to access services and frustration by drug services trying to retain Traveller clients in treatment. Traveller groups have been trying to respond to these issues in recent years with limited resources.

The complexity of the drug issue in Ireland has been set out in many of our previous reports and other publications. The cross cutting nature of the issue requires that the wide range of agencies already engaged in addressing the day to day issues affecting Travellers such as accommodation, health, education, employment and physical safety take account of the added difficulty of drug use in this context and that they provide for a more holistic approach to tackling the drugs issues, in this particular group.

The NACD has made five core recommendations to Government which address the need for drugs prevention and education which is culturally specific to Travellers; the provision of diversity training for all services; collaborative engagement with Travellers on addressing the issue of drugs; improved ethnic monitoring in surveillance systems and research and also the implementation of equality proofing of drugs policy and planning.

It is the desire of the NACD that this research will lead to improved provision of and access to drug services for Travellers and increased involvement of Traveller families and communities in supporting the treatment and recovery of problem drug takers within the Traveller Community.

Finally, I would like to express my sincere thanks to all those involved in the research both in the planning and monitoring. A special thank you to all those Travellers, young and old, drug user and non drug user who gave of their time freely to help inform Government through the NACD of the issues affecting their lives.

Dr Des Corrigan
Chairperson

Acknowledgements

The 137 Travellers and 34 agency workers who participated in the research must remain anonymous, but are gratefully thanked for giving up their time to discuss their experiences and perceptions of drug use amongst the Traveller community. Without their assistance, this project would not have been possible.

The project's Research Advisory Group are also thanked for their valuable advice and assistance throughout the study:

Helen Campbell	Exchange House
Ann Costello	Clondalkin Traveller Development Group and later of the Galway Traveller Movement
Catherine Joyce	Irish Traveller Movement
Deirdre McCarthy	Traveller Specific Drugs Initiative, Pavee Point Travellers Centre and later of Community Technical Aid
Cathryn Mannion	National Traveller Women's Forum
Rosaleen McDonagh	Traveller Health Advisory Committee
Father Stephen Monaghan	Parish of the Travelling People
Patrick Nevin	Irish Traveller Movement
Aileen O'Gorman	National Advisory Committee on Drugs and later of University College Dublin
Mary O'Reilly	Department of Health and Children
Sinéad Smith	Traveller Specific Drugs Initiative, Pavee Point Travellers Centre
Mairéad Lyons	National Advisory Committee on Drugs

Sinéad Smith is especially thanked for her extensive work in approaching Traveller organisations to participate in this project, the provision of relevant documents, and her responses to the author's many questions. Mairéad Lyons and Dr Aileen O'Gorman of the National Advisory Committee on Drugs (NACD) also merit special thanks for their essential guidance and support throughout the project, and for efficiently dealing with the author's requests for information during the compilation of this report.

Thanks are due to Vision 21, a social research and community consultation company, for conducting interviews and focus groups with the 171 Travellers and agency workers who discussed their experiences and perceptions to provide data for this study, and for preparing an initial version of this report.

Colm Power of the Centre for Ethnicity and Health, University of Central Lancashire, and Una Molyneux of the NACD assisted with the collection of some of the background information for this report, and Ciara Brennan transcribed tapes. Their help is much appreciated.

Last, but no means least, staff at sixteen organisations (including two prisons) throughout Ireland assisted with this project by organising focus groups with Travellers and by participating in interviews as agency workers. In order to avoid identification of any study participant or locality, they must remain anonymous, but they are gratefully thanked for their indispensable contributions.

Terminology

'Settled'

Some Travellers do not live a nomadic lifestyle and are referred to by some as 'settled Travellers,' but in this report, the term 'settled' is used only to describe the non-Traveller population.

Drug use and problematic drug use

Throughout this report, the author has been sensitive to the difference between drug use and problematic drug use. As noted in the National Drugs Strategy (Department of Tourism, Sport and Recreation, 2001), drug use refers to 'any aspect of the drug taking process.' The author has used the term 'problematic drug use' to describe

the illegal or illicit drug taking...which leads a person to experience social, psychological, physical or legal problems related to intoxication or regular excessive consumption and/or dependence... drug taking which causes harm to the individual, their significant others [such as their family or partner] or the wider community [National Treatment Agency for Substance Misuse (NTA), 2003].

Ireland's National Drugs Strategy uses a similar definition of problematic drug use:

drug use which causes 'social, psychological, physical or legal difficulties as a result of an excessive compulsion to continue taking drugs' (Department of Tourism, Sport and Recreation, 2001, quoting the Health Research Board).

'Agency worker'

In order to preserve their anonymity, interviewees from Traveller organisations, the church, primary health care, youth work, social work, drug services, and local authority and health boards are all referred to as 'agency workers' in this report.

Black and minority ethnic

The Centre for Ethnicity and Health is very conscious that various terms are used to refer to the many diverse communities in Ireland and elsewhere. The Centre prefers the term Black and minority ethnic communities. This reflects that the Centre's concern is not only with those for whom 'Black' is a political term, denoting those who identify around a basis of skin colour distinction or who may face discrimination because of this or their culture. 'Black and minority ethnic' also acknowledges the diversity that exists within these communities, and includes a wider range of those who may not consider their identity to be Black, but who nevertheless constitute a distinct ethnic group.

Executive summary

This report presents the findings of an exploratory study aimed at assessing the nature and extent of drug use amongst the Traveller community in Ireland. The results are intended to inform the policy debate by providing data on drug use, problematic drug use, patterns of drug use, drug-related risk behaviours, the impact of drug use on the Traveller community, and gaps in service provision, thus highlighting the needs of Travellers for drug service planners, commissioners, and providers.

The overarching message of this report is that the social exclusion of Travellers puts them at risk of problematic drug use, and there are indications that this is already occurring in this community. However, overall, Travellers lack the information to tackle drug use and problematic drug use, and there is inadequate consideration by drug policy and drug services of Travellers' drug-related needs. The report's recommendations, which are firmly based on the findings presented in this report, focus on how these issues can be addressed.

It is important to emphasise that several sections of this report consist of data on the perceptions of the study participants concerning drug use and the related issues. Some had little direct knowledge of these issues, and individual comments should not be taken out of this context and treated as 'facts'.

Section 1

Background and research methods

The *National Drugs Strategy 2001-2008* identifies four socially excluded groups in Ireland – Travellers, prostitutes, homeless people, and early school-leavers – with which research on drug use should be undertaken, and requests that the National Advisory Committee on Drugs (NACD) accommodate studies of these in its research programme. As part of their response, the NACD commissioned this study.

The project was devised, and the researchers advised throughout, by a Research Advisory Group comprising mainly of members of Traveller organisations and members of agencies working with Travellers. **The aims of the study** were to:

- provide an overview of the nature and extent of illicit drug use amongst the Traveller community;
- identify patterns of problematic drug use and drug-related risk behaviours;
- and describe what interventions are needed to prevent and deal with the harmful health consequences of illicit drug use.

Data collection methods consisted of a comprehensive literature search and review, and semi-structured interviews and focus groups with 137 Travellers and 34 agency workers:

- one-to-one interviews were conducted with 26 agency workers and three group interviews with a further eight. The 34 agency workers comprised representatives of Traveller organisations, the church, primary health care workers, youth workers, social workers, drug service workers, and local authority and health board officials;
- twenty focus groups were undertaken with a total of 122 members of the Traveller community. Travellers were recruited to participate in the study by Traveller organisations, and most of the focus groups were held with members of established Traveller groups, although one group consisted of participants recruited specifically for the research, two of Travellers in prison, and one

of Traveller community leaders. Twelve of the focus groups were conducted in the Dublin area and eight throughout the rest of the country;

- one-to-one interviews were conducted with 15 drug using Travellers (14 of whom were current or ex illicit drug users and one of whom used alcohol and sedatives), four of whom were in prison. This element of the study was designed to illustrate the data from the other elements by providing detail on the context of drug use.

The data were **analysed thematically**, according to the themes that most consistently arose and that are pertinent to the project's aims. Notes and tape recordings taken during interviews and focus groups were fully transcribed and all the comments made on a particular issue were collated. The use of a thematic analysis makes it possible not only to report on the issues surrounding drug use that arise for Travellers and agency workers, but also to identify areas of consensus and divergence on specific issues. The analysis is therefore firmly grounded in the data received from the study participants.

Section 2

The Traveller context

It is estimated that there are around 30,000 Travellers living in Ireland (at least 0.6% of the total population), and a further 15,000 in the UK, many of whom travel between there and Ireland. Although Travellers have a long shared history and value system, and their own language, customs and traditions, the distinctions between Traveller culture and that of the settled community have only recently been acknowledged as cultural differences, and many institutional procedures and practices continue to reflect a lack of acceptance of Travellers' culture and identity. In addition, the media has been accused of creating and promoting negative stereotypes of Travellers.

Despite a raft of policies and legislation aimed at improving many aspects of their lives, Travellers in Ireland continue to experience racism and discrimination at institutional and individual levels. Institutional racism is *'The collective failure of an organisation to provide an appropriate and professional service to people because of their colour, culture, or ethnic origin. It can be seen or detected in processes, attitudes and behaviour which amount to discrimination through unwitting prejudice, ignorance, thoughtlessness and racist stereotyping which disadvantage minority ethnic people'* (Macpherson, 1999 p.9).

There have been many calls for policy-makers and service providers to acknowledge Traveller culture when drawing up legislation and commissioning, planning and providing services. There have also been some creditable responses, aiming to ensure that Travellers are not unfairly affected by government decision-making, and that they have access to services that are sensitive to their particular needs. However, this so-called 'Traveller-proofing' is not yet universally applied within an equality framework.

The result is that Travellers are socially excluded: they cannot participate fully in economic, social, and civil life, and suffer from linked problems such as high unemployment, poor education, low income, poor accommodation and bad health. The link between Travellers, social exclusion, and problematic drug use is clearly recognised by the *National Drugs Strategy 2001-2008* by the inclusion of Travellers in the request that research studies are conducted on drug use amongst socially excluded groups in Ireland.

Section 3

Perceptions of the nature and extent of drug use amongst Travellers

The national drug prevalence survey on drug use in Ireland, conducted in 2002-2003, did not record ethnicity, and cannot therefore provide statistical data on the prevalence of drug use amongst Travellers. However, the results of recent research conducted prior to the current study concur that the prevalence of drug use and problematic drug use, whilst not at the levels of the rest of the population, both occurs and is increasing amongst Travellers.

Despite the accumulating evidence, illicit drug use amongst this population has been described as a taboo subject for the Traveller community, but the interviews and focus groups with Travellers conducted for this study did not reflect this.

Although the perceptions of this study's participants of drug use amongst Travellers are broadly in line with the findings from the national drug prevalence survey on drug use amongst the whole population of Ireland, some participants had little direct knowledge of this issue and most were unable to distinguish between drug use and problematic drug use.

The data collected for this study reveal that:

- the substances (illicit and licit) thought by participants in this study to be most widely used by Travellers – **cannabis** and **sedatives, tranquillisers, and antidepressants** – are also those reported to be most widely used by the general population and by previous studies of drug use amongst Travellers;
- the participants thought that **cocaine powder** and **ecstasy** were the next most-used drugs, as reported by the national drug prevalence survey. Studies of Travellers in the UK have also reported the use of these drugs. The national drug prevalence survey found equal prevalence of these drugs, however, whereas the present study suggested that there was more use of cocaine powder than ecstasy amongst Travellers;
- the national survey reported that **amphetamines, magic mushrooms** and **poppers** (amyl or butyl nitrite) were the next most prevalent drugs used by the general population, and amphetamines have been reported to be used by Travellers in the UK. There were few reports of the use of amphetamines and magic mushrooms amongst Travellers from participants in the current study, and the use of poppers was reported by only two of the drug-using Travellers and not by any other participant;
- amongst the general population, the substances least used are **heroin, crack cocaine, LSD** and **solvents**, and the data from the current study show that this is also the case amongst Travellers. Previous studies have reported heroin and crack cocaine use amongst Travellers in the UK and also that heroin use is increasing amongst Travellers in Ireland. The participants in the current study reported heroin use amongst Travellers more often than the other three substances;
- although previous studies have reported an increasing number of female Travellers using illicit drugs and alcohol, the perception of the participants in the current study on the **gender** of substance users from the Traveller community is that many more males than females use these substances. The national drug prevalence survey reports that, amongst the general population, over twice as many males as females had used an illicit drug in the last year, although the

difference between the proportion for alcohol use was far less (86% male and 81.6% female). The participants in this study also perceived that sedatives, tranquillisers, and antidepressants were used mainly by female Travellers, whilst the national drug prevalence survey reports the ratio as 1 male:1.7 female;

- a wide **age** range of Travellers was perceived to be using illicit drugs by the participants in this study, although the age range from adolescence to the early thirties was most often mentioned. This echoes the findings from the national drug prevalence survey;
- the national drug prevalence survey did not report on **injecting drug use**, but previous surveys and the current study suggest that prevalence of this mode of administration is low amongst Travellers;
- there is a perceived widespread use of a range of drugs by **prisoners**, including amongst Travellers.

Drugs were perceived to be widely available to Travellers, and around half of the agency workers and Travellers who participated in this study thought that drugs are sold by some Travellers. However, neither the agency workers nor the Traveller community members had detailed knowledge about the various levels of distribution (ranging from wholesale importing to drug users selling a small amount to finance their own drug use) and drug dealers were frequently portrayed in a stereotypical manner. For example, some Travellers insisted that dealers gave or sold drugs to children in order to get them 'hooked,' and some Travellers and agency workers perceived that dealers made vast profits.

Section 4

Risk and protective factors for problematic drug use amongst Travellers

There are no statistical data on problematic drug use amongst Travellers. The National Drug Treatment Reporting System, which could be a source of information on this issue, does not record ethnicity. The result is, as with drug use, the nature and extent of problematic drug use amongst Travellers is reliant on the perceptions of Travellers and those working with them. That said, perceptions of problematic drug use are likely to produce less reliable data than those of drug use because, unless the perceivers are working in the drugs field, their definitions of what constitutes 'problematic drug use' are likely to be inconsistent. Therefore, this study examined problematic drug use amongst Travellers from the perspective of risk and protective factors.

The risk factors for the development of problematic drug use, particularly amongst young people, are well-documented, and can be categorised as interrelated problems in each of nine areas: education, health, employment, accommodation, previous and current drug use, criminal justice, family, social networks, and the environment (in terms of social deprivation, community disorganisation, and neighbourhood disorganisation). The evidence base on factors that protect against problematic drug use is small compared to that on risk factors, however.

The evidence collected for this study, summarised below, shows that, because of the inextricable link between disadvantages in the nine areas that characterise social exclusion and the risk factors for problematic drug use, the position of many Travellers – especially young people – is that their interrelated social and economic circumstances mean that they are at risk of problematic drug use.

Education

Not attending school, and not achieving whilst there, are risk factors for problematic drug use. Of those who have ceased education, over three times the proportion of Travellers compared to members of the settled population have received either no formal education, or have at best remained in the system up to primary level.

Health

The risk factors for problematic drug use related to health include mental ill health and living with parents who have mental health problems. Despite a lack of systematic data collection on the health of Travellers, particularly their mental health, the information that is available reveals that they are particularly disadvantaged in terms of health status compared to the rest of the population.

Employment

Unemployment is a risk factor for problematic drug use. Social and economic changes and recent legislation have adversely impacted upon Travellers' traditional means of earning a living, and in the 2002 census, almost three-quarters of Traveller males and two-thirds of females reported that they were unemployed.

Accommodation

The risk factors for problematic drug use related to accommodation are homelessness, running away from home, and being looked after by a local authority or foster parents. Data on homelessness in Ireland do not include an ethnic identifier, but several groups of Travellers are vulnerable to homelessness, including those whose caravans are confiscated because they are living on unauthorised sites. The combination of factors that put stress on the traditional constraints of the Traveller family has meant that some young people may run away from home, and Traveller children are around six times more likely to be in the care of local authorities or foster parents than the rest of the population.

Previous and current drug use

Drug use amongst Travellers occurs and is increasing. An early onset of drug use is a risk factor for problematic drug use: the youthful demographic of Travellers, and their vulnerability to the other risk factors related to social exclusion gives cause for concern that drug use amongst them may begin at an early age.

Involvement in the criminal justice system

The risk factor for problematic drug use related to crime is offending at a young age and association with delinquent peers. Although there are no statistical data on crimes amongst young Travellers, it is known that some young Travellers are using drugs, and if this occurs within a deviant peer group, then they are at risk of problematic drug use.

Family

The risk factors for problematic drug use related to the family are centred around drug use by other family members and family disruption, breakdown and conflict. Family influence is a

significant element of Traveller culture and this influence and 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. Equally, the closeness of the extended family can act as a protective factor if drugs are not being used within it. However, there are some indications that the Traveller family may be becoming increasingly vulnerable to disruption, breakdown and conflict, and that the influence of these protective factors may be being eroded.

Social networks

The risk factor for problematic drug use related to social networks is problematic drug use by peers and the protective factor is pro-social (non-deviant) peers. The lack of opportunity for some Travellers to extend their social networks beyond other Travellers functions as a protective factor only if drugs are not being used within their Traveller-only social network. Similarly, 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.

Environment

The above indicators of social exclusion contribute to the phenomena of social deprivation, community disorganisation, and neighbourhood disorganisation that are risk factors for problematic drug use. The risk is heightened if Traveller accommodation is located in disadvantaged areas where there are already drug problems. The evidence clearly shows that many Travellers experience all these disadvantages and that few of the factors that may protect them against problematic drug use are operating.

Section 5

The perceived impact of drug use on the Traveller community

The definition of problematic drug use used in this study includes the harm caused to the individual, their significant others (such as their family or partner), and the wider community. Major issues identified by the participants in this study were: the impact on the health of drug users, which, as Travellers is already poorer than that of the general population; and the stigmatisation of drug use by the Traveller community leading to families hiding the drug use of a member and the community rejecting drug users.

The agency workers and Traveller community members identified the impacts on the **individual** drug-using Traveller as drug use leading to:

- poor health, including HIV and hepatitis C, mental ill health (including suicide), and overdose and possible death;
- criminal activity to fund drug use, including violence and stealing from their families and other Travellers;
- a lack of motivation to do anything other than use drugs;
- and exclusion from the family and community.

In addition, the **drug-related risk behaviours** identified by the participants in this study were injecting (although this was not thought to be common); polydrug use; and the use of sedatives, tranquilisers, and antidepressants by those for whom they were not prescribed.

The issues concerning the impact of drug use on drug users' **significant others** as perceived by the agency workers and Traveller community members were stress on family relationships; concern about the drug user's influence on other family members; and the negative effect on the drug user's family's finances.

In terms of the impact of drug use on the **Traveller community**, participants in this study reported the increased stigmatisation of Travellers, the normalisation of drug use, an increase in drug-related crime, and the challenge to Traveller culture.

Of the 14 illicit drug users and ex-drug users from the Traveller community, those whose main drug was cannabis did not consider its use to be problematic, but those whose main drug was heroin or cocaine gave accounts that illustrate many of the issues raised by the other participants in the study when discussing the impact of drug use.

Section 6

Travellers' methods of tackling drug use

Many of the Travellers who participated in this study were extremely concerned about drug use in their community, but overall, their lack of knowledge about drugs and drug services hampered their attempts to address it.

The main response by Travellers to tackling drug use in their community identified by this study was parents **talking to young people** in their family, stressing that they must not use drugs, and punishing them if they did. Other strategies, although less often reported, were:

- attempting a '**home detox**.' This was reported by only two Travellers, and involved restraining a drug user by tying them down or locking them in a room so that they could not obtain drugs;
- **self-regulating drug use**, mainly by avoiding drug-using friends, but also by drug users taking the pledge by promising a priest that they would remain abstinent;
- **seeking help** from drug services, although access to these was rarely reported to have been successful.

Although a range of responses was reported within the above categories, it was clear from the discussions with Travellers that many saw the responsibility for tackling the issue of drug use as the family's.

There was no consensus amongst Travellers over how members of their community tackle **drug dealing** within it. Whilst some thought that Travellers would confront dealers, others disagreed. However, a few Travellers and agency workers agreed that the gardaí were not taking action against drug dealing on Traveller sites. Perceived reasons for this included that the dealers have information about other crimes so the gardaí ignore their dealing in return for it, and that some Traveller sites were '*no-go areas*' for the gardaí because they were afraid and lacked sufficient staff to cope with the situation.

Section 7

Travellers' drug service needs

Across the European Union as a whole, drug policy and practice reflect the needs of the majority population, and this report presents evidence that this also reflects the situation of Travellers in Ireland, where strategic consideration of their drug-related needs is relatively recent.

Although there are some examples of effective practice, many gaps remain and consideration of Travellers' drug service needs at national, regional, and local levels is patchy and ad hoc. Despite the establishment of local and regional drug task forces and the related Young People's Facilities and Services Fund, some task forces have progressed the issue of addressing Travellers' needs and Traveller representation more quickly and more thoroughly than others. In addition, although Ireland's current *National Drugs Strategy* notes that Travellers are one of the risk groups for problematic drug use and a request for further research into drug use amongst them is called for, their needs are rarely explicitly addressed by it.

In terms of **drug education needs**, there is evidence throughout this report of the lack of knowledge about drugs and drug use amongst Travellers (including those who use drugs), despite accounts of it being delivered from a variety of sources, including schools, Traveller organisations, drug services, schools, the gardaí, priests, and leaflets. Drug education is a major service need for Travellers, not only so that they can make informed decisions about their own drug use, but also formulate informed responses to it by others in their family and community.

Although many of the Travellers participating in this study (usually females) had had some form of drug education, the awareness of drugs, drug use, and of drug services and their functions generally remains low. Consequently, the Traveller community's response to drug use can include, for example, some dangerous and overly-optimistic practices such as 'home detoxes' and hoping that parents telling children not to use drugs will prevent them from doing so.

Discussions amongst the study participants revealed that the overriding concerns in terms of drug education are that it is delivered by Travellers, in locations where they feel comfortable, and should not be dependent on the recipients being able to read. Drug education also needs to take into account not only Travellers' current beliefs about drugs and drug-related risk behaviour in a sensitive manner, but also that issues other than drugs - particularly accommodation - may be higher on some Travellers' agendas than drug use.

Section 8

Barriers to drug service access by Travellers

The National Drug Treatment Reporting System does not record the ethnicity of those receiving drug services, so statistical evidence on the representation of Travellers cannot be extracted. However, a significant element of social exclusion is a lack of access to all services, including drug services: research amongst Black and minority ethnic communities across the European Union, including Travellers in Ireland, has shown that members of these communities are under-represented as clients of drug treatment, education, and prevention services, and face barriers to accessing them.

The barriers to drug service access that confront Travellers are common to those faced by other socially excluded groups, particularly members of Black and minority ethnic communities, and those identified by the participants in this study were:

The lack of awareness of the existence and nature of drug services

Although most Travellers were aware of drug education services, which were much appreciated, they lacked knowledge about drug treatment services, how to access them, and what drug treatment entails.

The lack of formal education

Travellers' poor literacy skills were reported to be a barrier to drug service access, particularly in respect of filling in forms. In addition, Travellers' inexperience of a formal learning environment was reported by a few agency workers to make it difficult to deliver drug education sessions to them in the same way as to the settled community.

Stigma and embarrassment

The majority of the participants in this study discussed stigma and embarrassment about drug use amongst Travellers, and three reactions that can greatly obstruct access to drug treatment services by problematic drug users were identified: the drug user not telling their family they were using drugs; the family knowing about the drug use of a member, but hiding it because they did not want other Traveller families to know; and both the drug user and their family not wanting to discuss this issue with drug services, nor to be seen accessing these services.

The lack of cultural competence by services

The data from the study show that many services have given little consideration to cultural competence in terms of responding effectively to Travellers' needs. The discussions with Travellers and service providers revealed several issues concerning the incompatibility of drug service procedures with Traveller culture: the lack of inclusion of the family in drug treatment; waiting lists; the appointment system; acceptance for treatment being dependent on catchment areas; the predetermined privileges that clients at a therapeutic community must earn; the necessity for medical cards before treatment can begin; questionnaires and form-filling on registration at a treatment service; and the inclusion of counselling sessions in drug treatment programmes.

Racism, discrimination and stereotyping

Several of the agency workers gave examples of institutional racism by services (defined in section 2, above). However, several also reported that they had been in contact with Traveller organisations for advice and/or training on how to work with Travellers in a culturally competent manner or in partnership with Traveller organisations.

Section 9

Recommendations arising from the study

The final section of this report collates the results from all the elements of the study in order to make practical and achievable recommendations for service development and further research.

The study has provided evidence – from the study participants and from previous research – that there is drug use and problematic drug use amongst Travellers; that Travellers, because of their social exclusion, are at a high risk of developing problematic drug use; and that members of this population face barriers to drug service access. This document therefore serves as the evidence base for the recommendations for the development of drug services.

There is a total lack of statistical prevalence estimates of drug use and problematic drug use amongst the Traveller community in Ireland, and whilst Travellers are thought to be under-represented as drug service clients, the lack of ethnic monitoring by drug services means that the extent to which this under-representation occurs cannot be accurately ascertained. However, the current lack of statistical data should not be used as a justification for services to delay addressing the drug-related needs of Travellers: the wealth of qualitative evidence presented in this report can be employed immediately to address developments in drug services.

The majority of the issues that have been raised in this report mirror those raised in relation to the drug use and drug service needs of Black and minority ethnic communities and socially excluded white communities throughout the European Union. The following recommendations, which are in no particular order and are interrelated, can therefore also be applied to Ireland's currently increasing immigrant population.

- 1 **Develop procedures on ethnic monitoring** within drug treatment reporting systems and drug service planning systems. These should be in line with current work being carried out under the National Traveller Health Strategy's ethnic identifier pilot project and with international best practice.
- 2 **Carry out equality proofing** of drugs policy and of drug service planning and delivery.
- 3 **Increase awareness** amongst Travellers of drugs, drug-related issues, and drug services.
- 4 **Adapt the organisational culture** of drug services to consider the cultural diversity of Ireland by considering Travellers' drug service needs in terms of the importance of the family, outreach work, nomadism, specific and generic services, literacy skills, appointments, waiting lists, social exclusion, and workforce development.
- 5 Implement an effective **Traveller community engagement programme** through the collaborative model of the Drug Task Force process.
- 6 Conduct **further research** on: prevalence and patterns of drug use amongst Travellers, including transitions to problematic drug use, injecting drug use, illicit drug use amongst female Travellers, and the use of prescribed sedatives, tranquillisers, and antidepressants; factors influencing successful access to drug treatment services by Travellers; factors influencing retention in drug treatment; drug-related risk behaviour; and engaging male Travellers in drug-related community initiatives. The results of the current study, and those of further research into aspects of drug use amongst Travellers, should be widely disseminated.

1 Background and research methods

The *National Drugs Strategy 2001-2008* (Department of Tourism, Sport and Recreation, 2001, Action 98) identified four socially excluded groups in Ireland – Travellers, prostitutes, homeless people, and early school-leavers – with which research on drug use should be undertaken, and requested that the National Advisory Committee on Drugs (NACD) accommodate studies of these in its research programme. In 2001, this request was echoed by the Minister of State responsible for the National Drugs Strategy. As part of its response, the NACD commissioned this exploratory study, the results of which provide an overview of the nature and extent of illicit drug use amongst the Traveller community according to the experiences and perceptions of Travellers and agency workers. The results are intended to inform the policy debate by providing data on drug use, problematic drug use, patterns of drug use, the impact of drug use, and gaps in service provision, and to highlight the needs of Travellers for drug service planners, commissioners, and providers.

After outlining the structure of the report, this section describes the project's research methods, which comprised a comprehensive literature review and interviews and focus groups with Travellers and agency workers.

Section 2 gives brief details of the size and culture of the Traveller population in Ireland, and summarises the racism, discrimination, and social exclusion that it experiences.

Section 3 of this report details the current knowledge base on the nature and extent of drug use amongst the Traveller community, and adds to it with the data gathered during this study. The section also discusses the availability of drugs to Travellers, and their involvement in drug dealing.

Section 4 examines problematic drug use amongst Travellers. The section presents evidence on the extent to which Travellers are socially excluded, and how social exclusion and the risk of problematic drug use are inextricably linked: drug use can lead to social exclusion but the processes of exclusion are characterised by circumstances which have been identified as risk factors for the development of problematic drug use. The risk and protective factors for problematic drug use amongst Travellers are discussed in relation to their education, health, employment, accommodation, previous and current drug use, involvement in the criminal justice system, family, social networks, and environment.

Section 5 presents the perceptions of the Travellers and agency workers interviewed for this study in relation to the impact of drug use on drug users, their families, and the Traveller community as a whole.

Section 6 details Travellers' methods of addressing drug use and drug dealing in their community, and **section 7** examines the extent to which Travellers' drug service needs are currently addressed, highlighting drug education as a major need for this population. Section 7 begins with a brief history of how, over the last few years, Travellers' drug-related needs have been increasingly acknowledged and some responses devised.

A significant element of social exclusion is a lack of access to all services, including drug services, and **section 8** identifies the barriers that confront Travellers attempting to access and/or benefit from drug services.

The final section of this report, **section 9**, collates the results from all the elements of the study in order to make practical and achievable recommendations for service development and further research.

1.1 Methods

This section details the methods employed to collect data for this study, including specially designed research instruments, access strategies, ethical and fieldwork issues, and data analysis techniques.

Prior to preparing the research proposal, the NACD examined existing evidence on drug use amongst Travellers from sources such as the National Drug Treatment Reporting System (NDTRS) and relevant literature and documents. The outcome of this preliminary investigation demonstrated the lack of empirical knowledge regarding the overall prevalence and patterns of drug use amongst Travellers, not least because this population is not identified by most of the existing data. However, qualitative research results from, for example, Fountain et al. (2002), Hurley (1999), and Khan et al. (2000b) indicate that drug use amongst Travellers is perceived both to occur and to be increasing.

1.1.1 Research Advisory Group

In order to formulate the proposal for this study, the NACD began by liaising both formally and informally with Travellers and representatives from community and statutory Traveller organisations. Background information was sought from key Traveller organisations, especially those conducting drug-specific work such as Exchange House and Pavee Point Travellers Centre. The NACD then contacted national Traveller organisations and those identified as working on the issue of drug use, and enclosed a consultation document for their consideration and feedback. From this exercise, a research planning group, and later, the project's Research Advisory Group (RAG) were established (members of whom are listed on the acknowledgements page of this report).

The RAG was highly active and involved in the project. Before the contract was awarded and fieldwork commenced, it had met ten times to discuss the research design, prepare the tender documentation, and agree the contract. Throughout the study, the RAG refined the research design and the data collection instruments, facilitated access to the research participants, promoted participation in the study, resolved any problems as they arose, and provided a monitoring and mentoring role to the field research team. Once the research had begun, RAG meetings were held as frequently or infrequently as required.

1.1.2 Aims

The aims of this study were to:

- 1 Provide an overview of the nature and extent of illicit drug use amongst the Traveller community;
- 2 Identify patterns of problematic drug use and drug-related risk behaviours;
- 3 Describe what interventions are needed to prevent and deal with the harmful health consequences of illicit drug use.

1.1.3 Research teams

Vision 21, a social research and community consultation company, collected and collated background information via a literature review, undertook the interviews and focus groups with Travellers and agency workers, and prepared a summary report. Due to internal constraints, Vision 21 were unable to continue with the study and returned all the raw data to the NACD for further analysis. Professor Jane Fountain from the Centre for Ethnicity and Health at the University of Central Lancashire was then commissioned by NACD to analyse the data, complete the literature review, and prepare this final report.

1.1.4 Research design

A literature search for information on drug use amongst Travellers in Ireland (and amongst Irish Travellers in the UK) was conducted using the databases of the National Documentation Centre on Drug Use, PsycInfo, Web of Knowledge, European Monitoring Centre for Drugs and Drug Addiction, and DrugScope. Searches were also conducted for literature on other aspects of Travellers' lives to provide background information, and for data on risk and protective factors for problematic drug use. Other documents and 'grey literature' (such as research reports to funders and reports of conference proceedings) were also collected and reviewed by the research teams, and included those provided by members of the RAG.

Data were collected from interviews and focus groups with a total of 171 participants, comprising 137 Travellers and 34 agency workers.

One-to-one interviews were conducted with 26 agency workers and three group interviews with a further eight. The 34 agency workers comprised representatives of Traveller organisations, primary health care workers, youth workers, social workers, drug service workers, and local authority and health board officials working with Travellers across Ireland. A small proportion of this sub-sample were Travellers.

Twenty **focus groups** were undertaken with a total of 122 members of the Traveller community, comprising 97 females and 25 males, with an age range of 18-50. Most of the focus groups were held with members of Traveller Community Development Groups, although one group consisted of participants recruited specifically for this study, two groups were held with Travellers in prison, and one group comprised Traveller community leaders. Twelve of the focus groups were conducted in the Dublin area and eight throughout the rest of the country. A small proportion of this sub-sample were also agency workers.

One-to-one interviews were conducted with 15 drug using Travellers (14 of whom were current or ex illicit drug users and one of whom used alcohol and sedatives), comprising twelve males and three females, with an age range of 19-45. Four of these were in prison at the time of the interview.

1.1.5 Research methods

The NACD consulted widely with Traveller organisations to ensure a relevant and ethical approach was adopted by the study, and the research tender proposed the research methods best suited to capturing the social and cultural context of drug use amongst the Traveller community. Qualitative research methods were selected because, as stressed by Hartnoll (2000 p.13):

Qualitative research focuses on the meanings, perceptions, processes and contexts of the 'world of drugs' and offers ways of understanding drug use patterns and related responses. It can be an effective first step towards generating hypotheses or identifying issues that require more extensive and systematic data collection.

Elements of the Rapid Assessment and Response (RAR) method were also incorporated into the research design. RAR combines various research methods and data sources in order to construct an overview of a phenomenon by cross-checking the information from each source (WHO, 2003).

1.1.6 Research instruments

Three research instruments were designed for this study:

The interview schedule for agency workers was concerned with perceptions and experiences of the prevalence and patterns of drug use amongst Travellers and the issues surrounding the provision of drug services for this population;

The focus group schedule for Travellers was designed to generate descriptive data on the nature of drug use amongst the Traveller community, the impact of drug use on the community, and issues surrounding drug services;

The interview schedule for drug users and ex-drug users from the Traveller community collected socio-demographic data, drug-using history, and data on issues surrounding drug services.

1.1.7 Access strategies

The RAG compiled a list of agency workers working with Travellers and these were contacted, usually by telephone, the aims of the project explained and discussed, and, if the worker agreed, an interview arranged. Snowballing from these initial contacts identified further potential interviewees.

All fieldwork with Travellers was carried out with the input of local and national Traveller organisations. Nearly 200 Traveller organisations were identified from the databases of Pavee Point Travellers Centre and the Irish Traveller Movement, and an information sheet on the study was sent to them, asking for expressions of interest in participating in the research. The RAG believed an initial low response rate was due to the closure of many Traveller organisations during the summer months (when the letters were sent), so the Traveller Specific Drugs Initiative telephoned local Traveller groups who were working on the drugs issue, and other groups in the regions in order to ensure a study sample that covered the whole of Ireland. Some groups were initially reluctant to participate because of concerns around the upcoming National Traveller Health Study that would include a question on drugs, how the study would address the sensitivity of drug use amongst Travellers in an ethical manner, and because they perceived that Travellers were becoming over-researched. However, the Traveller Specific Drugs Initiative was able to address and allay these concerns by pointing out the value of involvement and that national Traveller groups were involved in the study.

The participating Traveller groups were asked to act as co-ordinators for focus groups with Travellers, and discussions on the aims and objectives of the study were held with them. Confidentiality, anonymity and other ethical considerations were highlighted, and focus group procedures outlined. The co-ordinators passed on this information to potential participants and also explained the rationale for tape recording the proceedings.

There were some difficulties accessing Travellers who were drug users or ex-users to participate in this study. This was not unexpected, as this group are doubly marginalised because of their ethnicity and their drug use. Some participants were identified via agency worker interviewees and others were accessed via the focus groups.

1.1.8 Ethical issues

The NACD submitted the research proposal to the Traveller Ethics Research and Information Working Group (TERIWG). TERIWG had some initial concerns about how the study would fit with existing studies and how the findings would be used, which the NACD addressed. TERIWG approved the project in May 2003 and the research was also conducted in accordance with the NACD's *Guidelines on Good Research Practice – Research Ethics*.

Ethical approval for the elements of the project conducted by the Centre for Ethnicity and Health, University of Central Lancashire (section 1.1.3) was obtained from the Faculty of Health Research Ethics Committee in June 2005.

1.1.8.1 Informed consent

To ensure voluntary participation, potential interviewees and focus group participants were made aware of their right to refuse to participate, and to withdraw from the study without prejudice whenever and for whatever reason they wished. An information sheet outlining the aims and methods of the research project was produced, which explained the purpose of the research prior to asking for informed consent to participate. The information was repeated, in terms meaningful to the potential participants, at the beginning of each data collection session. Where a potential participant's literacy was poor, extra effort was made to ensure they understood the information.

1.1.8.2 Confidentiality and anonymity

The confidentiality of records and data generated by the research was protected at all times. All members of the interview and focus group team were made aware of their obligations in this respect.

Before the Centre for Ethnicity and Health received the transcripts of interview and focus groups for analysis, participants' names and anything that could identify them were removed.

Throughout the project, all material, including the notes and tape recordings from interviews and focus groups, were securely stored and available only to members of the research teams.

Throughout this report, great care has been taken to prevent data being presented in a form that would permit the identification of the study's participants, and of sites and localities where Travellers live.

1.1.9 Fieldwork

The fieldwork for this study was conducted in late 2003 and early 2004. Interviews and focus group discussions, which generally lasted between 45 and 90 minutes, were based on semi-structured interview/focus group schedules, but the study participants were also encouraged to raise issues that were important to them. Detailed notes were taken throughout the interviews and focus groups discussions, and where permission was granted, they were tape recorded and fully transcribed.

1.1.9.1 Agency worker interviews

The agency worker interviews were conducted in a variety of venues. These interviews were recorded onto audiotape, apart from one, because it was neither appropriate nor practical to do so as it was conducted whilst walking around a Traveller halting site.

1.1.9.2 Focus groups with Travellers

The majority of the focus groups with Travellers were conducted using participants from established groups which met regularly, such as community development groups or those set up around health or training initiatives. Many of the focus groups were held with members of Traveller Development Groups. As pointed out by members of the RAG and by some of the agency workers interviewed for this study, in general, women in Ireland, including Travellers, tend to be more involved in community organisations than men, and the sample of 122 focus group participants reflects this: 97 (80%) were female.

1.1.9.3 One-to-one interviews with drug-using Travellers

Two of the focus groups that were undertaken for this study were held in prisons. After these focus groups, four drug-using prisoners were interviewed on a one-to-one basis. The remaining eleven interviews were conducted with drug-using Travellers recruited mainly via the agency workers who were interviewed for this project.

1.1.10 Data analysis

All the comments made by interviewees and focus group participants on a particular issue were collated and analysed thematically according to the themes that most consistently arose and that are pertinent to the project's aims. The analysis is therefore firmly grounded in the data received from the participants in this study.

During fieldwork, the opportunity arose to conduct one-to-one interviews with two Travellers who did not fit into any of the sample categories for these interviews because they were neither drug users nor agency workers. The data from these interviews were therefore analysed with those from the focus groups in the area where these interviewees lived.

The use of a thematic analysis makes it possible not only to report on the issues surrounding drug use that arise for Travellers and agency workers, but also to identify areas of consensus and divergence on specific issues.

The qualitative nature of the research means that although interviewers and focus group moderators had a list of themes to guide data collection, not all participants discussed a particular issue, and were encouraged to raise their own. Therefore, although the proportion of the sample who discussed a particular topic is frequently given in this report, the typicality of these perceptions and experiences cannot be assessed.

2 The Traveller context

This section gives brief details of the size and culture of the Traveller population in Ireland, and summarises the racism, discrimination, and social exclusion that it experiences. It should be emphasised here that this is not a report on racism and discrimination, and the work of many statutory and other bodies in tackling these issues in relation to Travellers is acknowledged throughout. Nevertheless, these issues must be confronted in any examination of drug use amongst Travellers and the relevant service provision, and are discussed in these contexts in later sections of this report.

2.1 The Irish Traveller population

Travellers are a minority ethnic group, documented as being a part of Irish society for centuries. Travellers have a long shared history and value system, their own language, customs and traditions. The distinctive Traveller lifestyle and culture based on nomadic tradition, sets them apart from the sedentary population or 'settled people'. (Pavee Point, 2002)

In Ireland, the distinctions between Traveller culture and that of the settled community have only recently been acknowledged as cultural differences. This is most strongly evidenced by the early policies of assimilation which sought to tackle the problems facing the Traveller community by aiming to assimilate them into the 'mainstream' (settled) culture. This approach is now generally recognised as mistaken: culture bestows identity and belonging upon an individual and, as the Report of the Task Force on the Travelling Community (Department of Justice, 1995) points out *'identity and belonging is vital to everybody, and is equal to physical wants and needs'* (p74).

Estimates of the number of Travellers in Ireland vary. McCarthy (2005), for instance, calculates that there are 30,000 individuals, a figure also reported by Pavee Point Travellers Centre (2005b), whereas the 2002 census reports the total Traveller population as 23,681 (CSO, 2002). The census figure is likely to be an underestimate, however, because some Travellers (such as those living on the roadside or travelling at the time) were probably not included. In addition, this was the first census in which Travellers were asked to self-identify as such, and although an awareness-raising campaign was undertaken, it is likely that some Travellers did not complete the question.

Travellers account for at least 0.6% of the population of Ireland, and whilst they live across the country, 50% are found in four counties: Dublin (24%), Galway (12.1%), Cork (7.2%), and Limerick (5.7%) (CSO, 2002). There are approximately 15,000 Irish Travellers living in the UK (many of whom travel regularly between there and Ireland), and a further 10,000 Travellers of Irish descent living in the USA (McCarthy, 2005).

2.2 Racism and discrimination

In 2000, the Traveller Communication Committee commissioned a survey as part of its Citizen Traveller campaign (summarised in Pavee Point, 2003b). The results included that 36% of Irish people would avoid Travellers; 97% would not accept Travellers as members of their family; 80% would not accept a Traveller as a friend; and 44% would not want Travellers to be members of their community. The Task Force for the Travelling Community (Department of Justice, 1995) points to behaviours on both sides that fuel this dysfunctional relationship between Travellers and the rest of the population in Ireland, and O'Connell (1998a) stresses that *'the most public and controversial area where anti-Traveller discrimination arises is in relation to the provision of accommodation. Resident associations make*

their opposition to Travellers living in "their" areas very clear. At the same time, some actions of some Travellers, such as illegal occupation of public land, arouses resentment of them. Thus, as the Task Force for the Travelling Community points out (Department of Justice, 1995 p.61), Travellers are in a no-win situation:

On the one hand they are subjected to criticism and abuse because of the unsightly and unsanitary conditions in which they are forced to reside. On the other hand when efforts are made to improve their social and living conditions, through the provision of improved accommodation, the same people within the 'settled' community make strenuous efforts to frustrate and delay those very endeavours which will remove the unsightly and unsanitary conditions.

Limited contact between Travellers and the rest of the population means that the perceptions of the former by many of the latter are greatly influenced by the media. O'Connell (1998a) and Pavee Point (2002) expose the role of the media in creating and promoting negative stereotypes of Travellers, and the Irish Council for Civil Liberties (ICCL, 1996) protest against the '*[media] hysteria [that] has been the scapegoating of the Traveller community*' and '*call on journalists and editors to act responsibly and to refrain from a mode of reporting which fuels prejudice, intolerance and hatred*'.

2.2.1 'Traveller-proofing'

Despite a raft of policies aimed at improving many aspects of Travellers' lives, including tackling discrimination and specific legal recognition under equality legislation, the Government of Ireland does not explicitly recognise Travellers as an ethnic group (for example, Department of Justice, Equality and Law Reform, 2003; NCCRI, 2004). This stance has attracted criticism from, for example, an alliance of over 40 organisations representing anti-racism and human rights groups, and the United Nations International Convention on the Elimination of All Forms of Racial Discrimination (RTE, 2005). It is outside the remit of this report to debate this further, but where appropriate, it does draw attention to aspects of the issue in relation to drug use and drug services. One example is ethnic monitoring, which is necessary to determine current use of services; identify gaps; assess needs; improve quality; evaluate changes; achieve equal access; provide a baseline for planning; allocate resources more equitably; and to measure improvements (Fountain et al., 2003a).

The *Report of the Task Force on the Travelling Community* (Department of Justice, 1995) and *Traveller health – a national strategy 2002-2005* (Department of Health and Children, 2002) are comprehensive compilations of evidence reporting that Travellers experience direct and indirect discrimination at individual and institutional levels (a definition of institutional racism is given in section 2 of the executive summary of this report). Both documents identify institutional procedures and practices that reflect a lack of acceptance of Travellers' culture and identity. There have been many calls for policy-makers and service providers to acknowledge Traveller culture when drawing up legislation and commissioning, planning and providing services. There have also been some creditable responses, aiming to ensure that Travellers are not unfairly affected by government decision-making, and that they have access to services that are sensitive to their particular needs. However, this so-called 'Traveller-proofing' is not yet universally applied within an equality framework: the work on this issue is ongoing, and guided by the Working Group on Equality Proofing, established under the Department of the Taoiseach Programme for Prosperity and Fairness. Details of the working group's activities, including the implementation of several equality/equal status reviews, will be published during 2006, and examples of their work are referenced in the appropriate sections of this report.

The Task Force on the Travelling Community (Department of Justice, 1995) concluded that whilst legislation alone would not put an end to discrimination, it could make an essential contribution. Thus, for example, the Employment Equality Act 1998 prohibits discrimination in private and public sector employment (with some exceptions). The Equal Status Act 2000 moves the concept of discrimination beyond the workplace and into the public arena where people buy goods, use services, obtain accommodation, and attend educational establishments. According to these acts, which also prohibit victimisation, discrimination because of race and membership of the Traveller community are amongst the nine grounds for complaint that members of the public can bring to the attention of the Equality Tribunal for investigation and mediation.

2.3 Social exclusion

The term 'social exclusion' is used as shorthand for the consequences when *'individuals or areas suffer from a concentration of linked problems such as unemployment, poor skills, low income, poor housing, high crime, bad health and family breakdown'* (Khan et al., 2000a p.62). Social exclusion can be defined as the consequence of a group of people being

prevented from participating fully in economic, social and civil life and/or when their access to income and other resources (personal, family and cultural) is so inadequate as to exclude them from enjoying a standard of living that is regarded as acceptable by the society in which they live (Gallie and Paugam, 2002).

The link between Travellers, social exclusion, and problematic drug use is clearly recognised by the *National Drugs Strategy 2001-2008* (Department of Tourism, Sport and Recreation, 2001) in the request that research studies are conducted on drug use amongst socially excluded groups in Ireland, one of which is Travellers. This request is supported by *Traveller health – a national strategy 2002-2005* (Department of Health and Children, 2002), which begins by emphasising that *'In the Ireland of today, the Traveller community continues to experience high levels of social exclusion and disadvantage'* (p.2) and recommends further research into the use of alcohol and drugs amongst Travellers.

Irish Travellers have a different history, ancestry and language to the Gypsy/Roma/Tzigane populations found elsewhere in the European Union, but there are similarities between their cultures. These similarities, however, include negative aspects such as their social exclusion; stereotyping and scapegoating, including in relation to drug use and distribution and other crimes; and individual and institutional discrimination and racism. Reports collating data on these issues include O'Connell (1998a,b), Fountain et al. (2002), and Khan et al. (2000a,b). Khan et al., in a study across the European Union (EU), explored the relationship between Black and minority ethnic groups, social exclusion, and drug use in depth. Their conclusion was:

Although the use and abuse of drugs is not restricted to any one sector of society, its high prevalence and associated social problems are particularly marked in areas and localities marked by social exclusion...drug users [from Black and minority ethnic communities] could therefore be said to be facing a position of double jeopardy: they carry the stigmata of racial exclusion and of drug use (p.9).

3 Perceptions of the nature and extent of drug use amongst Travellers

This section summarises the current knowledge base on drug use amongst Travellers and discusses the level of acknowledgement of this phenomenon. It continues by reporting the perceptions and experiences of the participants in the current study in relation to the extent and nature of drug use amongst Travellers, the availability of drugs to Travellers, and of members of the community's involvement in drug dealing.

3.1 Current knowledge base

In comparison with the other European Union countries and Norway, Ireland is not amongst those countries with the highest prevalence rates for the use of cannabis, amphetamine-type stimulants, LSD and other synthetic drugs, cocaine and crack cocaine, and heroin, nor for injecting drug use (EMCDDA 2004).

The national drug prevalence survey (NACD/DAIRU, 2005b) reported that across all measures for the prevalence of illicit drug use (lifetime, last year, and last month), cannabis was the most widely-used drug in Ireland, with 17.4% of the population aged 15-64 ever having used it, and 5.0% in the last year. The next most-used drugs, cocaine powder and ecstasy had each been used by 1.1% in the last year, and heroin and crack cocaine by 0.1%. Across Ireland as a whole, whilst there are some deviations from the general trend, drug use tends to occur amongst young men, and they are most likely to use cannabis.

The national drug prevalence survey (NACD/DAIRU, 2005a,b) did not record ethnicity, and it is therefore unknown, statistically, whether or not drug use amongst Travellers follows the general trends. However, there is a growing awareness that drug use occurs within the community, as evidenced, for example, by the request for research made by *National Drugs Strategy 2001-2008* (Department of Tourism, Sport and Recreation, 2001) and consideration of the issue in *Traveller health – a national strategy 2002-2005* (Department of Health and Children, 2002). To support this concern, as detailed in section 4 of this report, Travellers experience many of the problems that have been identified as risk factors for problematic drug use, and few of the protective factors. Further, the results of recent research prior to the current study concur that the prevalence of drug use and problematic drug use, whilst not at the levels of the rest of the population, is increasing amongst Travellers. For example:

- Male Travellers are more likely to have used illicit drugs than females (Hurley, 1999; McCarthy, 2005), as reported for the Irish population as a whole NACD/DAIRU (2005a).
- Drug use is increasing amongst Traveller men, women, and young people. Traveller women and young Travellers are also increasingly using alcohol (Pavee Point, 2004).
- Cannabis is the illicit drug most commonly used by Travellers in Ireland (Hurley, 1999) and by Irish Travellers in the UK (Parry et al., 2004), as reported for the Irish population as a whole NACD/DAIRU (2005a).
- Concern has been expressed that there may be problematic prescription drug use amongst Traveller women (Hurley 1999; Pavee Point, 2004). NACD/DAIRU (2005b) report that, in the population as a whole, women were more likely than men to report having used sedatives, tranquillisers, and antidepressants in the last year (7.3%:4.2%).
- There is some heroin use amongst Travellers, and prevalence is increasing (Fountain et al., 2002; Hurley, 1999; McCarthy, 2005). Heroin use amongst Travellers in the UK is reported by Parry et al. (2004) and Power (2004).

- There is little evidence of injecting drug use amongst Travellers (McCarthy, 2005).
- There is a perception that the number of drug-related deaths amongst Travellers is increasing (Pavee Point, 2004).
- Increased drug use amongst Travellers is concentrated in some areas of Ireland (Pavee Point, 2004).
- There is some cocaine powder use amongst Travellers (McCarthy, 2005; Pavee Point, 2004), and, amongst Irish Travellers in the UK, the use of cocaine powder and crack cocaine is reported (Power, 2004).
- Amongst Travellers in the UK, there are reports of the use of amphetamines (Power, 2004) and 'club drugs' (such as ecstasy, cocaine powder and amphetamines) by young men (Parry et al., 2004).

3.2 Acknowledgement of drug use amongst Travellers

Reluctance to acknowledge drug use amongst Black and minority ethnic communities by agency workers and by members of the communities themselves is reported by Fountain et al. (2002) in an EU-wide study, who believe that '*Reasons for this include a fear of accusations of racism by drawing attention to drug use in these communities, and a desire to avoid increasing stigmatisation of them*'. Fountain et al. go on to argue (p.8) that, whilst understandable,

This stance is misguided. Ignoring or hiding a problem does not make it disappear: it must be confronted in order that appropriate responses can be developed...refusing to accept that this behaviour may occur amongst them [Black and minority ethnic communities] does nothing to decrease the stigmatisation, and obstructs consideration of their drug service needs by policy-makers and service planners and commissioners.

Although some of the research results listed in section 3.1 may lack the statistical rigour of a national survey, they have, collectively and over time, produced valuable snapshots of drug use amongst Travellers and contributed to the growing awareness that drug use is an issue within the Traveller community.

All the 34 **agency workers** interviewed for this project agreed that there was some drug use amongst the Traveller community, although some of those not working in the drugs field were unable to provide many details of this phenomenon. The overall opinion was that drug use was increasing, although two interviewees pointed out that this perception could be the result of more research projects on drug use amongst this population, more services targeting them, and Travellers becoming more willing to discuss the issue with the various services with which they come into contact. Several agency workers spoke of drug use amongst Travellers as a '*huge issue*' and a '*serious problem*,' reaching '*epidemic proportions*' and '*the single biggest threat to the whole Traveller way*'. Several agency workers commented, however, that Travellers did not acknowledge drug use amongst their community, noting that it was a taboo subject and '*very much hush-hush*', not least because of the stigma of drug use within the community. Several agency workers, too, were extremely wary of naming particular Traveller sites where drugs were used because they wanted to avoid increased scapegoating and stigmatisation of Travellers.

Overall, the focus groups with **members of the Traveller community** and the interviews with **drug-using Travellers** did not reflect the 'hush-hush' approach to drug use in their community reported by the agency workers and by Hurley (1999). The vast majority reported that that drug use not only occurred, but had increased over the last few years. Comments included *'one-hundred-per-cent of Travellers are using one drug or another'*, *'there's not a Traveller out there that doesn't try hash'*, *'it's a big problem'*, *'it's nearly getting out of control'*, *'if nothing is done, it's going to get worse'*, *'there's absolutely no getting away from drugs'*, and *'drug use is getting popular all over now'*. In areas where little current drug use was reported by Travellers, it was predicted that *'we haven't got a problem now, but, say like in ten years down the road, there could be a big problem'*. As one focus group participant summed up, *'There is a denial period. I think we're overcoming that'*.

3.3 Perceptions of drug use and drug users amongst Travellers

This section reports on the results of this study in terms of perceptions of the drugs used by Travellers, the gender and age of drug users, and drug use by prisoners.

It is important to emphasise here that sections 3.3 and 3.4 consist of data on the perceptions of the study's participants concerning drug use and drug dealing amongst Travellers. Although the perceptions of drug use amongst Travellers are broadly in line with the findings from the national drug prevalence survey (NACD/DAIRU, 2005a,b) on drug use amongst the whole population of Ireland (as discussed in section 3.3.4), some participants had little direct knowledge of these issues and were unable to distinguish between drug use and problematic drug use (as defined in the terminology section at the beginning of this report). Individual comments should not be taken out of this context and treated as 'facts'.

3.3.1 Drugs used

The perceptions and experiences of agency workers and Travellers on drug use amongst Travellers are reported in this section. A summary is provided in section 3.3.4.

3.3.1.1 Agency workers' perceptions

Not all the agency workers worked in the drugs field, nor exclusively with Travellers. Therefore, although they all agreed that there was drug use amongst this population, many had little knowledge of its nature and extent and were unable to comment on the prevalence of drug use in general and of specific substances. That said, many named permanent, transient, and unofficial halting sites, and purpose-built accommodation schemes where they perceived drugs to be widely used.

The drugs most often perceived by agency workers to be used by Travellers were **cannabis**, **cocaine powder** and **ecstasy**. Heroin use was also reported - mainly by those working in the drugs field - although prevalence was thought to be relatively low. The agency workers thought that whilst cannabis was used regularly and that use *'seems to be acceptable'* to many Travellers, the use of cocaine powder and ecstasy was thought to be largely restricted to celebrations such as weddings and parties, and to nightclubs:

[At Traveller wedding receptions] the one place I tend to avoid is the toilets, because that's where the dealing is done and cocaine tends to be a big issue at the moment at social occasions like that – it's readily available.

It was also noted that there was widespread **alcohol** use amongst Travellers, especially males, and that alcohol was used in combination with drugs.

Prescription **sedatives, tranquillisers, and antidepressants** were thought by most agency workers to be used mainly by older female Travellers, although some reported males and young females being prescribed these drugs too. Agency workers thought many of those with a prescription shared the drugs with friends and relatives:

...somebody would come in and say 'I'm feeling depressed' and 'sure, I've got tablets here – I'll give you one'...it wouldn't be done in a 'let's all have a tablet way', it would be kind of in a helpful situation and a caring situation.

Only two agency workers perceived that there was **crack cocaine** use amongst Travellers and three that **amphetamines** were used in this community. Use of **solvents, morphine sulphate tablets** (a pharmaceutical painkiller) and **LSD** were each reported by just one agency worker.

3.3.1.2 Traveller community members' perceptions

The results from the focus group element of this study reveal that a wider variety of illicit drugs were perceived to be used by Travellers in the Dublin area than elsewhere in the country. This finding is supported by the national drug prevalence survey (NACD/DAIRU, 2005b), which shows that a greater proportion of the general population in the Dublin area use a wider range of drugs when compared to the rest of Ireland.

The focus groups with members of the Traveller community revealed that knowledge about drugs and drug use varied greatly. Some found it difficult to distinguish between different drugs, and most had little knowledge of the extent of drug use. Young Travellers demonstrated a greater knowledge of the types of drugs and the extent of drug use than older focus group participants, and knowledge about drugs and drug use also varied across Ireland: in general, the participants of the twelve focus groups undertaken in Dublin had more knowledge than those from focus groups undertaken elsewhere. The different levels of drugs knowledge could also be explained by the amount of formal drug education members of a focus group had received. However, although those who had received such education could usually distinguish between the different types of drugs, they could not always discuss the extent of drug use in their local area (Travellers' knowledge of drugs and drug use is discussed further in section 7.3).

All of the 20 focus groups (comprising a total of 122 Travellers) perceived that cannabis was widely used amongst their local Traveller community. The consensus was that **cannabis** users used the drug frequently, that it is *'very normal to smoke hash'*, and that use was not greatly stigmatised amongst many Travellers. Male adolescents and teenagers were most often mentioned as cannabis users:

The majority of the boys would be on the dope.

Every time you go out, you're looking at the young fellas from ten years of age [upwards] – they're rolling joints.

However, most focus groups also thought that cannabis use was common amongst all ages. Although a few participants thought that as many females used the drug as males, the majority thought female cannabis users were rare, or that females did not use the drug at all.

Half (10) of the focus groups reported **cocaine powder** use amongst Travellers, and, like the agency workers, that this was largely restricted to celebrations and social occasions.

Many Travellers reported that 'drugs' were mixed with alcohol, and some specified that this was cocaine powder:

They'd be sat in the pub and they'll put it into their drinks. If there was ten of them, about eight would be doing that.

As with cannabis, estimates of the prevalence of cocaine powder use on these occasions varied widely, from 'a tiny percentage' to 'at a party, there'd be a quarter using it'. As with cannabis, it was thought that cocaine powder was used mainly by males from the mid-teens upwards.

Ecstasy use was reported by 12 (60%) of the 20 focus groups for Travellers. It was generally thought that ecstasy was used at celebrations and in nightclubs, but there were suggestions that prevalence was lower than cannabis and cocaine powder. Ecstasy was thought to be used by young people, mainly males.

Nine (45%) of the focus groups perceived that there was **heroin** use in their community, but it was thought to be used by only a small proportion of Travellers, and, once more, to be used mainly by young males. In two areas where no heroin use amongst Travellers was reported, the situation was predicted to change:

It's only a matter of time before heroin becomes an issue with the community.

Female 1: *You don't really hear of Travellers on that [heroin]. It hasn't caught on here yet.*

Female 2: *But it will, I'd say.*

Female 3: *In a while, it'll be all over the place.*

Amphetamine use amongst Travellers, mainly males, was reported from seven (35%) focus groups.

Members of only three (15%) focus groups perceived that **crack cocaine** was used by Travellers. Knowledge of the nature and extent of crack cocaine use was extremely vague, however.

All the focus groups reported high levels of prescribed **sedative, tranquilliser, and antidepressant** use by female Travellers, and in one group consisting of nine females, age range 20-45, six currently had a prescription for these. Whilst some Travellers thought that mainly older women used these drugs, others perceived that younger women and men were prescribed them too, and there were reports of sedatives, tranquillisers, and antidepressants being prescribed to females as young as 15. Like the agency workers, Travellers reported the extensive sharing of these drugs with others, but it was also reported that they were sold and used with alcohol by males, and with 'high-energy' caffeine drinks when ecstasy was unavailable.

It was reported from eight (40%) focus groups that young teenagers used **solvents**, especially petrol and glue, but that prevalence was very low and had decreased greatly over the last two decades.

The use of **LSD** and **magic mushrooms** were each reported from only two (10%) focus groups, and '**morphine tablets**' (presumably morphine sulphate tablets) by one (5%). **Steroid** use by males in gyms was reported from one (5%) focus group.

All the focus groups noted the widespread use of **alcohol** amongst Travellers, sometimes in combination with drugs. Whilst some thought that alcohol use was mainly by males, others disagreed. Participants of one focus group discussed this in terms of their perceptions that the Traveller culture was changing, and that young males begin drinking alcohol at an earlier age than previously:

A few years ago, it wasn't until they got married.

The fathers have lightened up a bit – they trust their sons, so they let them [drink alcohol].
(Exchange between two Travellers)

Inadvertent use of drugs

Members of six (30%) of the focus groups spontaneously raised the issue of drinks being 'spiked' with drugs in pubs, clubs and bars or other social gatherings, although they were unaware of the type of drugs used:

They put it in your drink, behind your back, and you're in a pub, sitting down, talking away. You could turn your head for two seconds, leave your drink, and all of a sudden...all consciousness of everything, you don't know where you are, what you're doing.

One female focus group participant had personally experienced her drink being spiked:

I had two drinks and there's no memories, no remembering getting home, how I got home...just opened the sliding door, just threw myself out in the middle of the road...no memories of it, never knew what happened to me. That was two drinks, and I could drink a good few...but I had two and a blackout...the people that was in my company said that I was drugged.

Some discussed the precautions they take against their drinks being spiked, such as watching each others' drinks whilst they go to the toilet, and always holding their drink in their hand.

3.3.1.3 Drug-using Travellers' perceptions

Although not specifically asked which drugs were being used in the Traveller community, the interviews with drug-using Travellers revealed that they thought that cannabis use was widespread, and that cocaine powder, ecstasy and heroin were also used.

3.3.2 Perceptions of the gender and age of drug users

The consensus amongst the **agency workers** was that, regardless of the drug being discussed, Travellers who used them were likely to be young males, except in the case of prescribed sedatives, tranquillisers, and antidepressants which were reported to be used mainly by females.

The age range of males who used drugs was reported to be from the mid-teens to 30, although use was thought to be concentrated amongst those in their twenties. Some agency workers thought that experimentation with drugs did not begin amongst Traveller males until their twenties because until then they were '*kept on a tight leash*' by their families.

Some agency workers perceived that female Travellers did not use illicit drugs, because they were strictly supervised by their families until marriage, although several pointed out that newly-married females are at risk of drug use once they are away from these restrictions, especially if their husbands use drugs. Most, however, reported that female Travellers did use a range of illicit drugs, although they did not think that use was as prevalent amongst females as amongst males.

Like the agency workers, most **Traveller community members** perceived that illicit drugs were used mainly by males and prescribed sedatives, tranquillisers, and antidepressants mainly by females. Some focus group participants - especially the males - were convinced that no female Travellers used illicit drugs:

Traveller girls wouldn't touch drugs – they would know better.

The girls don't take it [ecstasy] 'cos they don't know where to get it.

Mothers and young women don't get involved with drugs. They know they have to be there for their family.

Many Travellers also considered that females in their community do not drink alcohol to the same extent as men because of their family responsibilities:

Oh, they wouldn't drink the same as the men. The women would probably drink the odd night because they're going to have children to get up in the morning.

That said, it was acknowledged by some participants that female Travellers who were using illicit drugs would keep this hidden because of the stigma:

It's worse if a girl starts with drugs – it is against Traveller ways. They aren't allowed to drink [alcohol] before they get married, so you can see how bad it is to take drugs.

Interviewer: *Do women in the Traveller community use drugs?*

Male: *You want a women's group for this...they wouldn't tell us.*

Most of the **drug-using Travellers** who discussed the gender of drug users amongst their community also believed they were mainly young men. Although one thought that young females were also using drugs, another echoed the comments of other participants in this study that restrictions on them precluded drug use:

See, the young ones [girls] are not allowed out much. They could be out for an hour and then they're getting called, or ringing them up on the phone 'where are you? Come back this way, I want you'. So they wouldn't really have an opportunity to do it [use drugs].

3.3.3 Perceptions of drug use amongst prisoners

Of the twenty focus groups that were undertaken with Travellers, two were conducted with prisoners in two prisons, and four drug-using prisoners were also interviewed on a one-to-one basis. The prisoners reported that drugs were widely used in prisons, including amongst Travellers. The *National Drugs Strategy* (Department of Tourism, Sport and Recreation, 2001) agrees: 'there is clear evidence of a significant level of drug use occurring within Irish prisons,' including injecting drug use. The prisoners participating in the current study maintained that alcohol, cannabis, cocaine, ecstasy, amphetamines, heroin, and prescription sedatives, tranquillisers, and antidepressants were available there, and that

obtaining these substances was relatively easy: they were brought into the prison by prisoners' friends and family during visits and passed over to the prisoners.

Several prisoners said that non-drug-using prisoners were pressurised into asking their visitors to bring in drugs because the prison officers were less vigilant about searching them and watching them on visits:

There is a lot of bullying in the prison...trying to get somebody to bring in drugs.

It was reported to be easy to hide drug use from prison officers:

They [prison officers] think I don't take drugs...but I'm heavy on drugs. They think I'm not because I've not been caught...they think we're absolutely drug-free.

Interviewer: *How would you be able to hide it?*

In the cells with the lights off. Smoke by night. They won't know if you're smoking or not.

Two Travellers had used heroin for the first time in prison, and others reported knowing Traveller prisoners who had not used any illicit drugs prior to imprisonment:

I know fellas never took drugs in their life...until they come to prison, and they're on drugs – strung out.

I know a young girl who was never on drugs in her life until she came to prison, and she started on drugs [in prison], and she ODD [overdosed] on drugs.

Anyone who comes in are more or less learning...how to take them [drugs], and how to use them, and how to go about getting them...when I came in I was just as bad. I knew nothing about drugs and I had never seen hash in my life and I'm strung out on it now.

Several Travellers in prison said although they had used drugs before they went to prison, their use had increased once there:

When I came to prison, I got worse on it [cannabis].

Coke I'm on. I smoke coke or I snort coke till it's out of me ears.

The prevalence of drug use in prison was reported to make it difficult for prisoners not to use drugs:

Interviewer: *How easy is it for a Traveller that comes into prison and stay off drugs?*

Prisoner 1: *You don't stay off it.*

Prisoner 2: *It's not easy 'cos it's all around you, like.*

Prisoner 3: *Not when you've five or six [drug users] in your company.*

...hanging around with them [drug-using prisoners] – that's how you go back on the drugs.

Members of one of the focus groups for prisoners were particularly concerned to point out that Travellers from a location where drugs were not used (especially rural areas) would, if they had begun to use drugs in prison, influence others in their home area to do so on release.

3.3.4 Drug use amongst Travellers: summary of perceptions

The data presented in sections 3.3.1 - 3.3.3 are combined in the table overleaf to give an overview of drug use amongst Travellers in Ireland as perceived by the agency workers, Traveller community members, and drug-using Travellers interviewed for this study. It should be reiterated here, however, that these are qualitative data reporting perceptions, and should be interpreted as such.

Summary of substance use* amongst Travellers as perceived by agency workers (n=34), Traveller community members (n=122), and drug-using Travellers (n=15)

	prevalence	age of users	gender of users	notes
cannabis	widespread	all, including many young people	mainly male	use not greatly stigmatised amongst the Traveller community
heroin	relatively low overall, but higher in some localities	young	mainly male	rarely injected
cocaine powder	common at celebrations	mid-teens upwards	mainly male	used mainly at celebrations, with alcohol
crack cocaine	very low	**	mainly male	
amphetamines	very low	**	mainly male	
ecstasy	possibly lower than cocaine powder	young people	mainly male	used at celebrations and nightclubs
sedatives, tranquilisers, anti-depressants	widespread	mid-twenties upwards, but mainly older women	mainly female, to whom they are prescribed	women share the drug with others sold on the illicit market males use these drugs with alcohol and high caffeine drinks
LSD	very low	**	mainly male	
magic mushrooms	very low	**	mainly male	
solvents	very low	adolescents	mainly male	use has greatly decreased in popularity since the 1980s
poppers (amyl or butyl nitrite)	**	**	**	reported by only two participants
morphine sulphate tablets	**	**	**	reported by only two participants
alcohol	widespread	all	mainly male	is sometimes used in combination with drugs

*Any substance reported by only one participant in this study is not included in this table.

**Insufficient or inconsistent data.

The results presented in the table on the previous page can be compared to substance use in the last year amongst the general population (NACD/DAIRU, 2005b p.17) and to previous research on substance use amongst Travellers, listed in section 3.1. The major differences and similarities with the current knowledge base are:

- The substances (illicit and licit) thought by participants in this study to be most widely used by Travellers – **cannabis** and **sedatives, tranquillisers, and antidepressants** are also those reported to be most widely used by the general population and by previous studies of drug use amongst Travellers.
- The participants thought that **cocaine powder** and **ecstasy** were the next most-used drugs, as reported by the national drug prevalence survey. Studies of Travellers in the UK have also reported the use of these drugs. The national drug prevalence survey found equal prevalence of these drugs, however, whereas the present study suggested that there was more use of cocaine powder than ecstasy amongst Travellers.
- The national survey reported that **amphetamines, magic mushrooms** and **poppers** (amyl or butyl nitrite) were the next most prevalent drugs used by the general population, and amphetamines have been reported to be used by Travellers in the UK. There were few reports of the use of amphetamines and magic mushrooms amongst Travellers from participants in the current study, and the use of poppers was reported by only two of the drug-using Travellers and not by any other participant.
- Amongst the general population, the substances least used are **heroin, crack cocaine, LSD** and **solvents**, and the data from the current study show that this is also the case amongst Travellers. Previous studies have reported heroin and crack cocaine use amongst Travellers in the UK and also that heroin use is increasing amongst Travellers in Ireland. The participants in the current study reported heroin use amongst Travellers more often than the other three substances.
- Although previous studies have reported an increasing number of female Travellers using illicit drugs and alcohol, the perception of the participants in the current study on the **gender** of substance users from the Traveller community is that many more males than females use these substances. The national drug prevalence survey reports that, amongst the general population, over twice as many males as females had used an illicit drug in the last year, although the difference between the proportion for alcohol use was far less (86% male and 81.6% female). The participants in this study also perceived that sedatives, tranquillisers, and antidepressants were used mainly by female Travellers, whilst the national drug prevalence survey reports the ratio as 1 male:1.7 female.
- A wide **age range** of Travellers was perceived to be using illicit drugs by the participants in this study, although the age range from adolescence to the early thirties was most often mentioned. This echoes the findings from the national drug prevalence survey.
- The national drug prevalence survey did not report on **injecting drug use**, but previous surveys and the current study suggest that prevalence of this mode of administration is low amongst Travellers.
- There is a perceived widespread use of a range of drugs by prisoners, including Travellers, which is consistent with data on this issue (Department of Tourism, Sport and Recreation, 2001).

3.4 Perceptions of the availability and supply of drugs

This section examines the participants of this study's perceptions of the availability of drugs to the Traveller community, and of members of this community's involvement in drug dealing.

3.4.1 Perceptions of the availability of drugs

The 122 Travellers who participated in the 20 focus groups for this study were asked how available drugs were in their local area. Overwhelmingly, they perceived that '*drugs are everywhere*':

It's like going to the shop for a bag of sweets.

Oh, there's pushers [dealers]...they're around the shops – they're hanging out everywhere.

They're [dealers] on motorbikes, they're on horseback, they're even on pedal bikes... ..chip shops, taxi ranks.

Male 1: Ten years ago...you could have got them [drugs] in certain parts of Dublin, but you'd have to be well known...

Male 2: ...but today you just give your money and get the drug.

As discussed in section 3.3.3, the focus groups and interviews with drug-using Travellers held in prisons agreed that drugs were also easily obtained there, and five of the focus groups perceived that drugs were freely available in schools.

Several agency workers and drug-using Travellers also discussed the availability of drugs to Travellers. Five of the drug users and four agency workers reported that drugs were easily available, one adding that it was easier for young Travellers '*to get drugs than get a drink in the pub*'. One of the Traveller community members agreed, pointing out ironically that although Travellers may not be allowed into a club or pub by the doormen, the dealers selling drugs nearby did not similarly discriminate: '*they don't mind if you're a Traveller*'. One agency worker pointed out that the availability of drugs to Travellers in the area where they worked was facilitated because a halting site was built in a location notorious for drug use and drug dealing.

3.4.2 Perceptions of Travellers' involvement in drug dealing

The majority of the participants in this study discussed drug dealing and dealers. When asked if Travellers sold drugs, 13 of the 16 focus groups who discussed this issue reported that they did, whilst members of the remaining three groups were unsure. Twenty-three of the 34 agency workers talked about dealing, and 15 of them perceived that Travellers sold drugs. All eight of the 15 drug-using Travellers who discussed dealing reported that some Travellers were involved in this, and four of them had themselves sold drugs. It should be noted here that, as when discussing their perceptions of drug use amongst Travellers (sections 3.3.1 – 3.3.3), neither the agency workers nor the Traveller community members had detailed knowledge about drug dealing and, as shown in the following sections, drug dealers were frequently portrayed in a stereotypical manner. For example, some Travellers insisted that dealers sold drugs to children in order to get them 'hooked', and some Travellers and agency workers perceived that dealers made vast profits. These perceptions ignore that young people usually access drugs via their own peer networks and that the distribution of drugs occurs at many different

levels, ranging through bulk selling at wholesale level, retailing, and drug users selling small quantities to finance their own drug use. As noted by, for example, O’Gorman (2005), the roles of buyer and supplier are frequently interchanged amongst user-dealers who circulate drugs amongst their friendship networks, and the Effective Interventions Unit (2004) note that selling by user-dealers ‘tends to be *ad-hoc, unpredictable and inconsistent*’ (p.1).

3.4.2.1 Perceptions of drug dealers

Traveller community members from seven focus groups were emphatic that drug dealers were ‘*the real fucking scum*’ and that ‘*anybody that sells drugs doesn’t have a conscience*’. It was believed by members of six focus groups that dealers targeted children and young teenagers to ‘get them hooked’ and from two that dealers also then encouraged these young people to deal:

They sell to children and they know in their own heart and soul that they’re robbing that money from their parents.

I hear rumours that there’s an awful lot of Travellers into pushing it [drugs] and selling it...and giving it to children to sell as well, but not taking it themselves – god knows what poor children they’re getting hooked along the ways. Someone said to me that they just give ‘em one to try, and then of course on the first try, they’re hooked.

They start the young ones off on hash [cannabis] and then try to get them to sell it.

Whilst most of the Travellers discussed drug dealing in terms of unspecified ‘drugs’, one of the agency workers, who worked for an agency providing Travellers with support around a range of issues, thought that opinions of drug dealers varied according to the substance:

Coke [cocaine] has quite a prestige in the Traveller community – it’s cool, gives you power, and also generates a lot of income...you could be selling ounces of coke and people would be OK with you, but if you’re dabbling in heroin, you’re demonised.

3.4.2.2 Perceived reasons for dealing by Travellers

Traveller community members from four focus groups perceived that Travellers sold drugs for economic reasons, and five agency workers agreed. Many of these study participants linked this to the lack of job opportunities for Travellers (as discussed in section 4.1.3 of this report): for example, one Traveller commented that some Travellers sold drugs ‘*because they took away all the scrap dealing and the horses...the Travellers’ way of living – there’s nothing now to do*’, and an agency worker made the same connection, noting that those Travellers who traded in drugs did so ‘*like they used to trade in other things*’.

Four of the focus groups for Traveller community members and five of the agency workers perceived that the profits from selling drugs were large:

It’s like ‘I’ll come up [make a lot of money] in a year or two years and I won’t have to work for the rest of my life’. (Traveller)

You can earn a lot of money [dealing]. (Agency worker)

3.4.2.3 Perceptions of Traveller dealers' customers

Three of the focus groups reported that Travellers sell drugs only to other Travellers because they do not want to get involved in dealing 'turf wars' with dealers from the settled community, and because Travellers '*say it's easier, like, more comfortable, to get drugs off somebody they know*'. Six focus groups, however, reported that Travellers sell drugs to both other Travellers and to members of the settled community.

3.5 Drug-using Travellers: drug-using histories

Fifteen drug-using Travellers were interviewed in depth about their drug use, including four prisoners. It should be emphasised that the results from this element of the study cannot be used to make generalisations about drug use amongst all Travellers: rather, it was designed to illustrate the data from the other elements of the study by providing detail on the context of drug use.

The sample characteristics of the drug-using Travellers interviewed for this study were:

- 12 males and 3 females, age range 19-45;
- 6 were living in non-Traveller specific accommodation, 3 on halting sites, 1 in a caravan, and 1 in Traveller group accommodation. Four were in prison;
- 10 were married, 1 living as married, 1 engaged, and 3 single;
- of the 11 not in prison, just 2 were in employment;
- 14 used (or had used) illicit drugs and 1 had used only alcohol and sedatives prescribed;
- 5 were currently receiving treatment with methadone (these interviewees were asked to discuss their drug use prior to entering treatment).

3.5.1 Drugs used

The following drugs had ever been used by the sample of drug-using Travellers:

- 14 of the 15 had used cannabis
- 12 cocaine powder
- 11 amphetamines
- 10 ecstasy
- 8 heroin
- 7 methadone, all of whom had also used heroin
- 6 sedatives, tranquillisers, and antidepressants
- 5 crack cocaine, all of whom had also used heroin
- 5 LSD
- 3 magic mushrooms
- 3 solvents
- 2 poppers (amyl or butyl nitrite)

In addition, twelve of the 15 had ever used alcohol, and two described themselves as alcoholics.

With one exception, the eight Travellers who had used heroin had used a wider variety of drugs than those who had not. Again with one exception, the six who reported their main drug as cannabis had used only ecstasy and/or cocaine powder and/or amphetamines in addition.

3.5.2 Main drug used

The table below shows the main drug currently (or last) used by the sample and its frequency of use.

n	current or last main drug	frequency of use of main drug
7	heroin	daily
6	cannabis	daily (n=4) weekends/social occasions (n=1) once or twice a week (n=1)
1	cocaine powder	every weekend
1	prescribed sedatives and alcohol	almost daily

Those whose main drug was heroin used the drug daily, with friends, relatives or partners, and in two cases to 'come down' from stimulants. None had ever injected the drug. One of these interviewees had 'frequently' used heroin whilst in prison.

Typically, those whose main drug was cannabis used it with their friends and two of them reported using alcohol and cocaine on the same occasions that they used cannabis. The drug was usually smoked in joints, although some users had also smoked the drug via a bong (a water pipe) and in an ordinary tobacco pipe.

The interviewee whose main drug was cocaine powder snorted it and also added it to alcohol. He used the drug with friends and relations.

The interviewee whose main substances were sedatives and alcohol used neither every day. Although the sedatives were prescribed for daily use, she reported that she did not always feel she needed them and did not have the money to drink alcohol on a daily basis, although 'I'd drink steady for the seven days a week if I had the money'. This interviewee had never used any illicit drugs.

3.5.3 Initiation into illicit drug use

Cannabis was the first illicit drug used by 13 of the 14 Travellers who had used illicit drugs, and heroin the first used by another. The remaining interviewee had never used an illicit drug, and the first drug she used was antidepressants that were prescribed to her when she was aged 32.

Eight interviewees had first used an illicit drug at the age of 14 or younger (two had begun at the ages of ten and twelve) and four between the ages of 15-17. The remaining two illicit drug users had not begun until the age of 20. Overall, those who had used alcohol reported that they had first used it at the same age, or older, as their first use of an illicit drug.

Only two interviewees had attended school beyond the age of 14 and three had left school aged 11-12. In five cases, the first use of an illicit drug coincided with leaving school, in two it had occurred within a year of leaving school, and another two before leaving school.

Most of the interviewees reported being with friends or relatives the first time they used an illicit drug, and although most knew nothing about the drug (cannabis in all but one case) they had not been worried when they used it. No pressure to use was reported, but rather interviewees had used the drug because others were doing so:

They were smoking it and I thought I'd try it.

It was just everyone else was doing it, so I done it, and I liked it.

They were all smoking it at my cousin's home.

I wanted to be one of the boys.

4 Risk and protective factors for problematic drug use amongst Travellers

The definition of problematic drug use employed in this report is

the illegal or illicit drug taking...which leads a person to experience social, psychological, physical or legal problems related to intoxication or regular excessive consumption and/or dependence... drug taking which causes harm to the individual, their significant others or the wider community (NTA, 2003).

As discussed in section 3.1, there are no statistical data available on drug use amongst Travellers in Ireland, as ethnic monitoring was not conducted by the national drug prevalence survey (NACD/DAIRU, 2005a,b). For the same reason, there are no data on problematic drug use amongst Travellers available. The National Drug Treatment Reporting System (NDTRS), which could be a source of information on this issue, does not record ethnicity. Even if it did, it would provide information only about Travellers in contact with drug services, who, as discussed in section 8, are likely to be under-represented as clients.

The result is, that as with drug use, the nature and extent of problematic drug use amongst Travellers is reliant on the perceptions of Travellers and those working with them. However, perceptions of problematic drug use are likely to produce less reliable data than those on drug use because, unless the perceivers are working in the drugs field, their definitions of what constitutes 'problematic drug use' are likely to be inconsistent: in the extreme, some will perceive the use of any illicit drug – however infrequent – as inherently problematic, whilst others will reserve this definition for the stereotypical 'junkie', which encompasses injecting heroin, committing crimes such as burglary and mugging to fund drug use, unemployment, prostitution, homelessness, and a sole aim of getting the next 'fix'.

Therefore, this section examines problematic drug use amongst Travellers from the perspective of the risk and protective factors for problematic drug use, which are inextricably linked to the characteristics of social exclusion, for which some statistical data are available. It presents evidence to show how the link between social exclusion and these risk and protective factors operates in the case of Travellers.

4.1 Risk factors for problematic drug use

The following definitions of risk and protective factors for problematic drug use are used in this report:

A risk factor is an individual attribute, individual characteristic, situational condition, or environmental context that increases the probability of drug use or abuse or a transition in level of involvement with drugs (Clayton, 1992 p.15).

A protective factor is an individual attribute, individual characteristic, situational condition, or environmental context that inhibits, reduces or buffers the probability of drug use or abuse or a transition in level of involvement with drugs (Clayton, 1992 p.16).

The risk factors for the development of problematic drug use, particularly amongst young people, are well-documented, and can be categorised as interrelated problems in each of nine areas: education; health; employment; accommodation; previous and current drug use, criminal justice, family, social networks, and the environment (in terms of social deprivation, community disorganisation, and neighbourhood disorganisation). Compilations and reviews of research identifying these risk factors include Clayton et al. (1995), Health Advisory Service (HAS) (2001), Patel et al. (2004), and various

authors contributing to a special issue of the academic journal *Drugs: education, prevention and policy* (DEPP, 1998). The evidence base on factors that protect against problematic drug use is small compared to that on risk factors, but it is logical to assume that these are the opposite of the identified risk factors.

In addition to the nine listed areas above, gender, age, and religion have also been identified as risk/protective factors for drug use: boys are at greater risk than girls (Zickler, 2000); the younger the age of onset of drug use, the more likely the development of problematic drug use (Kandel and Logan, 1984; Callen, 1985; Robins and Przybeck, 1985; von Sydow et al., 2002); and the greater the importance a young person attaches to religious beliefs, the less the risk of them using drugs (for example, Bahr et al., 1998; Regnerus and Elder, 2003).

It is important to note that the presence of a single or even multiple risk factors does not automatically predict problematic drug use (for example, Clayton, 1992 p.20). Nevertheless, the greater the number of risk factors present, the greater the likelihood of drug use (for example, Bry, 1983; Newcomb, Maddahian and Bentler, 1986; Miller and Plant, 1999; Smith et al., 1995) and subsequent problematic use. Whilst, as Fountain et al. (2002) report, all socially excluded groups, regardless of ethnicity, are vulnerable to problematic drug use, Black and minority ethnic groups are particularly vulnerable because they are disproportionately socially excluded.

The list of the nine areas in which risk factors for problematic drug use have been identified also serves as a list of the areas in which disadvantage characterises social exclusion, as shown in relation to Black and minority ethnic populations in England (Fountain et al., 2003a; Patel et al., 2004) and across the European Union (Fountain et al., 2002; Khan et al., 2000a,b). This section examines each area in turn, focusing on the Traveller context and, where data are available, the specific risk factors for problematic drug use amongst them.

4.1.1 Education

Over the last few years, the government has provided a range of support and funding for initiatives aimed at addressing the issue of education for Travellers. For example:

The Department of Education and Science has published a series of guidelines, evaluations, and action plans on the education of Travellers (such as Department of Education and Science, 2002a, 2002b, 2003, 2005), and has recently completed a survey of Traveller education provision in Irish schools, including the successes and challenges to date (Department of Education and Science, in press).

The Advisory Committee on Traveller Education was established in 1998.

The Visiting Teacher Service (which expanded during 1999 and 2000) and Resource Teachers for Travellers aim to facilitate Travellers' children's integration in mainstream schools.

The Quality Framework Initiative (O'Brien, 2005) has produced a model to assure the quality of education and training, to be used by Youthreach and Senior Traveller Centres (there are over 30 Senior Traveller Training Centres throughout Ireland, providing further education and vocational skills to Travellers aged over 16).

The Traveller Education Strategy is currently being drafted.

Such measures are clearly necessary, as data on Travellers' education reveal that up to 80% of adult Travellers are unable to read (Department of Health and Children, 2002), and, of those who have ceased education:

68% of Travellers have received either no formal education or at best, have remained in the system up to primary level, compared to only 21% of the whole population (CSO, 2002).

only 13% of Travellers have reached lower secondary level, compared with 22% of the whole population (CSO, 2002).

only 3% of Travellers have reached higher secondary level, compared to 28% of the whole population (CSO, 2002).

only 2% of Travellers have reached third level (non-degree, degree or higher post-school education), whereas 25% of the whole population have done so (CSO, 2002).

Criticisms of the education system for failing the Traveller population centre around Traveller culture and the education system's lack of appreciation and respect for it (Department of Justice, 1995; Kenny, 2000; Lodge and Lynch, 2004; McDonagh, 2000; and, in relation to Irish Traveller children in England, OFSTED, 1999). Kenny (2000) stresses that the dominance of the settled culture within the education system can make schools inhospitable for those who do not belong to it: *'minorities are physically present but their distinctive identities, strengths and needs are not registered'* (p.142). This manifests itself not only in dominant attitudes but also in the materials used in schools. To address the situation, Kenny continues:

[Schools] must reflect the full variety of the wider community's experience as normal in the school environs and in the intercultural anti-racist curricula and materials...if their [Travellers'] story isn't there, neither are they in the real sense of the term (p.146).

The problems caused by mono-culturalism in the education system are also evident in McDonagh's (2000) exploration of why Travellers might avoid it, arguing that *'the fact that the curriculum is so mono-cultural and fails to recognise Traveller culture means that Travellers can feel isolated in school and learning can be seen as irrelevant because it does not address their experience'* (p52). In addition, McDonagh reports concern amongst the Traveller community that *'formal education educates children "out of" their own culture'* (p52). Further, OFSTED (1999) reports from the UK that there is a fear amongst many Travellers that their children will adopt bad habits and poor morals, particularly in relation to drugs and sexual activity, from regular contact with young settled people in secondary schools.

Another factor that dissuades Travellers from sending their children to school is the low value that many members of this population, particularly the older generation, put on a formal education. McDonagh (2000) is among those who report that *'there is still confusion about the role that they think education plays in the lives of Travellers. Most would see the ability to read and write as sufficient'* (p.150) and that this population *'see other concerns as being of more value to their lives than education which is far from what they see as being vital or necessary'* (p.151).

A further concern surrounding the education of Travellers is the extent to which schools expect and accept less from them than their settled counterparts. Trainees of St. Joseph's Training Centre (2000), for example, felt that in Traveller-only classes the expectations were much lower than they were in

mixed or settled-only classes: *'When you go into an "all traveller class" it's all English and Maths and they're [teachers] not bothered. But if you go into a settled class you have to learn History, Geography, Irish, English, Maths, Arts, Crafts, Computers and all that'* (p.157).

The accommodation situation of Travellers (section 4.1.4) also impacts negatively on their education. Kenny (2000 p.141) notes *'Issues like inadequate insecure accommodation severely constrain what can be done in school'* and that the education system has difficulty dealing with the challenges of nomadism.

As noted above, the Department of Education and Science (2002a, 2002b, 2003, 2005, in press) is working to address these issues, but until the challenge is overcome, the barriers erode the likelihood that Travellers feel able and motivated to pursue formal education beyond the most rudimentary level. In addition, as even those Travellers who have gone through the education system have difficulties obtaining employment because of discrimination (section 4.1.3), the incentive to pursue education or training is further diminished (for example, Pearn Kandola, 2003). However, as discussed below (section 4.1.1.1), truancing is a risk factor for problematic drug use.

Ten of the 34 **agency workers** interviewed for the current study noted the lack of education as one of the problems facing Travellers, especially in terms of poor literacy skills. Half of the 20 focus groups with **Traveller community members** also thought education was a problem for Travellers, and although it was reported from three focus groups that some schools were good, four reported that Traveller pupils were treated differently to settled children:

In the classroom, they'd [Travellers] be allowed to colour all day. Now they can't read and write – they can't do nothing.

[Teachers] have the attitude that the [Traveller] kids are a mess anyway – they're not going to get a job.

It was reported from two focus groups that it was difficult to get Traveller children into schools because *'once they know they're Travellers, schools think it's trouble straight away'*. The result was that some Traveller children hid their identity at school. A rationale for this was reported from one of the focus groups for Travellers: a school in the locality had a comments book for pupils and when negative comments about Travellers were added to it, it was *'left open on top of the desk for the [Traveller] children to see and the other children to read out'*.

Other barriers to education reported from Traveller community members were the lack of facilities on Traveller sites to wash uniforms; parents' lack of education meaning they were unable to help their children with homework; boys dropping out of school early in order to work with their fathers and girls to help their mothers; and the fear that Traveller children will be introduced to drugs:

Your child needs an education, but how can we send them to that?...you're going to think at the end of the day 'well, I sent them to school' so you may as well say 'well, I started them on drugs'.

4.1.1.1 Risk factors for problematic drug use related to education

The risk factors for problematic drug use related to education are (DEPP, 1998; HAS, 2001):

- Exclusion from school
- Truancing

- Low school grades
- Attendance at 'special' school/lessons because of learning difficulties or challenging behaviour

The protective factors are (DEPP, 1998; HAS, 2001):

- Attachment to teachers
- Commitment to education
- Educational attainment

It is clear from the data presented above on the experiences and attainment of Travellers in the education system, that the majority of the risk factors for problematic drug use are present and that the protective factors are not.

4.1.2 Health

The most comprehensive collation of data on the health of Travellers is *Traveller health - a national strategy 2002 – 2005* (Department of Health and Children, 2002). The outcomes of its key actions are currently being reviewed, and the Health Services Executive is conducting a national equality review.

The strategy notes that *'There is currently no systematic or regular gathering of data relating to the health status of Travellers'*, although the recommendation that health databases begin to do so has been successfully piloted in the Rotunda and Tallaght hospitals and 'Irish Traveller' has been included as an ethnic group. Nevertheless, the strategy is able to catalogue evidence that shows:

Travellers are particularly disadvantaged in terms of health status and access to health services. Generally speaking, 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 (p.4).

The strategy acknowledges that amongst the factors contributing to this situation are social exclusion, *'a harsh living environment'*, and individual and institutional racism (pp.4-5), and that *'Stress, infectious disease including respiratory disease and accidents'* are *'closely related'* to the substandard accommodation occupied by many Travellers (p.28).

Travellers of all ages have a higher mortality rate than the general population (Department of Health and Children, 2002). The most recent statistical data are from 1986 and 1987 and show that Traveller women lived, on average, twelve years less than women in the general population and Traveller men an average of ten years less. Barry, Herity and Solan (1987) add that Traveller women had three times the risk of dying in a given year compared to their settled peers. A decade-and-a-half after these data were collected, the Department of Health and Children (2002) believes that *'it is reasonable to assume that there has been little, if any, improvement since then'*, as Travellers continue to be in poor health compared to the rest of the population and face barriers to accessing health services (p.24). Indeed, in 1995, the Report of the Task Force on the Travelling Community (Department of Justice, 1995) noted that *'male Travellers have over twice the risk of dying in a given year than settled males'* (p.57) and in 2002, only 3.3% of Travellers were aged over 65, compared to 11.1% of the whole population (CSO, 2002).

Statistics from 1987 also show that Travellers have a higher birth rate than the general population (Department of Health and Children, 2002), but also a far higher infant mortality rate - 18.1 per 1000

live births, compared to a national figure of 7.4, and, in 1999, the occurrence of Sudden Infant Death Syndrome amongst Traveller families was twelve times the national average.

The strategy on Traveller health (Department of Health and Children, 2002) does not provide any data on the mental health of Travellers, and Linehan et al. (2002) point out that the prevalence of mental illness amongst this population is unknown. Pavee Point (2003b, 2005b), however, discuss the circumstances of Travellers' lives that result in their vulnerability to mental ill health, including suicide.

Twelve of the **agency workers** interviewed for this study discussed the poor health of Travellers, believing it to be a major problem for the community. Mental ill health, particularly stress, depression, and low self-esteem was the aspect of health most often reported, and seven of these interviewees perceived, and expressed concern about, a high rate of suicide amongst the Traveller community.

Twelve of the 20 focus groups with **Traveller community members** also pointed out the poor health status of Travellers and almost all related this to substandard accommodation and a lack of basic facilities on temporary and unofficial Traveller sites. Six of the groups reported the risk of disease from rats on these sites:

You have the infections from rats running around the place...their urine and everything else all around that area [where water is supplied].

On an unofficial site they're living in their own dirt [because there is no refuse collection].

Female 1: *...vomiting and diarrhoea with kids picking up bugs and that's from dirty water, sewerage water.*

Female 2: *They're playing in the puddles.*

4.1.2.1 Risk factors for problematic drug use related to health

The specific risk factors for problematic drug use related to health are early pregnancy, being a victim of child abuse (physical and/or sexual), and childhood conduct disorders (DEPP, 1998; HAS, 2001). Psychiatric disorders - particularly depression and suicidal behaviour (Grant and Pickering, 1999; von Sydow et al., 2002; Weiss, 1992) are also risk factors for problematic drug use.

In terms of children, von Sydow et al. (2002) have identified living with parental mental disorders as a risk factor for cannabis dependence and these authors and Green (1999) have shown an association between parental mortality and drug use.

The literature search conducted for the current study revealed no national statistical data from Ireland on those aspects of health that are risk factors for problematic drug use listed above. However, studies of Irish Travellers in the UK have reported depression amongst them, which is perceived to be common, citing the loss of traditional occupations and stopping places that undermines identity, substandard accommodation, poverty, and racism as reasons for this (Crout, 1987; Ginnety, 1993; Hennink, Cooper and Diamond, 1993; Parry et al., 2004; Power, 2004).

Despite the paucity of statistical data, the available evidence clearly suggests that Travellers suffer disproportionately from mental ill health compared to the rest of the population. Those who do, and their children, are at risk of problematic drug use. Compared to the rest of the population, the youthful age of the Traveller population and the young age at which they die suggests that many children are living without one or both parents, and these young people are also at risk.

4.1.3 Employment

A feature of Traveller culture is that income generation focuses on self-employment, occupational flexibility, entrepreneurialism, and economic adaptation (Department of Justice, 1995; Pearn Kandola, 2003). Income-generating activities for Travellers are varied, and evolve as demand for certain skills changes. In the past, these included horse rearing, seasonal farm work, rural crafts, and selling domestic goods from door-to-door. More recently, Travellers' employment patterns include scrap-metal recycling, market trading, casual forms of building work, and gardening (Power, 2004). These activities may involve moving around Ireland (or between Ireland and the UK) to take advantage of different markets at different times of the year.

In 2005, the Working Group on Equality Proofing launched a round of employment equality and equal status reviews, with action plans. This is particularly relevant to Travellers, who have a high level of unemployment: 73% of Traveller men and 63% of women reported that they were unemployed in the 2002 census, compared to 9% of men and 8% of women in the general population (CSO, 2002). One reason for this is that Travellers' traditional means of earning a living are being eroded, not only by social and economic changes across Ireland, but also by various pieces of legislation. The *First Progress Report of the Committee to Monitor and Co-ordinate the Implementation of the Recommendations of the Task Force on the Travelling Community* (Department of Justice, Equality and Law Reform, 2000) points to the Control of Horses Act 1996 as an example. Whilst believing that the act was necessary, the committee state that the way in which it has been implemented 'creates huge difficulties for travellers' (p31). The *Traveller Legal Unit Strategic Plan 2003-2006* (Irish Traveller Movement, 2003) also cites this act as 'very negative for Travellers...preventing many from keeping horses as the conditions for keeping horses in by-law areas are virtually impossible to meet' (p3). Another example is given by Pavee Point (2002), who draw attention to changes in street trading laws in the Casual Trading Act 1996 that have negatively impacted on the Traveller economy, and McCarthy (2005) adds the Trespass Legislation 2002 and the introduction of national car testing.

Such laws have reduced the viability of the traditional Traveller economy and members of this community are therefore increasingly reliant on obtaining employment within the mainstream economy. However, as Pearn Kandola (2003) report, discrimination by employers means that many are unable to secure and keep such work, citing a Traveller male who 'spoke about keeping his Traveller identity secret for many years for fear of less favourable treatment by his colleagues and his manager. He also spoke about advising his children and local youngsters to do the same' (p.19).

Four of the **agency workers** interviewed for this study saw unemployment amongst Travellers as one of the major problems facing the community, one noting that as the traditional Traveller methods of earning a living are becoming increasingly less possible, the skills are not being passed to the younger generation, so that young people 'are just hanging around, bored'.

Although it was noted from five of the focus groups with **Traveller community members** that young Travellers were bored and 'there's nothing for them to do', only two groups spontaneously highlighted the employment situation amongst Travellers as a major problem. One group perceived that 'Young Travellers looking for jobs now – if you haven't got a settled address, they're only wasting their time'. The other group reported that young Travellers attended training courses only for the allowance, because 'there's nothing at the end of it, only the door'.

4.1.3.1 Risk factors for problematic drug use related to employment

The risk factor for problematic drug use related to employment is unemployment (DEPP, 1998; HAS, 2001). That almost three-quarters of Traveller males and two-thirds of females are unemployed (CSO, 2002) clearly puts them at risk of problematic drug use.

4.1.3.2 Sex work

It should be noted here that one form of income generation, sex work, is also a risk factor for problematic drug use. There are no statistical data on sex work amongst Travellers in Ireland, although anecdotal information from agencies working with Traveller women who are sex workers reports that drugs are used by them (personal communication, 2005a).

4.1.4 Accommodation

The Report of the Task Force on the Travelling Community (Department of Justice, 1995 p.72) notes that *'Traveller nomadism...takes a range of forms. It includes those who are constantly on the move, those who move out from a fixed base for a part of any year, and those who are sedentary for many years and then move on'*. The accommodation needs of Travellers are varied and changing and the types of accommodation meant to be provided specifically for them by local authorities in Ireland are:

Group housing: purpose-built housing specifically designed to accommodate a number of Traveller families who wish to live together.

Permanent halting sites: permanent structures with individual bays and a permanent structure which incorporates a kitchen, toilet and shower with hot and cold water.

Temporary halting sites: structures with running water, electricity, toilets and refuse collection, for Travellers who are waiting for permanent accommodation with a local authority.

Transient halting sites: halting sites for nomadic Travellers who are stopping for a short period of time. At the time of writing, there is only one such site in Ireland.

On 26 November 2004, local authorities across Ireland reported on the accommodation situation of 6,991 Traveller families in their areas. Of these, 73% (5,106) were accommodated by, or with the assistance of, a local authority, including 1,321 on halting sites (19% of those accommodated in this way). A further 9% (601) were living on unauthorised sites – on the roadside, in private yards, gardens, fields, and on unofficial sites. This proportion has declined by almost 500 families with the implementation of five-year local Traveller Accommodation Programmes (Department of the Environment, Heritage and Local Government, 2005).

However, the Task Force for the Travelling Community (Department of Justice, 1995) notes that a lack of planning for the projected Traveller population increase has meant local authorities are seldom able to provide sufficient accommodation for all Traveller families at any one time. Therefore, some families are living in substandard conditions whilst waiting for more accommodation to be built. The Department of Health and Children (2002 p.27), for instance, reports that *'one in every four Travellers has no piped water supply (or at best has a shared cold water supply), no flush toilet, no bath or shower, no access to mains electricity and no refuse collection'*. The lack of basic services particularly affects those who are living on unauthorised sites, who, under the Housing (Miscellaneous Provisions) Act 2002, can be moved on or have their caravans seized.

The problems that Travellers currently face in terms of accessing accommodation that enables them to live according to their culture are not new. Unlike much earlier reports, such as the *Report of the Commission on Itinerancy* (Department of Social Welfare, 1963), the *Report of the Traveller People Review Body* (Traveller People Review Body, 1983) did recognise the importance of good quality Traveller-specific accommodation. In some respects however, the review body approach indicated that the best option was to provide Travellers with the opportunity to move into mainstream culture: *'the 1983 report favoured standard housing as the best accommodation for Travellers, and believed that this was the preferred option of the great majority of Travellers'* (Department of Justice, 1995 p.95). Thus, whilst housing provision for Travellers increased after 1983, the lack of appropriate Traveller-specific accommodation prevented many Travellers from living as they wished.

More recently, the Task Force for the Travelling Community (Department of Justice, 1995) explicitly stated that *'It is important to recognise that the provision of Traveller specific accommodation for the Traveller community is the desired option'* (p.101). The task force recommended an increase in all types of accommodation for Travellers, along with the development of a national network of permanent and transient halting sites. However, Pavee Point (2005a) shows that there has been only *'some slow and piecemeal progress over the last ten years in providing Traveller specific accommodation'*, meaning that *'local authorities are now required to prepare new Traveller accommodation programmes to cover 2005-2008 under the existing inadequate legislation with new targets of the provision of all forms of Traveller accommodation for each year'* (p.27).

Around half of the 34 **agency workers** interviewed for this study perceived inadequate accommodation as one of the biggest problems facing Travellers. Several noted that opposition to Traveller sites by the local settled population led to friction between the two communities and one of them stressed that, in terms of adequate accommodation for Travellers,

Progress is slow – lack of political will, lack of interest in support for Travellers. Over the last five years there has been an increase in housing development but the rest of the population are more vocal and their needs are prioritised.

Although some good accommodation for Travellers was reported from the focus groups for **Traveller community members**, 15 of the 20 groups thought that accommodation was a major problem for the community. The following comments are typical of the descriptions given of halting sites, particularly the temporary sites:

If you have cold water outside, every time you want water, you've to go out in the rain, hail, or snow to get it...rats running around the place...and them [halting sites] that has showers, there's no hot water.

So you're standing there in the middle of winter having a shower. Sure, you'd get pneumonia.

Two of the focus groups reported that some Traveller sites were too large, meaning that families could not monitor the behaviour of their children and young people.

Members of four of the focus groups complained that local authorities had been slow to provide Traveller-specific permanent accommodation:

It's all broken promises...meeting after meeting, promises and no further down the road after all the meetings.

These groups reported that even when such accommodation was provided, it was sometimes of poor quality or unacceptable conditions were attached:

[The local authority is] trying to blackmail us: 'OK, we'll give you good accommodation [if] you lose your culture, whether you're into scrap or horses'...or if they have a family, they threaten them around antisocial behaviour - there's all kinds of tricks. If you want to buy privately, they say 'you're no longer Travellers, live like the settled'. We wouldn't change that, for god's sake, like we are who we are and that's it.

4.1.4.1 Risk factors for problematic drug use related to accommodation

The specific risk factors for problematic drug use related to accommodation are homelessness, running away from home, and being looked after by a local authority or foster parents (DEPP, 1998; HAS, 2001). Fountain et al. (2003b), Johnson et al. (1997) and Neale (2001) are amongst those who show that that problematic substance (drugs and alcohol) use and homelessness are risk factors for one another: the first episode of homelessness is associated with a prior history of drug use and having ever been homeless is predictive of drug use.

Data on homelessness in Ireland do not include an ethnic identifier and so the proportion of homeless people who are Travellers is unknown. Pavee Point (2003a p.3) '*would not consider it useful to define Traveller families as homeless if they were living on a temporary, unofficial or roadside site without facilities*' (p.3). However, under the Housing (Miscellaneous Provisions) Act 2002, such families' caravans can be seized, rendering them homeless. Pavee Point (2003a) also consider that, because of the racism and discrimination encountered by Travellers attempting to access mainstream services, other Traveller groups vulnerable to homelessness are young Travellers leaving the care of a Health Service Executive; Travellers leaving prison; young problematic drug and alcohol users; Travellers with mental ill health; and women who have left their family home because of domestic violence.

There are no statistics on Travellers running away from home, but, as discussed in detail in section 4.1.7, it has been reported from the UK that the '*tight restrictions and discipline within families*' can mean that some young people '*break away from Traveller constraints and conventions in urban situations*' (Power, 2004, p.12). This may include running away from home and subsequent homelessness.

Data on Traveller children being taken into care are limited (Traveller Health Unit Eastern Region, 2004a), but a study in the Eastern Region commissioned in 2002 concluded that '*it seems that Traveller children are about six times as likely to be taken into alternative care when compared with the local population*' (p.3).

4.1.5 Previous and current drug use

Section 3 of this report presents the current knowledge base on drug use amongst Travellers, including the perceptions of the participants of this study, and a summary of the data gathered for this study is provided in section 3.3.4.

4.1.5.1 Risk factors for problematic drug use related to previous and current drug use

An early onset of drug use is a risk factor for problematic drug use (Hawkins, Catalano and Miller, 1992; DEPP, 1998; Fleming, Kellam and Brown, 1982; HAS, 2001).

The Traveller population consists of a large proportion of young people (CSO, 2002):

almost two-thirds of Travellers (62%) are under the age of 25, in stark contrast to the population of Ireland as a whole, where 37% are under 25.

42% of the Traveller population are below the age of 15 compared to 21% of the general population

the average age of Travellers is 18, compared to 32 nationally

This youthful population and Travellers' vulnerability to the other risk factors related to social exclusion detailed throughout section 4.1 gives cause for concern in terms of Travellers beginning to use drugs at a young age.

Availability of drugs is, obviously, a factor affecting their use. Li, Pentz and Chou (2002 p.1548), for example, report that the more often young people were offered cigarettes, alcohol and marijuana, *'the less sure an adolescent was to refuse an offer. The less sure an adolescent was, the more likely he/she was to use substances'*. In terms of exposure and access to drugs, the national drug prevalence survey reports that a greater proportion of those living in Dublin had used a wider range of drugs than those in the rest of Ireland. That almost a quarter of Travellers in Ireland live in Dublin (CSO, 2002) exacerbates the risk of drug use. In addition, Hurley (1999) points out that those young Traveller men who have spent time in the UK are likely to have been exposed to drugs whilst there.

4.1.6 Involvement in the criminal justice system

Pavee Point (2003a p.5) discusses anecdotal and research evidence that *'suggests that Travellers, particularly Traveller women, are over-represented in the prison system'*, but there are no national statistical data on the extent of crime committed by members of the Traveller population. Pavee Point (2002) argues that, notwithstanding the media portrayal and the perceptions of many of the general population of Travellers as criminals, Travellers may more often be the victims of crime rather than the perpetrators, and that, despite the link between crime and marginalisation

the level of criminality within the Traveller community is not what one would expect given the social situation of Travellers. For many Travellers, to the credit of the Traveller community, strong family networks and strong moral codes mitigate the negative effects of such disadvantage.

Eight of the **agency workers** interviewed for this study discussed crime in relation to the Traveller community. Four of them perceived Traveller sites as 'no-go' areas for the gardaí, who did not enforce the law there, but one disagreed, saying that *'you are more likely to find a guard on the site sometimes than you would in the station'*. Five of the workers highlighted domestic violence amongst the Traveller population as an area of concern.

Most of the **Traveller community members** participating in this study discussed crime in terms of drug dealing and funding drug use, and these data are reported in sections 3.4.2, 5.1.2, 5.2.3, and 5.3.3. Being suspected of crimes and followed around by security guards in shops and pubs was reported from three of the focus groups, however.

4.1.6.1 Risk factors for problematic drug use related to involvement in the criminal justice system

The risk factor for problematic drug use related to crime is offending at a young age (DEPP, 1998; HAS, 2001). Several commentators (Bell, Wechsler and Johnston, 1997; Miller and Plant, 1999; Windle, 1990) point out that adolescent drug use appears to be '*part of a general syndrome of deviance or risk-taking behaviours*' (Miller and Plant, 1999 p.893).

The association between criminal behaviour by young people, anti-social behaviour and conduct disorders, and the development of drug use is well-documented in the relevant literature (Beman, 1995). A review of the risk factors for problematic drug use by Clayton et al. (1995) concludes that longer duration of involvement with delinquent peers increases the likelihood of introduction to drug use via these peers, and thus heightens risk for developing problematic use.

As there are no data on young Travellers and offending, this risk factor for problematic drug use cannot be reliably assessed. However, given that, as shown in sections 3.1 - 3.3, it is known that some young Travellers are using drugs, and if this occurs within a deviant peer group, then they are at risk.

It is a cause for concern, given the over-representation of Travellers in prison (Pavee Point, 2004), that drugs are freely available there (section 3.3.3); that the first use of drugs, or of a specific drug such as heroin, can occur in prison (section 3.3.3); that a high proportion of prisoners use drugs, inject them, and share injecting equipment (Department of Tourism, Sport and Recreation, 2001); that 13% of drug-related deaths are associated with imprisonment or release from prison (Byrne, 2002); and that prison drug services are still under development (Department of Tourism, Sport and Recreation, 2001).

4.1.7 Family

The aspects of traditional Traveller families that differ from those of the majority population include child rearing traditions, the number of children living with parents, courtship and marriage traditions, division of household chores, and the importance of the support of the extended family (personal communication, 2005b). For example, in the past, arranged marriages, characterised by short courtships and marriage at a young age, were not uncommon, and currently, a characteristic of the Traveller culture is '*different patterns of dating or forming relationships to those of the settled community*' with strict standards and socialising patterns imposed on young unmarried Traveller women (McDonagh, 2000 p.59). However, as with any community, there are a variety of traditions within the Traveller community and variation in the extent to which they are practised.

Ten of the **agency workers** interviewed for this study discussed the pivotal role of the family in Traveller culture. However, several pointed out that a problematic aspect of the Traveller focus on the family meant that domestic violence is hidden, and that families found it difficult to deal with situations where this role is challenged, such as marriage outside the community and family support initiatives which can be interpreted by Travellers as suggesting they have poor parenting skills. The focus groups for **Traveller community members** also underlined the importance of the family in Traveller culture, but also pointed out that, especially on large Traveller sites and where young Travellers mixed with the settled population, the influence of the family was lessened.

4.1.7.1 Risk factors for problematic drug use related to the family

The risk factors for problematic drug use related to the family are (DEPP, 1998; HAS, 2001):

- Problematic drug use by parents
- Problematic drug use by siblings
- Problematic drug use by partner
- Family disruption
- Family conflict
- Family breakdown
- Poor attachment to parents (see also Farrell and White, 1998)
- Poor communication with parents
- Family criminality
- Tolerance of drug use in the family (see also Miller and Plant, 2003 p.24)
- Inconsistent parental discipline

The family-related protective factors for problematic drug use are (DEPP, 1998; HAS, 2001):

- Parental supervision
- Strong parent-child attachment

Hurley (1999 p.26) points out that Traveller families tend to live and socialise in extended family networks, and *'for the bulk of Travellers their main sphere of influence and knowledge is within the confines of their extended family'* (p26). This influence and 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 also that shared activities could include using drugs. Equally, however, the closeness of the extended family, especially between parents and children, can act as a protective factor against drug use if drugs are not being used within it.

In terms of parental supervision, Hurley (1999) reports that Traveller girls may be protected from drug use if they adhere to the strong social boundaries placed around them. Following marriage, however, Hurley points out that a woman's husband becomes their main influence, and if he is a drug user, then she is at risk of drug use.

Although the family is a significant element of Traveller culture, it is susceptible to disruption, breakdown, and conflict, which are risk factors for problematic drug use. The extremely youthful demographic, the lack of adequate temporary and permanent halting site provision (particularly that large enough to accommodate extended families), a deteriorating nomadic economy, and the urbanisation of the population, has, as Power (2004 p.9) puts it, *'placed huge strains on the extended family unit, breaking down traditional constraints in some cases'*.

4.1.8 Social networks

Heron et al. (2000) note that *'historically, Travellers' survival has depended on the group's solidarity and cohesion, their acceptance of each other as similar, their sense of belonging and their unwillingness to conform to the lifestyle of the dominant society'*. However, attempts to marginalise opportunities

for Travellers to lead traditional lives has not led to Travellers' conformity to the dominant culture in Ireland, but their social exclusion. For many, this includes limited opportunities to extend their social networks. For example:

Travellers are under-represented in the education system (section 4.1.1) and in employment (section 4.1.3).

Young Travellers are frequently denied access to youth clubs and other youth recreational facilities (Department of Health and Children, 2002; Hurley, 1999; McCarthy, 2005), and all age groups are *'often barred, not welcome in or excluded from commercial venues and facilities'* (Khan et al., 2000b p.45).

It has been suggested that *'It is easier for Travellers to access illegal drugs than to get served in pubs, from which they are often barred'* (Fountain et al., 2002 p.152).

Nomadism means that even if relationships are formed outside the Traveller community, they are disrupted if the Travellers move on.

Twelve of the **agency workers** interviewed for this study discussed the social networks of Travellers, most pointing out that although, traditionally, this was largely restricted to the family, new anti-discrimination laws and a reducing nomadic lifestyle has meant more interaction by Travellers with the settled community, particularly in the Dublin area. In terms of drug use by young people, several interviewees pointed out that whilst *'Travellers' parents think that protecting them and keeping them away from the big bad world is best'*, but that this *'only creates naive and easy targets'* in terms of initiation into drug use when Travellers mix with the settled population. Two agency workers perceived that those Travellers whose social networks included members of the settled community and perceived themselves as *'modern types'* were in *'no-man's land'* in terms of their social networks and speculated that this may have resulted in *'a conflict with identity...not fitting into either culture'*.

When discussing social networks, members of four of the focus groups for **Traveller community members** stressed that the more Travellers mixed with the settled population, the more likely it was that they would use drugs. Five of the focus groups reported that, as there were no social and leisure facilities on the sites where they lived, young people either just hung around aimlessly, or went into the nearest town to use the facilities there. Although three of the groups reported that their community *'mixes well'* with the local settled population, another three pointed out that discrimination such as Travellers being barred from pubs and clubs precludes this, and that at school,

If you have friends, they'll usually be Travellers. Not that you don't want settled kids [as friends], it's just they won't be friends with you.

Fountain et al. (2002) also discuss this issue in terms of Black and minority ethnic groups throughout the European Union. According to some commentators in some countries, the more integrated the Black and minority ethnic group is with the majority culture, the more likely it is thought that their drug use will mirror that of the rest of the population. On the other hand, it was also suggested (although less frequently) that lack of integration was a risk factor for drug use.

4.1.8.1 Risk factors for problematic drug use related to social networks

It has long been reported that the strongest predictor of young peoples' drug use is that of peer relationships. For example, as Oetting and Beauvais (1987 p.206) summarise, '*Peers shape attitudes about drugs, provide drugs, provide the social contexts for drug use, and share ideas and beliefs that become the rationales for drug use*'. This influence is shown more recently by a cross-sectional study of 2,641 young people aged 15-16 years (Miller and Plant, 2003). The authors report that, even after accounting for other variables, those whose friends smoked cannabis '*were more than 15 times as likely as other subjects to have smoked cannabis themselves in the past 30 days*' (p.24). Miller and Plant (p.24) add that illicit drug use '*seldom occurred in isolation. It was typically a social activity among a group of friends*'. In the same way, the risk factor for problematic drug use related to social networks is problematic drug use by peers. The protective factor is pro-social (non-deviant) peers (DEPP, 1998; HAS, 2001). As Clayton et al. (1995 p.10) stress, however, the influence of family, school and peers '*are not mutually exclusive domains of influence - they are often concurrent, sometimes countervailing, and always intricately intertwined*'. Fergusson and Horwood (1999) are amongst many commentators who concur.

Social networks, then, can function as a risk factor for problematic drug use if drugs are used within them, or as a protective factor if they are not. The lack of opportunity for Travellers to extend their social networks beyond other Travellers only functions as a protective factor if drugs are not being used within that network. This also applies when social networks are extended: as Parry et al. (2004) report, those young male Travellers who visit the UK mix more with the rest of the population than they do in Ireland and '*go clubbing and get drugged up*' (p.59).

Taylor (2004) believes that one effect of the decreasing nomadic lifestyle of Travellers is increasing drug use amongst them:

Most of the people using drugs are those who have settled on sites, with a smaller percentage of drug users being on the road, although there are signs of that changing quickly...as we settle we have taken on the habits of the settled community, from their schools, on the street and in the clubs or bars.

Thus, there is some rationale in Traveller families' reluctance to send children to school because of a fear that they will adopt the 'bad habits' of the settled population such as drug use (as discussed in section 4.1.1). In summary, as pointed out by Patel et al. (2004, p.xvi) in relation to another group of socially excluded young people, refugees and asylum seekers in London:

Many refugees and asylum seekers experience difficulties making friends because opportunities for creating social networks are limited by language, cultural differences, racism, and exclusion from education and employment opportunities. The limited opportunities for assimilation may protect some adopting local drug-using patterns, but an awareness of drug use in their immediate environment and the influence of 'Western values' makes these young people vulnerable to drug use.

4.1.9 Environment

Although the use of drugs is not restricted to any one sector of society, its high prevalence and associated problems are particularly marked in areas and localities marked by social exclusion (Khan et al., 2000a,b). The Advisory Council for the Misuse of Drugs (ACMD, 1998) points out that although

there is no correlation between drug use and deprivation, there is a clear link between problematic drug use and deprivation, and whilst not all *problematic* drug users live in deprived areas, a disproportionate number do.

4.1.9.1 Risk factors for problematic drug use related to the environment

The risk factors for problematic drug use related to the environment are social deprivation, community disorganisation, and neighbourhood disorganisation (DEPP, 1998; HAS, 2001).

Sections 4.1.1 – 4.1.8 have detailed the risk and protective factors for problematic drug use in the areas of education, health, crime, employment, accommodation, drug use, family, and social networks. Disadvantages in these areas contribute to the phenomena of deprivation, community disorganisation, and neighbourhood disorganisation, characterised by the combination of poor services, poverty, poor health, inadequate accommodation, educational disadvantage, and lack of employment opportunities. The evidence in this section has shown that the position of many Travellers – especially young people – is that their interrelated social and economic circumstances mean that they are at risk of problematic drug use. The risk is heightened if Traveller accommodation is located in disadvantaged areas where there are already drug problems. As O’Gorman (2005) and Pearson (1987) note, a ‘catch 22’ situation develops in such neighbourhoods: the presence of drug users in a locality makes it highly likely that low-level dealing networks will develop in the area, and visible drug markets add to the level of disorganisation in the community.

4.1.10 Summary: factors impacting on the risk of problematic drug use amongst Travellers

The evidence in relation to Travellers of the inextricable link between disadvantages in the nine areas that characterise social exclusion and the risk factors for problematic drug use is summarised below.

Education

Not attending school, and not achieving whilst there are risk factors for problematic drug use. Of those who have ceased education, over three times the proportion of Travellers compared to members of the settled population have received either no formal education, or have at best remained in the system up to primary level.

Health

The risk factors for problematic drug use related to health include mental ill health and living with parents who have mental health problems. Despite a lack of systematic data collection on the health of Travellers, particularly their mental health, the information that is available reveals that they are particularly disadvantaged in terms of health status compared to the rest of the population.

Employment

Unemployment is a risk factor for problematic drug use. Social and economic changes and recent legislation have adversely impacted upon Travellers’ traditional means of earning a living, and in the 2002 census, almost three-quarters of Traveller males and two-thirds of females reported that they were unemployed.

Accommodation

The risk factors for problematic drug use related to accommodation are homelessness, running away from home, and being looked after by a local authority or foster parents. Data on homelessness in Ireland do not include an ethnic identifier, but several groups of Travellers are vulnerable to homelessness, including those whose caravans are confiscated because they are living on unauthorised sites. The combination of factors that put stress on the traditional constraints of the Traveller family has meant that some young people may run away from home, and Traveller children are around six times more likely to be in the care of local authorities or foster parents than the rest of the population.

Previous and current drug use

Drug use amongst Travellers occurs and is increasing. An early onset of drug use is a risk factor for problematic drug use: the youthful demographic of Travellers, and their vulnerability to the other risk factors related to social exclusion, gives cause for concern that drug use amongst them may begin at an early age.

Involvement in the criminal justice system

The risk factor for problematic drug use related to crime is offending at a young age and association with delinquent peers. Although there are no statistical data on crimes amongst young Travellers, it is known that some young Travellers are using drugs, and if this occurs within a deviant peer group, then they are at risk of problematic drug use.

Family

The risk factors for problematic drug use related to the family are centred around drug use by other family members and family disruption, breakdown and conflict. Family influence is a significant element of Traveller culture and this influence and 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. Equally, the closeness of the extended family can act as a protective factor if drugs are not being used within it. However, there are some indications that the Traveller family may be becoming increasingly vulnerable to disruption, breakdown and conflict, and that the influence of these protective factors may be being eroded.

Social networks

The risk factor for problematic drug use related to social networks is problematic drug use by peers and the protective factor is pro-social (non-deviant) peers. The lack of opportunity for some Travellers to extend their social networks beyond other Travellers functions as a protective factor only if drugs are not being used within their Traveller-only social network. Similarly, 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.

Environment

The above indicators of social exclusion contribute to the phenomena of social deprivation, community disorganisation, and neighbourhood disorganisation that are risk factors for problematic drug use. The evidence clearly shows that many Travellers experience all these disadvantages and that few of the factors that may protect them against problematic drug use are operating.

4.1.11 Study participants' recognition of social exclusion as a risk factor for problematic drug use

Many of the 34 agency workers interviewed for this study displayed an awareness of the interrelated factors that characterise social exclusion. For example:

Discrimination, marginalisation, poverty, dreadful housing conditions. I mean, the living conditions of families on the [Traveller] sites that we are working on – it's just unthinkable that that would exist for the settled community...lower life expectancy, things like that...integration issues – relationship with the settled community is obviously an issue...the sense of a community displaced, isolated and marginalised by society.

Although a few of the Traveller community members who took part in focus groups and one-to-one interviews for this study made the link between aspects of social exclusion and problematic drug use, most who commented on this issue saw drug use amongst young people as a result of boredom because they had 'nothing to do' and, especially, of mixing with the settled community at school or socially.

Several of the agency workers related the social exclusion experienced by Travellers directly to the risk factors for problematic drug use. For example:

When you look at the problems that face quite a lot of our clients, they should really get a medal for getting out of bed because of the awfulness of the situation...most of their kids in prison, and the others out of control...some of their kids in care, they get beaten up regularly...they are made homeless, they get arrested for shoplifting or suspected of shoplifting. I mean, every day there is something which would floor most of us. They have it every day. So I would be taking drugs if I was living like that.

Ninety-nine per cent of them [Travellers using drugs] have dropped out of school and have never gone to secondary school. A lot of them would have come from large families, where there would have been a certain amount of violence. A lot of them would never have been employed, or, if they have been employed, in very menial jobs. And a lot of them would suffer from depression or there would have been a history of depression in the family.

They [heroin users] tend to be more marginalised and dysfunctional family groups...a particular family group that I know, they've come from a very hard, violent, tough background...a really difficult life and their whole life has been involved with alcohol and abuse and violence, and heroin seems to be a problem for them.

5 The perceived impact of drug use on the Traveller community

The definition of problematic drug use used in this study (see Terminology section at the beginning of this report) includes the harm caused 'to the individual, their significant others [such as their family or partner] or the wider community' (NTA, 2003). This section presents the perceptions of the Travellers and agency workers in relation to these three impacts.

It should be reiterated here that not all the 34 agency workers interviewed for this study worked in the drugs field, nor exclusively with Travellers, and some worked in areas of Ireland and/or in occupations where they encountered little problematic drug use. Eight of these interviewees were therefore unable to comment on its impact on the individual, their significant others, and the Traveller community. Similarly, the 20 focus groups with 122 members of the Traveller community revealed that their knowledge of drugs and drug use varied greatly. For example, many found it difficult to distinguish between different drugs and their effects, and between drug use and problematic drug use. However, it was clear from the responses of many of the Traveller community members that drug use – and especially addiction – was greatly feared, despite not being fully understood, and that many parents were extremely worried that their children would start to use drugs: as one of them put it, 'every Traveller mother and every Traveller father has that fear'.

5.1 The impact of drug use on the individual

The discussions by agency workers and Traveller community members on the theme of the impact of drug use on the drug user can be categorised as health, funding drug use, lack of motivation, and exclusion from the family and community. In addition, the drug-related risk behaviour reported to the study is examined in terms of its impact on the drug user.

5.1.1 Health

The impact of drug use on health most often discussed by the agency workers was the transmission of HIV and hepatitis C (and, less often, hepatitis B) by injecting drug users, including that poor standards of accommodation meant a high risk of transmission. That said, it was thought that few Travellers injected the drugs they used.

Two agency workers thought that drug use led to mental health problems, including suicide, and this was also reported from six of the focus groups for Traveller community members.

Members of five of the focus groups discussed how drug use can lead to death and/or overdose, and seven groups reported the effects of drug use, particularly ecstasy, on the brain. Other perceived effects on health were lethargy and 'heart problems.' Members of two of the focus groups also concentrated on the most severe effects of drug use on health:

People on drugs are killing themselves.

I've seen people wasting away in a couple of months with crack cocaine.

Drug users are destroying their body and sending themselves to an early grave.

5.1.2 Funding drug use

Two of the agency workers discussed the criminal activity perpetrated by Travellers to fund their drug use, including theft from their families and other Travellers. It was reported by one agency worker and

from two focus groups for Traveller community members that prison was a consequence of this for many, with some drug users in a cycle of 'drug use, jail, drug use, jail.' One agency worker and one focus group reported that females funded drug use by prostitution.

One agency worker and one focus group perceived that drug use resulted in heavy debts, including to moneylenders:

They're getting into loads of debt and that can mean people coming after them for their money (Traveller).

Violence by drug users, as a result of the substance used or in order to obtain funding for it, was noted by three agency workers and one focus group:

They'll do whatever it is to get that [money for drugs] and they don't care – they don't care who they hurt along the way (Traveller).

5.1.3 Lack of motivation

Traveller community members participating in three of the focus groups perceived that drug use led to lethargy and a lack of motivation to, for example, socialise, work, and pursue education and training: 'Once they take the drugs, nothing else matters to them'.

5.1.4 Exclusion from family

Most of the participants in this study discussed the impact of drug use in terms of the family rather than the individual (section 5.2), but one agency worker noted that the family of a drug user can prevent a drug-using member from attending family events in order that their drug use can be hidden.

Three of the focus groups for Traveller community members believed that a drug user would be completely excluded from some families, especially when they were committing crimes including stealing from their families, to fund their drug use: 'when they rob...the only alternative is not to live together – to move away'.

5.1.5 Exclusion from community

Six agency workers reported that drug users – particularly heroin users -- are ostracised by the Traveller community, one adding that this sanction can apply to the family of a drug user too. Seven of the focus groups for Traveller community members discussed this issue at some length, with most participants agreeing that they would shun a drug user in case they were encouraged to use drugs themselves, or more often, thought to be doing so because of the association:

Me and [name] is very close, but if I thought she was taking drugs, I'd drop out from her...I'd just be afraid that I'd do it [use drugs] meself.

If you're friendly with that person and it's known that person is on drugs, well then they are going to say the same about you 'well, you have to be on it as well for to keep hanging around with them'.

Travellers from two of the focus groups reported that they would tell their children not to mix with known drug users:

I'd call my little boy and I'd say to him 'keep away from him over there. He's on drugs and he's not good company. Go away and don't be seen with him'.

One agency worker noted that this sanction applied particularly to heroin users:

Heroin and heroin users, they're very much demonised within the Traveller community and they'd be very much ostracised and seen as the lowest of the lows, which marginalises and ostracises the individual – and often the family – from their community.

5.1.6 Drug-related risk behaviour

The risk behaviours related to drug use amongst Travellers identified by the participants in this study were injecting, polydrug use, and the use of sedatives, tranquillisers and antidepressants by those for whom they were not prescribed.

5.1.6.1 Injecting

There was a consensus amongst the agency workers that there was injecting heroin use amongst Travellers, but that this was not commonplace. Although several of the focus groups with members of the Traveller community reported that used injecting equipment could be found littering Traveller sites, drug users from the settled community were invariably cited as leaving it there. If injecting is occurring amongst Travellers however, and if injecting equipment is shared, there is a risk of the transmission of HIV and hepatitis B and C. If sexual intercourse occurs with someone infected with these diseases, there is a risk of transmission.

5.1.6.2 Polydrug use

DrugScope (2001 p.4) defines polydrug use as *'the use of more than one drug, often with the intention of enhancing or countering the effects of another drug'*, adding that polydrug use may *'simply occur because the user's preferred drug is unavailable (or too expensive) at the time.'* Some combinations of drugs can be used concurrently (for example alcohol and cocaine), whilst others are used consecutively (such as alcohol before a club, stimulants at the club, and cannabis after it). Those who use ecstasy may be categorised as polydrug users because of the other substances (such as amphetamines) commonly added to preparations sold as ecstasy.

Polydrug use can include the use of licit substances, especially alcohol, but also 'high energy' drinks (such as Red Bull, which contains the stimulants caffeine and taurine), prescribed drugs such as benzodiazepines and methadone, and over-the-counter medicines such as ProPlus (a 'pep pill', high in caffeine) and medicines containing codeine or morphine (opiates).

The following briefly describes the health risks of common combinations of substances (largely extracted from DrugScope, 2001) reported by the participants in this study. Obviously, the strength and specific effects of any combination is uncertain because of the unknown composition, purity and strength of illicit substances.

Depressants and alcohol

This combination was reported amongst women who were prescribed sedatives, tranquillisers and antidepressants, and also amongst men, using either their own prescription or, more usually, the drugs from others.

Both alcohol and benzodiazepines (some sedatives, tranquillisers and antidepressants) are central nervous system (CNS) depressants, and work by enhancing inhibitory effects. A consequence of use is the depression of the CNS and respiratory system. Behavioural consequences include disinhibition, ataxia (the inability to co-ordinate voluntary movements) and accidents. Whilst overdose on benzodiazepines alone is unlikely, the combination of a large dose of benzodiazepines and a large dose of alcohol could be fatal.

Stimulants and alcohol

It was reported to this study that a combination of cocaine and alcohol was used amongst the Traveller community. Cocaine reduces alcohol-related sedation, and alcohol reduces the insomnia and anxiety resulting from cocaine use. Both substances lead to coronary vasoconstriction (narrowing of blood vessels to the heart) and impair myocardial (heart muscle) function, and in the body it is thought they combine to form another substance, cocaethylene. Research on this substance suggests it is more directly toxic to the heart than either cocaine or alcohol, and prolongs raised blood pressure, thus compounding the risk: alcohol is found to be present in most cocaine cardiac deaths. Other health risks are strokes, liver damage, seizures, withdrawal anxiety, aggression, and trauma.

Alcohol impairs the body's thermal regulation and increases dehydration. When used with ecstasy, the risk of central neurotoxicity (poisoning of the nerve tissue) and impaired cardiac function increases. Additional increased risks are accidents and risky sexual behaviour.

Alcohol and amphetamines are associated with aggressive behaviour.

More than one stimulant

There were reports that some Travellers combined amphetamines, ecstasy and cocaine powder, and also drank 'high energy' drinks at the same time. The combined use of different stimulants can lead to hyperactivity of the nerves supplying the involuntary muscles and glands. Physically, this can result in impaired thermal regulation, impaired cardiac functioning, increased activity levels, and possibly neurotoxicity. Psychologically, a polystimulant user can experience panic, anxiety, paranoia, aggression and the depression of a 'comedown'.

Cannabis and alcohol

This combination was reported to be common amongst Travellers. The degree of impairment is linked to the tolerance of one or both substances. The combination can lead to increased sedation, ataxia, confusion, disorientation, disinhibition, disorientation, amnesia, nausea, and vomiting. It has a marked impact on driving, and there were several reports to this study of Travellers driving erratically whilst 'on drugs'.

Cannabis and other drugs

All the illicit drug users interviewed for this study had used cannabis and other drugs. Strong varieties of cannabis may intensify the effects of other drugs, particularly hallucinogens and stimulants, increasing the likelihood of paranoia or anxiety.

5.1.6.3 Use of others' prescribed sedatives, tranquillisers and antidepressants

It was reported by the participants in this study that sedatives, tranquillisers and antidepressants prescribed to Travellers (usually females) were shared with others and that this practice was common:

If they knew someone was having a bad time of it, I'm sure they'd offer them some - 'go on have these, these will help you' (Traveller).

This practice was confirmed by some of the agency workers. For example:

Often, these prescribed medications are actually passed on from mother to daughter or to the next-door neighbour, because it's seen as the cure, part of the tradition... 'I give it to you because it works for me'.

There were also a few reports from the study participants that Traveller men were reluctant to visit a doctor for depression and used their partners' prescriptions for sedatives, tranquillisers and antidepressants; that young people stole these drugs from their homes and used them with alcohol to get a 'buzz'; and that these substances were sold on the illicit market for the same purpose.

5.2 The impact of drug use on significant others

The issues concerning the impact of drug use on drug users' families, as perceived by the agency workers and Traveller community members can be categorised as stress on family relationships, concern about the drug user's influence on other family members, and the effect on the family's finances.

5.2.1 Stress on family relationships

Five of the 34 agency workers interviewed for this study perceived that having a drug user in the family could lead to the breakdown of relationships within it, including between partners. One commented that it was often *'just one person in the family who's making life hell for so many people'*. Around three-quarters of the 20 focus groups for Traveller community members agreed, and discussed this issue in some depth, with several pointing out that the stress on mothers was especially great. One agency worker added that the stress of having to deal with drug use meant an increased number of Traveller women were seeking prescriptions for sedatives, tranquillisers, and antidepressants.

Three of the agency workers reported that Traveller families did not know how to deal with drug use by a family member, and tried to tackle it themselves whilst keeping it hidden from other members of the community because of the stigma of having a drug user in the family. Traveller community members from five focus groups agreed that avoiding this stigma was a big concern:

They'd be an embarrassment in the family...and everyone would be talking about them.

People will go 'all high and mighty and look at their young fella taking drugs'.

5.2.2 Influence on other family members

As discussed in section 4.1.7, the family is a pivotal aspect of Traveller culture, and the strength of its influence was clear from discussions in 13 of the 20 focus groups with Traveller community members, who perceived that if one member used drugs, the others would also be influenced to do so. For example:

A lot of Travellers out there has big families – some could have fourteen...twenty children, and the older brothers are taking drugs, and sisters, and you fear for the younger ones, because they're watching what's going on and they think it's OK to do this.

I felt sorry for the mother [of a drug user]. She couldn't do anything for him. She kept taking him back, but she had to put him out in the end for the sake of the other kids.

We have four [drug users] in our family... If they're exposed to younger nephews or whatever, you're praying that those younger boys are not susceptible.

5.2.3 Family finances

An agency worker reported the financial impact of drug use by the male head of a Traveller family:

Back to the poverty line again – children doing without...the wife and kids – you know straight away it's them that suffer the financial things.

Travellers from eight of the focus groups agreed that drug users caused financial problems for their families, not least because they stole from them to finance their drug use:

I know a woman had to carry keys like in Mountjoy [prison] to lock everything up because her son had a serious drug problem.

If a kid is on drugs, they will rob everything in the house to pay for it.

It was perceived by members of one focus group that some families attempt to support a drug user amongst them by paying for their drugs in order that they do not have to steal to buy them.

5.3 The impact of drug use on the Traveller community

The agency workers and the Traveller community members were asked to discuss the impact of drug use on the community, and their responses can be categorised as the increased stigmatisation of Travellers, drug users 'setting a bad example' to other Travellers, an increase in crime, and the challenge to Traveller culture.

5.3.1 Increased stigmatisation of Travellers

Discrimination against Travellers was discussed in section 2.2, and three of the agency workers reported that drug use amongst Travellers was perceived by the community to bring increased negative attention to them: as one of them put it, '*Drugs is another stick to beat the Traveller community with*'. Members of three focus groups with Traveller community members agreed. A feature of this negative attention was reported by an agency worker to damage any relationships that had been built up between Travellers and the settled community in an area, as it led to '*mutual suspicion by Travellers and the settled community*' and by a focus group member as '*any sort of bad feeling spins off in everybody's direction.*'

5.3.2 Normalisation of drug use

The influence of drug-using members of a family on other members, discussed in section 5.2.2, was reported to extend to an influence on the rest of the community. Very few Travellers expressed any sympathy for drug users they saw in public, and two agency workers and six focus groups reported that Travellers were worried that, if drug use was seen by children and young people, they would perceive it as 'normal' and begin to use drugs themselves:

If children is watching where everyone on their site drinks and takes drugs...your children are going to think that's OK to do (Traveller).

I don't think it's a great example when you're rearing up little boys...being right where people's on drugs where they're living (Traveller).

5.3.3 Drug-related crime

Three agency workers and four focus groups pointed out that drug use and the crime – especially robberies – associated with funding the use of some substances attracted more gardaí to Traveller sites. That said, a few Travellers complained that the gardaí did not respond to calls from Travellers reporting crime on sites, and section 6.5 reports how some agency workers and Travellers perceived that the gardaí did not tackle drug dealing on some sites, and had designated some as 'no-go areas'.

In this context, it should be noted that the Garda Racial and Intercultural Office was established in 2000, with a responsibility for co-ordinating, monitoring and advising on all aspects of policing in the area of ethnic and cultural diversity. There are 145 Garda Ethnic Liaison Officers, and although Travellers are not recognised by the Irish government as an ethnic group, these officers' training included an input from Pavee Point Travellers Centre, and they are tasked with interacting with Travellers in the same manner as with Black and minority ethnic communities.

5.3.4 Challenge to Traveller culture

An agency worker pointed out that *'The ethic within the Traveller community is quite a strong anti-drug ethic...some of that has broken down in recent times'*. Evidence for this comes from the lack of stigmatisation of cannabis use (amongst males, at least) by many Travellers, reported in sections 3.3.1.1 and 3.3.1.2, even though many also perceived that the use of cannabis would eventually escalate into the use of 'hard drugs', including heroin, as drug users strived for 'a bigger buzz'. Nevertheless, pressure on the Traveller culture and community because of drug use was perceived by members of three focus groups with Traveller community members in strong terms:

Drugs are destroying the community.

Things have changed forever.

In particular, three focus groups perceived that the ostracism of drug-using families and drug users stealing from neighbours had increased tensions within the community. Three agency workers were concerned about Traveller drug users' antisocial behaviour.

5.4 The impact of drug use on drug-using Travellers' lives

The 14 illicit drug users and ex-drug users from the Traveller community who took part in this study were asked about the impact of their drug use on their lives. Their accounts illustrate many of the issues raised by the other participants in this study detailed in sections 5.1 – 5.3.

5.4.1 Cannabis use

The two youngest drug users were both aged 19 and their main drug was cannabis, although they also used ecstasy, and cocaine powder and amphetamines occasionally. Although both were unemployed, the relatively low cost of cannabis meant that financing their use was unproblematic. One reported that drug use had *'not affected my life'* apart from feeling more lethargic than previously. The other also reported feeling lethargic, but added that his drug use had affected his relationship with his parents, to whom he was more antagonistic, and who were trying to *'get somebody to help me get off them, but I said I won't be giving them up'*.

Both these young men's social networks consisted of those who used the same drugs as they did, and one no longer had contact with two friends who did not use drugs, describing them as *'mummy's boys'*. Neither used drugs in the presence of anyone other than their drug-using friends, and both believed that their younger relations should not use drugs, one commenting that if they did he would *'kick the crap out of them and make them stop'*. Both felt their drug use was unproblematic and believed that they would stop using when they *'get bored of them'*, although one thought *'I'll probably be smoking hash for the rest of me life'*.

Of the remaining four drug users whose current (or last) main drug was cannabis, none considered this use to be problematic.

5.4.2 Heroin use

All the eight Travellers (six males and two females, age range 23-41) who had ever used heroin reported that they had also used a range of other drugs. They also all reported that drug use had seriously affected their lives, particularly in terms of damage to their relationships with their families and partners. One, who was currently following a methadone maintenance programme, said that his partner did not trust that he was not using heroin and still checked items in their home to see if had sold them to buy heroin: *'I've got a long way yet to go to get that trust back'*. Another said that the Traveller community ostracised him when they realised he was a heroin user.

Five of the heroin users revealed that they financed their drug use through borrowing money from friends, family and moneylenders, and crime, including theft and dealing. One, who had spent 200 euros a day on heroin, reported:

I'd rob cars, rob shops...robbing me mother and robbing anything she had and left her with nothing.

Other reported impacts of drug use by the heroin users were *'my life flew by'* for fourteen years; risk of losing the family, partner, home and children; mental ill health, including self-harm and attempted suicide; prison because of crimes committed to fund drug use; and, from those currently receiving treatment with methadone, shame and disgust when they looked back to the period when they used

heroin – ‘Looking at it now, it’s disgusting me. Really’. For example, one recounted how his mother was now unable to obtain local authority housing because he was using drugs and had been convicted of dealing whilst living with her.

5.4.3 Cocaine use

The two drug users who had used cocaine extensively reported the same impact on their lives as the heroin users.

5.5 The impact of drug dealing by Travellers on the Traveller community

Three of the focus groups for Traveller community members discussed the effect of drug dealing on the sites where they lived. They recounted how settled dealers came there, threatening drug-using Travellers who owed them money (*‘I mean, the threats I’ve heard – Jesus, they’d make the hair stand on end’*), and to buy drugs from, or sell them to, Travellers who lived there. Four agency workers stressed that dealers and drug users on Traveller sites turned them into intimidating locations. For example:

People are saying they have to move from a very nice house because of the drug pushing and drug taking...there’s a family terrorised by a couple of young lads who are selling and taking drugs and encouraging other people to come in [to the site] and that brings money lenders and all that.

There is quite a few Travellers dealing on the site and they’re leaving themselves vulnerable to so many kinds of addicts coming into the site...unsavoury kinds of characters wandering around. Also, I think they leave themselves open to turf wars...somebody just coming in with guns...there is big money involved in it [dealing], it’s territorial and there’s an awful lot of violence involved in it...people have no difficulty about coming in and shooting each other.

Three of the agency workers spoke of drug dealing on some sites being organised and controlled by Traveller families who were ‘terrorising’ the other inhabitants, and linked to organised crime in the settled community. Two of these believed that those Travellers who sold drugs were becoming more organised and less reliant on the settled community’s networks for supplies.

One agency worker added that the situation in some locations meant that the agency feared for the safety of their outreach workers, and on occasions had suspended their work:

There are some halting sites [official and unofficial] that at times are caught up in the whole milieu of drug use, drug dealing, etcetera, and you just can’t go in for a few weeks because guns are being pulled.

Three of the focus groups for Traveller community members thought that an impact of some Travellers selling drugs was that all Travellers became ‘tarred with the same brush’ and further stigmatised.

6 Travellers' methods of tackling drug use

Thirteen of the 20 focus groups with Travellers and seven interviews with agency workers included discussions of how Travellers addressed drug use. The methods are categorised in this section as strategies to prevent drug use amongst young people, attempting a 'home detox', self-regulation of drug use, and seeking help from drug services. Travellers' methods of tackling drug dealing in their community are also reported in this section. Although a range of responses was reported within these categories, it was clear from these discussions that many Travellers saw the responsibility for tackling drug use as the family's. Indeed, Traveller members of only two of the focus groups reported that if they discovered someone in their family was using drugs, they would approach a GP or public health nurse for help. As one Traveller put it, 'All Travellers feel that in all situations, they don't need outside help – their families should be able to help them' and several women condemned families who did not help a drug user amongst them:

Families should help [homeless drug users] – they have people out there belonging to them, but do they really care?...if they have someone out there that cares about them, that's taking drugs, that's sleeping on the streets...they should go looking for them.

[The mother of son who was using drugs was] sitting at our table and she's crying her eyes out... what can you do with her?...[I told her] I'd bring them to a clinic and say 'what can you do?' But [she said] he wouldn't want it...if I was his mother, I'd stand there with him...I'd pick him up and I'd drop him back...and then when I was at work, I couldn't wait to get back to the house to see if he's there....to see if he looked stoned.

The women in one focus group who had attended a drug awareness course, although clearly concerned about drug use in the Traveller community and willing to pass on what they had learned, were unsure whether or not they would extend help to those outside the family:

If a stranger walks up to me and said 'you done a drugs awareness course, can you help me?' and if I thought I could help them, I'd refer them to [drug worker well-known on the site] and I'd try and get them help if I could...I don't know if I could turn me back on someone...[but] you can become dragged into it, pulled into it, you can't walk away from that person, yet you may have tried to help them umpteen times, and your own family is...getting deprived because you're so much trying to look after this person.

6.1 Strategies to prevent drug use amongst young people

In terms of drug prevention and education, members of seven of the focus groups for Traveller community members reported that they talked to their children and told them not to use drugs:

I'm blue in the face telling them.

[I tell my children] 'don't take things off anyone you don't know, don't take tablets, don't take nothing. Run if anyone asks you to buy anything.'

One female commented that, although 'I definitely believe talking to children will help', 'Traveller parents must also 'cross your fingers and pray'. That said, it was recognised by many that young Travellers would hide their drug use from their families because, as a member of the focus group for young Travellers put it, if parents knew, they would 'talk, talk, talk to you'. A young drug-using Traveller

agreed and said he hid his drug use from his parents because *'they were always nagging me'* to get help.

A member of one of the focus groups for Traveller community members thought that a strict upbringing was an effective method for parents to prevent their children using drugs, and one woman regretted *'this law'* that forbids parents hitting their children: *'There's no obedience when you cannot chastise your own child. When they're free to do what they want, they **will** do what they want'*. One of the young drug-using Travellers said he would use physical punishment if he discovered his younger relations using drugs, and a woman from a focus group agreed that drug use by a young person attracted this punishment:

When you see a young person getting beat, you know that the parents have found out about the drugs.

Drug testing by families to ascertain if their child was using drugs was thought to be a good idea by some members of three focus groups. One Traveller believed that a local drug clinic would provide this service, whilst two reported that testing kits could be bought at pharmacists:

If you thought your child was taking drugs...it's like a pregnancy test and you get them to do it...it's great, it's always there to help in the discipline.

One focus group reported that the method of drug prevention used by the older generation of Travellers was to move away, because they *'think that you can [avoid drugs] by going to a completely isolated spot, rear your family that way'*. A social worker also reported that *'a family will move, as they think that would keep ahead of the problem - solve the problem'*.

Few methods of Travellers tackling drug use beyond their immediate families were reported, although several members of a focus group for youth workers from the Traveller community had devised a drug education booklet for young Travellers, believing that *'It's up to Travellers themselves...to give out some help to people, because it's their community at the end of the day'*.

6.2 'Home detox'

One Traveller reported that, when they had discovered a family member was using drugs, and there was a waiting list for a detoxification place, they had used a 'home detox':

It took nearly five weeks to detox him. We used to tie his arms and legs...it's very hard...he was in agony.

Another Traveller also reported this technique:

They'd [drug users' family] tried helping themselves, by locking him up, tying him down.

This method of dealing with drug dependence has also been reported to be used by South Asian families in the UK (Fountain et al., 2003a).

6.3 Self-regulation of drug use

Four agency workers and one of the drug-using Travellers (but none of the Traveller community members who participated in the focus groups) reported that drug-using Travellers attempted to stop or to regulate their use by taking the pledge (promising a priest that they would remain abstinent), the traditional way of dealing with alcohol use. However, it was pointed out by the drug user that taking the pledge did not stop him using drugs because he needed 'professional help', and by two of the agency workers that the strategy was not seen by Travellers nor priests as permanent:

[Travellers say to a priest] 'I want to take the pledge for the weekend. I will give up alcohol and drugs for the weekend and I'll give it back to you on Monday', which means he can then drink and take drugs [during the week]...and this is an acceptable part of the culture and the church will go along with it. (Agency worker)

Five of the drug-using Travellers, who had all used a variety of drugs including heroin, reported that one of the methods they used to stop was to stay away from their drug-using friends. One of these, who had been on a methadone maintenance programme for over a year, said:

Before I started this maintenance, all me friends were on drugs...you'd all hang around together... I don't talk to any of me friends...because I'm on the clinic and I want to stay at that...I'm keeping meself to meself. I'm just me and me girlfriend and the three kids – that's all I want for the time being, till I get a bit longer into this maintenance.

Another of the heroin users reported that his attempts at self-regulation had failed:

I tried to have a break and I couldn't, and I tried to do cold turkey [stop using heroin without medication] and I couldn't do it, so I went upstairs and sliced myself up...from one of the cuts I done, I was three days in hospital.

A 19 year-old Traveller whose current drug-using repertoire comprised mainly cannabis but also ecstasy and occasionally amphetamines and cocaine powder, self-regulated his ecstasy use: 'I wouldn't take too much of them...just one or two would do me'. Another 19 year-old, who used the same range of drugs, had reduced his use of stimulants because of the effects of the 'comedown'.

One drug-using Traveller interviewed for this study used sedatives and alcohol, but no illicit drugs. She accepted she was an alcoholic, but not that she was dependent on prescribed drugs, because she self-regulated her intake: although she was supposed to take them daily, she did not do so.

6.4 Seeking help from drug services

Sections 7 and 8 of this report discuss Travellers and drug services in detail. In summary, although Travellers interviewed for this study (usually females) had had some form of drug education, overall, their awareness of drugs, drug use, and of drug services and their functions was low, and a series of barriers face those who could benefit from drug education, prevention, and treatment services.

Although the eight drug-using Travellers who had used heroin had also all used drug treatment services some of them pursuing programmes on several occasions, this may be a feature of the sample of drug users of this study, most of whom were accessed via agency workers.

Several Travellers reported searching for a service to help a problematic drug user (themselves or someone in their family), but being 'turned away,' 'no-one could help us,' or 'we had nowhere to go for help'. This may be because they were told there was a waiting list, or because they were seeking help at inappropriate services: for example, one of the heroin users said that his mother took him to a 'drugs place' but it was a needle exchange and 'there was nothing they could do for me because I wasn't injecting.'

6.5 Dealing with dealers

Whilst members of three of the focus groups for Travellers thought that other Travellers would confront a dealer selling drugs to their family, members of another three groups disagreed:

A lot of people won't face the people [Travellers] that's selling the drugs – there's the fear.

It would cause trouble...[dealers would respond] 'well, is it anything to do with you? Sure, we're not giving it to you'.

It was suggested by women from two of the focus groups that Travellers who discovered their children were using drugs would 'would go looking for the pusher and make sure they ended up in hospital':

Female 1: They've [families of drug users] gone to burning trailers with people [dealers] in them and everything now, it's gone that bad.

Female 2: They want to lynch whoever's selling the drugs instead of saying 'we'll try and help the child'.

It was perceived by the members of one focus group and by one agency worker that, in addition to selling drugs on Traveller sites, dealers from the settled community paid Travellers to store their drugs there, believing them to be safer from detection by the gardaí there than elsewhere. One focus group with Traveller community members and four agency workers discussed why it appeared that the gardaí were not taking action against drug dealing on Traveller sites. The focus group participants thought that dealers have information about other crimes so the gardaí ignore their dealing in return for it, and one of the agency workers also suggested this:

The guards know who they are – whether they're giving information to the guards or shopping the bigger boys, I've no idea, but they seem to be able to do it [sell drugs] with absolute impunity.

The other three agency workers, however, thought that the lack of prosecution of Traveller dealers was because some Traveller sites were 'no-go areas' for the gardaí because, they suggested, they were afraid and lacked sufficient staff to cope with the situation. These circumstances, they stressed, were advantageous to dealers from both the settled and Traveller communities and encouraged dealing on Traveller sites.

7 Travellers' drug service needs

This section examines the extent to which Travellers' drug service needs are currently addressed, and continues by highlighting drug education as a major drug service need for this population.

7.1 Strategic consideration of Travellers' drug service needs

Fountain et al. (2002) report that, both within and between member states of the EU there is considerable variation in the consideration of Black and minority ethnic communities when drug services are commissioned, planned, and provided. Across the EU as a whole, however, drug policy and practice reflect the needs of the majority population. Evidence that this also reflects the situation of Travellers in Ireland comes from *Traveller health – a national strategy 2002-2005* (Department of Health and Children, 2002), which includes the following 'points of concern' (p.93) in the context of the National Drugs Strategy:

- *The ongoing need to promote awareness among the Local and Regional Drugs Task Forces of the issues for Travellers in relation to drug use;*
- *The need to ensure the inclusion of Travellers in the plans and strategies that are developed by the Local and Regional Task Forces as appropriate;*
- *The lack of information and awareness among Travellers themselves and drug service providers about the nature and extent of drug misuse in the Traveller community;*

However, as noted at the opening of a recent conference on responses to drug problems in the Traveller community:

...statutory services and the state were slow to react to the drug problem in disadvantaged communities within the settled community, in spite of the fact that community groups and activists were saying for a long time that there was a drug problem (Collins, 2005 p.4).

Indeed, in Ireland, strategic consideration of Travellers' drug-related needs is relatively recent. The 1995 *Report of the Task Force on the Travelling Community* (Department of Justice (1995), made no reference to drug use, although it acknowledged that health services did not meet the needs of Travellers. As Hurley (1999) points out from a study conducted for Pavee Point Travellers Centre, Travellers' drug service needs were also unmentioned in Ireland's first and second ministerial reports on drugs in 1996 and 1997 (Government of Ireland, 1996, 1997). Hurley also reports from 1999 that over half of 35 drug agencies surveyed divulged that they had no knowledge of how drugs were affecting Travellers, that few had designed services to meet the needs of this community, and that some agencies felt these were not necessary.

Pavee Point (2004) reports that, although more Travellers – particularly men – are accessing drug treatment services, '*many Travellers remain "out of the loop", when it comes to accessing the limited services that are available*' (p.3). Seven agency workers also commented that drug services were inadequate and underfunded, meaning that, in some locations, the full range of services was not available. For example, the only options in one area of Ireland was reported by an agency worker to be either '*a psychiatric hospital or prescribed medication*', and that this discouraged those who had reached the stage of help-seeking.

In 1997, 13 **Local Drugs Task Forces** (LDTFs) were formed in the areas experiencing the highest levels of problematic opiate use: Ballyfermot, Ballymun, Blanchardstown, the Canal Communities (Bluebell, Inchicore, and Rialto), Clondalkin, Dublin North Inner City, Dublin South Inner City, Dublin 12, Dun Laoghaire/Rathdown, Finglas/Cabra, North East Dublin, and Tallaght (all in the greater Dublin area) and Cork city. In 2000, Bray was designated an LDTF area. LDTFs are a partnership between the statutory, voluntary and community sectors and have devised action plans which include a range of measures in relation to drug treatment, rehabilitation, education, prevention, and curbing the local supply of drugs. The focus of these plans is on the development of community-based initiatives to link in with, and add value to, the programmes and services already delivered or planned by statutory agencies. In addition, LDTFs provide a mechanism for the co-ordination of services in their area, whilst at the same time allowing local communities and voluntary organisations to participate in the planning, design, and delivery of those services. The type of projects receiving support from LDTFs include local information, advice, and support centres for drug users and their families; Community Drug Teams; special projects aimed at children involved with drugs or at risk; the production of drug awareness materials; drug training programmes for community organisations, teachers, youth workers and other professionals; rehabilitation programmes; and initiatives to allow local communities to work with the state agencies in addressing issues of drug supply.

There are **Regional Drug Task Forces** (RDTFs) in each of Ireland's ten Health Services Executive areas (formerly Health Board areas). RDTFs bring together all the state agencies and voluntary and community sectors involved in the field of drug use in their region, and their role is to research, develop, and implement a co-ordinated response to drug use through a partnership approach. The RDTF guidelines (National Drugs Strategy Team, 2002) state (p.7) that the development of services *'could include, for example, treatment referrals, service for travellers, homeless persons and sex workers involved in illicit drug use, training for drug workers, etc.'* which is repeated in the guidelines for the development of RDTF strategy plans (National Drugs Strategy Team, 2004 p.5) and *'It is important to recognise that, in addition to area-based communities, there may also be communities of interest who can play an important role in the work of RDTFs and their participation should also be facilitated'* (p.14).

At the time of writing, some advances have been made by LDTFs and RDTFs in terms of addressing Travellers' needs and Traveller representation on the task force, although a review of their plans reveals that some task forces have progressed these issues more quickly and more thoroughly than others.

The **Young People's Facilities and Services Fund** (YPFSSF) was established in 1998 to support the development of facilities and services for young people, including sport and recreational opportunities, in 18 disadvantaged areas where there was a significant drug problem or the potential for one to develop. The YPFSSF's aim is to attract young people aged 10-21 who are at risk of problematic drug use. Structures established to implement the YPFSSF included a National Assessment Committee (NAC) operating under the auspices of the Interdepartmental Group of the National Drugs Strategy. Guidelines included that, in areas where an LDTF existed (14 of the 18), the Local Development Group (LDG) had to comprise representatives from the Vocational Educational Committee, the local authority, and the LDTF, with a chair appointed by the LDTF. The LDTF had the responsibility for initiating the work of the LDG, and became part of the consultation process carried out by LDGs to rule out overlap, and to ensure convergence with LDTF plans, other services in the area, and that the target group was at risk of drug use. LDG plans were then submitted to the NAC for

approval. An evaluation of YPFSF (Ronayne, 2003) reveals, however, that there were many conflicts in the planning and implementation of this process.

The *National Drugs Strategy* (Department of Tourism, Sport and Recreation, 2001) notes, without naming Travellers, that YPFSF's activities are aimed at young people *'who traditionally have found themselves outside the scope of mainstream youth activities because of their family background, their involvement in crime or drug misuse or their lack of education'*. At the time of writing, YPFSF were supporting eleven projects specifically for Travellers, most of them in the Dublin area.

Ireland's current *National Drugs Strategy* (Department of Tourism, Sport and Recreation, 2001) reports that *'In general, there is no evidence to suggest that illicit drug use among the Traveller Community is, at present, a major issue, although obviously there is always potential for such a problem to develop in the future'*. The strategy reflects this statement, and although Travellers are noted as one of the risk groups for problematic drug use and a request for further research into drug use amongst them is called for, their needs are rarely explicitly addressed. The lack of attention to Travellers by the strategy – and by a mid-term review of it (Steering Group for the Mid-Term Review of the National Drugs Strategy, 2005) – may be an attempt to avoid further stigmatisation of the community by singling them out: the strategy does recognise the link between disadvantaged communities, the risk of problematic drug use (the actions on which are discussed throughout this section), and presents research results by O'Higgins (1998) on the correlation between drug use and young people, poverty, unemployment, low educational attainment, and deprivation, before noting that Travellers are therefore at risk.

7.2 Current drug-related initiatives targeting Travellers

The drug-related initiatives that targeted Travellers that were identified by this study are listed below. This list is not meant to be exhaustive, but is provided to give a flavour of initiatives and services identified from the documents available to the research team at the time of writing, and by the Travellers and agency workers who participated in the study.

In 2000, the **Traveller Specific Drugs Initiative** at Pavee Point Travellers Centre was formed, supported by the National Drugs Strategy Team. The focus of this initiative is to work with Travellers and Traveller organisations to support their access to existing and proposed local and regional initiatives addressing drug use; work with a range of statutory and voluntary organisations to raise their awareness and understanding of the distinct needs of Travellers (a core curriculum module for all Primary Health Care projects is currently being completed); source funds and promote research into Travellers and drug use and promote the inclusion and sensitivity to Travellers and Traveller issues in all drugs research; and to work at a national level to ensure positive outcomes for Travellers in existing and emerging new structures that impact on policies, procedures and services.

During 2004–2005, an eight-day **training programme**, developed by the Traveller Specific Drugs Initiative and funded by the Combat Poverty Agency, trained members of Traveller organisations who are developing responses to drug issues in their local area.

In 2003, in response to the perceptions of a growing problem of drug use amongst the Traveller community but a lack of Travellers accessing existing drug services, **Exchange House** appointed

a drug addiction counsellor as part of their Family Support Team, in order to develop culturally appropriate responses to Travellers in South Inner City Dublin who are at risk of drug use and problematic drug use. The work has included an outreach counselling service, outreach intervention, advocacy, and a drug awareness programme for young Travellers.

Trav Act (formerly Northside Travellers Support Group) provides a drug education outreach worker from the Travelling community to deliver drug education and prevention to Travellers in the Coolock area of Dublin. This worker also acts as an advocate for drug-using Travellers and their families.

The Daish Project is run by the Bray Travellers Development Group and aims to respond to drug use amongst Travellers in Bray and the surrounding areas via education and prevention programmes for children and, for drug users and their families, links to treatment and rehabilitation programmes. The project's objective states *'this marginalised group are targeted to address their needs with due consideration to the cultural barriers which may exist for access to information, treatment and rehabilitation'* (McCarthy, 2005 p.31).

Local Traveller groups are increasingly carrying out drug awareness programmes with primary health care groups, youth programmes, and women's groups. One example of this is Co-Operation Fingal Primary Health Care Programme - a partnership between Co-Operation Fingal Traveller Programme (now the Primary Health Care Group, Balbriggan Travellers) and the Northern Area Health Board. It has trained ten Traveller women on the Primary Health Care Programme, which included training in substance use. The programme has developed a drugs training module that *'will be offered out to community groups and health boards to improve awareness of health related drug issues in a Traveller setting'* (Traveller Health Unit Eastern Region, 2004b p.22).

Several agencies working in the **Tallaght and Clondalkin** area have provided some training for Travellers on drug issues and set up projects involving recreational activities, sport and employment training for young people at risk (McCarthy, 2005).

In the UK, DrugScope / Department of Health (undated) have prepared a briefing paper on drug-related work with Travellers, which includes three good practice examples: **Face it**, a drug education, information, and advice service at North Nottinghamshire Young Person's Drug Service; **Lagged no longer**, a drug awareness video commissioned by the Home Office's Drugs Strategy Directorate, Diversity Team; and **Drugs and the Travelling Community**, an audiotape resource from Cambridge Drug Action Team.

Also in the UK, there is a **Drugs Advice Telephone Line** run by the National Romany and Gypsy Traveller Alliance.

7.3 Travellers' drug education needs

There is evidence of the lack of knowledge about drugs and drug use amongst Travellers throughout this report and that drug education is a major service need for Travellers, not only so that they can make informed decisions about their own drug use, but can also formulate informed responses to it by others in their family and community. Of course, this lack of knowledge is not exclusive to the Traveller population, and the *National Drugs Strategy* (Department of Tourism, Sport and Recreation, 2001) has several actions to address increasing drug awareness:

To ensure parents have access to factual preventative materials which also encourage them to discuss the issues of coping with drugs and drug misuse with their children. (Action 35)

Drug prevention programmes should include 'the development of initiatives aimed at equipping parents of at risk children with the skills to assist their children to resist drug use or make informed choices about their health, personal lives and social development'. (part of action 42)

Action 95 requires RDTFs to 'consider the development and implementation of community-based initiatives to raise awareness...which are capable of being mainstreamed...there are communities that have a very limited knowledge of the nature or manifestations of drug misuse'.

Half of the 34 agency workers and 15 of the 20 focus groups for Traveller community members discussed Travellers' knowledge of drugs and drug use, and perceived that, overall, there was a lack of drug awareness amongst them, despite reports of it being delivered from a variety of sources, including schools, Traveller organisations, drug services, the gardaí, priests, and leaflets. It was also noted by several agency workers that, despite these initiatives, many Travellers rely on the media for information about drugs.

In the focus groups for Travellers, many participants displayed a lack of drug awareness, although some or all of the members of eleven of the 20 groups had received some form of drug education. Extracts from discussions in three focus groups illustrate this:

Female 1: *You can only inject heroin or smoke it.*

Female 2: *No you can't...*

Male: *...you're able to snort it...*

Female 2: *...and you can rub it on your gums.*

Male: *You can rub it all around that area and you just get a massive high on it. Wasn't there some celebrity in England from one of those soaps taking it?*

Female 1: *That was coke [cocaine].*

Male: *Shows how much I know.*

Female 1: *Cocaine is heroin, isn't it?*

Interviewer: *No, it's two different things.*

Female 2: *What's speed then?*

Female 1: *A young chap was in a disco, never took drugs in his life...he went to the toilet... and something was put in his drink. Could he become a drug addict because of that?*

Interviewer: *No.*

Female: *No? Because I thought that some part of it stays in your veins.*

Several agency workers also pointed out this lack of knowledge amongst Travellers:

They have the idea that heroin is there for injecting...and that the heroin you smoke doesn't have the same effect or addictive qualities...there's a lot of misinformation.

[Travellers have a] lack of understanding of the consequences of any form of addiction. If a Traveller gives up using drugs for a week, they think they can give it up at any time for any length [of time]. They think they can control it.

One drug worker pointed out that a reason for the lack of drug awareness amongst Travellers was that, unlike the settled community, they 'are now just beginning to become conscious that drugs are an issue that they must face' and that there remains 'a lot of naivety around the whole drugs issue'. A Traveller Development Group worker agreed: 'It's a whole new area, what happens after it stops being fun, [and there is a] tendency to look at it as if it's not a problem until it blows up in your face'. The consequence is, as an agency worker pointed out, that 'Travellers are afraid of drugs - they're not informed enough to protect themselves', and another added:

I certainly think in the Traveller community that it's all or nothing. You just don't do drugs because if you do, that's it, you're gone. Whereas we would see drugs as something people are going to do every now and then.

That said, some sections of the Traveller population were thought to be more informed about drugs than others. Two of the agency workers reported that Traveller women were better informed about drugs than men, because it was usually only women who attended drug awareness courses. One of the focus groups reported that younger Travellers knew more about drugs than the older generations, and two of the groups stressed the importance of drug education for parents:

It's very important for parents – that there's support for the parents, education for the parents on how to deal with drugs, how to look out for the signs...and what they can do then (Traveller).

There's no point in children having all the awareness in the world [from drug education sessions at school] when they go home and mommy and daddy don't have it (Traveller).

7.3.1 Drug education in schools

Drug education is an element of the Social, Personal and Health Education curriculum, and several Travellers reported from the focus groups that their children had received drug education at school. Some appreciated this because the children passed on what they had learned to their parents:

I never knew what coke [cocaine] was until he [son] showed me the book – showed me a picture of what all these drugs are...he was able to tell me what was good to take and what was bad to take.

Three Travellers disagreed that children should receive drug education at school, however:

Only last week I was talking to a child of eight years of age, and the child was telling me...what the hash plant was, how to use it, how to roll it up into a cigarette, how to heat it...describing how you put it into the cigarette, and you smoke it, and you get a big thrill out of it – an eight-year-old child...I was in shock...an eight-year-old telling you how to use drugs.

You're only reminding them what's out there, things that they didn't know that's there.

If they don't hear about it, they don't want to try it.

Members of four of the focus groups pointed out that those Traveller children who do not go to school or leave early may miss out on drug education delivered there.

7.3.2 Drug-using Travellers' drug education needs

Eleven of the 14 illicit drug-using Travellers discussed what they knew about drugs, and six said they had received no drug education. All eleven reported that they knew little about the first illicit drug they had ever used (cannabis in most cases) but were not worried when they first used it. Two said they still knew very little. For example, the interview with an individual whose main drug was cocaine included the following exchange:

Interviewer: *Have you ever had heroin?*

Male: *I don't think so – I'm not sure.*

Interviewer: *How do you mean, you're not sure?*

Male: *I'm not sure what it is. Like, I often took stuff with other chaps, but I'm not sure what it was.*

7.3.3 The educators

Discussing who should deliver drug education to Travellers, five of the focus groups for Traveller community members and four agency workers stressed that Travellers should do so because:

The evidence around the outside expert approach isn't very convincing (Agency worker).

[Services are needed] where, when they [Travellers] come in, people are speaking the same language...You need role models within the Traveller community who will stand up and say 'look... this is the danger and the consequences'...I do feel it needs people from within...to address it and talk about it and I think that's when people would begin to listen (Agency worker).

If you've a Traveller talking to young Traveller boys or young Traveller girls, they'd listen to him more than they would listen to a settled person...they'd just laugh at a settled person (Traveller).

There should be more Traveller involvement in running the [drug education] course, because you need people from your own community to show you the error of your ways (Traveller).

Several agency workers had met with Traveller organisations to discuss this issue, and highlighted the role of such organisations in terms of drug education:

My understanding from the meeting...was that they [Traveller organisation] could handle it and are best placed in doing the work...if a request came in from a Traveller's group, certainly we'd be happy to work with them, but in terms of developing drugs education initiatives with them...I'd have reservations about officers saying 'OK, let's definitely target Travellers without having negotiation from the other side. Travellers' groups know what Travellers want.

That said, as one agency worker put it:

There's only so far as a Traveller group can go to breaking down the barriers. We can get Travellers in here [drug awareness sessions], we can explain stuff to them, but if the services

don't begin to break barriers down within their own service, there's going to be very little we can achieve...we're going to be the ones bringing people in, and then they're not providing proper stuff on the other side.

7.3.4 The locations of drug education sessions

The preferred venues for drug education sessions for Travellers were discussed by some of the study's participants, who agreed that many are unfamiliar with a formal learning environment, and that sessions should be held somewhere where Travellers feel comfortable. Community centres on Traveller sites were suggested as ideal locations, although the lack of these on many sites was reported.

7.3.5 The media for drug education

The poor literacy skills of many Travellers was discussed in section 4.1.1, and this was emphasised in discussions on drug education in the focus groups for Traveller community members. Members of four of the focus groups thought television was an ideal medium for drug education:

Shouldn't it be on television about drugs? It's on about drunken driving, about fags, about everything else.

Members of a further two focus groups suggested that drug education videos should be distributed amongst Travellers. A focus group for youth workers with the Traveller community also reported that drug education material for Travellers should not assume recipients can read: they were in the process of producing a booklet aimed at young Travellers whose literacy skills were poor and it consisted mainly of pictures '*so if they can't read, they can just look*'.

Two agency workers reported that they were expected to use '*the latest buzz word*' drug education packages with Travellers, and that this strategy should be reconsidered:

Health boards push a particular product or approach...if you asked me to say can I recommend one particular product or promotional approach for the Traveller community, it doesn't work that way...I'd be very wary of going in and saying 'this is what you should be doing' (Agency worker).

7.3.6 The drug education message

Throughout this report, there are extracts from interviews and focus groups with Travellers that reveal that drug use was frequently portrayed by them in terms of the most damaging consequences, and that harm reduction messages are alien to those who believe, for example, that all drug use and drugs are equally harmful and lead to addiction and death. For example, some members of one of the focus groups for Travellers were in the process of producing a booklet aimed at young people whose literacy skills were poor, and had included pictures of graveyards and headstones and '*pictures of families and what it does to them*'; and it was pointed out by several agency workers that issues surrounding the use of, and dependence on prescribed sedatives, tranquillisers, and antidepressants is perceived by many Travellers to be different from the issues surrounding illicit drugs. Clearly, to be successfully implemented, drug education messages must take Travellers' current beliefs about drugs and drug-related risk behaviour into account in a sensitive manner. In addition, issues other than drugs – particularly accommodation – may be higher on some Travellers' agendas than drug use, and planned initiatives may need to incorporate these concerns. As Henderson (1995 p.8) notes:

Some of the local drugs prevention teams have learned that going into communities on a drug prevention ticket can be sustained only if the concerns of local people are recognised and respected.

Pavee Point (2004) also recommend a 'holistic approach [to drug services] that incorporates and takes cognisance of the issues Travellers experience daily i.e. accommodation and living conditions, health, education, discrimination, poverty and social exclusion' (p.5), such as the vulnerability to drug use of young Travellers not at school and the discrimination that denies many of them access to leisure facilities.

8 Barriers to drug service access by Travellers

A significant element of social exclusion is a lack of access to all services, including drug services, and research amongst Black and minority ethnic communities across the EU, including Travellers in Ireland, has shown that members of these communities are under-represented as clients of drug treatment, education, and prevention services (Fountain et al. 2002). However, in Ireland, the National Drug Treatment Reporting System (NDTRS) does not record the ethnicity of those receiving drug services, so statistical evidence on the representation of Travellers cannot be extracted.

Amongst those who have identified the barriers Travellers in Ireland face to accessing health (including drug) services are the Department of Health and Children (2002), Hurley (1999), McCarthy (2005), Merchants Quay/NACD (2004), Pavee Point (2004, in an examination of the strengths and weaknesses of the National Drugs Strategy in terms of Travellers), and the speakers at the conference *Moving forward: exploring responses to drug issues in the Traveller community* (Pavee Point, 2005c). These barriers can be summarised as:

- poor literacy amongst Travellers;
- a lack of awareness of the existence and nature of services by Travellers;
- discrimination by health services against Travellers on individual and institutional levels;
- a lack of services targeting Travellers;
- a lack of cultural sensitivity by services;
- a lack of Traveller health needs assessments;
- a lack of the involvement of Travellers in researching drug service needs and in planning and providing these services;
- and the stigma attached to drug use within the Traveller community.

It is important to note here that these barriers have been identified as facing many Black and minority ethnic groups in the UK by, for example, Fountain et al. (2003a) and Sangster et al. (2002) and across the European Union by Fountain et al. (2002) and Khan et al. (2000a,b).

Data from the current study were examined in terms of the barriers that confront Travellers attempting to access and benefit from drug services, and these were identified by the study participants as; the lack of awareness of the existence and nature of drug services; the lack of formal education; stigma and embarrassment; the lack of cultural competence by services; and racism, discrimination and stereotyping.

8.1 Lack of awareness of the existence and nature of drug services

Action 96 of the National Drugs Strategy (Department of Tourism, Sport and Recreation, 2001) includes 'for those misusers who may not be in contact with mainstream agencies, [user groups] can help foster awareness about support services available e.g treatment options, needle exchanges etc.' Action 96 adds that there should be 'local publicity about...the type of measures/initiatives being put into place [by user groups]...this information should be disseminated as widely as possible'. However, if these actions are being carried out, it appears that such information is not reaching most Travellers. The interviews and focus groups conducted for this study revealed that, overall, Travellers lacked

knowledge about **drug treatment services**, how to access them, and what drug treatment entails. Seven of the agency workers explicitly stressed this, and four of them also noted that Travellers were unaware of the nature of drug treatment, expecting a 'quick fix' solution:

They don't understand about addiction and...they think there's a little magic wand.

They ask for Librium [chlordiazepoxide] to stop them shaking...as soon as the signs and symptoms are under control, they're gone [withdraw from the treatment programme].

It was clear from the discussions in several focus groups that some Travellers perceived that a problematic drug user could 'get off drugs' without intervention from drug services, although the following exchange shows that some did not agree:

Female 1: *You'd often hear people saying they're trying to get off it, but they're doing it on their own.*

Female 2: *...doing it by themselves...*

Female 3: *A lot of people goes off for a while, thinking they can get off it, with their own help, but they cannot...they need help – you just can't get off it yourself.*

The focus groups for Traveller community members revealed that the majority had only a vague knowledge of drug treatment services. Several groups discussed these in terms of the lack of all services for Travellers, insisting that 'There's no help at all for Travellers', and

There's probably help out there in general, but there's no help when it comes to Traveller-friendly services.

Travellers were more aware of **drug education services**, which were much appreciated. Around half of the community members reported that they or their children had received these from a variety of sources, including schools, Traveller organisations (especially Pavee Point), the gardaí, priests, and from leaflets.

The focus group and interviews with prisoners in one prison reported that there were no drug services there, only urine tests and punishment if they were positive for drugs, whereas prisoners in the other prison reported that drug services were provided there.

8.2 Lack of formal education

When asked about barriers to drug services faced by Travellers, 13 of the agency workers and four of the focus groups for Traveller community members cited poor literacy skills, particularly in respect of filling in forms at services. In addition:

They can't read stuff in the paper [information about drug services] and they can't find their way there on a map (Traveller).

Two agency workers reported that, at one drug treatment service, clients were expected to keep a written diary, which assumes a degree of literacy skills:

We ask clients to commit themselves on a daily basis to what they're going to be doing in their evening times and at the weekend. And they write out what we call a request...'OK, I'm leaving

at five this evening, I'm going home, have my dinner, watch some telly and then maybe go for a walk'...reviewed the following day.

Poor literacy skills were also reported by seven service providers to impact on Travellers' understanding of, and compliance with, an appointment system, as they could not read letters giving appointment dates, and did not use calendars nor diaries to record them.

Three agency workers pointed out that Travellers' inexperience of a formal learning environment meant that it was difficult to deliver drug education sessions to them in the same way as to the settled community:

It was very, very difficult to actually put the information across that I wanted to put across, because one was being distracted here, there and everywhere the whole time...they're not really used to sitting down and taking authority from a learned guy or learned woman up in front.

8.3 Stigma and embarrassment

The majority of the participants in this study discussed stigma and embarrassment about drug use amongst Travellers, and three reactions that can greatly obstruct access to drug treatment services by problematic drug users were identified: the drug user not telling their family they were using drugs; the family knowing about the drug use of a member, but hiding it because they did not want other Traveller families to know; and both the drug user and their family not wanting to discuss this issue with drug services.

Six of the focus groups reported that a drug user would hide their drug use from their family:

They'd [think] they'd be an embarrassment in the family...and that everyone would be talking about them. I think they'd hide it...a young boy wouldn't like go up, say he's got a problem and get it worked out.

Half the Travelling people out there would be ashamed to say they're on drugs...the only ones that knows would be the ones that's taking drugs with them...they won't tell their families...they'd be too embarrassed.

One mother commented on the consequence of hiding drug use from the family: *'If they're not doing it in front of you, if you don't know, how can you get help?'* This underlines that tackling drug use is seen as the responsibility of the family, as discussed in the introduction to section 6.

Three focus groups reported that a Traveller family would hide the drug use of a member from other Travellers:

They'll deny it... 'my family is perfect'.

If I was on drugs...I'd be ashamed to tell [friend] I needed help...I wouldn't want other Travellers to know.

One of the drug-using Travellers agreed:

If you [interviewer] go around this area now and see all the Travellers, [they will tell you] 'Oh no, there is no one on drugs'. I know in this area alone there's about thirty Travellers on it [heroin]...I think they're ashamed of it...they always want to say 'Oh, Travellers never touch the stuff'.

Eight focus groups reported that the effect of trying to keep drug use hidden because of stigma and embarrassment is that individuals and/or their families do not seek help:

Female 1: *There is help there but Travellers is ashamed...*

Male: *...to let anybody know...*

Female 2: *...what their family is up to.*

Well, I know for a fact that Travellers I know, if they're on drugs, they wouldn't go around a place like that [methadone clinic]...I'd say it's very hard to go in there and talk to people and open up... they'd be ashamed, they wouldn't know what to say.

A lot of them won't even go for information, won't go for help, because they're ashamed in case another Traveller would see them.

Although a few of the agency workers pointed out that there was stigma and embarrassment about drug use amongst the settled community too, it was thought that this issue was especially significant to Travellers, because as a Traveller Development Group worker pointed out, 'a community that is [already] marginalised...the last thing that anybody wants is to have the finger pointed at them'.

Eight of the agency workers agreed with the Travellers that the stigma and embarrassment of problematic drug use meant that Travellers were reluctant to access drug treatment services, in case they were seen there by other Travellers:

Everybody goes there [methadone maintenance clinic] at half nine...and so they're visible – it puts a lot of people [Travellers] off.

This is a small town. You're seen going in the door and are asked 'what are you doing going in there?' What if you met someone you knew going in?

Supervised [methadone] consumption – everyone will know if you have to drink it in the chemists

One of the drug users thought it was easier for settled people than Travellers to access drug treatment: '*settled people*' can go to a clinic and talk to them...a Traveller won't, he'll try to hide it' Two other drug users who had accessed drug treatment services reported being embarrassed because all the other clients there were settled people. In one case, this embarrassment was exacerbated because the Traveller did not want the settled clients to know that he could not read.

8.4 Lack of cultural competence by services

Various terms are used to describe the ability of a service to meet the needs of the diverse populations it serves. For example, in an overview of the delivery of drug services to Black and minority ethnic communities, Sangster et al. (2002) use 'cultural competence,' and Pavee Point (2004 p.13) use 'culturally appropriate' to describe one of the mechanisms through which cultural competence is achieved: a '*practice or approach, or materials/resources that are designed or used to minimise exclusion, support identity, promote respect and support inclusive practice*'.

Several commentators on drug services, including Hurley (1999), McCarthy (2005) and Pavee Point (2004) have pointed out that those designed for the settled population are often not appropriate

for Travellers. For example, McCarthy (p.30) discusses an outreach counselling service delivered by Exchange House Travellers Service in the Dublin area, because *'it was found that Travellers were reluctant to engage with the traditional model, where a counsellor would meet with a client/service user in a comfortable room, with two chairs, with a session lasting no more than 45 to 50 minutes'*. As one of the Travellers who participated in the focus groups for the current study pointed out:

We don't have a tradition of... 'let's sit down and talk about this'...when drugs is in a family, there isn't the whole drill of getting help, or going to the family or going to the addiction centre.

An agency worker added:

There's a very strong resistance [by Travellers] to change at times and a very strong resistance to looking at life from any other aspect....[Travellers will say] 'that's how settled persons talk...I'll not have any of that settled person's carry-on'... 'I'll get through this on my own'.

It was clear from the participants of this study that many services have given little consideration to cultural competence in terms of responding effectively to Travellers' needs. As one of the agency workers interviewed for this study put it:

There are good workers who understand Travellers and go out of their way to accommodate them, but I don't think one should be dependent on finding the right doctor or nurse...The present policy is a bit stacked against the average Traveller getting treatment and being successful in their treatment.

The discussions with Travellers and agency workers revealed several issues for consideration in terms of cultural competence which are discussed in the following sections. It should be noted here that all the agency workers from services that did not specifically target Travellers revealed that they had few Traveller clients, although they could not give precise numbers because ethnic monitoring was not conducted.

8.4.1 The role of the family

As discussed in the introduction to section 6, the pivotal role of the family in Traveller culture can include taking responsibility for tackling drug use by a family member. If a family decides to access drug services, and if the barriers to doing so listed throughout this section are overcome, the cultural competence of the service is crucial if Traveller clients are to be retained.

The role of the family in drug treatment was discussed by only one of the focus groups for Traveller community members, which reported that residential programmes were not appropriate for Travellers, because *'Travellers don't like being away from their families'*. Ten of the agency workers discussed this issue in greater depth, however, and several had clearly given the issue a great deal of thought. For example, one wondered how doctor/drug worker-client confidentiality measures could adapt to, for example, families wanting to know the results of a drug-using member's urine analysis, and drug users being brought to the clinic by family members who expected to sit in on consultations.

Doctor-patient confidentiality was also discussed by another agency worker in terms of Travellers' families accompanying them to treatment sessions, but in somewhat less sympathetic terms:

Their families would be coming down to the Centre with them and they think they can sit in the car park with two carloads of people and this breaks the confidentiality of our other clients...they

wouldn't be rude or anything when you go out and move them – they'd be saying 'yes sir, we understand', 'yes sir', and all this. But the next day they'd be back there again.

A third agency worker pointed out the difficulties in marrying conventional drug treatment with the Traveller culture:

The Travellers regard the family as being the central unit, whereas the culture of Western medicine is the individual, so things like confidentiality, dosage, etcetera are not revealed to the family.

Several agency workers made comments along the lines of 'Travellers don't like to talk about things outside the family', and 'Travellers sort out their problems within the family, not at services'. One pointed out that one result of this was that the influence of the family could override that of the treatment service:

People are being taken out of treatment because the family aren't comfortable or happy with it, not sure what it's about, or think that once they know about it and they keep an eye on it, it will be fine.

8.4.2 Drug service procedures

An agency worker, discussing the procedures by which drug treatment services operate, commented that it led him to question 'whether Travellers' lifestyle and the regime in place actually suits them at all' and the participants in this study gave illustrations of the discrepancies between the two: waiting lists, the appointment system, catchment areas, predetermined privileges at a therapeutic community, medical cards, form-filling, and counselling services.

8.4.2.1 Waiting lists

Four of the focus groups for Traveller community members perceived that there were long waiting lists to obtain drug treatment. Four of the drug-using Travellers said they had had to wait several months to get a place on a methadone maintenance programme or for a detoxification, and this had added to their perceptions that services were reluctant to help Travellers.

8.4.2.2 The appointment system

Seven agency workers noted that Travellers were poor at keeping appointments:

There doesn't seem to be a calendar importance amongst the Travellers...so if we are going to give appointments weeks and months down the line, there is no way they are going to remember that.

Another pointed out that if a client arrives late at some drug services, 'doctors say "you're late, I won't treat you...Come back tomorrow"'.

8.4.2.3 Catchment areas

Seven agency workers discussed how the nomadic lifestyle of some Travellers (whether voluntary or because they are moved on from unofficial sites) was incompatible with the way drug services were run, commenting, for example, that 'people disappear', 'they come to us and then fade away – some go to England', 'they come and they go - there's no way of following them up'. For example, a worker described how moving away affected Traveller clients receiving methadone on a daily dispensing basis:

Maybe you're going down the country -- it's impossible, because you won't get it [methadone] down the country, I'll guarantee you that...these things can't be done overnight – they take months to organise...if you're located in Dublin and getting treatment, it means that if you move anywhere [else]...even in places that could give you treatment, the processes by which things are done are so slow...very often, the GP or the prescribing doctor will want three or four weeks' notification...proof that it's going to happen [the client is going to arrive in another town]. But it's very hard to prove that you're going to drive your caravan to Kerry or wherever.

Several agency workers stressed that because services operated on a catchment area basis, 'if you turn up somewhere else, you'll not be treated'. One reported that post is not delivered to some Traveller sites because post workers are afraid to go there, so some Travellers use an address where they know post will be delivered. If this address is not in the service's catchment area, the service is not allowed to take them on as a client. Another pointed out that Travellers who regularly move (although, as shown in section 4.1.4, these are in the minority) would find it difficult to access local support movements: 'if they link into a local support group, when they move on, there may be no support group in the area'.

8.4.2.4 Privileges

Another example of the discrepancy between drug service procedures and Travellers' lifestyles was described by an agency worker, who explained that although clients in residential drug treatment can write letters to their families, telephone calls and visits from and to the family are privileges that clients must earn. The importance of the family in Traveller culture and the poor literacy skills of many Travellers are clearly incompatible with this system.

8.4.2.5 Medical cards

Two agency workers reported that some general practitioners are reluctant to register Travellers, but without the medical card with a local address received on registration, they could not be taken on as clients:

They don't have medical cards...that's a problem, with addresses...we always have to get them for them – chase up medical cards, that sort of stuff.

8.4.2.6 Form-filling

Four agency workers commented on the form-filling that registering with a drug service involved, one noting that it was 'harder to get information from Travellers than settled people':

The rigmarole you have to get through to get into a clinic...you have to fill out forms...you've to disclose a lot of information, and Travellers are actually quite conservative in giving information about themselves to settled people.

Apart from form-filling being difficult for those with poor literacy skills, two agency workers also wondered if Travellers had only previously encountered such detailed probing and bureaucracy from the police, and thought that this may lead to them giving incorrect responses, especially about a criminal record:

They probably have a natural fear that they won't get on the programme if they tell us about their [criminal] record.

8.4.2.7 Counselling

One focus group, three drug-using Travellers, and one agency worker discussed drug counselling services. There was a difference of opinion amongst these study participants. The focus group for Traveller community members reported that Travellers would be 'too embarrassed to go for counselling,' and an agency worker commented:

They [Travellers] interact very well with support workers, but they don't make the step up to the counsellors...we haven't been successful in getting any of them into the counsellors.

On the other hand, three of the drug-using Travellers reported good experiences of counselling, one of them choosing this option to address his drug use rather than medication.

8.5 Racism, discrimination and stereotyping

Racism, discrimination and stereotyping against Travellers is discussed in section 2 in general terms, whilst this section focuses on these issues as reported by the study participants in relation to drug services.

Three agency workers reported direct racism to Travellers from settled clients at their services:

Comments would be made, probably inadvertently, that would be of a very derogatory manner, in relation to ethnic groups, racist remarks and so forth.

The participants in this study more often discussed institutional racism, however. This is defined by Macpherson (1999 p.9) as:

The collective failure of an organisation to provide an appropriate and professional service to people because of their colour, culture, or ethnic origin. It can be seen or detected in processes, attitudes and behaviour which amount to discrimination through unwitting prejudice, ignorance, thoughtlessness and racist stereotyping which disadvantage minority ethnic people.

Not unexpectedly, none of the agency workers reported that the service for which they worked discriminated against Travellers, but the way in which they discussed this issue revealed that some had given the issue less consideration than others, and negatively stereotyped Travellers. For example, a few did not appear to think that the service needed to change:

Travellers are reluctant to access services – they are fearful of change. It isn't because the services aren't appropriate.

I'm not going to say 'one size fits all'...having said that, I certainly would not exclude any kind of ethnic and minority groups...I think it's purely down to the individual and how badly that individual requires treatment and recovery...and I think people [clients] can adjust.

Travellers find it difficult to attend settled services, but there are two sides to this story – we do not understand Traveller culture, but Travellers do not declare their needs and find it easier to walk away...Travellers have a poor record of keeping appointments. If they are challenged about keeping appointments, then it becomes an issue and they feel like they are being chastised... Travellers need to be taken by the hand. Travellers are likely to run from their problems.

Others balked at such attitudes: for example, one worker thought some services for Travellers had 'very charity-based, traditional approaches', and a social worker added that 'Travellers don't take kindly to people telling them what to do or talking down to them'. Another was more direct:

There are some agencies that are aware of Traveller needs, but the vast majority...there's institutional racism, to put it in a nutshell: 'we don't have time'. 'If they [Travellers] can't fit in....' Trying to put the Traveller dimension on the agenda, people look at you very strangely, as if to say 'why are you bringing up Travellers? Sure, aren't we all equal?'

An agency worker and two Travellers thought that Travellers were reluctant to access mainstream services because they expected discrimination there:

There's an underlying message from all service providers that we hear as Travellers – 'you're not worth it'. There is a message out there that says 'fuck you, you're a knacker, and you're an addict, you're total scum, you may as well die, and you're not wanted' (Agency worker).

Anyone can ask...'can we go to the open prison because we're on drugs and we're trying to get off drugs?'...and they've been refused. I think because they're Travellers (Traveller in prison).

An agency worker working with Travellers reported that 'there are agencies who are trying to address the issue...[a therapeutic community] have been in contact with me saying 'how do we best work with Travellers?'. Several other agency workers said that they had been in contact with Traveller organisations (Pavee Point was specifically mentioned by five of them) for advice and/or training on how to work with Travellers in a culturally competent manner or in partnership with Traveller organisations:

Pavee Point did a session with staff to sort of educate them as to the pitfalls and things to watch out for in the event of Travellers coming to the therapeutic community...I think the staff were happy that it broadened their perceptions and it helped them identify maybe some of their own prejudices.

We met with the Traveller Specific Drugs Initiative at Pavee Point and our response there was anything we could do in terms of support, resources, partnerships [we would do it].

An agency worker described the issues being considered in terms of adapting the service where they worked to incorporate the stigmatisation of drug users by the Traveller community:

[If a Traveller misses an appointment]...we can ring [telephone]...but one of the questions we've been asking is can you call at a Traveller's house or caravan? Because if you're known in the area for the work you're doing [the visit identifies them as a drug user].

9 Recommendations arising from the study

Note: throughout this section, 'drug services' means all drug education, prevention, and treatment services, unless otherwise specified.

This section collates the results from all the elements of the study in order to make practical and achievable recommendations for service development and further research. The recommendations were compiled in consultation with the NACD and relevant government departments.

This report has provided evidence – from the study's participants and from previous research – that there is drug use and problematic drug use amongst Travellers; that Travellers, because of their social exclusion, are at a high risk of developing problematic drug use; and that members of this population face barriers to drug service access. This document therefore serves as the evidence base for the development of drug services as set out in the recommendations detailed in this section.

In the absence of statistical information on the prevalence of drug use and the extent of drug service use by Travellers, this report has presented the perceptions of the study participants on drug use and the surrounding issues. These perceptions indicate variations in the prevalence of drug use and the substances used between localities, particularly between the Dublin area and the rest of Ireland. This is consistent with published data from the NACD for the general population. However, future drug prevalence surveys and research on other aspects of drug use should record the ethnicity of samples in order to collect statistical data to support the qualitative research findings presented in this report. In addition, the ethnicity of drug service clients should be recorded: whilst Travellers are thought to be under-represented as clients, the lack of ethnic monitoring by such services means that the extent to which this under-representation occurs cannot be accurately ascertained.

The majority of the issues that have been raised in this report mirror those raised in relation to the drug use and drug service needs of Black and minority ethnic communities and socially excluded white communities throughout the European Union and in the UK (Fountain et al., 2002, 2003a). The following recommendations, which are in no particular order and are interrelated, can therefore also be applied to Ireland's currently increasing immigrant population:

- 1 Develop procedures on ethnic monitoring within drug treatment reporting systems, routine data collection, and drug service planning systems. These should be in line with current work being carried out under the National Traveller Health Strategy's Ethnic Identifier Pilot project and with international best practice.
- 2 Carry out equality proofing of drugs policy and of drug service planning and delivery.
- 3 Increase awareness amongst Travellers of drugs, drug-related issues, and drug services.
- 4 Adapt the organisational culture of drug services to consider the cultural diversity of Ireland by considering Travellers' drug service needs in terms of the importance of the family, outreach work, nomadism, specific and generic services, literacy skills, appointments, waiting lists, social exclusion, and workforce development.
- 5 Implement an effective Traveller community engagement programme through the collaborative model of the Drug Task Force process.

- 6 Conduct further research on prevalence and patterns of drug use amongst Travellers, including transitions to problematic drug use, injecting drug use, illicit drug use amongst female Travellers, and the use of prescribed sedatives, tranquillisers, and antidepressants; factors influencing successful access to drug treatment services by Travellers; factors influencing retention in drug treatment; drug-related risk behaviour; and engaging male Travellers in drug-related community initiatives. The results of the current study, and those of further research into aspects of drug use amongst Travellers, should be widely disseminated.

9.1 Recommendation 1: ethnic monitoring

Develop procedures on ethnic monitoring within drug treatment reporting systems and drug service planning systems. These should be in line with current work being carried out under the National Traveller Health Strategy's Ethnic Identifier Pilot project and with international best practice.

Fountain et al. (2003a) collated the evidence that argues that ethnic monitoring is necessary to determine current use of services; identify gaps; assess needs; improve quality; evaluate changes; achieve equal access; provide a baseline for planning; allocate resources more equitably; and to measure improvements. Once collected, regular reporting and analysis of ethnic monitoring data from drug services and research studies should take place.

Implementation of this recommendation requires that all relevant bodies be familiar with the Ethnic Identifier Pilot project, that protocols be agreed for its assimilation into routine and non-routine data collection, and that training on data collection and analysis is provided.

9.2 Recommendation 2: equality proofing

Carry out equality proofing of drugs policy and of drug service planning and delivery.

Equality proofing is advocated by the Equality Authority and there are established mechanisms in place for achieving this. In addition, it is important in the climate of an ever-changing Ireland to monitor – by conducting differential impact assessments – the extent to which drug services are reaching out to, and including, Travellers and Black and minority ethnic groups in their service development and provision.

All national drug policies, Local and Regional Drug Task Forces Strategies, Service Level Agreements, and other key documents should be systematically equality proofed.

The evidence presented throughout this report – particularly in section 8 – highlights a number of barriers faced by Travellers seeking information about drugs, drug services, and treatment for problematic drug use. The report, therefore, acts as an initial differential impact assessment, and should be used to inform the establishment of procedures whereby all existing and planned drug service policies and functions can be equality proofed.

Implementation of this recommendation requires robust baseline data, commitment of services to the process, use of standard ethnic identifiers, provision of appropriate training on diversity and anti-racism, and integration into planning and outcome information systems.

9.3 Recommendation 3: awareness of drugs and drug services

Increase awareness amongst Travellers of drugs, drug-related issues, and drug services.

Section 3 of this report reveals an overall lack of awareness by Travellers of drugs and drug use, although there are variations in the level of awareness according to gender, age, and geographical location. This is consistent with the awareness of these issues amongst the general population (Bryan et al., 2000). A more widespread lack of awareness amongst Travellers of the existence and nature of drug services and their functions is apparent from the data in sections 6 and 8, especially concerning drug treatment services (section 8.1).

The recommendation to increase Travellers' awareness of drugs and drug services is supported by the sample of Travellers and agency workers participating in this study: 14 of the 20 focus groups, six of the 15 drug-using Travellers, and 18 of the 34 agency workers interviewed thought there should be more drug education for Travellers.

A lesson from the Local Drug Task Force experience is that local community members should be involved in the delivery of drug education: they should therefore be encouraged and supported to access drug education training. This would also improve the possibilities for those from within a local community seeking to work in this area.

The implementation of this recommendation will involve consideration of who the educators are, the locations where awareness-raising sessions take place, the target audiences, the media used to transmit the information, and the message being transmitted. Travellers should be involved in producing user-friendly information on drugs, as they have been, with great success, on public health issues. The good practice guidelines that have been developed by the Traveller Specific Drugs Initiative for drug education workers working with Travellers should be followed.

9.4 Recommendation 4: cultural competence

Adapt the organisational culture of drug services to consider the cultural diversity of Ireland by considering Travellers' drug service needs in terms of the importance of the family, outreach work, nomadism, specific and generic services, literacy skills, appointments, waiting lists, social exclusion, and workforce development.

This report has identified a major barrier to drug service access by Travellers as a lack of cultural competence by drug services (section 8.4). The recommendations to address this comprise consideration of Travellers' drug service needs in terms of family support; outreach work; nomadism; specific and generic services; literacy skills; waiting lists; appointments; social exclusion; and workforce development.

9.4.1 The importance of the family

Action 60 of the *National Drugs Strategy* (Department of Tourism, Sport and Recreation, 2001) is:

To ensure that treatment for young people includes family therapy...in order to encourage family involvement which is a crucial component in the treatment of young people.

Throughout this report, there are many illustrations of the importance of the family in Traveller culture, and it is clear that family involvement should not be limited to the drug treatment of young people. There is a need to examine and utilise appropriate models in order to be more inclusive of Traveller families where drugs are an issue. This recommendation is reinforced by forthcoming research on family support from the NACD.

9.4.2 Outreach work

Action 64 of the *National Drugs Strategy* (Department of Tourism, Sport and Recreation, 2001) includes:

To continue to develop good-practice outreach models, including mechanisms to outreach drug misusers who are not in contact with mainstream treatment or support agencies.

In the case of Travellers, it is clear that, although information about drugs and drug services via outreach workers is frequently recommended (by, for example, Hurley, 1999 and McCarthy, 2005), there needs to be further consideration of how this method can successfully engage members of this community. It is also clear that, if outreach drug information services are not acceptable to Travellers, then other drug outreach services, such as a methadone bus, would be even less so.

Where Travellers have received the appropriate training, outreach workers should be recruited from within the community to enhance existing capacity. The experience of the Local Drug Task Force process over the last eight years has shown the benefit of drawing on the experience of local people to benefit service delivery in their own community. However, the provision of outreach services should not be confined to drug services and should include Traveller organisations or other groups who are well-placed to provide this service. Outreach services could make a serious positive impact on the provision of information on drug awareness, and on Travellers' access to appropriate services.

9.4.3 Nomadism

The barriers to drug service access related to nomadism were discussed in detail in section 8.4.2.3 of this report, and centred around drug services' inability to deal with potential clients outside their catchment area. This was reported by two agency workers to be a particular problem for Travellers following methadone maintenance programmes where they had to obtain methadone mixture on a daily basis, or were allowed to have only two or three days' 'takeaway' supplies. This issue needs to be addressed within the Local and Regional Drug Task Force process, including Health Services Executive consultation, and within the context of clinical supervision, safety, and dispensing arrangements.

9.4.4 Specific and generic services

To cater for a diverse client group, specific services may be needed in addition to generic services. Travellers need to be informed about drugs and the related issues, to be enticed into services, and to be facilitated to receive a service specific to their needs. Where a need has been identified and the flexibility of a Traveller-specific response is required, services could be fulfilled by Traveller projects or agencies.

Generic services need to name the specific groups at whom their service is targeted. They have a clear responsibility to these target groups and must demonstrate performance against this strategic goal. Generic services should operate in partnership with Travellers to ensure culturally appropriate service delivery.

In order to deliver good quality services, both specific and generic services require that all staff are trained on anti-racism, ethnic monitoring, and cultural diversity in such a way that is relevant to their day-to-day work.

9.4.5 Literacy skills

Traveller health – a national strategy 2002-2005 (Department of Health and Children, 2002 p.4) reports that

up to 80% of adult Travellers are unable to read. This has a serious impact on the effectiveness of health promotion, as well as simple everyday tasks such as filling out forms for medical card applications or understanding instructions on prescription medicines.

Travellers' poor literacy skills acting as a barrier to drug service access was discussed in sections 8.2 and 8.4.2 and included difficulties reading and filling in forms, reading appointment letters, and keeping the diary that was part of treatment at a therapeutic community. This issue has a serious impact on how Travellers receive, process, and act on information, and requires service providers to be innovative and flexible in their communication with Travellers.

9.4.6 Waiting lists

Waiting lists are a problem for all drug services, and this is reflected in the mid-term review of the National Drugs Strategy (Steering Group for the Mid-Term Review of the National Drugs Strategy, 2005, sections 2.15 and 5.6). It is one of the review's recommendations to make access to treatment available no later than one month after assessment (Action 44, p.48).

The recommendation by the Traveller drug users and focus groups that there should be 'no waiting times' for drug services is perhaps over-optimistic and of course depends on the resources made available for these services. However, as this situation represents a barrier to drug service access by Travellers, the reasons for waiting lists should be explained, and methods of retaining potential clients until they reach the top of the list should be explored and implemented. These measures will contribute to increasing Travellers' confidence in drug services as an effective source of help.

9.4.7 Appointments

It was discussed in sections 8.2 and 8.4.2.2 that Travellers and the appointment system appeared incompatible and how this could lead to them being denied treatment. Drug services should examine their procedures in order to assess which aspects of their services currently managed by an appointment system could be changed in order that this barrier to access by Travellers is removed.

9.4.8 Social exclusion

Section 4.1 of this report detailed how the elements of the social exclusion of Travellers means they are at risk of problematic drug use. It is beyond the remit of this report to make recommendations addressing the range of issues concerning Travellers' education, health, employment, accommodation,

involvement in the criminal justice system, family, social networks, and environment other than in relation to illicit drug use, but the policy-makers responsible for each of these areas should be made aware of how their policies impact upon the risk for problematic drug use amongst this population.

The Department of Justice, Equality and Law Reform have responsibility to monitor government policy in relation to Travellers, and this should incorporate the inclusion and consideration of Travellers' needs in drug policy.

9.4.9 Workforce development

It is necessary to develop the skills of the workforce delivering services to Travellers by training in drugs and diversity for all staff, and to increase opportunities for Travellers to join the workforce.

It is recommended that all drug service staff are provided with a common induction level of training on drugs and diversity, covering legislative requirements concerning discrimination and a basic awareness of drug use and the related service provision. Intermediate and higher-level training on drugs and diversity should be provided for those staff with more involvement in identifying and assisting Travellers with drug-related problems.

Without mentioning Travellers, action 66 of the National Drugs Strategy (Department of Tourism, Sport and Recreation, 2001) includes *'To consider the feasibility of new suitably trained peer-support groups...[which] are regarded as an effective rehabilitative support'*. Although commendable, this action stops short of recommending that Traveller community members are themselves trained to conduct a variety of tasks related to the delivery of drug services, including not only acting as peer educators and supporters, but also working in drug treatment services. The Local Drug Task Force process has already demonstrated the value of recruiting from within communities affected by drugs to facilitate change and learning within that community, but Travellers should not be expected to conduct this work as volunteers and should be appropriately rewarded for their efforts.

9.4.9.1 Ethnicity of drug service staff

Fountain et al. (2002, 2003a) stress that the ethnicity of drug workers is a more complex issue than simply employing those who are from the same ethnic group as the clients the service is trying to attract. The complexities include that it should not be assumed that drug users want to see a worker from their own ethnic background, as feelings of shame may be amplified and, if the worker and the client are both members of a tightly-knit community with an efficient gossip network, confidentiality may be compromised.

All workers, regardless of their ethnicity, should be expected to play an explicit role in the delivery of culturally competent services. Nevertheless, ethnically diverse teams communicate an implicit message that services are catering for an ethnically diverse population and that diverse cultures are understood.

9.5 Recommendation 5: community engagement

Implement an effective Traveller community engagement programme through the collaborative model of the Drug Task Force process.

Section 7.2 of this report detailed some drug services targeting Travellers, and they had all involved Travellers in some way in their design and implementation. Despite these initiatives, however, participants at a conference hosted by the Traveller Specific Drugs Initiative pointed out that, although there are 'scattered pieces of work' that can be used as examples of good practice of engaging with Travellers, 'currently there are more gaps than good models in place' (Pavee Point, 2005c p.27).

Only eight of the latest 14 Local Drug Task Force plans and five of the ten Regional Drug Task Force Plans make mention of Travellers as a risk group, or give details of any projects that include Travellers, or of those specifically aimed at Travellers. This omission is despite a proposed action in *Traveller health – a national strategy 2002-2005* (Department of Health and Children, 2002 p.94) that 'Local and Regional Drugs Task forces, in preparing, implementing and updating their plans will examine issues, including Traveller drug misuse'. This action should be immediately addressed by Local and Regional and Drug Task Forces, using the data presented in this report.

The cornerstone of the *National Drugs Strategy* is the interagency and multi-sectoral collaboration exemplified by the structures that have been put in place at national, regional, and local levels. Community participation has been a feature of all aspects of the strategy and is reflected in each of the institutional structures. Common to many of the recommendations for drug service development by the Travellers and agency workers who participated in this study was the involvement of Travellers in researching, planning and delivering drug services. This model of community engagement could also address the very sensitive issues of drug dealing and supply, which are as great a threat within the Traveller community as they are within the settled community. For the greatest effect in the long term, a holistic response is necessary, incorporating engagement with Travellers on a local level to tackle the consequences of drug use; anti-social behaviour such as drug dealing; public health issues such as infectious disease prevention; and drug education, treatment and rehabilitation.

9.6 Recommendation 6: further research

Conduct further research on prevalence and patterns of drug use amongst Travellers, including transitions to problematic drug use, injecting drug use, illicit drug use amongst female Travellers, and the use of prescribed sedatives, tranquillisers, and antidepressants; factors influencing successful access to drug treatment services by Travellers; factors influencing retention in drug treatment; drug-related risk behaviour; and engaging male Travellers in drug-related community initiatives. The results of the current study, and those of further research into aspects of drug use amongst Travellers, should be widely disseminated.

9.6.1 Prevalence and patterns of drug use amongst Travellers

Traveller health – a national strategy 2002-2005 (Department of Health and Children, 2002) contains an action for more research into patterns of drug (and alcohol) use amongst Travellers. When

recommendation 1 (section 9.1) concerning ethnic monitoring of research samples, drug prevalence surveys, and of drug service clients is implemented, statistical data will begin to become available. The NACD will be repeating the national drug prevalence survey and could include the ethnic identifier in the demographic information it seeks. However, this will not produce prevalence data on drug use amongst the Traveller population: for this, a sub-sample of this population would be needed. Therefore, health and social studies carried out exclusively amongst the Traveller community should include questions on drug use (tobacco, alcohol, prescribed drugs, and illegal drugs), in line with those in the national drug prevalence survey.

It is also recommended that research on specific aspects of patterns of drug use is conducted, to identify the particular needs of Travellers. These include transitions to problematic drug use; injecting drug use; illicit drug use amongst female Travellers; and the use of prescribed sedatives, tranquillisers, and antidepressants.

9.6.2 Drug-related risk behaviour

Further research is required into patterns of drug-related risk behaviour in order to inform the appropriate interventions. The prevalence of injecting drug use amongst Travellers was perceived by Travellers and agency workers to be low (section 5.1.6.1), but further research is needed to confirm or deny this perception, and to identify the factors influencing drug-using Travellers' transition to injecting.

9.6.3 Factors influencing successful access to drug treatment services by Travellers

It is recommended that research is conducted into the factors that influence Travellers (both males and females) to seek help from drug services, particularly in terms of how the barriers detailed in section 8 have been overcome.

9.6.4 Factors influencing retention of Travellers in drug treatment

Research on factors influencing the retention of Traveller clients in drug treatment is required, in order to inform drug services of Traveller clients' needs.

9.6.5 Engaging male Travellers in drug-related community initiatives

It is clear during this study that far more Traveller females engage in drug-related initiatives than males. Further research is required in order to ascertain the factors that deter males from doing so, in order that future initiatives can ensure the involvement of all members of the Traveller community.

9.6.6 Communicating research results

It is intended that the dissemination of this report will encourage debate and further investigation, which are important stages in the development of service responses to drug use in the Traveller community. The way will then be paved for needs assessments to take place alongside changes within drug services, and, ultimately, evidence of prevalence and drug service uptake and retention can be systematically acquired. In the same way, there should be wide dissemination of the results of the further research recommended in this section, and of examples of effective practice in addressing drug use amongst Travellers. This process should be monitored throughout via drug service commissioning systems, to ensure that the needs of the Traveller population are being identified and appropriate responses are being implemented.

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