



The Needs Assessment on the Problematic Use of Drugs and Alcohol within the Traveller Community in the ECRDTF area



Wicklow Travellers Group, 2014
Report on research conducted by Suzanne Nolan
Edited by Judith Remy Leder and Máirín Kenny

**Problem use of drugs and alcohol
within the Traveller Community
in the area of County Wicklow served by
the East Coast Regional Drugs Task Force:
A Needs Assessment**

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Acronyms

AITHS	All Ireland Traveller Health Study
ECRDTF	East Coast Regional Drugs Task Force
LDTF	Local Drugs Task Force
NACD	National Advisory Committee on Drugs (since 2013, the National Advisory Committee on Drugs and Alcohol [NACDA])
WTG	Wicklow Travellers Group

Definitions

Agency worker: worker from any agency providing support for those who need drug treatment and rehabilitation services.

Daish: title of the Traveller-specific drugs programme in Bray. ‘Daish’ is a word from Gammon, the Travellers’ language. It means to look at or look through.

Drug abuse/drug and alcohol misuse: problem use of illicit drugs, licit prescription and non-prescription drugs, alcohol, and other substances that provoke addiction when mixed.

ECRDTF/Wicklow: The geographical area covered in this research: the eastern region of County Wicklow (excluding Bray LDTF area) which is within the boundaries of the overall ETRDTF area.

NDS National Drugs Strategy, 2009—2014. (Department of Community, Rural and Gaeltacht Affairs)

EXECUTIVE SUMMARY

This needs assessment, sanctioned by the East Coast Regional Drugs Task Force and conducted by Wicklow Travellers Group, identifies challenges to and opportunities for tackling problem use of illicit and licit drugs, alcohol and other substances among Travellers in the ECRDTF/ Wicklow area. Nearly all the Traveller families in east and west County Wicklow, South Dublin and County Wexford, are related. Substantial numbers have moved into east County Wicklow from those locations. It is clear to all concerned, that there is a growing issue of problem drugs and alcohol use among Travellers in this area.

The findings in this research closely match those in other research reviewed in this report. All consulted (Travellers, drugs prevention and treatment services and other agency workers) agreed that problem substance use is serious and growing in the Traveller community. Travellers expressed strong doubts about service accessibility (particular in terms of attitudes and cultural respect) for Travellers concerned about their own or a family member's usage. Drugs treatment workers saw their services as open to all, but were deeply concerned about the marked under-use of services by Travellers.

WTG's suite of community development programmes offers a holistic framework in which to address this serious issue at community and personal levels. Numbers of young Travellers engaging in youth projects have tripled since 2007. Without this engagement of young people in activities and learning, the substance misuse problem among Travellers in Wicklow would be far greater. The Bray LTDF/Bray Travellers CDG Daish service attracts Travellers with addiction problems from well outside its catchment area. It offers an effective model of integrated, targeted service provision that warrants development elsewhere.

Recommendations

The findings of this research have implications for Travellers, for professional practice, and for the structure of current provision across the ECRDTF/Wicklow area.

1. For Travellers

At community level, the National Drugs Strategy (2009) "pillars" (supply reduction, prevention, and treatment and rehabilitation) are interdependent. Building community solidarity, knowledge and skills will create a climate that discourages dealing (see section 2 below) and using, and support those with problems in addressing them. This cannot wait until the need is urgent, or be left only to those who are exposed or entrapped.

1.1 Education programmes, in schools and community-based, must:

- a) foster belief in the dignity and power of Travellers' group and individual identities
- b) engage traditional values on the side of shunning substance misuse, make staying free of it a mark of Travellers' resilience
- c) engage potential leaders, and build their skills and their status within the community
- d) strengthen family and community bonds
- e) disseminate sound information about substance misuse and its physical, mental, social effect
- f) build understanding of how to engage with medical services, and how to manage medications
- g) disseminate information about sources of help for Traveller families and friends of a member who has slipped, and for the member him or herself
- h) open up other life opportunities, to counterbalance the attractions of the drugs culture and enable those at risk to divert into positive choices.

- 1.2 Given the centrality of the family in Traveller culture, both education and service provision programmes must engage the Traveller community collectively, Travellers must make an input into the development of drugs prevention and treatment programmes which do or will impact on them. Daish offers a model of a culturally appropriate, targeted but integrated development.

2. For the structure of provision

Supply reduction: Travellers are not known to grow or manufacture drugs: supply originates outside this community. Community solidarity and outrage will help to discourage Traveller community/family members from dealing, but private citizens cannot take the law into their own hands.

- 2.1 Strong law enforcement is essential to break these supply lines, and to apprehend dealers, within and outside the Traveller community.

Treatment and rehabilitation: All agreed that there is no need for a Traveller-specific treatment or rehab centre; however, it is clear that on the structural level in this area, there should be:

- 2.2 a service based on the Daish model -- Traveller-targeted and embedded in local service provision
- 2.3 a Traveller-targeted element within the rehabilitation outreach services, staffed with experienced outreach workers, including Travellers
- 2.4 more detox places that are easy for Travellers to access
- 2.5 more culturally appropriate day facilities (i.e. drop in services)
- 2.6 at least part of one residential centre or hostel that is Traveller appropriate.

3. For professional practice

It is not possible to serve a population that is not understood. All health service professionals and drugs treatment agency workers need to:

- 3.1 learn more about the Traveller community and overcome prejudice against the population. An interagency response might help break down barriers that exist
- 3.2 prepare culturally appropriate care plans. These will almost always include provision for a family experience, given the core value and strength of the family in Traveller culture
- 3.3 address Traveller-specific aftercare needs (such as how to manage the danger of "*falling back in*" if there are other drug users in their tight-knit family network).

At a most basic level, availability of risky but licit drugs must be controlled. In particular, local GPs must:

- 3.4 limit the prescription drugs available
- 3.5 monitor the drugs they prescribe (probably on a monthly basis)
- 3.6 give understandable instructions and warnings regarding how these drugs should be used
- 3.7 establish some sort of local registry for addictive drugs in order to prevent prescription-shopping.

Concluding comment

There is a burgeoning substance misuse problem among Travellers in the ECRDTF/Wicklow area; recent population trends and drugs availability are exacerbating it. Findings in this study reflect those reported in research on this issue for Traveller communities elsewhere. Funding and structural support are essential, if the combined efforts of Travellers themselves, WTG and its work in CEART, community health services and drugs prevention, rehabilitation and treatment services in this area are to be effective. In short, the aim of all must be to foster a resilient Traveller community, and services that can competently engage with both the needs and the strengths of Travellers in the face of this threat.

1 INTRODUCTION

1.1 Location and networks

This needs assessment addresses the situation of Travellers in the East County Wicklow region of the East Coast Regional Drugs Task Force (ECRDTF/Wicklow) area. The ECRDTF covers South-East Dublin and East County Wicklow excluding the Bray Local Drugs Task Force (LDTF) area, established because Bray is one of the areas with the highest levels of drug misuse, particularly heroin. Bray LDTF has a Traveller-specific drugs programme, Daish.

The ECRDTF boundary was designed to fit drugs treatment services for the general population. However, it does not fit the WTG catchment: located in Wicklow Town, WTG serves Travellers across south and west County Wicklow. Nor does it fit the geography of these Travellers' extended family networks. The extended family and nomadic tradition are core elements of Traveller culture. While nomadism is dying away, Travellers are still more mobile than settled people. The vast majority of families associated with County Wicklow are related to families in South Dublin and County Wexford. Both WTG statistics and the annual Local Authorities count of Traveller families indicate that over the past seven years a significant number of Traveller families have moved into this county and live in private rented accommodation in the larger towns.

1.2 Need for this research

In 2008 WTG initiated a drugs prevention and education project with a part-time worker, as recommended in its needs analysis (Kenny, 2007). This analysis involved consultations with Travellers involved with WTG and WTG staff, and also local garda, public health, social work, and drugs support services. All concurred that they saw no illicit drugs problem among Travellers in the area, and that the town generally had escaped the worst of it. However, they all also said it would take very little for this to change (and it is likely that in 2007 some families had a problem but successfully hid it, even from their own community). The Travellers repeatedly asserted that it was only a matter of time, and they have been proven correct.

Three challenges suggested the need for the present research:

Firstly, increased Traveller population in Wicklow, and increased availability of drugs: Some of the Travellers currently presenting with drug-related issues are from incoming families, and problems are becoming visible in some indigenous families also. Illicit drug supply and use have increased in the area generally. The tight-knit and self-contained Traveller community structures make this contagion particularly difficult to ward off or to manage

Secondly, increased use by Travellers of drug treatment and support services: the findings of this research confirm the perceptions of community members and workers: there is a significant increase in drug use among Travellers in the area. However, the statistics must be read with caution. The locations where statistics are registered may not be the clients' home bases – which may or may not be within the ECRDTF area.

One strategy for hiding the problem from one's own community is to go outside the home base to seek services. People also go outside to attend a more accessible service elsewhere (for instance, to keep attending a GP they attended when living elsewhere). While some settled people seeking services also do this, WTG's observation is that mobility encourages the practice for Travellers, and saving the family from shame within the close-knit Traveller community is a powerful factor. Daish, in

its 2010 audit of its client numbers, identified 27 Travellers (19 male, 8 female) from the ECRDTF area (outside Bray LDTF boundary). These clients either self-referred or were referred by Gardaí.

Thirdly, concern about Travellers' under-use of drug treatment and rehabilitation services: In 2010 the ECRDTF recommended that Traveller access to local services be reviewed. WTG concur; though the problem is no longer so hidden, secrecy and shame still prevent Travellers needing help from seeking it. The Daish project is well respected among Travellers. WTG believe that this warrants study.

It is significant that one ECRDTF-funded Treatment and Rehabilitation service closed during this period. Whatever the reasons for its closure, for this work in the region it resulted in a further loss of over €200,000 on top of the austerity cuts to the Drugs Task Force budget.

The positive impact of the current intervention warrants further investment. In 2007/08 approximately 40 young Travellers between the ages of 7 to 17 were availing of WTG youth and community activities. Due to an increase in the volume of work by 2010, WTG applied to make the post full-time; this was done in 2011. Given the significant increase in overall Traveller numbers in this area over the past seven years, the situation would be far more challenging without the intervention of the WTG project.

The summer project exemplifies this. With the current full-time drugs prevention and education worker, the number of young people taking part in the project has almost tripled, rising from 40 in 2008 to over 100 last year; in that period the total Traveller population has increased by a maximum 15%, from about 208 to 230 families. This suggests that a very high percentage of young Travellers use this service; this year promises to attract at least as many. By engaging with WTG programmes, these young people are diverting away from risk locations, learning about issues of addiction, strengthening their connectedness to their community, and building the personal and group confidence and skills that will enable them to stay free of the mesh of substance misuse. In the current fragile situation, this intervention is crucial.

WTG secured funding from the ECRDTF to investigate the extent of drug and alcohol misuse in the Traveller community in the ECRDTF/Wicklow area. WTG facilitated the research in CEART (Centre for Education and Resourcing Travellers); it set up a Steering Group comprising key WTG staff members and Traveller representatives to design and oversee the research process. Suzanne Nolan, an independent researcher, was engaged to undertake the work.

An outline of research methods concludes this introduction; relevant literature is reviewed in Section 2; field research findings are presented in Section 3; Sections 4 gives the conclusions arising from this study, and recommendations for action.

1.3 Research methodology

This research aimed to investigate the following issues in relation to Travellers in this area:

- 1 The extent of illicit drugs use, and of problem use of prescription and non-prescription drugs
- 2 Alcohol related problems including the issue of underage drinking
- 3 Travellers' awareness of drug treatment services available and the barriers they encounter when they try to use support services.

To address the issues revealed in this investigation, two further aims were set:

- 4 To explore current best practice with potential to strengthen resilience in the Traveller community overall, in families with members misusing drugs/alcohol, and among young people at risk.
- 5 To make recommendations for improved service provision for Travellers in the ECRDTF/Wicklow area.

Research Methods

Desk Research: a review of literature on the social and cultural context for the Traveller community as it engages with this problem, the nature and extent of drug use among Travellers nationally, and frameworks for supporting and working with Travellers who are drug users.

Quantitative research: data gathered on Travellers who accessed drug treatment services in Wicklow.

Qualitative research: focus groups (defined in Curry, Nembhard, & Bradley, 2009) and one-to-one semi-structured interviews were used to establish the Travellers' perception of drug use in their community and their knowledge and perceptions of drug treatment services. Allied agency personnel and service providers were also consulted, individually or in groups as appropriate.

Consultations with Travellers: Twelve Traveller women took part in two focus group sessions, and three sessions were held with Travellers aged 13-18 years (total participants 36). Follow-up interviews were conducted with five of the women in the focus group, and two adult male Travellers were interviewed.

Consultations with agencies and service providers: Individual semi structured interviews were held with 25 key people from the following: WTG, Traveller services, addiction services, youth and family services, statutory agencies and religious organisations. Telephone interviews were held with another 16 persons from these sectors; some sent additional responses by e-mail. An additional focus group was held with staff from one service and two Traveller men. Members of four key agencies were asked to complete a one page questionnaire (a print-out of the schema for the focus group and oral interview sessions); no replies were received.

Participants in focus groups, interviews and other consultations were asked for their observations and views on the following practices among Travellers in the ECRDTF/Wicklow area:

Illicit drug use: prevalence, patterns, substances of choice, occasions of use, poly-substance use, gender and age differences among users.

Prescription and over-the-counter drugs misuse: extent, gender and age differences, attitudes towards self-medication/sharing medication

Alcohol misuse: nature and extent; age and gender differences; extent of under-age drinking

Support services: Travellers' awareness of and access to services; barriers to access; supports used by people in difficulty; numbers known to use services, and what their experience was.

Finally, participants were asked for suggestions as to how to **improve service provision** to Travellers who are drug users.

A total of 63 people were consulted. Records of group discussions and interviews were transcribed and thematically analysed, to identify concerns for each sector, and levels of consensus on these.

Ethical procedures

While undertaking the research the following protocols were adhered to: the Terms of Reference set by the Traveller Ethics, Research and Information Working Group, (Sub group of the Traveller Health Advisory Group, 2002); NACD research guidelines (2002); and the Children First (2011) National Guidance for the Protection & Welfare of Children.

All persons consulted were assured that the findings would be presented collectively and that every possible effort would be made to ensure that no person or agency could be identified in any way at any time. The confidentiality of records and data collected was protected at all times.

2 OVERVIEW OF RESEARCH LITERATURE

In the year 2000, a Traveller Specific Drugs Initiative (now known as the Drug & Alcohol Programme) was established in Pavee Point. Since then, concern about drug misuse in the community has become widespread. In 2011, Pavee Point issued *Pavee Pathways: Good Practice Guidelines for Drug and Alcohol Services Working with Travellers* (author: Siobhán Cafferty). The continued growth of the problem since 2004 is reflected in the following national and local reports on this issue:

2004 (Pavee Point to the National Drug Strategy Team): *Submission from Pavee Point Travellers Centre on the Mid-Term Review of the National Drug Strategy 2001-08.*

2006 (Jane Fountain for the NACD): *An exploratory study of an overview of the nature and extent of illicit drug use amongst the Traveller community.*

2007 (Máirín Kenny for WTG): *Analysis of needs and potential for a Traveller-specific drugs strategy in the Wicklow Travellers Group catchment area.*

2009 (Anne-Marie Van Hout for the Western RDTF): *Substance Misuse in the Traveller Community: a needs assessment.*

2010 (Brid Walsh for Blanchardstown LDTF): *Cultural Dislocation & Consequences. An Exploratory Study of Illicit Drug Activity in a Traveller Community in North Dublin.*

2011 (Pavee Point): *The use of benzodiazepines within the Traveller community: An overview of the extent of the problem with recommended actions for change.*

2013 (Anne Marie Carew, Siobhán Cafferty, Jean Long, Delphine Bellerose, & Suzi Lyons): *Travellers Accessing Addiction Services in Ireland 2007-2010: Analysis of Routine Surveillance Data.*

For full details of these and other research cited below, see reference list at the end of this report.

2.1 Travellers, identity and exclusion, risk and protective factors

Research into substance misuse among Travellers places discussion of the issues in the broader context of racism and ethnic identity. That is the framework for this study also.

There is debate, among Travellers and others, as to whether Travellers are an ethnic or a culturally distinct group, and whether to call the exclusion they endure discrimination or racism (Walsh, 2012). Whichever terminology is used, the identity and experience of Travellers are the same. WTG recognises Irish Travellers as an ethnic minority who share Irish citizenship with the majority of the Irish population.

The Equal Status Act (2004) defines 'Traveller community' as

the community of people who are commonly called Travellers and who are identified (both by themselves and others) as people with a shared history, culture and traditions, including a nomadic way of life in Ireland.

In research for the National Advisory Committee on Drugs (NACD), Fountain (2006, p. 12) highlighted that 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".

Following Fountain, this research adopts the following definition of institutional racism:

... 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 or racist stereotyping which disadvantages minority ethnic people (Macpherson, 1999, cited in Fountain, 2006, p. 92).

Both addiction and denial of it can be linked to racism:

There has been a noticeable rise in public utterances and displays of racism in Ireland in the last few years although allegations of drug misuse have not been a prominent feature of the invective ... it could also be that an excessive desire to avoid or eliminate racism and discrimination may lead some to ignore, deny or overlook drug misuse in ethnic communities." (European Monitoring Centre on Drugs and Drug Addiction, 2003, cited in Pavee Point, 2005, p. 7)

Travellers endure high unemployment, poor education, low income, poor accommodation and bad health; they are disproportionately affected by addictions because of the stresses imposed by their socio-economic position (AITHS, 2010). Nomadism, a core value and historic cultural practice informing Travellers' ethnic identity, has been used as the main weapon to attack and assimilate them. For some Travellers, the effect of this is a sense of alienation from or denigration of their roots. Recognising the links between social exclusion and problem drug use among Travellers, the Department of Community, Rural and Gaeltacht Affairs *National Drugs Strategy 2001-2009* ([NDS], 2009) included this community in research on drug use amongst marginalised groups.

2.1.1 Identity, and risk and protective factors

There is an extensive body of research literature linking minority ethnic identity both to substance misuse and to strategies for addressing it. Walsh applied the theories of Alexander (2008) to Travellers. He argued that: "all addictions are individual or societal responses to a lack of psychosocial integration: a condition of separateness from one's own cultural identity [which causes] 'poverty of the spirit' ... 'cultural dislocation', brought on by modern consumer society: 'people adapt to this dislocation by concocting the best substitutes that they can for a sustaining social, cultural, and spiritual wholeness, and addiction provides this substitute for more and more of us' (Alexander, 2008, cited in Walsh, 2010, p. 9). Walsh noted that among the Travellers she engaged with, severe disadvantage was compounded by "an intense cultural ambiguity about their own identity [and] relatively passive sense of acceptance ... of continuous prejudice from the dominant population". Identifying this as "cultural dislocation", she noted that as a result, "drug issues have manifested themselves and become more polarised and condensed" (Walsh, 2010, p. 31). Berry (2001, cited in Kenny, 2007) also noted spiritual homelessness, loss of connectedness to one's community and traditions, among Australian Aboriginal people as contributing to substance misuse.

On the other hand, Nagshi et al. (2011) emphasised the value of the strong family bonds in some minorities, in enabling young people to resist the attraction of drugs. McKenzie (2012) argued that young people who are *both* well integrated into their home community and family, *and* able to relate outwards, have more capacity to resist. The importance of cultural identity (whether defined as ethnic or not) has been emphasised specifically in relation to Irish Travellers (see for instance, Fountain, 2006, Van Hout 2009, 2010, 2011, 2012; Walsh, 2010; Merchants Quay Ireland and Pavee Point, 2010). It is essential that Travellers' cultural values and practices be employed as extensively as possible in addressing addictions and recovery from addictions. Travellers need to reclaim and rediscover the powerful, life-preserving elements in their culture.

Kenny (2007) noted that young people who are neither at school nor able, due to exclusion, to access public leisure facilities are at particularly high risk of becoming involved in drug use and misuse. The risk is higher if their connectedness to their families is weakening. Prisoners are another sector cut off from

family support, and at particular risk of developing addiction; paradoxically, Travellers (1% of the national population, but 11% of the prisoner population) may access services more easily in prison than in the hostile local community context (Drummond et al., 2014). Given the pivotal role of family and family elders in Traveller culture, excluding Traveller family members from interventions and rehabilitation processes will impede the positive outcomes for individual drug users (Pavee Point, 2011).

The NDS (2009, p. 39) identifies “supporting engagement of people in community life” as a foundational universal primary prevention strategy. It is also the essential context in which people can confront and address their risk and addiction problems. Walsh (2010) noted that strategies rooted in family and community have been found to work well with marginalised and indigenous minorities (see also Meyers and Squires, 2001). Such approaches ensure that drug users, with their families, tap into their personal and communal strengths, can access services with dignity, and gain the knowledge and skills they need for resilience.

WTG programmes, for Traveller women, men, and young people, offer opportunities to identify and celebrate the overlooked and often heroically positive in their family and community heritage.

2.2 Problem drug use among Travellers

Historically, there has been limited information on the extent of drug use amongst the Traveller community. However, with the inclusion in 2007 of an ethnic identifier question in the National Drug Treatment Recording System, official figures on numbers of Travellers accessing drug treatment became available, and these reveal an increase in those numbers since then. However, these figures reflect only the Travellers registered with drugs services, so the extent of the problem in the Traveller community is greater than that (Carew et al., 2013). In research into drug misuse in any population, numbers of service users are generally multiplied by a factor of three to estimate the actual number with misuse problems in that group.

As noted above, the growth of substance misuse among Travellers in this century has been reflected in local and national reports. The findings are difficult to compare because each was based on distinct and nearly mutually exclusive sets of data and informants. Still, they present a chilling picture. Predictably, all report that Traveller men -- especially between mid-adolescence and late 30's--use drugs of all sorts far more than Traveller women. Men choose alcohol, cannabis and cocaine (not crack) and to a lesser degree ecstasy and amphetamines. Drugs of choice among women are alcohol and opiates.

What is most startling is the sharp increase in reported drug use. In 2006, Fountain noted that drug use among Travellers *“is increasing but does not yet present at the level of the Irish population.”* A scant four years later, Carew et al (2013) found that the *“incidence of treated substance abuse in the Traveller community was three times that among the general population”*; poly-substance use among them had skyrocketed: hash, ecstasy, and amphetamines were more common and were being mixed with old standbys -- cannabis, cocaine and alcohol. The number of Travellers seeking treatment for heroin and methadone had increased by 291%. Addiction to cannabis had increased 200%. When measured against drug use in the settled population, registered numbers for Travellers are always higher --sometimes twice or three times as high. However, denial and shame about addiction remain (see for instance, Fountain, 2006; Walsh, 2011). This is an Ireland-wide pattern, but it is clear that ECRDTF/Wicklow has experienced a sharp increase of drug abuse in the last seven years.

2.2.1 Problem use of prescription and other licit drugs among Travellers

In its study of the use of benzodiazepines (drugs prescribed for anxiety and sleeplessness) in the Traveller community, Pavee Point (2011) noted that *“the issue ... has consistently been raised as a cause for concern by addiction support groups and communities for a decade now”* (p. 10); and was a problem for the Traveller community in each of the regions surveyed.

Carew et al. (2013) found a sharp increase in Travellers reporting that their main problem substance was benzodiazepine: numbers more than tripled, going from five in 2007 to seventeen in 2010. A significantly less pronounced upward trend (118% increase) was observed in the settled population. Even in the settled community, patients are prescribed benzodiazepines over long periods, prescriptions are rarely reviewed, and the addiction risk is not stressed. These problems are exacerbated in the Traveller community because the Travellers tend to believe that any drug prescribed by a medical professional is not harmful to anyone (thus prescriptions are freely shared with family members). Also, like settled people, some Travellers shop around for GPs who prescribe more readily than others. Obtaining prescriptions from more than one GP gives access to *“huge quantities of legally prescribed medication”* that can be consumed, shared or sold on the black market. Clearly, there is a need for new regulations to be implemented. Carew et al. made many recommendations for action—key ones are:

- A national monitoring system to be developed to record the number of benzodiazepine prescriptions per GP and patient
- Proactive measures to be taken to change Travellers' presumption that sharing prescribed medication is acceptable.

2.2.2 Alcohol misuse among Travellers

“In 2002, the World Health Organisation identified alcohol as the third highest risk factor (after tobacco and hypertension) for premature death and ill-health in developed countries” (DCRGA, 2009, paragraph 1.16). All the research into alcohol misuse among Travellers recognises how widespread the problem is. In 2006 Fountain's informants said that alcohol addiction was most common among men of all ages. In 2009, Van Hout asserted that alcohol "remains the substance of concern" affecting men, and increasingly, women. At that time, Travellers believed that alcohol presented a much less serious risk than other drugs, and they attempted to tackle the addiction using GP-assisted or non-medical detoxification. In the following year (2010), AITHS reported that alcohol was thought to be “socially acceptable” and an important social outlet for men, who “tend to downplay problems of alcoholism” (p. 129). In 2013, Carew et al. found that alcohol abuse was the most common problem, for which not only Travellers (42.3%) but also the settled population (52.7%) sought treatment. The social acceptability of binge drinking was of concern even to the young Travellers interviewed in this study.

2.3 Travellers, and substance treatment and rehabilitation services

Several key themes emerge in literature that addresses the Travellers use of drugs treatment services. Travellers find it difficult to trust service providers because of the long history of discrimination they have experienced from the settled community and its institutions (Pavee Point, 2004; Kenny, 2007; AITHS, 2010; Cafferty, 2011); reluctant to seek outside help, they attempt instead to solve problems within the family or community. Members of most minority communities are reluctant to reveal addiction because they do not want to lose face (Reid et al., 2001, cited in Pavee Point, 2011, p. 14).

The combination of shame about addiction and wariness about state support has been exacerbated by years of government incompetency. No reference to Travellers' drug misuse was made in reports and

documents in the mid- to late-1990's. Hurley (1999) reported that over half of the 35 drug agencies she surveyed said they had no knowledge of how drugs were affecting Travellers; few had designed services to meet Travellers' needs, and some agencies believed such services were not necessary. Pavee Point noted that *"many Travellers remain 'out of the loop' in terms of accessing the limited services that are available"* (2004, p. 3).

Across the EU, drug policy and practice reflect the needs of the majority population (Fountain, 2006). In Ireland, in its *Traveller Health – a National Strategy 2002-2005* (2002) the Department of Health and Children stated that Travellers must be included in the Local and Regional Task Forces' plans and strategies. But even after the National Drug Treatment Reporting System (2007) began to record the ethnicity of those accessing drug treatment and rehabilitation services, the situation did not improve.

Cafferty (2011) noted that minorities such as Travellers are under-represented among clients of drug treatment and rehabilitation services (for reasons mentioned above), and that like other minority members, Travellers who do seek services must accommodate to support structures designed for the needs of those in the dominant culture. The specific vulnerabilities of minorities like Travellers need to be considered in order to provide targeted, appropriate and effective addiction services (Cafferty, 2011). Pavee Point (2004) argued that within the Traveller community the stigma and shame of drug use inhibits development of responses, so Travellers need space where they can work to break down the feelings of shame and mobilise the community positively to address the issue.

2.3.1 Improving treatment & rehabilitation services

'Cultural competence' denotes the ability of a service to meet the needs of the population it serves. It is achieved by employing *"approaches ... designed ... to minimize exclusion, support identity, promote respect and support inclusive practice"* (Fountain, 2006, p. 88). Pavee Point (2011, citing Corr, 2004; Kelly, 2009; Cunningham 1993; Fountain 2006) emphasise that providing cultural competency training to staff is the most effective mechanism for meeting the needs of minority ethnic groups. In 2004, Pavee Point recommended *a holistic approach* to drug prevention, treatment and rehabilitation services, citing the importance of factoring in Travellers' daily experience regarding accommodation, living conditions, health, education, discrimination, poverty and social exclusion. Kenny (2007) argued for a community development approach to build 'social capital' – the important informal social support networks which underpin community resilience and form a supportive context for individuals and families.

Pavee Point (2011) listed ten simple, obvious recommendations that certainly should be adopted:

- 1 Establish an inclusion policy at all drug service centres
- 2 Provide cultural competency training to staff members
- 3 Ask Travellers what their needs are and what can be done to support them
- 4 Explain confidentiality before posing ethnicity questions
- 5 Teach Traveller families the nature of addiction and recovery
- 6 Outreach at sites where drug abusing Travellers are known to congregate
- 7 Make Traveller peer support workers available if they are requested
- 8 Encourage Traveller women to attend appointments with a friends or family
- 9 Allow women to choose the gender of their case managers
- 10 Engage Traveller family members in care plans.

Fountain and Van Hout phrase these goals differently, but the message is the same. If drug related services are to work, they MUST take into account the culture of the Travellers.

3 TRAVELLERS AND CONCERNS ABOUT SUBSTANCE MISUSE AND RELATED SERVICES IN ECRDTF/WICKLOW: RESEARCH FINDINGS

This section presents the findings of the research. It is important to note that some of the agency workers interviewed stated that they do not work directly in the drugs field or with Travellers and so their experience or knowledge was limited.

3.1 Participants' accounts of the nature and extent of illicit drug use among Travellers

3.1.1 Acknowledgement of illicit drug use among Travellers

In consultations for this study, agency workers and Travellers alike recognised that illicit drug use in Wicklow is an issue that needs to be addressed. Agency workers described it as a “widespread,” “significant,” “serious” problem. Most Travellers in the focus groups and one-to-one conversations were open about it, saying that “[drug use] is there” or even “everywhere.” Some of the Travellers consulted said that they did not personally know anyone who was using; others identified large numbers of their immediate and extended family members who were using or had used drugs. In comments confirming Kenny’s findings (2007), it is clear that there is still a shroud of secrecy around the problem: “There’s a very serious addiction problem in the Traveller community but it’s hidden”; “People know what’s going on but it’s kept contained and covered up”; “You wouldn’t be told, you’d only know by their speech and movement”; “It’s kept covered up especially by the older generation who covers everything up.”

Several argued that other issues are just as hidden: “You wouldn’t hear of [homosexuality] but it is there ... [drug] users and homosexuals are despised within the community ... hugely frowned upon.” Agency workers also said that drug use is often not acknowledged by Travellers in Wicklow town. Travellers suggested that denial is due to the stigma involved: “[People have] an ‘if we don’t talk about it it’s not so’ attitude”; “The older generation don’t want to see [drug addiction because] of the shame involved”; “Families don’t want to [acknowledge a family member’s addiction] -- the whole family would be tarred by the same brush”. Travellers said many addicts are blacklisted from their own families; and in other families members are told to keep away from families where anyone was known to use drugs.

Travellers and agency workers agreed that the drug problem in Wicklow (town and hinterland) is not as serious as it is in Bray. Travellers in Wicklow assert that they are more traditional. Many service providers stated they don’t hear about addicted Travellers outside of Bray. There was also general agreement that as Travellers increasingly mix with settled people, they are increasingly getting involved in drug use and drug dealing. Some agency workers reported that the drug problem has increased in the past 12 months in Wicklow, especially among the newer population in private rented accommodation. Some Travellers alleged that there is one major pot dealer in Wicklow. It was generally asserted, however, that the occurrence of Traveller addiction is no higher than that in the majority community.

3.1.2 Accounts of drugs used

Agency workers agreed that poly-substance use is relatively common. One noted that pairing alcohol with other drugs is an “absolutely huge problem” but that Travellers do not see it that way. Travellers formerly presented with alcohol problems; now they combine alcohol with opiates, cannabis, prescription pills or other available substances. In general, however, Travellers and agency workers do not report significant use of hard drugs, and claim that there is “very little heroin” in Wicklow but a “huge” problem in Bray. These reports may be true, but they may also reflect denial. Informants agreed

that people use whatever drugs are available to them; and, once started, use becomes regular. This suggests that the Wicklow area should expect a sharp increase in hard drug use within the next few years.

After alcohol, the Travellers' drug of choice seems to be cannabis: it has been a popular recreational drug in the community for the past eight years. It is used mostly by men from late teens to late thirties; women are more likely to smoke weed only if they are with men who are doing so. Agency workers reported that there is a lot of cocaine use around Christmas, New Year and other celebrations. They said that other drugs used include ecstasy, mephedrone (bubbles) and head-shop drugs. One agency described the pattern among Travellers who use drugs as stimulant-driven but not restricted to stimulants; a mix of alcohol and drugs (prescription and street) in the same session; cocaine but no crack. Sniffing lighter fluid got occasional mention. Drug use occurs most commonly in group settings.

3.1.3 Observed age and gender of drug users

The consensus among agency workers was that, regardless of the drugs being used, Travellers who use them are predominantly men between 20 and 40 years old, and that Traveller women are more likely to use drugs if in relationships with drug-using men. Travellers concurred but commented that those who use drugs continue to use them into their mid to late 40's. Whatever their age, Traveller men (especially those from broken families) were reported as using drugs in times of stress and loss, and being unaware of the risks of *"spree use."* The few Traveller women who seek treatment are reported to be generally unstable adolescents, single women on methadone, poly-substance abusers, women who have been in care or in prison, and who are either not connected to or not under the control of their community (*"wildish"*). Reports on Traveller women in general were positive: *"Traveller women are doing really well, their esteem is accessible and visible"; "Women seem to be stronger and more balanced in personality whether they are on treatment or not."* One of the services, however, said that after age 25, the ratio of women to men seeking assistance is 50-50. This seems significantly different from the experiences of other clinics.

It was generally agreed that Travellers access service when they are deep into problem substance use. Several service providers stated that the number of Travellers receiving service has increased slightly in recent years. Service agencies supplied some data on numbers of Traveller clients, but for many reasons these did not prove helpful in measuring the extent of the problem: on the one hand the providers used different time frames for the data; on the other, some Traveller clients may have accessed services outside their home base, some may have attended more than one service, some may have gone outside the ECRDTF area (for instance, to Daish). This highlights the difficulty in quantifying the issue. For instance, one service reported for this research that in the last five to seven years, 18 Travellers attended its service. Among the unknowns in this piece of data are: for what periods within these years any of this 18 attended, how often they did so, and whether they were all from that service's catchment area. This points to a need to develop a more precise data collection mechanism; an ethnic identifier on its own, though very helpful, would not clarify all the necessary issues requiring address within any DTF service.

3.1.4 Accounts of the availability of drugs

Travellers report that drugs are easy to find. Some Travellers, with their high physical mobility and mobile phones, are well able to supply drugs to each other and to the settled community. One agency worker commented that drug users in the settled community know which Travellers can get what for them. Travellers, then, are already well represented in the supply chain. Of the Travellers consulted in

this study, those with extended family connections in Bray and Dublin--where using and dealing is common--said that the number of Travellers who deal drugs has increased over the last ten years.

In general, the Travellers consulted expressed concern about their own children and about Traveller children in general becoming involved in drugs; they were eager to prevent this. Agency workers were concerned that Travellers don't know how dangerous the drugs they are taking can be, and are unaware of the risks involved in combining drugs. There has possibly been an up-tick in efforts to hook Travellers on drugs: there were reports of party packs (which contain cannabis, cocaine, and heroin) being circulated recently free of charge, and of bubble being introduced to men in their 40s by younger men.

3.2 Participants' accounts of the misuse of prescription and other legal drugs among Travellers

3.2.1 Acknowledgement of prescription drug misuse

The majority of Travellers and agencies reported the widespread misuse of prescription drugs – e.g., swapping medications and using medicines prescribed for other people. Agency workers described this as anywhere from a "problem" to a "massive problem." Some Travellers and some agency workers noted that Travellers are buying tablets on the street and on the internet and selling them along with prescription drugs in the community (a "small economy").

Three exceedingly serious problems were discussed in the focus groups

Firstly, most Travellers are not aware of the dangers of taking medications prescribed for others.

"Travellers do not see tranquillisers and benzodiazepines as drugs. There's a belief that, if it's prescribed by a GP, it's ok." "Most Travellers would take anything from a GP." (Agency workers).

Secondly, perhaps because they don't understand the risks, some Travellers readily take whatever drugs are available: "Whatever tablets can be got will be taken" (Agency worker). They mix and match freely: "Men think it's no harm to swop Xanax – they're not afraid to take other people's medicines, they'll take medicines wherever they can get them, they don't see it as a problem" (Traveller). They take drugs blindly: "Some people don't know what they're taking and don't read leaflet" (Traveller). It seems to have become socially acceptable to mix prescriptions, alcohol and street drugs; all the agencies expressed concern about the increase in poly-substance use. Agencies have already recorded several deaths from intentional and unintentional drugs overdoses.

Thirdly, these two problems can be exacerbated by poor prescribing practices: "GP's don't explain side effects and Travellers generally don't read the patient information leaflet" (Traveller). There were reports of anti-depressant medication and sleeping pills being prescribed for three months at a time, and renewed repeatedly and without monitoring – and of this continuing for decades in some cases. Older Traveller women are often long-term users of prescription medication.

3.2.2 Accounts of prescription drugs misused

The following are the prescription drugs mentioned most frequently:

- Benzodiazepines: valium (diazepam), known as 'Yellows'; Lyrica (a pain killer and anti-psychotic drug, known as 'the new valium'); and D10, known as 'Blues,' and D5, known as 'Whites', which can be bought for €5 per pill, or €20 per tray
- Anti-depressants (Lexapro was noted in particular)
- Sleeping tablets (Zimovane)

- Tranquillisers (Xanax in particular)

Also identified were:

- Nurofen/nurofen plus (codeine based)
- Solpadeine, a pain reliever (codeine based)
- Difene (not addictive according to the HSE drugs advice webpage)

Less frequently mentioned:

- Cough medicines—(non-prescription, but highly addictive)
- Ponstan, for primary dysmenorrhoea (not a drug of addiction, but mentioned in mixes)
- OxyContin, for severe pain (morphine based, and often sold as a street drug).

One agency reported that some Travellers they meet use benzodiazepines from any source in any quantity; they also experimented with anti-depressants, mood stabilisers and anti-psychotic drugs. Travellers reported that many of their community are addicted: they *"have to have [the drugs], they can't do without them"* and they will search until they find the drug they need. *"Xanax and difene are known as the good ones, they're taken after a lot of drink to calm them."* *"I'd say three out of five Traveller women are on benzodiazepines but that they'd never tell you"*.

3.2.3 Observed age and gender of prescription drug users

Prescription drug use was reported to be widespread throughout the whole Traveller community. Women, especially women over 40, are often long term users of prescription medication. It was generally acknowledged that many men use prescription drugs prescribed for females in their family-- *"It's mostly women who get [the pills], but men know who to go to for a supply: ... aunts, friends or someone they trust"*. One agency reported treating Traveller children as young as 10 years old for misusing prescription medication. Young Traveller men use prescription drugs with alcohol or cannabis or other available street drugs. Some young Traveller girls drink Red Bull with Skittles¹, and follow this combination with a chaser of pain killers to help them sleep.

3.2.4 Availability of prescription drugs

Many prescription drugs are secured from GPs. Travellers identify as *"good doctors"* those GPs who require a consultation before issuing a repeat prescription and who do regular medical check-ups. Travellers know which GPs prescribe more easily than others, and they know that since there is no central register *"multiple GPs can be accessed at the same time."* Additionally, Travellers can be *"persistent and resourceful in getting prescriptions. They can be aggressive with the GPs, especially when drink has been taken"*. Occasionally, proxy patients are sent to secure medications from doctors. Travellers believe that *"Women can get anything from a GP;"* *"Everyone knows it's so easy to get doctors to give [drugs] out to you, sometimes they just want to get rid of you."* In short, prescription medicines are very easy to get. A correctly issued prescription of anti-anxiety medication can turn into a family drug stash; women on anti-depressants may choose to save drugs on "good days". Suspicious of how dangerous the pills can be, they hide the stash from their teenagers or husbands, but persuasion sometimes releases the stash into the hands of family members.

¹ Red Bull is a non-alcoholic stimulant drink, and Skittles are high-energy sweets; consuming them together compounds stimulant effect. However, Skittles are commonly melted in a shot of vodka or rum, and that cocktail is consumed with the Red Bull. The interviewees did not say if they had observed this practice.

Prescription drugs can also be obtained in non-prescription form. Street versions of benzodiazepines, for example, can be bought on the street or the internet for as little as two euros each. Using non-prescription versions of any prescription drug is particularly risky because there is no quality control.

3.2.5 Views on normalisation of self-medication

All informants agreed that self-medication has, for practical purposes, become "normalised" (socially acceptable). Travellers will self-prescribe a family member's drugs for pain, anxiety, and sleeplessness. One agency worker explained this as *"learned behaviour"*. One agency worker commented that *"Travellers can have an entirely different experience of medication than that described by the patient information leaflet."* If the leaflet says a particular medication is dangerous, but the Traveller has seen it providing a "good high", *"the credibility problem of the leaflet is enormous"*.

3.3 Participants' accounts of the extent of alcohol use amongst Travellers

3.3.1 Acknowledgement of alcohol use

Agency workers described alcohol misuse as *"widespread"*, *"common"* and *"a major issue"*. They expressed the view that alcohol is *"extensively abused"* within the Traveller community with some stating that they believe it to be the most commonly used drug. Almost all agency workers believed drinking to excess is somewhat acceptable in the Traveller community and many believed that it is much more acceptable than drug taking. However, the majority of Travellers consulted did not identify alcohol misuse in the Traveller community as problematic: *"A person is only classed as an alcoholic if they are drinking 24 hours a day"*.

Very few Travellers interviewed identified alcohol misuse as an issue. *"You wouldn't advise anyone to go to rehab for drinking, just say 'cut down on that' or 'pull yourself together'."* *"Travellers don't see [alcohol] as an addiction"*. Some of the young Travellers said they knew only a few men with bad alcohol problems and didn't know anyone whose life was ruined by it. *"People drink because they like it"*.

Although they did not perceive alcohol abuse as a problem, many said it is increasingly being combined with other drugs; young Travellers mentioned nurofen. Agency workers reported an emerging trend over the past four or five years of D10's and D5's being taken very frequently with alcohol.

3.3.2 Who misuses alcohol?

Agency workers reported that although some Traveller women drink during times of 'dispensation' (weddings, funerals, Christmas), alcohol use has receded significantly among women. Although alcohol misuse is not uncommon among men aged 20–50 years, young males are the main group coming for support services. Young Travellers do not see alcohol addiction as a problem, as many of their parents have had alcohol issues. Agency workers reported that weekend binges were common but that the recession has curtailed this somewhat. They also reported that poly-substance misuse involving alcohol is mostly engaged in by men in their early 20's, young couples, and some older men.

Though the Travellers interviewed did not see alcohol as a problem in their community, they conceded that some men (especially those aged 50+ years) drink to excess. Many stated that a number of men drink to treat depression and that some men *"could drink for a week"*. Some Travellers also commented that some young married couples regularly drink to excess: *"A good time is getting drunk"*. Both Travellers and agency workers stated that drinking is frequently done at home as Travellers often cannot get served in pubs.

3.3.3 Accounts of underage drinking

Most Travellers said that alcohol consumption is generally confined to special occasions (such as Halloween and weddings) but some said it is more widespread; some Travellers reported adults giving young boys alcohol at weddings, and claimed that many Travellers believe it is better if young people drink with adults than on their own.

It was widely reported that over the last five years many parents have “eased up” and are “turning a blind eye” to boys 16-17 years old drinking. Some said children as young as ten are drinking.

One Traveller interviewed said that older males who misuse alcohol are the ones who will stop young people from drinking until they are at least 16 years old. Agency workers stated that parents who are not drug addicted are able to exercise more control over their sons than drug addicted parents.

Travellers interviewed spoke about some boys drinking but said that girls do not drink. The Traveller girls said that they will not drink alcohol before they get married because they don't want to disrespect their families or damage their own marriage prospects. Still, when listing energy drinks popular with Traveller girls (Red Bull, Red Thunder and Boost), the girls interviewed also listed WKD, which contains alcohol; and as noted above, they said they drink Red Bull with Skittles (whether as sweets or in an alcoholic cocktail was not said). This suggests confusion regarding what they consume.

The Traveller boys recognised that parents are less harsh about alcohol consumption than consumption of other drugs. “*Drugs would be way much worse than drinking.*” Other factors mentioned as fostering alcohol consumption included “*living in a disadvantaged area*” or an area that had “*no community centre.*” Some Travellers attributed under-age drinking to lack of activities available to Traveller youth.

Some agency workers said they did not see a significant level of underage drinking; others said that early exposure to alcohol is common, and young men often start drinking at age 13 or 14 and have addiction problems by age 18 to 21. One worker suggested that Travellers under age 16 may well have alcohol problems but do not seek help because they would have to be accompanied by an adult to secure services.

Travellers also identified a number of factors which make drug use of all kinds less likely among their young men: parental control and expectations; the availability of a community centre like CEART, sports, and “*sticking with*” Traveller friends in Wicklow. Most of the young people consulted said that the key things inhibiting their drinking were their involvement with CEART, and the relationships they have with key staff members in the WTG youth project.

Almost all young people spoke about the value of knowing that they had somewhere to go, and that they could talk to a trusted worker in CEART about their concerns and seek support. Several young people identified CEART as one of the most important things in their lives: “*Well, there’s your family, your house, CEART, hurling, dogs and lamping that’s important*”

The following table summarises the main points from the research participants’ inputs regarding substance misuse in the ECRDTF/Wicklow area:

**Key findings on the nature and extent of substance misuse among Travellers in the ECRDTF/
Wicklow area**

Drug type		Prevalence	Age	Gender	Notes
Illicit Drugs	Cannabis	Widespread	All age groups from 15 years up, especially early 20's & 30's	Mainly male	Frequently part of poly-substance abuse
	Cocaine (powder)	Used at celebrations	Some young Travellers	Mainly male	
	Heroin	Low level of use	Among early 20's and 30's	Mainly male; some women (usually in relationships with using men)	Only access services in late stages of addiction
Prescription Drugs	Benzodiazepines	Very widespread	Among all ages	Prescription drug misuse not involving other drugs – primarily women, especially among those aged 40+	Mainly obtained by some women from GP's but also used by some men; supplies available in many homes; medicines are exchanged or traded; belief that medications (especially benzodiazepines) are not harmful because they are prescribed by doctors; often not seen as drugs; prescription drugs are very easily obtained
	Tranquillisers	Widespread			
	Anti-depressants	Widespread, some experimental use			
	Sleeping pills	Widespread			
	Pain killers	Widespread			
	Mood stabilisers & anti-psychotic drugs	Some misuse	Men aged under 50 years; part of poly-substance misuse		
Alcohol	Alcohol	Widespread and very misused	All ages, esp. 20-50 years; some men in 20's & 30's using as part of poly-substance misuse	Mainly men	Possibly the most commonly misused drug; socially acceptable; not recognised as a big issue within the community

3.4 Participants' accounts of drug treatment services: awareness and barriers to access

3.4.1 Reported awareness of drug treatment services

Many agency workers reported that Travellers are generally aware of drug-related services; some said that Travellers are resourceful and access the services they need. However, equal numbers said that Travellers are not as aware of services as might be thought. Pavee Point (2011) reported that Travellers have limited knowledge of services available to them and that word of mouth is their main information source. Unfortunately, information from peers can feed unrealistic expectations about services.

It was generally recognised among those consulted in this study that Traveller men access hospital services *"because their wives and families have told them it's what they should do"*; or in some cases perhaps *"young men and boys say they've a drink problem and go in [to psychiatric hospital] as an excuse when there's a court case"*. Agency workers confirmed this, but said the same happens in the settled population. Both agency staff and Travellers admitted that parents believe that drug addiction problem can be resolved by attending a centre: *"There's an attitude of 'put him in there and he'll be fixed' whereas the addict must want help."*

3.4.2 Accounts of barriers to drug treatment service access by Travellers

According to almost every agency staff consulted, there are *"no barriers to anyone"* accessing their services, and they operate *"an open door policy."* The Travellers, however, listed many barriers. These can be classified as internal, external, and practical:

Internal barriers (personal difficulties with access):

- Shame about having an addiction and shame about being regarded as weak
- Fear of discovery (within the community, and by authorities)
- Guilt (seeking help involves leaving the family unit)
- Fear of losing children (especially if both parents are addicts)
- Fear of being without family support at the clinics
- Shame about illiteracy and the concomitant inability to fill out forms
- Unwillingness to face discrimination from the settled community

External barriers were indirectly identified, in statements of what Travellers could not trust:

- Settled society (which has so often discriminated against them)
- Agencies run by the settled community
- Settled workers offering the services
- That Travellers' records would be held confidential.

Practical barriers for some Travellers include

- Lacking the local address that is required to access some services
- Fearing that they will be attacked (by debtors) if they go to clinics
- Being ashamed of their illiteracy (the Department of Health and Children [2002, p.4] reported that "up to 80% of adult Travellers are unable to read").

The shocking disconnect between the evaluations of the agency workers and those of the Travellers is revelatory.

4 NEEDS IDENTIFIED BY RESEARCH

All those consulted during the course of this study were honest and generous with their responses about this difficult topic. Overcoming the shame that every community in the world feels about drug addiction (am I responsible? could I have done something more? is it my fault?), the Travellers, whose sense of community and community responsibility is deeply felt, are especially to be complimented for their wholehearted participation. During the consultations, informants were asked to suggest ways of improving drug prevention, treatment and rehabilitation services for Travellers. The many suggestions from both agency workers and Travellers are presented here in order of importance.

4.1 Develop Traveller leadership

Traveller organisations need to challenge Travellers to find their heroes and leaders within their communities, and then to support and encourage them. One credible Traveller man who has walked the walk and come out the other side, or one respected and powerful Traveller woman who understands the horror of drug addiction can set rules and standards. The Travellers need to find someone in the Wicklow area with heroic ambition and stature.

Travellers themselves need to begin to challenge the idea that substance abuse is a consolation for their marginalisation. Interventions will be most successful if they tap into personal beliefs. It is likely to be more powerful if a peer says to a Traveller that drug abuse is a way of conceding much of what the settled community has often said of Travellers --a way of letting the settled society and institutions win.

WTG's suite of community development programmes offers a holistic framework in which to address this serious issue at community and personal levels. In particular, the full-time drugs prevention and education worker has developed a youth programme, and numbers engaging in it have tripled since 2007. Young people are particularly vulnerable to substance misuse; without this engagement in activities and learning, the misuse problem among Travellers in Wicklow would be far greater.

WTG believes that Daish, with its strong Traveller presence in leadership and service provision, sets a great example of what can be done to tackle substance misuse in this community. While many Travellers do not want a segregated service (Pavee Point, 2004, 2010; Walsh, 2010), evidence cited in this report shows that Travellers trust and access this service, which is embedded within both the Bray LDTF and the Bray Travellers Community Development frameworks. It focuses on harnessing the strengths of Traveller individuals, families and community. The presence of Travellers in the team is one powerful pull factor, as is the evident cultural competence of all in that team.

4.2 Education for the whole community

The spread of substance misuse poses an unprecedented threat to Travellers' communal, family and individual well-being. Education at school and community levels is needed, to enable Travellers to harness their historic resilience in the face of oppression, in a collective and personal "we can do it" response to this threat.

Travellers need the necessary knowledge to make informed decisions about drug use and how to help those who become addicted. Two young Travellers captured the need for careful sympathetic education well: "*Travellers don't understand addiction*". "*Addiction has to be in a family before you understand it. If it doesn't affect people it doesn't bother them*". It is the task of the service agencies to help not only the settled community but also the Travellers to understand what addiction is and how it affects all of us.

The comments of the Travellers we consulted reveal that the Traveller community has either been misinformed or has misinterpreted information not only about the nature of drugs (e.g. it is safe to share medications because if a GP prescribed something, it is good for you), but also about the drug treatment and rehabilitation services available to them. The fact that agency workers genuinely believe that they have an open door policy, while Travellers believe the agency doors are closed against them suggests that much outreach work must be done.

This research revealed the strengths of WTG's education programmes for families and young people. The vote of confidence that young Travellers gave to CEART was heartening. However, the data reveal the importance of reaching youngsters from 11 to 18--*before* they have begun abusing drugs. WTG's primary health care project, the youth projects, men's groups, all are in a position to focus on this, and work within the community to develop its own strategies for tackling this grave issue.

Work on tackling the blocks of shame and secrecy is essential. There is a wide gap between the situation of individuals or families so defeated by their drug problem that they cannot even persist with denial and secrecy to defend their good name, and individuals or families who decide that the first step towards tackling a drug problem is to name it out loud, and find solidarity in facing the struggle.

RECOMMENDATIONS

The findings of this research have implications for Travellers, for professional practice, and for the structure of current provision across the ECRDTF/Wicklow area.

1. *For Travellers*

At community level, the four NDS (2009) "pillars" (supply reduction, prevention, treatment and rehabilitation) are interdependent. Building community solidarity, knowledge and skills will create a climate that discourages dealing (see section 2 below) and using, and support those with problems in addressing them. This cannot wait until the need is urgent, or be left to those who are already exposed or entrapped.

1.1 Education programmes, in schools and community-based, must:

- a) foster belief in the dignity and power of Travellers' group and individual identities
- b) engage traditional values on the side of shunning substance misuse, make staying free of it a mark of Travellers' resilience
- c) engage potential leaders, and build their skills and their status within the community
- d) strengthen family and community bonds
- e) disseminate sound information about substance misuse and its physical, mental, social effect
- f) build understanding of how to engage with medical services, and how to manage medications
- g) disseminate information about sources of help for Traveller families and friends of a member who has slipped, and for the member him or herself
- h) open other life opportunities, to counterbalance the attractions of the drugs culture and enable those at risk to divert into positive choices.

1.2 Given the centrality of the family in Traveller culture, both education and service provision programmes must engage the Traveller community collectively, Travellers must make an input into the development of drugs prevention and treatment programmes which do or will impact on them. Daish offers a model of a culturally appropriate, targeted but integrated development.

2. For the structure of provision

Supply reduction: Travellers are not known to grow or manufacture drugs: supply originates outside this community. Community solidarity and outrage will help to discourage Traveller community/family members from dealing, but private citizens cannot take the law into their own hands.

2.1 Strong **law enforcement** is essential to break these supply lines, and to apprehend dealers, within and outside the Traveller community.

Treatment and rehabilitation: All agreed that there is no need for a Traveller-specific treatment or rehab centre; however, it is clear that on the structural level in this area, there should be:

- 2.2 a service based on the Daish model -- Traveller-targeted and embedded in local service provision
- 2.3 a Traveller-targeted element within the rehabilitation outreach services, staffed with experienced outreach workers, including Travellers
- 2.4 more detox places that are easy for Travellers to access
- 2.5 more culturally appropriate day facilities (i.e. drop in services)
- 2.6 at least part of one residential centre or hostel that is Traveller appropriate.

3. For professional practice

It is not possible to serve a population that is not understood. All health service professionals and drugs treatment agency workers need to:

- 3.1 learn more about the Traveller community and overcome prejudice against the population. An interagency response might help break down barriers that exist
- 3.2 prepare culturally appropriate care plans. These will almost always include provision for a family experience, given the core value and strength of the family in Traveller culture
- 3.3 address Traveller-specific aftercare needs (such as how to deal with the danger of *"falling back in"* if there are other drug users in their tight-knit family network).

At a most basic level, availability of risky but licit drugs must be controlled. In particular, local GPs must:

- 3.4 limit the prescription drugs available
- 3.5 monitor the drugs they prescribe (probably on a monthly basis)
- 3.6 give understandable instructions and warnings regarding how these drugs should be used
- 3.7 establish some sort of local registry for addictive drugs in order to prevent prescription-shopping.

Concluding comment

There is a burgeoning substance misuse problem among Travellers in the ECRDTF/Wicklow area; recent population trends and drugs availability are exacerbating it. Findings in this study reflect those reported in research on this issue for Traveller communities elsewhere.

Funding and structural support are essential, if the combined efforts of Travellers themselves, WTG and its work in CEART, community health services and drugs prevention, rehabilitation and treatment services in this area are to be effective. In short, the aim of all must be to foster a resilient Traveller community, and services that can competently engage with both the needs and the strengths of Travellers in the face of this threat.

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