

***Social Capital and the Irish Drug
Scene: Rural Youth, Cocaine and
Irish Travellers***

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Abstract

National prevalence surveys indicate that lifetime and recreational drug use among all social classes have increased steadily over the last decade in Ireland (Moran *et al.*, 2001a, Mayock, 2002, National Advisory Committee on Drugs, 2008a). Drugs research has been traditionally based on the identification, weighting and interrelatedness of risk and protective factors within a *"risk prevention paradigm"*. This paradigm has been criticised for its lack of inclusion of individual, group and wider structural aspects, and occurs within a greater awareness of greater social discourse and societal shifts. The research papers in this portfolio of work are thematically analysed and conceptualised within the theoretical framework of cognitive and structural social capital. The descriptive research and later, more conceptual papers investigating drug use among rural youth, Travellers and cocaine use, are thereby explored in terms of the potential *'normalisation of rural youth drug use'* within contemporary risk discourse, the assimilatory threat of increasing drug use among the *'Traveller community'*., and the emergence of the *'recreational cocaine user'* in Irish society. The social processes of individualisation, reciprocity and trust which constitute social capital are deemed to provide potent collective frameworks for the navigation of risk in day to day *'localised'* settings. The *'interrelated normative frameworks'* and *'processes of risk neutralisation'* are underpinned within a wider social capital understanding of the meaning of drug activity in associational life based on *'interpersonal and institutional trust'* and *'mutual resource acquisition'*. Contemporary drug policies must consider the contextual constraints of the *'risk society'*, which impact on inherent individual *'power resources'*, whereby individual agency and drug taking is better understood within situational agency of *'localised'* social, gender, ethnic and cultural capital.

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Chapter 1. Introduction

This thesis will discuss the normalisation of recreational drug use in contemporary Ireland, using the tenets of social capital theory, according to three settings in the Irish drug scene, namely; inner city cocaine use, rural youth and the Traveller community. The research portfolio uncovers distinct middle class cocaine using groups in Dublin, a contamination of Traveller culture with illicit drug use and the dissipation of traditional farming life leading rural youth toward new pathways of urban drug cultural navigation. This forms an initial starting point for the conceptualisation of the published works using the chosen social capital theoretical framework by plotting these localised inner drug networks within a broader social and structural context. Specifically, this portfolio of work illustrates and discusses the relationship between structural agency, space and status, and that of rationalised drug consumptive decision making in applying social capital to a greater depth of understanding of recreational drug use within the normalisation drug discourses of local associational life in Ireland. Firstly, this chapter sets out to describe the Irish drug scene in terms of prevalence and treatment data, introduces the normalisation theory relating to recreational drug use, and presents how this phenomenon of sub-cultural acceptance of social drug use can be better understood using social capital theory as heuristic device to situate these localised drug movements.

Substance Use in Contemporary Ireland

Substance prevalence trends, consumptive patterns and drug trajectories in Europe and Ireland are dynamic, increasingly diverse and closely dependent on substance availability, price, user accessibility and choices, user demographics, group practices and community norms (Moran *et al.*, 2001a; Moran *et al.*, 2001b; Hibell *et al.*, 2009). Alcohol is the primary substance of choice in Ireland, as evidenced by national treatment statistics and alcohol related prevalence surveys (Mongon *et al.*, 2007; NACD, 2008a; Alcohol and Drug Research Unit [ADRU], 2009). There is an emerging pattern of frequent and heavy drinking in Ireland, as evidenced by upward trends of drunkenness among Irish youth (Hibell *et al.*, 2009). Indeed, the majority of Irish school children have consumed alcohol, with the likelihood of lifetime prevalence of alcohol in Irish school going children increasing with each year of age (Nic Gabhainn *et al.*, 2007; Hibell *et al.*, 2000; 2004; 2009). The Health Behaviours for School Children

[HBSC] in 2008 highlighted emerging trends of drinking in Irish primary schools, with consumption rates increasing during the junior cycle at second level. Irish girls initiate into drinking later than boys, but by age 14 and 15 years report similar trends in lifetime prevalence and drunkenness (Gavin *et al.*, 2008). Research shows that the purchase and consumption of alcohol for those of school-going age does not appear to be fraught with any difficulties, and although young people report awareness of the potential harm of alcohol consumption, this is tainted by general positive risk comparisons to other substances and does not appear to restrict youth drinking behaviours (Hawkins *et al.*, 2002). Excessive youth drinking patterns are commonly reinforced by the presence of normative group boundaries (Parry and Bennetts, 1998; Mongon *et al.*, 2007). In addition, alcohol cannot be underestimated as potential gateway substance to drug experimentation and pathways toward poly substance use (Kandel, 2002). Cigarettes may also present a gateway issue for drug initiation (Kandel, 2002). Molcho *et al.*, (2007) reported that Irish young peoples' self reported lifetime prevalence of cigarette use increases with age, with few gender differences evident. However, at later stages (15-17 years) more Irish girls than boys report current smoking patterns (Gavin *et al.*, 2006; Nic Gabhainn *et al.*, 2008).

National drug statistics in Ireland report increasing drug consumptive trends among all social strata in the last decade (National Advisory Committee on Drugs [NACD], 2008a; NACD, 2008b). Currently, Irish statistics show that 1 in 4 respondents reported taking any illegal drugs at some point in their life, with cannabis indicating the greatest trends of use among both adults and youth cohorts (NACD, 2008a; NACD, 2008b; ADRU, 2009). Illicit drug use (i.e. lifetime, last year and last month) is most common among young Irish adults under 24 years (NACD, 2008a; NACD, 2008b). Since 2003, the NACD (2008a/b) national prevalence surveys indicated an increase in young Irish people aged 15 to 35 years reporting lifetime prevalence of an illegal drug, with similar proportionate increases in cannabis use and with the majority of young people using cannabis during teenage years (NACD, 2008a). Cocaine use was identified as an emerging drug trend in Ireland in the Noughties with increasing lifetime prevalence among Irish people over the age of 16 years (NACD, 2008a; Bellerose *et al.*, 2009) and appeared to be replacing ecstasy, amphetamines and other stimulant drugs on the recreational drug scene (Mayock, 2001b; NACD, 2008a). Research in 2009 identified the presence of two distinct profiles of cocaine use in Ireland in terms of those using

cocaine in combination with opiates or opiate substitutes, and those using cocaine in combination with alcohol, cannabis and/or ecstasy, with a clear majority of users consuming this drug sporadically as weekend drug (Bellerose *et al.*, 2009). Recent research in 2010 identifies a displacement toward the consumption of designer drugs such as substituted cathinone derivatives [i.e. mephedrone, methedrone and methylone]; party pills [BZP and TFMPP] and synthetic cannabinoids in Ireland (Long, 2010). National treatment statistics also indicate an increase in treated drug use among 15 to 64 year olds since 2003, with alcohol cited as most common primary problematic substance, and the majority client profile for problematic drug use to be young, male, with low educational attainment and unemployed (ADRU, 2009). However, these statistics are unlikely to represent anything more than the identification of problematic drug use and treatment uptake, with little concrete evidence with regard to patterns of recreational use in Ireland.

Normalisation and Irish Drug Use

One can speculate that we exist in a drug conscious Irish society, and indeed prompt speculation that Irish drug use is '*culturally legitimised*' to a certain extent within contemporary drug discourse (see Parker and Egginton, 2002). Measham and Brain (2005:262) observe the presence of distinctive drug and alcohol use practices within contemporary society as a '*new culture of intoxication*'. Indeed, the emerging appetite for recreational alcohol and drug use in Ireland, and the movement toward greater social acceptability of illicit drug consumption was centralised in the '*Celtic Tiger*', a time of great wealth and economic expansion in Ireland, and potentially connected with a heightened appreciation of the social situatedness of drugs within leisure time, and the striving to '*act out like the rich*'. Research on substance use suggests that increased prevalence rates may be associated with economic growth (Graves *et al.*, 2005), increased consumerism (Parker *et al.*, 2002), decreased importance of religion, changes in parenting patterns and restricted educational opportunities (Silbereisen and Kracke, 1997). In addition, Moore and Miles (2004) comment on the mechanism and role which drugs play in contemporary society, whereby drug use can create '*parallel lives*' to counteract day to day uncertainty. Perceptions of potential harm relating to drug use are facilitated by individualised drug experiences, gender, media coverage of drugs and drug use, and personal demographic characteristics (Parker *et al.*, 2002). In particular, estimations of drug related risk depend on the types of drugs consumed,

modes of administration, and hinge on the distinctive social and structural constructs in each local environment (Rhodes, 2002). Indeed, Shildrick (2008:179) has observed the transition of Class A drugs in the UK toward '*mainstream drug markets in terms of acceptability as well as use*'. National survey data reflects that illicit drug use is no longer limited to the East coast of Ireland or the greater Dublin urban area, the traditionally deprived areas or indeed those deemed particularly vulnerable, with the emergence of comparable rural drug trends, and rising drug use amongst otherwise law abiding citizens and within the Traveller community (Fountain, 2006; NACD, 2008a; NACD, 2008b; Health Service Executive [HSE], 2008; ADRU, 2009). The Irish HBSC studies have also identified a narrowing of the gender gap in terms of lifetime youth alcohol and drug use. Researchers in the UK have pinpointed a similar reduction in gender gaps in early youth drug trying rates, but with young men self reporting greater levels of drug consumption on a more frequent basis, when compared to women (Parker *et al.*, 1998; Newcombe, 2007), and with gender differences in older cohorts of young people remaining evident (Measham *et al.*, 2001; Measham, 2002; Aldridge, 2008).

The normalisation theory of drug use was developed in the Nineties in the United Kingdom and used to explain the increase in youth illegal drug consumption at that time, and recognised movements toward recreational drug use, similar to that of alcohol and tobacco (Parker *et al.*, 2002). Fundamentally, this theory attempted to merge prevalence (lifetime and recent use), seizure and street price data with changing societal values pertaining to illegal drug use, and looked at the emerging presence of recreational drug use in UK society, fuelled by positive attitudes, heightened social accommodation and corresponding availability of drugs such as cannabis, ecstasy and amphetamine in leisure time. In a nutshell, normalisation theory is comprised of the following five dimensions; '*availability/access; drug trying rates; usage rates; accommodating attitudes to 'sensible' recreational drug use especially by non users; and degree of cultural accommodation of illegal drug use*' (Parker *et al.*, 2002:941). Within the Irish drug scene, accessibility is most commonly highest for cannabis, followed by club drugs such as cocaine and to a lesser extent ecstasy and amphetamine (NACD, 2008a; NACD, 2008b). High prevalence rates for cannabis particularly among urban working class youth reflect increasing normalisation of cannabis use among young Irish people (Moran *et al.*, 2001b) with the most recent

Health Behaviours for School Children survey [HSBC] (HBSC, 2006) survey reporting minimal differences in socio economic status in the consumption of cannabis among school children. The popularity of cannabis use among young people, often reinforced by the social accommodation of consumption within normative groups and minimal social stigma is similarly reported in the UK (Shildrick, 2002). However, whilst cannabis has to some extent satisfied certain dimensions of normalisation (i.e. cannabis availability, cannabis trying rates, and socially accommodated cannabis use) in Ireland, it may take some time before other street drugs (i.e. ecstasy, cocaine or amphetamine) or indeed emerging designer drugs (i.e. substitute cathinone derivatives, party pills and synthetic cannabinoids) are viewed in a similar manner.

Previous studies on drug use, whether on youth or other hidden groups of drug users, have focused on both the traditional psycho biological risk predictors for substance abuse (Boeck *et al.*, 2006) and the processes of individualisation and negotiation of the risk society (Shildrick and MacDonald, 2006). However, the personal and social accommodation of infrequent, opportunistic and controlled drug use in recreation time (most commonly cannabis) by users, abstainers and those young people who have experimented and no longer use drugs remains an essential construct of the normalisation theory (Measham *et al.*, 1994; Measham *et al.*, 2001; Parker *et al.*, 2002; Parker, 2003; Elliott *et al.*, 2005). The dynamics of such '*accepted*' recreational drug sub cultural processes hinge on drug choices, patterns and practices of use, normative group sanctions for use and to a larger extent, the underlying presence of wider community, social, ethnic and cultural values (Peretti-Watel, 2003). Indeed, some research has criticised the normalisation theory for presenting rather a simplified and static focus on youth drug use and has emphasised the need to understand such drug movements, and the internalised acceptability of recreational drug use within the context of specific and distinct '*lived*' group contextualisations of leisure and social settings, locales and placed within wider drug discourse (Shiner and Newburn, 1997; Shildrick, 2002). This ideology was reciprocated by Shildrick and MacDonald (2008) who suggested the inclusion of '*critical moments*', socio-economic transitions and '*local consequences*' in garnering a better understanding of youth drug trajectories. In this way, rational decision making processes surrounding drug consumptive practices within contemporary society may be viewed as individual processes of choices around risk taking as situated within the immediate social context. Such concepts are

particularly interesting in terms of the potential flux between these paradigms as individuals make decisions within the risk infused normative collective frameworks of social connectiveness within associational life (Furlong and Cartmel, 1997). Individual and group risk negotiation and harm formations are imbibed in '*socially constructed discourses of risk and morality*' (Rhodes, 2002:86) and constructed as linear and non linear complexities between individuals and their immediate environments (Galea *et al.*, 2009). Indeed, the contextual constraints of contemporary '*risk society*' necessitate understanding within consideration of the presence of power resources between individual and situational agency within their risk environment (Rhodes, 1997a; Rhodes, 1997b). Miller (2005) observed that risk behaviour is rational when understood and reinforced within the '*localised*' world of the user or his/her cultural context. Thereby, the processes of drug risk neutralisation or denial (see Peretti-Watel, 2003) can be better understood when distinctive cultural, individual, social and ethnic variables within lay associational life are considered in understanding drug behaviours (Neaigus *et al.*, 1994; France, 2000; Lupton and Tulloch, 2002; Lovell, 2002; Boeck *et al.*, 2006; Friedman *et al.*, 2007; Boyce *et al.*, 2008; Fast *et al.*, 2009; Rhodes, 2009). Risk perception, risk taking and drug use are social interactions with a multiplicity of causes and outcomes, not only within an aggregate result but also with specific and minute differences in environmental conditions (Byrne, 1998). Indeed, Lupton (1995:35) has argued that risk is; '*inevitably mediated through ... social processes and can never be known in isolation from these processes*'. This leads us into the chosen theoretical framework of social capital in offering us a greater depth of understanding pertaining to recreational drug movements within certain social networks. Of particular interest for this body of work are the localised social mechanisms whereby the consumption of certain drugs become socially and culturally accepted over time, and represent a movement away from problematic drug use confined to deviant and deprived Irish sub cultures.

Social Capital Theory- An Introduction

The interplay between many risks and resiliencies identified for drug behaviours are grounded in the proposed tenets of social capital theory, namely; social networks and connectivity, values and norms, sense of belonging, safety, trust, resource acquisition and risk neutralisation (Boeck *et al.*, 2006) and within the context of this thematic work cannot be deemed to operate in isolation. In particular, the thematic analysis of these

published works seeks to interpret drug decision making, drug dealing and drug use by underpinning the key importance of understanding both the development of individual risk relationships in drug initiation, drug use and reinforcement of use within localised settings, and the influence of social capital tenets in introduction, facilitation and maintenance of such socially situated and localised drug using reflexes and relationships. One cannot underestimate the presence and potency of contemporary Irish public and lay drug discourses, and how each social capital '*micro*' environment '*enables*' the emergence of drug activity, socially situated risk, perceived harm and self responsibility within day to day associational life. Thereby, this portfolio of published papers shall be interpreted using the recognition of social capital existence as permeating throughout this collection of work, and contributes to the existing knowledge by underscoring how social capital both cognitively and structurally can inhibit, facilitate, mediate and deter the commencement and reinforcement of drug consumptive activities. The conceptualisation of drug decision making processes shall be illustrated through a greater appreciation of the processes of social capital connectivity in terms of '*interrelated normative frameworks*' and '*risk neutralisation*' within a wider social understanding of the meaning of drug activity in associational life grounded in '*interpersonal and institutional trust*' and '*mutual resource acquisition*' for the research cohorts.

As initial introduction to the chosen theoretical framework of social capital which shall be presented comprehensively in **Chapter 3**, the structural components of social capital describe and identify networks, associational life and interpersonal relationships, with cognitive elements contained within these social structures in terms of support, trust, cohesiveness and perceived civic engagement (Theall *et al.*, 2009). Social capital theory as a popular concept can also be utilised to describe or explain the presence of the mutual extraction of resources contained within social structural relationships between individuals and institutions (Coleman, 1988). The social justice perspectives of Putnam and Fukuyama's social capital theory relating to civic engagement, mutual obligations, trust and social cohesion are addressed in **Chapter 3** within a wider recognition of the roles played by friendship or group networks, families, communities and institutions such as schools. Fukuyama (2001) and Putnam (2001) have emphasised the role of trust, social norms and sanctions within social networks as facilitating connectiveness, collective action and strengthening communities. The

level of individual and community investment in these collective social relationships generates social capital in the form of resources that individuals can utilise to promote self growth and opportunity (Subramanian *et al.*, 2005). Most importantly, social capital theory is recognised as an important conceptualisation in achieving a greater understanding of community and individual behaviour, social control, social solidarity and health disparities (Furstenburg and Hughes, 1995; Portes, 1998; Kawachi *et al.*, 1999a; Veenstra, 2000; Baum, 2000; Rose, 2000; Hawe and Shill, 2000; Wright *et al.*, 2001; Muntaner and Lynch, 2002; Drucker *et al.*, 2003; Lochner *et al.*, 2003; Szreter and Woolcock, 2004; Putnam, 2004; Drucker *et al.*, 2005; Ziersch *et al.*, 2005; Subramanian *et al.*, 2002; 2005; Carpiano, 2006; Poortinga, 2006a; Poortinga, 2006b; Poortinga, 2006c; Kim *et al.*, 2006; Subramanian and Kawachi, 2006; Sundquist and Yang, 2007; Bartkowski and Xu, 2007; Friedman *et al.*, 2007; Maycock and Howat, 2007; Özbay, 2008; Engstrom *et al.*, 2008; Bantchevska *et al.*, 2008). Within a micro focus, Maycock and Howat (2007) utilise the health and civic enhancing potentials of social capital constructs as grounded in community and family solidarity, inner and outer trust, sense of belonging and safety, elements of volunteering and social reciprocity, collectivity and organisation within communities.

Indeed, Laub and Sampson (1993:301) have proposed that '*social capital and turning points are crucial in understanding processes of change* and '*the significance of continuity and change over the life course*'. Although social capital as analytical construct contains defined class positioning, the conceptualisation of social capital processes recognise that social space is not fixed and fluctuates as individuals strive to achieve or retain their position within their perceptions' of agency and credible cultural capital (Theall *et al.*, 2009). In terms of Irelands positioning, the National Economic and Social Forum has highlighted the presence of unprecedented economic growth in Ireland as co-occurring alongside a worrying gap in economic and social strata, with great concern for the dispersion of values relating to social cohesiveness, community connectiveness, equality and acceptance of ethnicity, mutual obligations and reciprocal respect (NESF, 2003). These identified tenets of the social capital theory underscore the undermining of social and civic engagements, disadvantage, the disconnection in associational life and lack of common purposes, compromised moral standards and obligations within Irish families, schools and individuals, as relating to changes in contemporary Irish culture (i.e. increased working practices, dual career families, urban

sprawls, long commutes and emphasis on materialistic values) (NESF, 2003). This national report also identified concern for the attribution of these compromised values contributing to heightened crime rates, drug activity and problematic drug use in Ireland, and emerging as direct consequence of community disempowerment. Indeed, research shows that civic social capital is linked to formal and informal controls and contributes to negative and positive outcomes relating to private versus public motives and levels of social exclusion (Fukuyama, 2001).

Therefore, within a greater reflection on the processes of social structure and connectivity, this doctoral process has taken the researcher from initial descriptive drugs research to including a recognition of the interplay pertaining to life circumstances, social relationships and interpersonal risk factors, and greater awareness of drug normalisation theoretical thrusts, using social capital theory as a heuristic device to better situate drug using pathways, relationships and meanings within changing cultural, ethnic, social and civic structures in Ireland. It is proposed that many individuals align their risk and health behaviours alongside levels of prevalence and acceptability of such behaviours in their communities (Duncan *et al.*, 2002). The researcher utilises the many elements of the social capital construct, and perhaps most especially those of Coleman which underscore the relationships between actors in securing social space, agency and access to networks within the local drug risk environment. In this way, the thematic work recognises the symbolic interactionism occurring within drug using groups, the presence of socially accommodated drug use, norms, sanctions and expectations surrounding drug seeking and consumptive behaviours. In terms of the structure of this portfolio of work, **Chapter 2** shall present epistemological and theoretical reasoning for research processes in the drugs field, a comprehensive section on employed research design and reflective commentary on the research methodologies selected. Thereafter, **Chapter 3** shall present the narratives within the identified strands of social capital pertaining to communities, families, groups and trust; mutual extraction of resources; and the neutralisation of risk within normative bounded social structures. Finally, **Chapter 4** shall discuss the integrated research findings within the social capital frameworks of socially situated risk, and conclude in terms of the contribution of this work to drug and sociological research.

Note: For ease of reading a tabular presentation of the 14 publications as contained in this research portfolio are presented on the following 3 pages.

Table 1: Publications

Paper	Title	Abstract	Status
1	Drug use among rural Irish adolescents- a Brief Exploratory Study.	This research aimed to provide a qualitative illustration of Irish youth substance use in a rural region. Semi structured interviews were undertaken with a random sample of 220 students from schools and youth training centres within a rural area of the South Eastern region of Ireland. The results show that against the backdrop of rising drug use prevalence, the attitudes towards drug use of both adolescent users and abstainer have become more liberal and ' <i>normalised</i> '.	Drug and Alcohol Today, 2009, Volume 9, Issue 1, 20-26.
2	An exploratory study of substance use among Irish Youth- A Service Providers perspective?	This research aimed to provide a qualitative perception of Irish youth substance use according to youth and drugs service providers in Waterford, Ireland. Semi structured interviews were conducted with a self selecting sample of community, law enforcement and drug services (n=42). The results suggested that adolescents' attitudes and substance using practices have become more liberal and indeed more ' <i>normalised</i> ', and that drug services may be aiming at a ' <i>transient target</i> ' of drug and alcohol taking patterns within the rural context.	Journal of Ethnicity in Substance Abuse. 2009 Volume 8, Issue 1, 99-111.
3	An Illustrative Picture of Irish Youth Substance Use. Letter to the Editor.	This letter shall describe recent exploratory research in Ireland, which was undertaken in order to provide a ' <i>snapshot</i> ' of the perspectives of youth, community, addiction, educational and health service providers, in terms of youth substance use and current service provision. Interviews were undertaken with a self selecting sample (based on availability, n=78) of youth, community, addiction, educational and health service providers in the South Eastern region of Ireland. The research provided a key insight into the opinions, thoughts and knowledge relating to youth drug and alcohol use from the viewpoints of the service providers themselves, in relation to their varied levels and types of contact with young people.	Journal of Alcohol and Drug Education. 2009, Volume 53, No 1, April, 7-14.
4	Youth Alcohol and Drug Use in rural Ireland- A Parents View.	The aim of this research was to provide an exploratory account of rural parents' perspective of alcohol use and illicit drug use among youth in Ireland: A convenience sample of parents with adolescent children was selected at a parent teacher evening at 3 rural schools, through facilitation of the school completion officers (34 mothers and 21 fathers, n=55). Semi structured interviews were conducted which included questions relating to the parents' perception of youth drug and alcohol use, both in terms of recreational and problematic use in their communities, levels of drug availability, risk perceptions, settings for adolescent substance use, service provision and drug information; and not necessarily with regard to their own children. The research suggested parental concern with regard to increased rural drug exposure within local rural communities.	The International Electronic Journal of Rural and Remote Health Research, Education, Practice and Policy. 2009 Online.

5	Differentiated Normalisation and Drug Transitions among Rural Youth in Ireland.	The research aimed to explore the contexts and meaning of drug use on rural youth transitions in terms of increased drug prevalence, recent influx of rural drug activity, normative tolerance of recreational drug consumption and fragmentation of traditional rural communities. Interviews were conducted with 220 young people (15-17 years), and 78 service providers in a rural area of Ireland, in order to yield contextualised narratives of their experiences of drug use and achieve a wider exploration of processes, drug transitions and realities of rural youth. The research suggests support for a 'differentiated' normalisation theory (Shildrick, 2002) in terms of consumerist and normative rural youth drug use transitions in their negotiation of risk within integrating rural and urban dichotomies.	Drugs: Education Prevention and Policy. 2010, In press.
6	Travellers and Substance Use- Implications for Service Provision.	The research aimed to yield an anecdotal presentation of Traveller substance use from the perspectives of drug, social, law and community service providers in Ireland. The research was qualitative in design and consisted of semi structured interviews with service providers (n=45) in order to generate a more comprehensive picture of current dominant perceptions of the 'experiences and issues relating to drug and alcohol use among Travellers'. The research findings indicated that drug and alcohol use in the Traveller community in Ireland is increasing in terms of excessive alcohol use, certain drugs used and patterns of problematic substance use.	International Journal of Health Promotion and Education. 2010, Volume 48, Number 2, 36-41.
7	Irish Travellers and Drug Use- An Exploratory Study.	The research aimed to provide an explorative account of the issue of drug use in the Irish Traveller community. The research consisted of focus groups (n=12) of Travellers (n=57) with a gender balance (47/53%) based on self selection and volunteerism. The Travellers described a fear of problematic drug use within their communities coupled with concern in terms of discriminatory experiences with health and drug services, lack of awareness of current service provision and the lack of culturally appropriate drug education material and addiction counselling.	Ethnicity and Inequalities in Health and Social Care. 2009 March, Volume 2, Issue 1, 42-49.
8	Alcohol Use and the Traveller Community in the west of Ireland.	This research yielded an exploratory account of Irish Travellers and alcohol use according to the perspectives of the Travellers and key service providers in the west of Ireland, within the context of a large scale study on Travellers and substance use. The research consisted of 12 peer accompanied focus groups of Traveller men and women (n=57) and 45 semi structured interviews with a self selecting sample of key service agencies. The Traveller community, and in particular Traveller men are presenting with increasingly problematic alcohol use, due to dissipation of their culture and their experiences of marginalisation, discrimination, depression, illiteracy and poverty.	Drug and Alcohol Review. 2010, January, Volume 29, 59-63.
9	Travellers and Substance Use in Ireland- Recommendations for Drug and Alcohol Policy. Policy Paper.	This paper draws on a Traveller and substance use regional needs analysis in Ireland, which comprised of 12 Traveller focus groups and 45 interviews with key stakeholders. Fragmentation of Traveller culture is occurring as Travellers strive to retain their identity within the assimilation process into modern sedentary Irish society. Treatment and outreach policies need to protect Traveller identity by reducing discriminatory experiences, promoting cultural acceptance with service staff and addressing literacy, implementing peer led approaches and offering flexible therapy modalities.	Drugs: Education, Prevention and Policy. In press.

10	A Primary Care Service Framework for Travellers in Ireland: Results from a Consultative Forum.	The research aimed to explore factors impacting on Traveller health and experiences of Primary Care Services from the perspectives of key Traveller Health stakeholders in Ireland. This pilot study was designed as initial consultative forum using a single focus group (n=13) in order to yield specific recommendations for the development of a designated Primary Care Service framework [PCSF] for Travellers. The research recognised the importance of Traveller community consultation in the design of Primary Care Service framework within each local needs analysis. Thereby, the promotion of Traveller advocacy, visible access and referral pathways can be achieved, with Primary Health Care Project for Traveller [PHCT] workers acting as a 'bridge' between Travellers and the designated area Primary Care Team.	<i>Community Practitioner Journal. 2010 Volume 85, Issue 5, May, 25-28.</i>
11	Assimilation, Habitus and Drug Use among Irish Travellers.	The aim of the research was to explore the assimilation process within the context of Traveller habitus and heightened drug activity within Traveller communities, once virtually non-existent. Qualitative research using 12 gender specific focus groups with Travellers (n=57) was conducted (see WRDTF Van Hout, 2009a). This initial descriptive drugs research was plotted against a selective assimilation theoretical framework, using the concept of habitus in exploring the recent advent of drug activity within Traveller associational life. Traditional anti drug Traveller culture is diminishing in potency, as families become fragmented and Traveller youth assimilate within educational settings, and over time one would question if drug use among Travellers will replicate or even exceed that of the "settled" population, given the marginalisation and discrimination they experience.	<i>Critical Public Health. In press.</i>
12	The Irish Traveller Community, Social Capital and Drug Use.	Research indicates there is a distinct lack of structural understanding of Traveller negotiation of conflict within dominant sedentarist societal norms and values (Cemlyn, 2008). Gender based focus groups (n=12) of Travellers (n=57) were conducted as part of a large scale regional needs analysis for Travellers and substance use in Ireland (Van Hout, 2009a), and analysed thematically using the social capital framework, in terms of Traveller experiences within 'settled' communities, exposure to drugs and drug using contexts. Discriminatory experiences, low levels of institutional trust and influx of drug activity in Traveller communities is contributing to the neutralisation of drug taking risk, and the development of normative and reciprocal relationships in drug activities. A holistic, inter governmental approach is needed to address social exclusion factors by reducing marginalisation, preserving the Traveller ethnic identity, minimising racist and discriminatory instances, understanding the Traveller risk environment, and fostering inclusive relationships with 'settled' communities.	<i>Journal of Ethnicity in Substance Abuse. Volume 9, Issue 3, July, 196-205.</i>
13	Traveller drug use and the school setting: Friend or Foe? Letter to the Editor.	The letter discusses recent research findings on Travellers and drug use in Ireland, in relation to an emerging key theme of the potential assimilatory threat which the formal educational setting poses for Traveller youth amidst rising drug activity within the Traveller communities. Gender specific focus groups (3-5 participants) were conducted in 12 locations in counties Roscommon, Mayo and Galway, in the western region of Ireland (n=57). The level of Traveller attachment to both Traveller and 'settled' values overtime will predict the risk for future drug prevalence and potential levels of problematic drug use.	<i>Journal of Alcohol and Drug Education. Volume 54, Number 2, August, 7-16.</i>

14	<p>A Community Perspective of Cocaine Use in Ireland.- A Brief Exploratory Study.</p>	<p>The study was undertaken due to rising community concern of apparent increasing pervasion of cocaine availability, increased cocaine use as social activity and the destructive impact on both individual and community context. 88 Interviews were conducted with a range of informants including drug-service providers, An Garda Síochána (Irish police), youth workers, drug counselors, family support workers, general medical practitioners, hospital personnel, night-club owners, publicans, parents and carers, taxi drivers, doormen, community workers, money advice and lending services, outreach workers, prison liaison officers, politicians and a small number of key informants considered to have experience of and insight into common and preferred drug-taking practices in the community. The research pointed to the increased visibility of cocaine in the community at many levels, and an increased likelihood of intranasal cocaine use among social poly-drug users, in addition to the problematic patterns (injecting and smoking cocaine) presented by those attending the methadone clinic in combination with alcohol and other drugs.</p>	<p><i>Contemporary Drug Problems. 2007, Spring, Volume 34, No 1, 103-111.</i></p>
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The next chapter shall commence with a theoretical and epistemological discussion relating to research methodology and drug use as hidden activity, present a methods section on each of the research designs employed in the course of this work, and concludes with a post research reflective commentary.

Chapter 2. Research Methodology

Drugs- A Covert Activity

Drug use as illicit activity ensures that such behaviour remains covert and that many drug users are not reflected in prevalence estimations or indeed treatment data. Multiple methods of illicit drug surveillance exist (Griffiths *et al.*, 2000), often utilise mixed method data from quantitative and qualitative studies (Hay, 1998) and are widely used to develop associated drug policy responses (Stimson *et al.*, 1999). The majority of drug prevalence methodologies are quantitative population surveys (EMCDDA, 2000). However such drug prevalence surveys may not adequately reflect clustering of drug trends, high/low prevalence trends, new emerging trends among specific groups and local variations within national settings (National Institute of Drug Abuse [NIDA], 1995; EMCDDA, 1996). According to Cvetkovski and Fry (2006) drugs research is not deemed a homogenous field, whereby opposing and varied research practices exist (i.e. positivist quantitative research, descriptive qualitative approaches and critical social science approaches). The quantitative/qualitative debate remains (Hammersley, 1989), with both approaches remaining somewhat oppositional (Bourgois, 2002) and dualistically defined by the following terms; '*individual/ social, objective/subjective, fact/value, thin/thick*' (Martin and Stenner, 2004:396). Quantitative research, in terms of deductive design, is '*construct driven*', whereby studies are driven on the basis of existing theoretical frameworks and hypotheses (Rhodes, 2000) and may often be considered too restricted and reductionist for the study of the social world of drug use (Martin and Stenner, 2004). Qualitative research findings in mixed method studies can be used to yield greater interpretation of quantitative research, enrich research findings and optimise on research validity (Hartnoll, 1995; Tashakkori and Teddlie, 1998; 2003; O'Cathain *et al.*, 2007). In addition to providing meaning and illustration of the experiences pertaining to drug use, qualitative research can additionally be used to guide and determine quantitative methodologies and theories of addiction, sub deviant sub cultures and issues of normalised behaviours (Becker, 1963; Agar, 1997; Agar, 2003). However, whilst the emergence of early trends within certain clusters of drug users or indeed hidden populations can be identified using qualitative and ethnographic methodologies, such approaches may also neglect emerging trends occurring outside of these groups (Griffiths *et al.*, 2000; Dietze, 2003). The mixed method process may therefore be considered to represent a legitimate and '*stand alone*' research design

(Creswell, 2003; Tashakkori and Teddlie, 1998; 2003; Hanson *et al.*, 2005:224) and can be used not only to improve understanding of a research problem, but additionally to represent the needs of minority, at risk or under represented groups in society, and thereby offer much to the drugs field (Mertens, 2003; Hanson *et al.*, 2005).

The theoretical focus of drug epidemiology has shifted away from its historical basis of individualised risk factors within a certain '*positivist*' perspective, and toward the embedding of such research within broader social and political frameworks (Bourgois, 2002; Dietze, 2003). In this context, qualitative research is based on a realist tradition, and indeed a participant framework of understanding, where the social and environment contexts of drug use are better understood, and not limited to risk factor matrixes (Parker *et al.*, 1998; EMCDDA, 2000; Rhodes, 2002; Agar, 2003; Martin and Stenner, 2004; Bourgois, 2003). As a result, qualitative methods are increasing in acceptance, yielding distinct research outputs and increasingly valid within the drugs field (Martin and Stenner, 2004). Drug use contains much social interaction, meanings, symbolism, processes, trajectories and varied interpretations thereof (Becker, 1963; Rhodes, 2002; Agar, 2003). Symbolic interactionism has stressed the recognition of the nature of socially situated behaviour in understanding substance use and dependency within a social and cultural context (Lindesmith, 1947). According to Rhodes (2000; 2002) in the tradition of drug ethnography, the focus of such research was to '*make sense*' of the lived social world of drug use from the user perspectives, often underpinned as rational, purposeful and normal from the perspectives of the users themselves, and thereby losing its deviant connotations, and indeed situated within the social contexts in which they occurred. This is the fundamental basis for this portfolio of work which sought to garner greater depth of understanding and illustration of the '*lived*' experiences of each cohort, within a wider social contextualisation of processes attached to drug trajectories. It is these concepts which act as primary themes in the analysis of this portfolio of published work, whereby the qualitative research is considered within meanings attached to social contexts, within both group and individual settings and wider interpretation of variations in environmental, cultural and economic structure. The researcher chose qualitative research methodologies in order to engage with the drug user and relevant stakeholders so as to gain an insight into the covert world of the recreational drug user (rural and Traveller youth, cocaine users and adult Travellers), the meanings attached to certain drug taking practices,

reinforcers for use, group contextual meanings, social sanctions for use, risk perceptions within the '*real life*' experience and processes facilitated by social, economic and cultural factors. It is this rational and '*real life*' approach to risk taking and drug activities which shall be '*unpacked*' in the thematic analysis of work contained in this portfolio, and underpinned within the theoretical threads of social capital connectiveness.

Of most importance here, is the element of research truth, where the chosen approach reveals '*what is really going on*' in the drugs field (Martin and Stenner, 2004). In this way, the interpretation of '*what is really going on*' can be performed in a variety of diverse and independent ways, whether as explanation, mode of further understanding, exploration of distinct causal mechanisms, general theory analysis, and conceptualisation of information (Martin and Stenner, 2004). One must note that qualitative and quantitative research methodologies yield representations of drug reality, and yet somehow neglect to show how this frame reflects and influences the picture yielded (Martin and Stenner, 2004). Given this predicament, the broader social framework (i.e. the social capital tenets) may bear some fruit in how to frame the meaning attributed to drug use and practices within recognition of dominant drug discourses. The post structuralist stance offers a sophisticated interpretation of social science functioning within this wider sense of social framework and describes governance as occurring from a distance whereby power and control is imposed through a variety of authorities who shape and mould norms of behaviours and social sanctioning (Foucault, 1982:221). Poststructuralist approaches recognise that threads of mutual reciprocity operate within long term historical, social and cultural discourse and thereby create and stimulate objects, subjects and behaviours. Thereby, individuals in contemporary society can be deemed '*free*' but paradoxically guided and mediated by attempts to practice '*freedom*' within the constraints of the '*systems of domination*' (Dean, 1999:165). This discourse, as representation of reality plays a central role in the definition of socially, culturally and historically constructed concepts such as '*addiction*', '*dependence*', '*drug problem*' and '*drug use*' (Martin and Stenner, 2004:398). In this way, these concepts shape conduct and attitudes by functioning through communication networks in associational life within social, cultural and historical contexts. This stance has important parallels to both the normalisation debate a la Parker *et al.*, (1998, 2003; 2005) in terms of accepted and controlled drug use and consumerist approaches to

social drug use in leisure time, and yet also with social capital and 'lived' connectiveness, where normative relationships influence risk neutralisation, trust and resource acquisition, and guide the quest for social space and agency. Within this process, knowledge acquisition relating to drug ethnography whether through lay or expert discourses plays a central role. According to Hall (1997:44);

'Discourse: . . . constructs the topic. It defines and produces the objects of our knowledge. It governs the way a topic can be meaningfully talked about and reasoned about. It also influences how ideas are put into practice and used to regulate the conduct of others. Just as a discourse 'rules in' certain ways of talking about a topic, defining an acceptable and intelligible way to talk, write, or conduct oneself, so also, by definition, it 'rules out', limits and restricts other ways of talking, of conducting ourselves in relation to the topic or constructing knowledge about it'.

Indeed, poststructuralist ideology has radically changed the conceptualisation of methodologies, '*speaking subjects*' and positioning of research participant narratives. In this way, interviews and observational analysis offer a way to construct reality, within a recognition of presupposed certain bounded thoughts, ideas, emotions, conscious judgments and personal responsibility, prior to the very '*constructive work*' of transcribing, coding and analysis of information garnered (Ashmore *et al.*, 2004). However, this form of assumption is challenged by many researchers, who advocate research practices as uncovering the social world and attempt to remain untainted by wider social forces (Sampson, 1983; Daly *et al.*, 2007). Thereby, discourse analysis within its broadest interpretations has much to offer the drugs field, whether from the institutional levels of discourse in law and science, or toward day to day associational life in informal communicational discourse (Martin and Stenner, 2004).

Reality and the situation of '*lived*' experiences in associational life remain the central question for this research process. Ontological and epistemological claim reality as operating within a range of reflexive realities within discourses, truths and power relations, and research is presented as '*localised*' and contingent arising from specific social, cultural and historical contexts (Wetherell *et al.*, 2001). Thereby, the researcher intends to illustrate, comprehend and extrapolate these research findings within a reflexive and practical sense of daily and localised associational life (Daly *et al.*, 2007). Thereby, the focus returns to the technologies of control and governance underscored

within social capital theory, in how the research techniques construct the research subject and their experiences relating to drugs. Research participants remain inherently aware of their positions within relations of power and social space, and reflexively aware of their communication generations with others (Martin and Stenner, 2004). Thereby, this portfolio of qualitative research in the form of interviews and focus groups must be recognised as *'communicative constructions articulated in specific contexts and located within particular discursive formations'* and thereby subject to some form of inherent restriction (Martin and Stenner, 2004:399). The post structural stance therefore uses this concept of *'second order'* observer to reveal and represent information regarding drug use, but also using drug use as medium for public governance (Martin and Stenner, 2004). The social context within qualitative research has much to contribute in terms of understanding fleeting moments, nuances and other paradigms of lived experiences in social reality both within empirical and theoretical approaches to historical and cultural constructions of social structures. Maher (2002) and Bourgois (2002) have described the ethnographic contribution in drugs research through its engagement with *'local'* social realities, and its potential contribution to pragmatic harm reduction and other social interventions by recognition of the individual as central to social production. One must note that ethical issues remain central to the protection of the *'voice(s)'* of the users and include, informed consent, respect for persons, decision-making capacity, voluntariness; beneficence; preventing harm and providing benefits; privacy and confidentiality; justice in recruitment and subject selection; the credibility of life world representations and potential misuse of generated research findings within the guiding principle of reflexive application of the research (Anderson and Du Bois, 2007). In addition, one must recognise that the interpretation of such ethical principles underlie the relative power of competing normative political agendas (Cvetkovski and Fry, 2006). Thereby, the crucial debate in terms of ethical and legitimate drugs research must be securely positioned within the broader social context of governance of drug activity.

Research Design and Methods Employed

Here follows a basic table [on the following page] used to illustrate the studies contained in this portfolio of published work, and for use as an easy reference when reading the thematic chapter.

Table 2: Research Designs

Name of Research	Fieldwork	Sample	Location	Papers
Rural Youth Substance use in the South East of Ireland	2005-2007	220 youth interviews 78 stakeholder interviews 55 parent interviews	South East Region of Ireland [Counties Kilkenny, Waterford and Carlow]	Papers 1-5 * Paper 1; Rural youth *Papers 2 and 3;Stakeholders *Paper 4 Parents * Paper 5 contains mixed perspective data from rural youth and stakeholders
Cocaine use in inner city Dublin	2006	88 stakeholder and key informant interviews	Cabra, North Dublin	Paper 14 Stakeholders and key informants
Travellers and Substance Use in the Western Region of Ireland	2008	45 stakeholder and key informant interviews 12 focus groups of 57 Travellers	Western Region of Ireland [Counties Galway, Mayo and Roscommon]	Papers 6-9;11-13 Paper 6; Stakeholders Paper 7; Travellers * Papers 8 and 9; mixed perspective data from Travellers and stakeholders Paper 11-13 Travellers.
Travellers and Primary Care	2009	6 interviews with key national Travellers representatives	Pavee Point National Traveller Centre, Dublin	Paper 10 National representatives

a) Rural Youth Substance Use

The research aimed to yield an exploratory ‘*snapshot*’ of rural youth licit and illicit substance use in the South Eastern region of Ireland (see page 290 for a map of the research area in the **Research Support Materials**) from a variety of perspectives namely; rural youth, key stakeholders and key informants, and rural parents. This qualitative phase was conducted alongside a regional prevalence survey (Van Hout and Ryan, 2010 forthcoming). Ethical approval for the research was granted by Waterford Institute of Technology, Ireland. The fieldwork was conducted in 2005 and commenced with detailed and ongoing literature searches and desk research. Three interview components (‘*service stakeholders/key informants, parents and youth*’) were incorporated, in order to optimise on research validity in garnering an insight into the substance trajectories, processes and settings of youth drug, tobacco and alcohol use in the rural area. The study’s emphasis was on exploring substance use from inner youth perspectives (Mayock, 2002) and followed by a comparison with the

perspectives and opinions of the service stakeholders/key informants and parents. The study was grounded in the following themes;

1. The Prevalence of Adolescent Substance Use
2. Drug Activity in the Area
3. Reasons for Substance Experimentation
4. Alcohol Use
5. Cigarette Use
6. Substance Type
7. Drug Use
8. Cannabis Use
9. Initiation of Drug Use
10. Negative First Time Experience
11. Reasons for Not Continuing
12. Subsequent Drug Use and the Peer Context for Reinforcement
13. Current Drug Use
14. Adolescent Attitude and Meaning of Drug Use
15. Maturing out of Drug Use
16. Risk Perception of Drug and Alcohol Use
17. Drug Information and Service Provision
18. The School Setting
19. Treatment for Adolescent Substance Abuse

All potential research participants partook voluntarily with their right to withdraw from the study at any stage if they so wished and this was emphasised throughout the research process (EMCDDA, 2000). Prior to seeking informed consent, each participant was given a comprehensive information leaflet, which provided details of the research aim (see page 293 in the **Research Support Materials**). This information was repeated prior to commencement of each interview, and participants were encouraged to ask for clarification if needed throughout the course of the interview.

Interviews with Rural Youth

A predevelopment research phase occurred whereby the researcher engaged with the young people during a host of sports, games and after school settings, in order to optimise on potential research retrieval and reduce the perception that the researcher was an 'outsider' to the chosen community. Previous researcher experience had

reinforced the need to garner trust and develop a positive relationship with the young people over time, in order to improve access and retrieve optimal levels of information (see Van Hout and Connor, 2008b). Small informal focus groups ($n=21$) were used to generate debate and fuel discussion around young people's perceptions of peer substance use, social settings for use and attitudes to illicit drugs. These initial exploratory discussions were used to inform and guide the interview schema (see Mayock, 2002) with informal group sessions occurring during activities such as art, drama and sports and comprising of approximately **8-10** adolescents. Thereafter, interviews were selected to avoid the influence of '*social normalcy of drug use*' affecting possible focus group dynamics, and optimise on recognition of data outliers (i.e. drug abstainers, drug users). A random selection of adolescents ($n=10$) aged 15 to 17 years ($n=220$; **115 males/105 females**) from classes 4, 5, and 6 of all participating schools and youth training centres was selected by the researcher using the class list of those present on the research day, and aimed for age and gender balance, with 94% of the total potential sample present.

The aim of youth interviews was to examine the participants' attitudes to licit and illicit substances, use of a variety of substances, perceptions of risk, drug taking trajectories, pathways and careers, situational factors and localised drug scene knowledge. The interview schema consisted of the following key themes; details pertaining to participant age, gender, first use of alcohol, tobacco and illicit drugs, patterns of use pertaining to abstinence, reinforcement and progression, current patterns of substance consumption, risk perception and drug taking appeal (see pages 291-293 in the **Research Support Materials**). The interview duration averaged at 30 minutes and took place in teaching areas. Each interview was thematically guided by the interview schema, and explored in a '*lengthy conversation pieces*' (Simons, 1982: 37). Participants were also probed and encouraged to discuss and explore their own observations, opinions and attitudes. On completion, the interview material was read aloud in order to reiterate the narratives and clarify any potential discrepancies, and was transcribed after each interview. This research was published in **Paper 1** with the narratives later reanalysed and used as medium for garnering greater depth of theoretical understanding of the normalisation theory in terms of drug exposure, availability, drug trying, recreational consumptive patterns, and social acceptability of normative use (Parker *et al.*, 1998, Parker, 2002) and published **Paper 5**.

Interviews with Stakeholders and Key Informants

The primary objective of this research phase was to explore the perspectives, opinions and concerns of a cross section of stakeholders and key informants of the teenage drug scene in the research area. This phase emphasised consultation with individuals who had direct contact with young people in the course of their work (youth, addiction and community services) and thereby uniquely placed to detect emerging youth drug trends (Mayock, 2001a). The researcher contacted a host of agency workers to advise on the research aims, and with internal snowballing of referrals (***n=78***), achieved a sample of a variety of stakeholders which included Probation and Welfare officers, juvenile liaison officers [JLO], An Garda Siochana (Irish police), health service executives, addiction and treatment services, community drugs initiatives, outreach, youth workers, child protection, school completion officers, home school liaison, hospital personnel [A and E], regional data coordinators, national youth organisations, addiction counsellors, youth programmes and other key informants in the research area. Semi structured interviews were guided by themes pertaining to youth alcohol and tobacco consumption trends, illicit drug prevalence, availability and patterns of use, initiation trends, reasons and settings for use, perceptions relating to risk and harm, maturing out of certain forms of drug use, and current youth service provisions in the area (adapted with kind permission from Paula Mayock, 2001a). This information was published in ***Papers 2 and 3*** with detailed interview themes are presented on page 294 in the ***Research Support Materials***. In terms of parental perspectives on youth substance use, rural parents (***n=55; 21 fathers/34 mothers***) were self selected as sample of those available on the night of Parent Committee Meetings at all schools and youth training centres involved in the research. However, the researcher noted that such a self selected sample of parents may not have been representative of parents in the research area, as not all parents are involved in Parent Committees at schools. Semi structured interviews with parents were conducted, which focused on parental perceptions of youth substance use, perceived illicit drug availability in rural areas, youth settings and patterns of use, perceptions of drug related harm, levels of youth service provision and treatment information services in the area. This information was published in ***Paper 4*** with detailed interview themes are presented on page 295 in the ***Research Support Materials***. The interviews for service providers/agency worker and parents lasted approximately 40 minutes and after each interview, the data were transcribed.

Data Analysis

In conclusion, due to its illegal nature, reliable and valid information on youth drug use is difficult to collect (NIDA, 1995). The frameworks which guided the groupings of interview data themes were essentially based on narrative analysis (Riessman, 1993), whereby the participants discussed and explored their understanding of drug exposure, drug decision making, risk perceptions, and normative behaviours by interpretation of their stories. The narratives were content and thematically analysed by hand and using Nvivo, according to emerging contrasting and corroborating opinions, formulations and themes (**Papers 1-5**). This process was adapted from Zemke and Kramlinger (1985) and generated a listing of relevant key words, phrases, narratives and ideas, which were subsequently formulated into categories by situating these identified ideas and narratives into sub topics, and by choosing the most prevalent and illustrative narratives for each category. The selected triangulation of narratives and themes from a variety of sources complimented and optimised on research validity, in order to explore and understand the socio context and trends of substance use within this population from the varied perspectives of rural youth themselves, their parents and stakeholders/key informants in the research area (**Papers 1-5**).

b) The Irish Traveller Community

This research was originally conducted as a regional needs assessment in the western region of Ireland (see page 290 for a map of the research area in the **Research Support Materials**) relating to Traveller substance use and service provision, and was funded by the Western Regional Drugs Task Force [WRDTF]. Fieldwork was conducted in 2008 and commenced with a comprehensive literature search and desktop research phase in order to establish the cohort profile, substance use trends and previous Traveller research in Ireland. The research aimed to attain a greater depth and richness of research findings, pertaining to the central themes of prevalence and reasoning behind emerging Traveller substance use, the impact of illicit drug use and problematic substance use within Traveller communities and underscore Traveller service related needs in the western region of Ireland.

The research contact, Dr Saoirse Nic Gabhainn of the NUI, Galway and the Western Region Drugs Task Force [WRDTF] Research Committee, in consultation with Pavee

Point National Traveller Centre ¹ and other experts in the area of Traveller health and social welfare conducted the initial meeting with the researcher in order to devise acceptable and appropriate research methodologies around access and sampling. Indeed, the Traveller Ethics, Research and Information Working Group [TERIWG] as sub section of the Traveller Health Advisory Committee guided the ethical standards for this research. Interviews and consultations with key regional stakeholders were conducted prior to engaging with the Traveller groups in order assist in the development of the Traveller focus group schema, improve on research validity by use of triangulated data, and most importantly to present their opinions and perspectives of Traveller substance use, attitudes, illicit drug trying rates, experiences of services and current approaches to addiction treatment garnered in the course of their contact or work with Travellers. The researcher was given a comprehensive listing of key stakeholders in the Western region (*n=68*) with 66% willing to partake in the research process (*n=45*). This self selected sample consisted of addiction services, youth services, county councils, health promotion and primary health care projects, juvenile liaison officers [JLO], probation and welfare, family support workers, community drug initiatives, local authority housing officers and An Garda Siochana (Irish Police). This information was published in *Papers 6, 8, 9* and *13*, with detailed interview schema presented on pages 298-300 in the *Research Support Materials*.

During this process, the researcher engaged with key Traveller workers in order to commence the pre development phase with the Traveller groups, by way of active dissemination of the research aims and objectives within each Traveller site. The pre development phase (6 weeks) aimed to initiate contact with the Travellers via the key Traveller worker as ‘*gatekeeper*’, forge trust and relationships between the researcher and the Travellers men, women and youth, and build a commitment to partake in the research. This form of accessing hidden Gypsy, Roma and Traveller [GRT] groups was supported by the Pavee Point Traveller Specific Drug Initiative guide, and facilitated by both the Community Drugs Liaison Workers [WRDTF] and the agencies in the research area with a specific Traveller remit.

¹ Pavee Point was established in 1983, comprises Travellers and members of the majority population and is a non-governmental organisation committed to human rights for Irish Travellers.

The research phase was peer-led by a selected Traveller (Traveller Research Accomplice or TRA), who was well versed in the research aims and objectives, assisted in Traveller recruitment and facilitated the focus group dynamics and discussions. This peer guided process was also chosen so as to develop a Traveller sense of ownership of the research outcomes, and encourage the dissemination of substance related information within their own communities. The focus groups were conducted gender and age specifically ($n=57$), with each group consisting of 3-9 individuals of similar gender and age (adults versus youth) within the counties Mayo, Roscommon and Galway. The primary aim was to discuss Traveller substance use, relating to alcohol, tobacco, licit and illicit drugs, their motives and settings for use, social situatedness of substance use, problematic use within their families and groups, and experiences of services in the area. The Traveller Research Accomplice [TRA] assisted the researcher in the verbal explanation of the research aims and emphasised anonymity prior to each focus group session. Each group were reminded of their voluntary participation in the research, and were encouraged to raise their own discussion, thoughts and ideas surrounding substance use in the Traveller community. This information was published in **Papers 7, 8, 9** and **13**, with detailed focus group schema presented on pages 295-296 in the **Research Support Materials**, and further conceptualised within a framework of assimilation and Traveller habitus (**Paper 11**) and social capital framework (**Paper 12**).

The content and thematic analysis using Nvivo of the stakeholder interviews and Traveller focus groups was conducted in order to identify and categorise emerging schema of comparative and contrasting narratives.

Note: Paper 10 was based on Primary Care and Irish Travellers, and was selected for inclusion in order to illustrate Traveller health disparity and exclusion within the sedentarist world. Matthew and Cramer (2008) have emphasised that research on ethnic minorities must maintain the core principle of equity and if ignored will contribute to increasing '*cultural fragility*' of certain ethnic groups. Primary Care represents an essential health service for Irish Travellers, given their low uptake of health services, experiences of institutional discrimination and inherent poor health outcomes. The research aimed to explore factors impacting on Traveller health and their experiences of Primary Care Services, with fieldwork conducted in mid 2009 and commencing with

a comprehensive literature search on Traveller health status, social inequality and level of social representation in policies and initiatives. Qualitative research using a single focus group as consultative forum with national key Primary Health Care stakeholders (**n=13**) was conducted in Pavee Point, National Traveller Centre, Dublin (Ireland). These individuals were chosen to reflect each region in Ireland and all were deemed as having contact with Travellers in the course of their work on a national level, with some of Traveller ethnicity (**n=6**) (see page 300 for detailed focus group schema in the **Research Support Materials**). A focus group was selected in order to obtain group perspectives and responses to certain consensus beliefs and group behaviours (see Krueger 1988; Stewart and Shamdasani, 1990). A content and thematic analysis using Nvivo was conducted, with the analysis mapping the narratives relating to Primary Care service provision for Travellers, namely; recognition of Traveller culture and ethnic identity; Traveller participation/engagement in the consultation process and establishment of Primary Care clinics; emerging issues in Traveller Health; role of the Primary Health Care worker for Travellers (PCHT) and recommendations for a positive Traveller Primary Health Care System.

c) Cocaine

This research was conducted in 2006 and was uniquely placed within heightened social and political concern in Ireland amidst increased cocaine availability, anecdotal reporting of increased cocaine use among problematic and recreational drug users, and supported by increased survey prevalence rates at that time (ESPAD, 2006; NACD, 2007a; NACD, 2007b). Thereby, the primary research aim was to provide a situational community analysis of cocaine use in a middle class area in north Dublin (see page 290 for a map of the research area in the **Research Support Materials**). The study was approved by the area Health Board ethical committee. The main research objectives were to explore the extent of cocaine use in the research area and to establish needs and gaps in service provision relating to problematic cocaine use. The research emphasis was on creating a community ‘*snapshot*’ of cocaine use by conducting semi structured interviews with a host of key stakeholders and other key informants from the research area (**n=88**). The sample consisted of youth workers, addiction counsellors, money advice and lending support workers, community drugs workers, general practitioners, night club and bar personnel, taxi drivers, An Garda Síochána (Irish police), priests, prison liaison officers and local counsellors. The

interviews aimed to discuss and probe into cocaine availability and use in the area, the presence of local cocaine using scenes, issues surrounding cocaine trafficking into the area, perceptions surrounding potential harmful use, and issues regarding addiction, family support and treatment services (see page 301 for interview schema in the **Research Support Materials**). All respondents resided in the research area. Full transcripts of all interviews, both service providers and key informants ($n=88$) were prepared. The narratives were analysed thematically, with the use of multiple data sources used present this investigative community picture of contact with cocaine within day to day life, where initial inductive processes ascertained cocaine trend data.

General Ethical Considerations

General ethical principles of the Economic and Social Research Council were adhered to throughout all research phases and consisted of the following main stipulations, which are cited directly from the ESRC [ESRC Research Ethics Framework :pp22-26];

1. 'Research was designed, reviewed and undertaken in a way that ensured its integrity and quality.'

The development of each research proposal was based on an accountable and quality assured commitment to conducting the research, in terms of scientific design, anticipation of potential research issues and processes of achieving the research objectives throughout each phases. The methodologies were guided by the NACD's Guidelines on Good Research Practice – Research Ethics (2002) and Children First National Guidelines for the Protection and Welfare of Children (2004) in Ireland.

2. 'The research participants were informed fully about the purpose, methods and intended possible uses of the research, what their participation in the research entailed and what risks, if any, are involved.'

Each phase of research obtained informed consent, whereby the researcher offered as much information as possible to the parents, stakeholders, young people, Travellers and key informants so that these individuals could make an informed decision as to their potential involvement. This comprised of research leaflets, verbal informative sessions (for adult Travellers due to literacy issues, and youth) and signed informed consent forms for all research participants. In the cases of the youth and the Traveller community this took place after the predevelopment phases in order to allow for the development and garnering of trust. Parental consent was sought for those participants under age by use of informative leaflets, and verbal information offered at

the Parent Committee evening. In this way a certain level of school, parent-child and researcher dialogue was achieved prior to conducting the research.

3. *'The confidentiality of information supplied by research subjects and the anonymity of respondents was respected.'*

The protection of participant's identities and confidentiality of records was ensured throughout the research process with individuals only identifiable in the research findings by their research group (i.e. rural youth, parent, stakeholder or agency worker type, key informant, and Traveller man/woman/young person). All research materials were securely stored and pass word protected.

4. *'Research participants must participate in a voluntary way, free from any coercion.'*

All participants were reminded that their voluntary participation in the research process and that they could withdraw at any stage.

5. *'Harm to research participants must be avoided.'*

The research studies were commissioned, designed and conducted to respect the participant's interests regardless of age, gender, race, religion, ethnicity and disability.

6. *'The independence and impartiality of researchers must be clear, and any conflicts of interest or partiality must be explicit.'*

The professional integrity of the research design, fieldwork and data analysis, and subsequent publication of results in the form of designated regional reports, and journal articles was ensured by the researcher. All funding, research support and permission to publish peer reviewed journal articles was acknowledged by the following insert;

'The opinions expressed in this article are of (the researcher) and are not necessarily those of the funding agency.'

In terms of local media, the researcher (and funding agency if relevant) approved newspaper and radio interviews prior to media dissemination. The Traveller and cocaine research studies in particular were of a sensitive nature whereby the researcher ensured that on publication, the material was not misconstrued by indeed the funding agency or potential media misrepresentation.

Note: The Irish Traveller (Van Hout, 2009a) and Cocaine (Cabra Resource Centre, 2006) research studies were initially published as needs analysis reports by the relevant funding agencies (see www.drugsandalcohol.ie) with several of the published papers recorded in the National Drug and Alcohol Strategy 2009-2016 Interim Report (**Paper 1-4, 6-8**).

Post Research Reflective Remarks

Research among hidden groups such as youth, ethnic minorities, and indeed drug users is exceptionally difficult, with research methodologies often compromised by lack of access, the necessity for lengthy pre development work in order to garner trust, recruitment procedures based on participant volunteerism and potential ethical issues regarding stigma and potential stereotyping (Matthews and Cramer, 2008). The identification and recruitment of these groups is a challenge, regardless of whether qualitative or quantitative methodologies are employed. In terms of youth drug use, researchers often face difficulties when attempting to collect reliable and valid quantitative data on drug use within the general population, as once off prevalence school surveys are also likely to under sample groups among whom drug use is relatively high i.e. those truant or identified as early school leavers, and therefore fail to present local differences in drug use (EMCDDA, 2005). Similarly, the Irish Traveller community is not identifiable in national prevalence surveys or treatment data in Ireland, due to lack of ethnic identifiers in health systems, under sampling due to low service uptake, poor volunteerism in research and literacy difficulties. Research activity around Traveller communities has always been described as '*hard to reach*' (Van Cleemput and Parry, 2001; Brown and Scullion, 2009). In this research, '*hard to reach*' appeared central to actually identifying '*who*' the Traveller communities, groups and families were in each county. Issues pertaining to access and commencement of fieldwork were not without problems, and for the Travellers especially appeared to be hinged on visibility, with many Travellers leading a '*settled*' life with identity grounded in the cultural nomadic practices of former generations (i.e. grandparents and great grand parents), and those nomadic proving far harder to reach, and thereby rather invisible to the researcher. In terms of this Traveller ethnic visibility, some of the participating Travellers were housed and semi transient in Traveller halting sites, with others housed in local council estates. Within this context, there appeared to be varying degrees of '*Travellerness*' and indeed '*separateness*', with all '*proud to be Travellers*' and many sad and angry to have relinquished their families '*itinerant way of life*'. The researcher was given a listing of Traveller halting sites and the names of relevant Traveller workers to contact and utilise as gatekeepers. This process was not without problems as some Traveller workers appeared suspicious of the reasoning behind the research. This identification of '*gatekeeper*' bias (see Groger *et al.*, 1999) was experienced within the Traveller support services, whereby the Traveller workers displayed strong

protective views of their client groups, relating to the research approach, levels of access secured and potential misuse of research information garnered. There was a *'tightrope'* of research bias to be followed in terms of these processes in gatekeeper selection. Brown and Scullion (2009:9) also mention this predicament in their discussions around researching the GRT populations in the UK, and they mention this bias in the form of *'cherrypicking'* those gatekeepers with the best stories to tell, and also the other side of the coin where Travellers perceive the researcher to be in cahoots with the *'gatekeeper'*. In this research, the Traveller worker used as gatekeeper was not of Traveller ethnicity, and had instead assumed the role of advocate and sedentarist networker between each Traveller group and the wider *'settled'* community. This may have boosted a feeling of trust, safety and leverage, with these workers specifically selected in order to build on the existing levels of reciprocity between the Travellers and the sedentarist communities where they lived.

Garland *et al.*, (2006) mention the inherent need to involve all Travellers within a community, as families represent varying degrees of community involvement and indeed social exclusion. In particular, initial attempts to access the various Traveller halting sites were met with suspicion and certain levels of hostility. It was common for the Travellers *'to disappear'* when strangers (i.e. the researcher) entered their halting site, and for the researcher and Traveller worker to be met by an older Traveller man, and several barking dogs. Many meetings with the Traveller adults were arranged and then *'apparently forgotten'* by the Travellers, when the researcher visited them. Time was taken to meet the Traveller women in the Primary Health Care Training for Traveller units, and this proved to *'open the door'* somewhat. This additionally formed the basis for the lengthy pre development phase, as the researcher was hopeful to meet and connect with new Travellers each time she was present. In addition, the researcher was aware that the Traveller men may have been involved in criminal behaviours, thereby further compromising research volunteerism resulting in poor representation, failure to disclose their identities, engage in the research process and concerns regarding the utilisation of research findings. Upon reflection, this may have been the case for many of the Traveller groups in light of emerging drug activities within their communities, and occurring in correspondence with a dispersion of their former economic and cultural activities (horse trading, tinsmithing, travelling fairs). Similar to research observations in the UK (Brown and Scullion, 2009), the continuum

of Traveller ethnic identity, transient or settled appeared centralised in unaccountability. One cannot underestimate the entrepreneurial efforts typical of Travellers coupled with this pervading sense of freedom and unaccountability, in that drug trafficking and dealing could present with a new way of life.

The researcher concurs that for some groups, it is difficult to define their known characteristics such as size and demographics, and this can further compromise the potential for gaining a representational sample or an accurate representation of the research question (Barratt *et al.*, 2007). The rural youth samples were therefore relatively large (**n=220**) in order to reduce bias, optimise on data saturation, represent data outliers and gain representational '*snapshots*' of rural youth substance use. The researcher recognised that the Travellers samples may have contained interrelationships, familial or group allegiances and thereby bias in the form of over representation of certain cohesive Traveller networks. This presence of insular social networks is explored within the context of social capital interpersonal and institutional relationships and trust in the **Chapter 3**. In contrast, these issues were generally not the case with the rural youth, who represented a somewhat more static group of individuals. To some degree, the young people attending the youth training centres (i.e. young people classified as early school leavers) represented a greater degree of inconsistencies, and inability to commit to the research. The researcher spent the time in this context, engaging with and '*making friends*' with these individuals, in order to ensure that '*their story would also be heard*'. The researcher hoped that the lengthy pre development phase for both Travellers and rural youth had garnered sufficient trust and familiarity in order to yield a certain level of honesty and frankness in responding within the interview and focus group contexts. In terms of youth (Traveller or settled), one can never under or over estimate the presence of social normalcy or youth perceptions pertaining to drug activity and consumptive practices. In contrast to the methodologies employed in the adult Traveller and cocaine studies, the researcher in the case of youth '*dressed young*' and throughout the course of interviews aimed to maximise on data retrieval by offering no personal opinions relating to drugs, not portraying reactions to the information offered by the young person and in some case gently probing for information in other instances. With regard to ethical considerations, special concerns remain with regard to drugs research conducted with minors, particularly in terms of obtaining adequate informed consent, in the form of parental

consent with minors assent (Miller *et al.*, 2004). In this research, all parents gave informed consent, and this success appeared related to the depth of information provided by the researcher in the form of educational leaflets prior to seeking consent. There was however two school principals, who declined the opportunity to partake. This could have stemmed from a potential fear of school labelling.

The rural youth and Traveller studies utilised triangulated data from additional stakeholder and key informant interviews (**Papers 5, 8 and 9** contain mixed data sources). The triangulation of data involves the consideration of multiple research approaches (Denzin, 1989) and is defined as; '*a concept derived from navigation where different bearings taken from different angles can precisely locate and characterise a feature in three dimensions.*' (see Rich and Ginsberg, 1999:375). Within this research portfolio '*snowball*' mechanisms were central to the development of links and relationships between service stakeholders, key informants, youth, gatekeepers and Travellers; the depth of material garnered and also the provision of comparable data to track changes over time. As mentioned, the involvement of key informants, and particularly those with '*indigenous or privileged access*', offers the creation of a relationship based on trust with the target group and therefore optimises on the research process and information garnered (Griffin, 2002a; Griffin, 2002b). The use of key informants aimed to snowball the levels of contacts within all pieces of research, whether as '*gatekeeper*' to gain access to the groups involved or in optimising on key stakeholder participation. All stakeholders whether from the initial starting list or via internal snowballing were contacted by phone on several occasions, and in order to boost participation were emailed the interview schema prior to conducting the interviews. The majority observed that this created a research '*friendly*' atmosphere, and garnered a certain level of familiarity and trust with the researcher. A minority of stakeholders expressed concern regarding the interview materials with reference to fear of disclosure, issues regarding confidentiality and potential media attention. In this way, while generalisability was not the primary goal, the researcher still sought to obtain a diverse group of stakeholders and key informants in order to achieve the maximum variation in experiences relating to each cohort.

It may also have been the case that some of the Traveller families may have been somewhat '*over-researched*' by local services, with little follow-up on research

completion. Luckily the Traveller research also took place prior to the National Traveller Health study, and therefore the researcher was able to connect with the groups before this extensive and invasive fieldwork was to take place. Upon reflection, had the Traveller research tender been awarded after commencement of this research [the last Traveller Health study took place in 1987], this research would have certainly been met with closed doors. In some ways the Traveller communities *'just want to be left alone'* and find research experiences rather pointless. Such difficulties have also been reported by Greenfields and Home (2006) and Cemlyn *et al.*, (2009) with these UK based GRT research projects reporting similar reluctances to fully engage in the research process. Smith and Pitts (2007:7) describe such fruitless research efforts as *'where well-meaning researchers arrive, collect data, often of a descriptive kind, and leave. The community awaits the next round of research.'* The Traveller research was launched by the then Minister for Drugs, John Curran (sadly none of the Travellers attended the launch) in the form of a presentation of findings by the researcher and publication of the report. It was felt by the researcher that the Traveller didn't attend the Ministerial Launch of their research because of fears of prejudicial experiences, poor literacy skills and negative media attention. The WRDTF then held a series of workshops to each Traveller group to highlight the findings within the medium of posters and drama role playing. The Traveller papers along with the rural youth were submitted to the National Drug Strategy consultation process, and published in the *'Interim National Drug Strategy'* report in 2009, where Travellers were indicated as targeted community vulnerable to problematic drug use. The research along with previous Irish research conducted by Fountain in 2006 (Traveller communities in the greater Dublin area) has in fact highlighted an important political and strategic need to address heightened drug activity filtering into the Traveller communities, with problematic drug use vulnerabilities compounded by identified risk factors in the form of poverty, marginalisation, health disparity, poor educational attainment and high unemployment.

It remained of paramount importance for the researcher, not only to be pragmatic and flexible, but also to fully ensure that the Travellers were aware of the reasoning behind the research, and to involve them in the potential outcomes. The researcher was aware that the Travellers in this work appeared cocooned in a sense of separateness from the wider Irish discourse. The research was therefore guided by greater efforts

on the part of the researcher to create a sense of ownership and thereby fuel debate. The '*gatekeeper*' and Traveller Research Accomplice's [TRA] in each setting emphasised the need to assume active engagement with the research process and that this was their opportunity to have a say and promote advocacy within their own communities. In relation to conducting the interviews and focus groups, the researcher disclosed under what conditions they would breach confidentiality, in order to reach a compromise between the protection of information garnered under trust, and ethical or legal obligations to report certain behaviours such as child abuse, and homicidality/suicidality (see Anderson and Du Bois, 2007). For the Travellers this remained a concern, with great suspicion relating to potential social service intervention in the event of child welfare and domestic violence concerns. Thereby, the researcher aimed to keep the Traveller focus group dynamics within a group empowerment approach. In terms of the Traveller research, the researcher had considered using some form of contingency management, but on consultation with the Traveller organisations felt that this implied coercion, and compromised the issue of free will, and community empowerment in partaking and '*owning*' the research. However, in contrast, Holway and Jefferson (2000) argue that for some individuals experiencing marginalisation and financial deprivation, such remuneration for their time indicates a certain level of mutual respect and power between the researcher and the participant.

It is therefore important to recognise that the research process in particular for inner city and Traveller communities experiencing heightened drug influxes could have represented a sense of hope for the individuals involved, and that the researcher recognised that participants could feel on completion that little result was achieved, however much research insight was garnered into the sense of the problem itself. Thereby, the utilisation of participation based methods (Lomax, 2008, Mayo and Rooke, 2008, Brown and Scullion, 2009) has much to offer the generation of information, equal power relations and empowerment of groups or communities. This outcome underpins the strands of social capital cohesiveness, solidarity, and collective action, and perhaps most poignantly for the Travellers operating within such a bounded system of existence. Thereby, the connectivity of using the Traveller Research Accomplice [TRA] offered much in the garnering of so called '*thick trust*' between both the sedentarist researcher and stakeholder services, and the insular Traveller

community. The process of using the Traveller Research Accomplice [TRA] was recommended by Pavee Point, the National Traveller organisation in Ireland, and on the whole was a very positive experience. In this way, the researcher felt supported and allied throughout the research process. On reflection, in some areas the selection of the Traveller Research Accomplice [TRA] proved difficult, as many Travellers didn't want to be the '*captain of the ship*'. However, simply engaging with and meeting the Travellers, and fueling debate and discussions within their own surroundings assisted the process. The focus groups may therefore have been tainted by the Traveller Research Accomplice [TRA]'s presence somewhat in perhaps hindering the development of some debates. However, the bonuses of using this approach far outweighed this potential form of bias, and instead assisted the development of focus group questions, the informed consent process, and a sense of cultural awareness for the researcher. The researcher made sure to wear modest clothing, and not to appear overly assertive. It was most important just to let the Travellers speak, and maintain a presence in the background. The community partnership or empowerment ideology emerged as central to the reflective process pertaining to the conceptualisation of the published works within social capital theory. The cocaine research also yielded the need for community consultation and partnership, in an area of Dublin which had already experienced successful vigilanteism in the early 1990's upon the outbreak of the heroin epidemic at that time. The circle appeared to be repeating itself, with this middle class '*old*' Dublin community acting together and very much committed to the research outcomes of '*dealing*' with drug activity, and assisting in the political call for the provision of much needed treatment, family support and money advice services within this locality. In contrast to the Traveller community empowerment dynamic, this research appeared grounded in a sense of fear and desperation of the inner city community, with issues relating to sample recruitment not unaffected by intimidation from Dublin underground attempting to deter involvement during fieldwork.

The data analysis for both the descriptive and conceptual studies consisted of four interlinked processes, namely: '*data reduction, data display, conclusion drawing, and verification*' (Rich and Ginsburg, 1999:374). Initially, this portfolio of published work consisted of several descriptive and atheoretical studies focusing on rural youth drug and alcohol use (**Papers 1-4**), cocaine use in inner city Dublin (**Paper 14**) and drug use within the Irish Traveller community (**Paper 6-10, 13**); whereby the studies simply

aimed to describe the participants views, opinions, thoughts and experiences relating to drug exposure within their communities. The initial descriptive studies (**Papers 1-4, 6-10, 13 and 14**) in this portfolio are used to offer insight into the day to day 'lived' experiences of drug users. In addition, it was frequent that research participants discussed other issues pertaining to general life experiences, and yielded narratives which co occurred with drug related information and observations. These findings however, may have been tainted by regional, local and group variations and are therefore not generalisable. However within each research area, the research yielded analytical categories, whereby the information was saturated in terms of their experiences viewed as coherent and explicable (i.e. shared life experiences, group settings and norms for drug behaviour) and also recognised as diversified in terms of outlying information (i.e. drug abstainers and older Travellers with anti drug views). The conclusions drawn from these initial descriptive studies were primarily used to give policy and service recommendations for drug prevention, identify research limitations (practical, theoretical and methodological) and future research directives. The reliability of these descriptive studies was also strengthened by the information garnered by relatively large sample numbers, and by the use of data triangulation, even though one must note that human behaviour is dynamic and situated within a certain societal and localised flux. The researcher feels that these multidimensional research findings complimented and strengthened the iterative process and internal dialogue in verifying conclusion and application of theoretical frameworks. In this way, when comparing the rural youth studies, the cocaine study and also the Irish Traveller studies a certain level of synchronic reliability was achieved, whereby two or more perspectives (in each case, stakeholders and study cohort) were in relative agreement as to the situation regarding alcohol and drug use within that research group.

The data from these research studies were then reanalysed both by hand and using NVivo whereby the initial data was sorted into coherent categories leading to the identification of themes in order to reinforce the resulting thematic analysis. The research design therefore contains some level of data transformation whereby, following this initial descriptive work (**Papers 1-4, 6-10, 13-14**) and taking into consideration the multiplicity of research approaches, the researcher reflected on each phase within an iterative process of studying the research narratives and plotted them within a conceptual framework of normalisation of drug use (Parker, 2003) (**Paper 5**)

and within a greater appreciation of assimilatory processes, habitus and social capital theoretical conceptualisation (Coleman, 1990) (see **Paper 11-12**). The validity of these studies was thereby further improved through later triangulation of these multiple data sets and positioning of the work using the conceptualisation of drug normalisation within social capital theory (**Chapter 3**). However, one must note that in terms of engaging in research and indeed the application of theoretical ideologies relating to risk, normalisation and social capital, the intertwining of moral and empirical reasoning in this process remains present, and recognise that research components such as fieldwork, data generation and the interpretation of information are '*ideologically driven and not entirely neutral endeavours*' (Bourdieu, 1991; Irwin and Fry 2007:77). In terms of achieving generalisable research findings for these study cohorts or indeed emerging trends, future research efforts can build on these initial attempts to understand Irish drug use from the perspectives of rural youth, stakeholders, cocaine users and Irish Travellers within the chosen broader frameworks of social capital, in order to provide a secure and realistic grounding for national drug policy.

The next chapter shall present the published works as underpinned within the chosen social capital theoretical framework.

Chapter 3. Social Capital and the Irish Drug Scene: Rural Youth, Cocaine and Irish Travellers

Introduction

The research forming this portfolio of work was undertaken in the period 2006 to 2009, amidst heightened reports of social accommodation of drug use within rural Irish youth subcultures, otherwise law abiding cocaine users and Irish Traveller communities; all traditionally somewhat isolated from the traditional urban, marginalised and indeed sedentarist drug problems. These emerging drug trends point to an increased filtering of so called '*legitimate*' drug use between mainstream and Traveller groups, and represent an interesting Irish societal shift in support of the normalisation concept proposed by Parker in 1998. A multi dimensional framework plotted against structural and global societal fluctuations in the contemporary world is needed in order to understand cultural shifts in drug use, risk neutralisation and denial of risk transitions, collective boundaries and other emerging drug use trends. It is these contextual and socially situated conditions operating within bounded social situations which will be explored using social capital tenets such as community cohesion and interpersonal trust, neutralisation of risk, mutual extraction of resources and group normative behaviour. The recognition of reciprocity of social status, agency and space within drug using sub cultures, whether deemed recreational or problematic can be better understood by uncovering the interplay between individuals, groups and communities within contemporary social discourse, and indeed the underpinning of lay and expert epidemiology in the mediation of drug decisions. Thereby, this collection of work seeks to further situate the practice of drug use, rational decision making and drug sub cultures within both a localised risk environment and a broader socially and culturally situated dimensional understanding of collective and individual behaviour, and in fact build on the normalisation theory by placing it within a wider social and cultural matrix. As previously outlined, Parker *et al.*, (2002:941) describes the five dimensions of normalisation of youth drug use as '*access and availability, drug trying, drug use, social accommodation and cultural acceptance*'. Such a framework can be utilised to offer greater understanding of particular forms of drug use, drugs of choice, the '*safe*' or recreational use of cannabis, and in particular the emerging social accommodation of stimulant drugs such as cocaine, which appear to be crossing boundaries from '*dance culture*' to the wider public. Increased prevalence trends in Ireland as seen in

national drug prevalence surveys (Nic Gabhainn *et al.*, 2007; NACD, 2008a; NACD, 2008b; Molcho *et al.*, 2008; ADRU, 2009; Hibell *et al.*, 2009) and indeed anecdotal ground reports underpin this research portfolio whereby each cohort (rural youth, Travellers and cocaine users) formed some level of support for the statistical probability of drug exposure in the Irish life course. Indeed, one must recognise that within social navigation of drug risk, changes in attitude and drug consumptive intent may be reflected by shifts in normative beliefs about a certain drug, perceived prevalence and acceptability of drug consumption (Hadland *et al.*, 2009). Of note is that issues pertaining to shame and stigma of drug use within the Traveller groups detract from the application of the normalisation theory. In this way, the normalisation shift in contemporary Irish society presents a threat to the traditional anti drug '*itinerant way of life*'. In contrast, with the urban-rural dichotomy no longer so pronounced in Ireland, the rural youth did in effect exemplify some characteristics pertaining to the social accommodation of cannabis use by both users and abstainers, with drug trying rates reportedly similar to national statistics. The researcher has published the findings from the regional survey (Van Hout and Ryan, 2010 forthcoming) which was conducted at that time, and which also reinforces increased drug trying rates within rural Ireland when compared with the NACD national data and that of the HBSC (2006). In addition, cocaine use appeared anecdotally integrated into middle class socialising in Dublin. It is this paradigm of moderated or somewhat normalised approach to drug use which represents contemporary drug transitions within a social and cultural context (Shildrick, 2002; MacDonald and Marsh, 2002; Pilkington, 2007a; Pilkington, 2007b) and shall be underpinned within the chosen social capital framework. In sum, the recognition of normative frameworks acting to condone and sanction moderated patterns of drug use within each research cohort and the emergence of consumerist cultures facilitating such recreational use form the framework for the conceptualisation of this work, in its consideration of a broader understanding of social capital processes relating to normative and reciprocal relationships, trust and social space in associational life in Ireland. Of interest for this thematic chapter is the level of drug exposure and corresponding development of individual and inter personal risk behaviours over time, within a broader recognition of structural and cognitive social capital, and highlights the need to understand drug use within interplay of present localised risk environmental conditions. Thereby, the research portfolio suggests support for a '*differentiated*' normalisation theory (see

Shildrick, 2002) in terms of the presence of localised consumerist and normative drug use transitions in the negotiation of risk within certain groups such as the integrating rural-urban; and Traveller -sedentarist dichotomies, and lastly within middle class law abiding circles. This thematic chapter shall present the research findings integrated within the theoretical framework of social capital literature relating to alcohol, tobacco and licit and illicit forms of drug use, in terms of consumption, prevalence and availability, resource acquisition, community and individual trust, neutralisation of risk and normative group settings for drug use. Here follows an introduction to the social capital theory prior to application of the research findings.

Social Capital Theory: An Introduction

The social capital theory emerged in the early twentieth century and was defined by Coleman (1994:302) as; '*social capital is defined by its function. It is not a single entity, but a variety of different entities claiming two characteristics in common; they all consist of some aspect of social structure, and they facilitate certain actions of individuals who are within the structure. Like other forms of capital, social capital is productive, making possible the achievement of certain ends that would not be attainable in its absence*'. For an excellent social capital overview see the World Bank (2006). However, in terms of this portfolio of work, and of particular interest for drug behaviours is that Berkman and Kawachi (2000:391) have noted three generalisations among the many diverse conceptualisations and applications of social capital theory and constructs, and conclude that social capital characteristics include; '*a collective good, the by product of social relationships and the creation of productive cooperative activity*'. Indeed, Coleman's social capital theory emphasises the presence of dense and interrelated social relationships in associational life, with indicators of social capital centralised in levels of trust in participation within organisations, communities, groups and families (Woolcock, 2001). This sub contextualisation of drug behaviours within localised civic life is central to the researcher's choice in applying social capital to her work. Social and cultural capital within associational and interpersonal life is grounded in memberships of social networks, institutional and relational trust, reciprocal trust and the facilitation of mutual cooperation in resources or benefits (Putnam, 2001; Baum and Ziersch, 2003). Coleman's definition places less focus on resources or benefits and greater emphasis on normative regulation and structural-functional elements of social norms which contributes to the underlying conversation regarding '*differentiated*

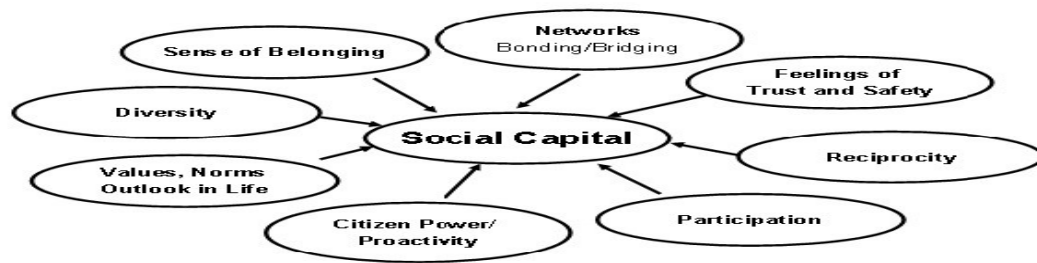
normalisation' for the research groups within Irish associational life and community connectiveness and relates to Durkheim (1972:57) who described the '*moral power of the clan and the sanctioning within social integration*'. In contrast, Bourdieu (1987:1) describes social capital as; '*the aggregate of the actual or potential resources which are linked to possession of a durable network of more or less institutionalised relationships of mutual acquaintances or recognition*'. This facet of social capital is additionally of interest when considering drug consumptive shifts, social exclusion and the Traveller situation within Irish sedentarism, and to some degree the urban-rural spread in post Celtic Tiger Ireland.

In terms of social capital and health, Engstrom *et al.*, (2008) describes social capital as containing a structural and cognitive aspect, whereby the former describes the presence of social networks and associational relationships between individuals, and the latter implies a level of interpersonal and institutional trust and reciprocity in normative values, attitudes and behaviours. The processes whereby social capital influences health behaviours are not clear (see Kawachi *et al.*, 1997; Kawachi *et al.*, 1999a; Baum, 2000; Hawe and Shill, 2000; Veenstra, 2000; Subramanian *et al.*, 2002; 2005; Muntaner and Lynch, 2002; Drukker *et al.*, 2003, Wen *et al.*, 2003, Bolin *et al.*, 2003; Lochner *et al.*, 2003; Putnam, 2004; Szreter and Woolcock, 2004; Drukker *et al.*, 2005; Ziersch *et al.*, 2005; Kavanagh *et al.*, 2006a; Kavanagh *et al.*, 2006b; Rojas and Carlson, 2006; Subramanian and Kawachi, 2006; Poortinga, 2006a; Poortinga, 2006b; Poortinga, 2006c; Kim *et al.*, 2006; Carpiano, 2006; Sundquist and Yang, 2007; Engstrom *et al.*, 2008). Rose (2000) observed that cognitive social capital is seen to operate as a consequence of structural social capital, with inherent theoretical difficulties present in disentangling these mechanisms of normative group sanctioning within generation of social space, status and agency, and the measurement of trust. These facets of social capital are of particular interest when examining drug use within a social cultural '*looking glass*'. Thereby, although the exact effects of social capital remain unclear and somewhat contentious, this portfolio of work seeks to use social capital as a heuristic device to better situate drug use within the contextualisation of each local environment. The distinction within social capital also exists horizontally and vertically, with social capital generation and acquisition between similar hierarchical levels referred to as bonding and bridging social capital, and linking capital representing a broader conceptualisation of vertical relationships between individuals

and groups differing in status (Woolcock, 1998; 2001). These identified matrixes play a definitive role in contextualising each research cohort within a broader sense of Irish society. The experiences of Travellers as marginalised group existing on the peripheral of society are very distinct from rural families experiencing the urban sprawl with the related upsurge in materialistic values. According to Subramanian and Kawachi (2006) in their study on self rated health and bonding versus bridging social capital, bonding social capital is generated out of relationships and social networks between similar persons (i.e. socio-demographic and socio economic characteristics). Thereby, the closed nature of the traditional '*itinerant world*' may represent bonding social capital which reinforces inner group perspectives, provides inner support and may breed exclusivity within such homogenous groups. In terms of the potential threat of problematic drug use sifting into their world, this may not be a bad thing. This form of social capital is based on primary relationships between individuals and grounded in perceived trust. Other research on health recognises the contribution of bridging social capital as based on '*thin trust*' which fosters a willingness to engage and trust individuals outside our circle, and operates between dissimilar individuals at the same level of social hierarchy, such as participation in clubs or organisations (Putnam, 2001; Rojas and Carlson, 2006).

Positive social capital within the uncertain modern world is seen as operating '*hand in hand*' with trust, thereby enhancing social cohesion and inclusion and mitigating the risk of conflict and promoting equitable access to development by enhancing participation of the marginalised (World Bank, 2006). This is of particular interest, in terms of rural youth experiencing changing social shifts in urbanisation in their local areas and Travellers, who as socially excluded group experience great hostility from the mainstream sedentarist population in Ireland. In summation, all forms of social capital have some heuristic value when considering levels of social exclusion, whether for bonding capital in the maintenance of interpersonal relations, the processes of bridging capital for establishing mutual respect and solidarity between different social groups and linking capital in promoting institutional trust (Hagan *et al.*, 1996; McNulty and Belair, 2003; Lindström, 2008). However, in this piece of work, the contextual effects of individual social capital within Irish society will be considered in terms of the potential confounding '*differentiated normalisation*' factors describing the effect of drug exposure within different social groups and risk environments (rural youth, Irish

Travellers and cocaine use in middle class Ireland). Here follows an illustration of the Social Capital Framework to assist with the following contextualisation of the work (Boeck *et al.*, 2006:1).



The Social Capital Framework (Boeck *et al.*, 2006:1)

Within a closer focus on this individual level of social capital, Coleman (1988) viewed social capital as embedded within social networks and relationships between individuals with common pursuits (in this instance drug behaviours), whereby this form of social capital contained information channels, responsibilities and trust, and norms and sanctions for deviant behaviours. Since social capital derives from levels of inter relations, it determines conduct, whether deviant or non deviant, accepted or not accepted, licit or illicit by way of generalised reciprocity. Thereby, the more in depth examination of social capital can place individual responsibility of conduct within a greater moral and collective responsibility of the community placement. It is this individual responsibility in drug decision making and the internalisation of sub-cultural or group behaviours which can be applied to the drug taking context and most particularly to the emerging '*normalisation*' or social accommodation of recreational drug choices (i.e. cannabis and cocaine) in Irish society. Indeed, Foucauldian (1988) perspectives advocate the underlying presence of power in contemporary drug discourses through human relations in terms of behaviours, actions, symbolism and concealment (see Bailey, 2005). In this way, drug use becomes a medium for not only in its capacity for group membership and support, but also as mechanism to raising ones profile or status based on reciprocity and trust within society, however underground this may operate (Cheung and Cheung, 2003; Lundborg, 2005; Lindström, 2004; 2008; Curran, 2007; Maycock and Howat, 2007; Winstanley *et al.*, 2008; Pilkington and Sharifullina, 2009). According to Rhodes in 2002 and supported by Boyce *et al.*, (2008), risk environments create and support cultures of risk and resilience, whereby these sub-cultures are grounded in social networks and

relationships which create and internalise social capital in the form of support, solidarity and cohesiveness. Similarly, Friedman *et al.*, (2007:S168) observed the presence of an '*intravention*' which can be utilised to illustrate how pro drug and anti drug social networks effectively create inner community resiliency, whether deviant or not. Thereby, one could surmise that normalisation of drug use may serve to reinforce one group and isolate another (see Portes and Landaut, 1996) and also appears rather dependent on localised neighbourhood and sub cultural elements (see also Shildrick, 2002; 2006). One cannot underestimate the importance in understanding community norms and levels of informal social control, in conjunction with the level of community cohesiveness in shaping normative behaviour, however unhealthy (Portes, 1998; Kushner and Sterk, 2005; Winstanley *et al.*, 2008; Ahern *et al.*, 2009). Here follows a comprehensive presentation of social capital and alcohol, tobacco and drug use findings.

Social Capital Theory and Alcohol, Tobacco and Drug Use

Few social capital studies have measured the actual processes of social capital influences on substance using behaviours, with most research taking place within a health promotional context, identifying community mechanisms for normative use, community collective actions to deter or restrict use, supportive social networks for those experiencing stress related substance use and potential forms of dissemination of anti smoking and drinking messages in communities (Holder, 2002; Treno and Lee, 2002; Friedman *et al.*, 2004; Dent *et al.*, 2005; Curran, 2007; Boyce *et al.*, 2008). There are no clear pathways between social capital and licit/illicit substance consumption, as certain individual risk factors such as excessive drinking and smoking are influenced by a variety of compounding factors within the localised risk environment (Blount and Denbo, 1984; France, 2000; Lovell, 2002; Rhodes, 2002; Peretti-Watel, 2003; Duff, 2003b; Jones, 2004; Lundborg, 2005; Miller, 2005; Boeck *et al.*, 2006; Sharland, 2006; Youngblade *et al.*, 2006; Stockdale *et al.*, 2007; Pilkington, 2007b; Theall *et al.*, 2009; Fitzgerald, 2009; Kloep *et al.*, 2009; Rhodes, 2009). Research suggests that social capital may reduce unhealthy or risky habits such as drinking and smoking, by mediation of the processes between perceived social capital and health status (Lundborg, 2005; Boyce *et al.*, 2008). The mediation of health risk appears to be associated with perceived levels of community organisation, levels of civic engagement and reciprocity of trust between residents; safety and social

relationships (Lindström, 2003; 2004; 2005; Patterson *et al.*, 2004; Poortinga, 2006a; Winstanley *et al.*, 2008; Theall *et al.*, 2009). The social capital literature thereby presents a distinction between smoking and alcohol whereby smoking behaviours are consistently associated with trust and community solidarity, but not with social participation within community involvement (Greiner *et al.*, 2004; Siahpush *et al.*, 2006), and drinking is directly associated with social participation (Lindström, 2005, Godoy *et al.*, 2006). Social capital measures such as social bonding, peer affiliation and volunteerism are associated with decreased alcohol, cigarette and drug use (Weitzman and Kawachi, 2000; Ensminger *et al.*, 2002; Lindström *et al.*, 2003; 2004). Interestingly, Poortinga in 2006a, reported that both individual and community levels of social capital were related to moderate levels of alcohol consumption. In terms of alcohol consumption, research also suggests that positive social capital is related to decreased alcohol consumption (Weitzman and Kawachi, 2000; Godoy *et al.*, 2006; Curran, 2007). One can speculate that cigarette smoking may represent a different medium to alcohol use in terms of potential coping mechanism for stress and worry (i.e. in the typical disorganised, excluded or deprived community) and indeed alcohol remains grounded in a far deeper cultural sense of *'togetherness'*. Alcohol consumption may also represent an *'agent of social cohesion'* (Eisenbach Stangl and Thom, 2009:4). Thereby, the mechanisms whereby trust and social interactiveness can facilitate or deter individual level smoking and drinking are unclear. Social capital studies can then only be seen as speculative of such substance use trends as these studies measure social capital in different ways (most commonly safety, income inequality, civic engagement, volunteerism, anger, sadness, fear; offering help). However of significance is that the research areas in this research portfolio with exception of the Traveller communities were not characterised by deprivation, disorganisation or social exclusion when the researcher considered their placement in contemporary Irish society.

Recent prevalence surveys indicate the occurrence of a social shift by presenting a decrease in adolescent drunkenness in the last year, in countries with a traditionally high level of adolescent binge drinking such as the United Kingdom, Ireland and Scandinavian countries (Nic Gabhainn *et al.*, 2007; Mongon *et al.*, 2007; Gavin *et al.*, 2008; Hibell *et al.*, 2009). Room (2001:192) reported that; *'there has been some convergence in levels of drinking in Europe; drinking has become a more regular*

activity in recent decades in the “dryer” countries north of the Baltic, and alcohol consumption levels have risen there while the levels in southern Europe have been falling. However, there has not been much apparent convergence in the cultural positioning of alcohol, though southern European cultures seem to worry these days about youthful beer-drinking in cafes in terms that resemble the concerns about drunken comportment of “dryer” societies’. In terms of rural youth, a certain level of drinking appeared accepted by parents, who often provided the first introduction and context for drinking within rural family culture. Irish Travellers in contrast presented with patterns of excessive and destructive drinking (particularly among Traveller males), and this was deemed possibly indicative of the greater strains experienced within dominant sedentarist society. Here follows several quotes from **Paper 4** entitled: **‘Youth Alcohol and Drug Use in rural Ireland- A Parents View’** and **Paper 6** entitled: **‘Travellers and Substance Use- Implications for Service Provision’** respectively;

“It’s very hard..they are given an early introduction to drinking...as if its macho to get drunk...the girls are the worst...much easier for them to get served...and what can you do...if they’re all going out ..how can you say no.” (Rural Parent)

“Sure they are drinking after school, and at those teenage discos...it’s not hard for them to alcohol in the supermarket.. or take drugs in the fields.. its very hard to control.” (Rural Parent)

“Drinking most commonly takes place at funerals and weddings with high levels of alcohol being consumed particularly among the Traveller men.”(Agency worker)

“Alcohol needs to be dealt with in Irish society never mind as part of Traveller culture. There is little difference now between the Traveller community and the settled.”(Agency worker)

In their study on drug use, trust and social participation, Johnell *et al.*, (2006) report that high levels of social participation can co exist with low levels of trust and poor social cohesion at both community and individual levels, which contributes to social disorder and heightened use of drugs as coping mechanism for social stress. Low social bonding is additionally associated with earlier drug onset and in particular adult drug use in females (Ellickson *et al.*, 2001). This gender disparity shall be discussed at a later stage (see pages 71-73). The emerging new concept of miniaturisation of

communities experiencing compromised trust has been empirically researched in terms of cigarette use (Lindström, 2003), cannabis use (Lindström, 2004), and the consumption of home-made alcohol (Lindström, 2005). These identified insular communities experiencing reduced trust are of interest for this portfolio of work, where the researcher surmises that trust is virtually non-existent between Travellers and sedentarist communities; and trust is hampered in rural and inner city Dublin communities experiencing an influx of drug activity. In this way, one must recognise that social capital as a dynamic construct means different things to different individuals dependant on their life state; and related to their ability to attain mutual resources, connect with others, share norms and values, feel safe and trust others within associational relationships. However, one must also note that alcohol, cigarette and drug use cannot be deemed a homogenous or indeed static occurrence, and thereby conceptualisations of social capital remain dynamic and not necessarily mutually exclusive, by way of individual ownership, social connectiveness and the influences of larger macro system processes (Lundborg, 2005). Social capital can offer us a greater depth of understanding of the dynamics of substance use choices and practices, and illustrate how social mechanisms relate to drinking and drug use. Levels of substance use, and indeed the potential adoption of normalisation tenets in the form of increased drug trying, social accommodation of use, and the exposure to drugs in the day to day life course all appear to be stimulated and internalised by these very identified multidimensional components of social capital theory, and central to social networks. Coleman (1994:303) defined social capital as a free flowing dynamic concept and *'resource for action related to certain – collectively stipulated – norms'*. In this way, social capital can demonstrate inhibition and facilitation of certain actions and symbols in contemporary society. Cheung and Cheung (2003) have presented new insights into the inter-relatedness between social capital and illicit drug use, by referring to certain networks and groups as positive or negative social capital. This model however appears excessively dualist and fixed, in terms of the network either represented as positive or negative, and neglects the dynamic aspect of social networks and relationships. In their case, peer drug users are often portrayed as negative or presenting with *'bad'* peer pressure. In contrast, emerging social accommodation of drug use (i.e. cannabis or cocaine) in contemporary Ireland has shifted away from the *'good'* versus *'bad'* ideology of drug use, with interesting repercussions for this social

capital debate, and indeed the operation of parallel lives in society (see Moore and Miles, 2004 on page 3).

Parker *et al.*, (1998, 2002) identified '*increased drug prevalence and drug exposure*' as two of the primary tenets of his theory of drug normalisation occurring in the United Kingdom. Research suggests that illicit drug use is becoming more commonplace in Irish society, and most particularly within the recreational context (Moran *et al.*, 2001a; Moran *et al.*, 2001b; NACD, 2007a; NACD, 2007b; NACD, 2008a; NACD, 2008b; ADRU, 2009). In addition, Traveller drug use, once virtually nil has crept up in recent years with male Travellers reporting increased drug prevalence rates and alcohol consumption, when compared to Traveller women (Hurley, 1999; McCarthy, 2005; Fountain, 2006) and with similar trends to the general Irish population (NACD, 2008a; ADRU, 2009). Cannabis prevalence rates between Travellers and national statistics are similar (Hurley, 1999; Fountain, 2006; NACD, 2008a). National trend data also indicate a rise in cocaine consumptive and availability patterns since 1999 (Corkery, 2000; Bellerose *et al.*, 2009). The social accommodation of cocaine use in middle class recreational settings was reported in the cocaine research which took place in 2006, during the '*Celtic Tiger*', a period of increasing affluence in Ireland, and indicated the presence of a social shift toward greater consumption of illicit drugs amongst all social strata in leisure time circles. In terms of the development of new drug markets (once confined to the East Coast urban marginalised areas) in Ireland, increasing urbanisation offers potential pathways for drugs to influx rural and socially excluded communities, by way of reciprocal traffic between those in contact with drug activity. Rural isolation may have previously hampered drug availability, but does not offer such resilience in contemporary Ireland, with identified resiliency factors compromised in light of changing rural families and westernised consumptive values affecting youth lifestyles. Here follows an excerpt from **Paper 5** entitled: '***Differentiated Normalisation and Drug Transitions among Rural Youth in Ireland***' which explored the normalisation theoretical framework in the context of rural youth in Ireland.

'Drug prevalence surveys of youth commonly emphasise 'lifetime use' which contributes to misleading media reports of youth drug consumption, and leads to speculation of the normality of such social behaviours within youth culture (Shiner and Newburn, 1997). In terms of the urban-rural context for youth drug use, Parker et al., (1998)

comment that in future years, and most certainly in urban metropolitan areas, the non drug trying group will become the minority.'

Here follows several quotes from **Paper 5** entitled: **'Differentiated Normalisation and Drug Transitions among Rural Youth in Ireland'**;

'The majority of rural youth commented on the increasing prevalence of illicit drug use among young people, in terms of drugs of choice, peer use and earlier ages of initiation leading to the establishment of drug taking careers. An older youth commented;

"Sure we never had a drug problem at school..all I wanted to do was play sport and have a drink after the match with my friends..things have changed...the younger lads are smoking hash in the fields now..it's so easy to get. You can get it at school..on the bus...the lads in the village." (17 year Male).

'Most rural youth remarked on the ease of purchasing drugs, whether they reported drug use or were currently abstaining, and most had been offered cannabis at some stage. They said';

"All you have to do is talk to the right lads at school..there's a gang of them..they can get you whatever you want.I never bought drugs..I just smoke some of my friends...if I started buying blow I wouldn't know when to stop...my friends usually get some for the weekend' (15 year old Male);

'If you really don't know where to get some..you just look for the runner on the telegraph pole..that's in town that is..but those lads would frighten me...I don't like that." (17 year old Male);

"We just get the blow at school..even if you didn't want to know..they are hanging around in the break times...we don't have break times in the yard anymore..the teachers have found out..lads were smoking in the lunch hour."(15 year old Male);'

And a quote from **Paper 2** entitled: **'An exploratory study of substance use among Irish Youth- A Service Providers perspective?'**:

"Young people from all backgrounds know a variety of avenues to get drugs and other substances." (Agency worker)

And in relation to cocaine use in inner city Dublin, an excerpt from **Paper 13** entitled: **'A Community Perspective of Cocaine Use in Ireland.-A Brief Exploratory Study':**

'Those working in the community sector and resident in the area indicated that cocaine seizures had increased in the last three years, that more individuals were presenting at the methadone clinic with a cocaine related difficulty, and that more clients were presenting with financial difficulties caused by cocaine debts.'

Thereby one may speculate that greater integration and sense of belonging within certain recreational drug using groups predicts less problematic use (achieved through social sanctioning) but not less drug use in itself. In this way, the application of social capital theory to normative sanctioning of drug using behaviours makes a contribution to the inner social dimension of drug use within a '*differentiated*' normalisation theoretical framework (Parker, 1998, Parker, 2002; Shildrick, 2002). The relationships between social bonding and substance use can then be viewed within a micro oriented perspective of locales in combination with the broader social focus of mutual resource acquisition, agency and social space. The individual centred approach to drug use describes personal decisions to invest in social capital in terms of time expenditure, creation of links and relationships and establishment of trust (see Glaeser *et al.*, 2002; Maycock and Howat, 2007). Indirectly, the inference of trust and group reciprocity may also facilitate the perception of '*safe and culturally accepted drug use*'. Cannabis and to a lesser extent cocaine springs to mind, with many youth commenting on the relative safety of cannabis and its comparability to smoking tobacco, and cocaine use somewhat insularised within night time socialising in Dublin. One can apply the concept of social capital as '*engine of action*' (Coleman, 1994:307) in terms of drug participation as inner group participants' drink, smoke or consume drugs together, and whereby inner group norms are internalised and adhered to as so called '*collective truths*'. These collective truths represent an interesting contribution to the literature base on normalisation theory, and in the opinion of the researcher run parallel with the social accommodation of certain drug use (in this case cannabis and to a lesser extent cocaine), the practices of moderated or '*controlled*' use (especially in the case of rural youth and their fear of addiction; and social cocaine users in Dublin attempting to '*live the high life*') and individual and group related perceptions of recreational versus problematic drug use lay discourse. In contrast, the Travellers did not or indeed could

not ascribe to this form of normative or normalised group behaviour surrounding any drug consumptive practices and with great exception of prescription medication abuse which appeared directly attributed to the presence of identified risk factors for Travellers centralised in poverty, poor life circumstances.

Social Capital and the Community Context.

Within a wider focus on drug risk environments, research shows that eroded community characteristics in terms of disorder, stress, poor mental health, lowered social cohesion, trust, safety and bonding are linked to drug use (Duncan *et al.*, 2002; Lofors and Sundquist, 2007; Winstanley *et al.*, 2008; Boyce *et al.*, 2008; Pilkington and Sharifullina, 2009). Sampson and Groves (1989:777) define social disorganisation as the '*inability of a community structure to realise the common values of its residents and maintain effective social control*'. These measures are inherently contained in the social capital framework and relate to neighbourhood attachment, perceived social control, safety; crime rates, poverty; intimidation, racism, residential mobility, population density and drug use within the community, school, family and peer settings (Furstenburg and Hughes, 1995; Ennett *et al.*, 1997; Kennedy *et al.*, 1998; Rose and Clear, 1998; Hadley-Ives *et al.*, 2000; Latkin and Curry, 2003; Salmi and Kivivuori, 2006; Wright and Fitzpatrick, 2006; Friedman *et al.*, 2007; Özbay, 2008; Dallago *et al.*, 2009). Whilst recognising that this portfolio does not stem from the underclass in Irish society, and instead reflects on rural communities, middle class Dublin areas and Travellers as they operate distinct from the mainstream Irish sedentarist society, the utilisation of social capital tenets offers us some insight into contemporary Irish communities and how these '*mini*' risk environments are underpinned by wider cultural and social movements. All of these afore mentioned measures of social capital come into play for the research cohorts in this portfolio of work, in terms of the rural '*Youth*', the '*Irish Traveller community*', and emerging middle class '*cocaine use*' in inner city Dublin. At community level, the norms for drug behaviours may be facilitated by internal social mechanisms of informal social control and community cohesiveness, whereby such norms and sanctions are conveyed through social interaction (Sampson and Groves, 1989). Sampson and Raudenbush (1999:612) advocate the theory of collective efficacy in social capital defined as the "*linkage of cohesion and mutual trust with shared expectations for intervening in support of social control*". This may well be the case for inner city Dublin residents experiencing cocaine use among otherwise law

abiding community residents, a dissipating rural-urban continuum and indeed for the Irish Traveller community in their struggle to retain their ethnic identity in the face of emerging drug use and drug entrepreneurialism within their own personal networks. Social disorganisation in some communities restricts the development of trust and solidarity between residents, making it unlikely they will intervene in the face of heightened drug activity (Musick *et al.*, 2008). This represented an interesting quandary for not only the Traveller research cohorts but also in the case of the inner city Dublin community experiencing an influx of cocaine use within their area, and noticeable fearful of comparisons to the heroin epidemic in Dublin in the 1980's. This heroin epidemic was dealt with very successfully at that time, by strong community vigilantism and media exposure, with many research participants from that era, and reportedly willing '*to go down that road again*'. This perhaps exemplifies the potency of community activity in dealing with such a problem. As mentioned in the post research reflective remarks, instances of suspicion grounded in fear of gang intimidation were not uncommon prior to conducting fieldwork for the cocaine study. Indeed, Collison (1996) describes an inverse process of how drug taking within urban life is perceived both as central to urban consumptive lifestyles and yet concurrently as social threat. Many research participants (community residents, workers and key informants) in the cocaine study were aware of parents whose children in the Eighties developed heroin addiction and have since died. In contrast, the Traveller communities were also experiencing a similar influx of drug activity and through inexperience and stigma surrounding drug use were not as apt to respond. This appeared to the researcher to be both centralised in the housing of Traveller in close proximity of one another (i.e. halting sites), and in other cases rather dispersed within local authority housing schemes (often familiar with anti social behaviour and drug activity). Also, the traditional Traveller way of dealing with a problem was '*to pack up and leave*', which is now compromised by governmental restraint on Traveller nomadism in contemporary Ireland, and resulting in Traveller communities '*closing shop*' and attempting to resolve issues within themselves.

The mechanisms whereby social capital can be associated with community and individual health relates to potential dissemination of health related information, interventions, improved access to health services and referral networks, community cohesiveness and support and the maintenance of positive health norms (Kawachi *et*

al., 1999a; Subramanian *et al.*, 2002; Subramanian and Kawachi, 2006). In this way, bonding social capital can be seen to operate within reciprocal and similar characteristics of solidarity, support, trust and stimulation of health behaviour change through peer modelling. On a wider scale, bridging social capital can incur health benefits for certain groups through the acquisition of mutual resources (see Sunquist and Yang, 2007). Social capital is commonly grounded within social interaction, engagement and civic levels of interpersonal and institutional trust (Putnam, 2004). Putnam describes *'thin trust'* as a general form of trust with individuals one is not directly acquainted with. In this way, communities characterised by good resident relations, civic participation, strong social control and solidarity have a lower sense of fear or insecurity (Sampson *et al.*, 1997; Lindstrom *et al.*, 2003; Lochner *et al.*, 2003; Carpiano, 2006; Stockdale *et al.*, 2007; Dallago *et al.*, 2009;). Social exclusion or isolation is a result of mistrust within greater social structures, which restricts the formation of social networks, development of interrelated groups, and contributes to heightened stress, tension, crime and substance abuse (House *et al.*, 1988; Boardman *et al.*, 2001; Katz, 2002; Latkin and Curry, 2003; Salmi and Kivivuori, 2006; Stockdale *et al.*, 2007). In terms of community disorganisation, the willingness of local individuals to intervene for the greater welfare of the community depends on levels of trust and solidarity. Here follows an excerpt from **Paper 12** entitled: ***'The Irish Traveller Community, Social Capital and Drug Use'***;

'Such 'thin trust' stimulates individual willingness to trust those outside of the immediate circle, within a reciprocal circle of trust and solidarity, enhancing social cohesion, collective action and inclusion (Putnam, 2001). The inherent lack of trust and avoidance of contact between Travellers and the 'settled' public discourse is historically grounded (McVeigh, 1997; Helleiner, 2000; Cemlyn, 2008). Traveller and 'settled' communities operate on a reciprocal stasis of mistrust, suspicion and hostility with 'settled' Irish society (Ni Shuinear, 1994; Stonewall, 2003; Helleiner, 2000; Pavee Point, 2007). The overall lack of Traveller representation in public and community discourse remains an issue (Cemlyn, 2008).'

The Traveller community in their day to day experiences with contemporary discriminatory Ireland present with low levels of institutional trust, which creates a problem in terms of increasing problematic substance use and reluctance to access

services, due to frequent discrimination and lack of cultural acceptance. Here follows an excerpt and a quote from **Paper 11** entitled **'Assimilation, Habitus and Drug use among Irish Travellers'**;

'This underlying level of racism on governmental, social and individual level has been present in Ireland for many decades (Clarke, 1998; Helleiner, 2000; Irish Traveller Movement, 2003; Pavee Point, 2005). It appears increasingly difficult to weaken Traveller prejudice within the sedentarist society or even garner a reasonable level of social inclusion for this ethnic minority. The Travellers observed a reciprocal and self fulfilling circle in terms of distrust and deep suspicion from both sides. The Travellers also commented on their will to remain among themselves'

"Sure we just want to be left alone you know..we don't mean to bother no-one." (Traveller)

Ethnic and religious diversity appear to have an adverse effect on social capital, whereby such diversity impairs the creation and maintenance of trust. Kim *et al.*, (2006) in their research on community bonding and the processes of bridging capital found that social capital measures of trust and relationships between members of one's own ethnic group are related to positive social capital, reduced risk taking behaviours and self perceived health status. The Traveller community in Ireland, as ethnic minority and existing within the mainstream sedentarist society experience much ethnic fragmentation of cultural values and restrictions on their nomadic way of life. Douglas (1976:84-85) described the presence of *'fringe elements'* in societies as representing the *'voluntary outcastes, tramps, gipsies, rich eccentrics, or others who retain their freedom at a cost'*. According to Gmelch (1996:177); *'Travellers do not work or live in a vacuum, their identity and lifestyle is unquestionably influenced by their connexion to the larger society'*. The concept of *'grid'* as private and inner classification of the Traveller self may therefore be delineated by social pressures on others to conform within situations of compromised freedom (Griffin, 2002b:110). The very reinforcement of Traveller rights, values and cultural traditions as distinction between their *'itinerant way of life'* and that of the *'settled'* population have resulted in a lack of tolerance and inclusion in Ireland (Pavee Point, 2007). It appears that hostility toward Travellers in Ireland remains acceptable by many in the dominant discourse and fueled by pervading negative media stereotyping (Pavee Point, 2005). The human rights of

Traveller gypsies in Europe have been violated throughout history in their experiences of persecutions, enforced assimilation through coerced settlement and cultural genocide by fostering of Traveller children through social care systems (Cemlyn and Briskman, 2002). Indeed, levels of contemporary human right denial range from socio political exclusions to the denial of their status as ethnic minority group (Cemlyn, 2008). Here follows an excerpt from **Paper 11** entitled: ***'Assimilation, Habitus and Drug use among Irish Travellers'***;

'Ethnic identity contains specific norms, distinct values and typical behaviours which are transmitted over generations within that culture (Kulis et al., 2002). The Travellers strive to maintain a strong sense of ethnic identity, attachment and affiliation to their culture (McVeigh, 1997; Vanderbeck, 2005). Helleiner (2000:101) quoted as follows 'I argue that Traveller culture and identity have been and continue to be produced out of sets of unequal social relations ... [that are] deeply structured by class, gender, and generation'. Travellers typify a distinct inner/outer normative boundary within sedentarist society in terms of marked differentiation between co existence and non co existence. Gmelch (1996) emphasised that the Traveller claim for ethnic separateness lies in their culture and identity, rather than historical basis. Travellers exist as a marginalized group, which exacerbates their visibility as a social problem and yet also their invisibility within public discourse as ethnic minority (Cemlyn and Briskman, 2002).'

Portes (1998) describes this negative social process as containing social capital elements restricting freedom; excluding outsiders, a downward levelling of norms and excessive claims on group members. Here follows a quote from **Paper 13** entitled: ***'Traveller drug use and the school setting: Friend or Foe?'*** :

'A Traveller youth described his experience of heroin addiction; "When I was on the gear [heroin]....smokin' was no good to me...It started with the lads after school....then I was on me own most of the time...I started injectin'.....I wasn't eating, I wasn't sleepin'..was puttin bad stuff into my body....I couldn't take it no more..I needed the help...I didn't want my daughter not knowin' who her father was..

‘settled’ folk were ignorin’ me on the street...and that goes for me own family as well.”

Thereby, Subramanian and Kawachi (2006:513) indicate that the degree to which individuals achieve a sense of cultural consonance in their day to day lives is associated with greater perceived social capital and in turn the prediction of positive and improved health outcomes. In this research, the Travellers commented on how their identity often recognised by their common surnames effectively prevented them in engaging in the sedentarist communities. Here follows a quote from ***Paper 11***;

“I can’t get a job..the training centre tried to get me a job, but they don’t want to know ya, when they hear me name..” (Traveller)

In contrast to observations by Thomas and Campbell (1992), where Travellers in the UK denied their own identity in order to avoid community hostility, in this research, the Travellers were proud to be Travellers, and reinforced their identities throughout all conversations. This is supported by an excerpt and several quotes from ***Paper 11*** entitled: ***‘Assimilation, Habitus and Drug use among Irish Travellers’***;

The Travellers in this research were proud to be Travellers and this Traveller orientation is typified by strong sense of pride in their culture, cultural values and family bonds. However, there appeared to be an intense resistance to adopting sedentarist values and behaviours, and most particularly among older Traveller generations.’

“I’ll always be a Traveller..they won’t ever take that away from me..I want me kids to understand the life.” (Traveller)

“I won’t never be like a settled person..no way..[spat on the ground]” (Traveller)

Ethnic discrimination is positively related to restricted perceptions of self-rated health with the very anticipation of being unfairly treated grounded in both individual experience and the collective experience of that social group, and affects psychological health in a negative manner, thus leading to poorer social capital (Denner *et al.*, 2001; Karlsen and Nazroo, 2002; Williams *et al.*, 2003; McNulty *et al.*, 2003; Schulz *et al.*, 2006; Gee *et al.*, 2006; Sellers *et al.*, 2006; Taloyan *et al.*, 2006; Lindström, 2008). This is indeed the case for Travellers and exemplified in their choices surrounding drug taking, with many reporting the use of anti-anxiety

medication. Here follows an excerpt from **Paper 12** entitled: ***'The Irish Traveller Community, Social Capital and Drug Use'***;

'The overall lack of opportunities in securing employment and completing education were deemed to contribute to depression, anxiety, boredom and low self esteem, and were seen as contributing to drug use in the Traveller community'. Many Travellers attempt to hide their identity to avoid racism and potential hostility, with Travellers in 'settled' housing often seen to be denying their own culture (Cemlyn, 2000; Morran, 2002; Garrett, 2004b; Cemlyn, 2008).'

Research on the Traveller community in Ireland shows that co-morbid psychiatric health issues are prevalent among the Traveller community, and viewed as a consequence of their compromised living standards, genetic predisposition and poor health practices (Fountain, 2006, DoHC, 2002, Pavee Point, 2005). In such cases, alcohol and drug use may offer escapism or relief from feelings of helplessness or greater cultural and social strain (Stockdale *et al.*, 2007; Lindström, 2008) and also represent instances of low bridging and linking capital within Irish society (see Lofors and Sundquist, 2007). Here follows an excerpt from **Paper 12** entitled: ***'The Irish Traveller Community, Social Capital and Drug Use'***;

'However, one must note that ethnic minorities such as the Travellers experience great social exclusion, which lowers levels of social capital, thereby posing a risk for drug use, however strong their inner perceptions of social capital are in terms of Traveller ethnicity, older generations of strong anti drug philosophy and close knit Traveller community boundaries.' ***'The failure to acknowledge Traveller ethnic culture and race equity lies in 'aggressively assimilationist attitudes' (Garrett, 2004a; Cemlyn, 2008:162). For these Travellers existing within dominant Irish discourse, the assimilatory experience was deemed stressful, and contributes to a loss of ethnic identity and fragmentation of the traditional culture and protective norms.'***

Many of the Travellers interviewed reported feeling 'a sense of numbness' in day to day life within the context of general hopelessness. This phenomenon was also observed by the key informants and stakeholders. Here follows a quote from **Paper 6** entitled: ***'Travellers and Substance Use- Implications for Service Provision'***;

“Traveller substance use is more than a coping mechanism .It is a set of circumstances.”(Agency worker)

However, in terms of risk behaviours within the community context, Youngblade *et al.*, (2006) report that heightened rates of risk taking behaviours associate with communities reporting lower levels of social capital, and a decreased likelihood of risk behaviours (such as drug use) among communities with greater ethnicity. Such findings point to inherent difficulties in disentangling such counter intuitive findings, particularly as ethnic minorities may experience a certain level of social exclusion, and thereby lowered levels of social capital, however strong their inner perceptions of social capital are within their own communities. This is supported by an excerpt from **Paper 11** entitled: ***‘Assimilation, Habitus and Drug use among Irish Travellers’***;

‘The cultural separation between the ethnic minority and the dominant society is cited as contributing factor to poverty, unemployment, compromised health and drug use (Greenman and Xie, 2008). Ethnic identity has been found to be negatively related to drug use and pro drug using attitudes, and studies suggest that the protection of ethnic identity has much to offer in terms of offering resilience to drug experimentation and increasing contact with pro drug using community norms and drug availability (Belgrave et al., 2000; Brook et al., 1998a; Brook et al., 1998b; Townsend and Belgrave, 2000; Waller et al., 2003; Brook and Pahl, 2005; McNulty et al., 2009).

‘However the stresses relating to assimilation can contribute to a loss of ethnic identity, fragmentation of traditional culture and norms often posing a risk for drug use and manifestation of psychosocial distress relating to difficulties assimilating between the ethnic group and cultural differences with the mainstream society (Brook et al., 1998a; Brook et al., 1998b; Kiddle, 1999; Kulis et al., 2002; Waller et al., 2003; Brook and Pahl, 2005; Walsh and Krieg, 2007). This is especially true for the Traveller community, who reported experiencing significant adversity in terms of the general lack of opportunity and high incidences of discrimination in their lives, and most particularly in terms of early school leaving, poor living conditions, large families, almost total unemployment and health disparity.’

In terms of ethnicity and drug prevalence, here follows an excerpt from **Paper 11** entitled: ***'Assimilation, Habitus and Drug use among Irish Travellers'***;

'Research indicates that indigenous groups with low reported drug use are those which are selectively acculturated, having adopted and merged both ethnic values with those of the dominant society (Oetting and Beauvais, 1991; Herring, 1994; Moran et al., 1999; Brook and Pahl, 2005). This process was described by the Travellers in the context of a supportive Traveller or sedentarist peer groups encouraging drug experimentation, or with the presence of a Traveller family member using drugs in close proximity in the caravan or halting site. Conversely strong Traveller family networks and close parent child relationships advocating abstinence acted as potential deterrent.' ***'The Irish Traveller community is at increasing risk of problematic drug and alcohol use not only due to their poor life circumstances, attempts to protect their ethnicity, culture and increased family fragmentation but also due to the 'inner versus outer' struggle of assimilation within sedentarist Irish society. Griffin (2002a; 2002b) observed that the reinforcement of both individual and familial autonomy has resulted in a fragile sense of internal community identity and contributed to increased dissipation of traditional Traveller culture within greater social structures.'***

McNulty et al., (2009) proposed that the greater the length of contact with the host culture, the greater the likelihood of adoption of the host cultures' normative behaviours, unless the family and community can facilitate selective acculturation, whereby the immigrant group adopts certain practices and rejects others whilst maintaining their individual ethnic identity. However, this connectiveness for Travellers appears to be increasingly fragmented and rather youth centralised (see **Paper 11** entitled ***'Assimilation, Habitus and Drug use among Irish Travellers'*** as follows)

'The Travellers reported a clear sense of old Traveller values being replaced by those of the 'settled' community among the youthful generation. Experiences of selective acculturation along the continuum of assimilation perhaps pose the greatest risk for younger generations of Travellers who experience cultural confusion and

cultural shame as they strive to integrate within schools and form friendships’.

Interestingly, and perhaps paradoxically for the Irish Travellers, the normalisation concept as first proposed by Wolfensberger (1980, 1984) was applied by Parker whereby; *‘Normalisation is about stigmatised or deviant individuals or groups becoming included in many features of everyday life whereby their identities or behaviour become increasingly accommodated and perhaps eventually valued.’* (Parker *et al.*, 2002:942). In this way, acculturation of migrant or ethnic groups, however selective and however buffered by family solidarity and ethnic retention, may still incur significant adverse affects in terms of cultural patterns in substance use (Denner *et al.*, 2001; Greenman and Xie, 2008). A similar parallel could be surmised for the rural youth encountering a weakening of rural family life and heightened urban negotiation. Here follows an excerpt from **Paper 13** entitled: ***‘Traveller drug use and the school setting: Friend or Foe? ;***

‘The research supported earlier Irish findings that the Irish Traveller community, and particularly Traveller youth are at increasing risk of problematic drug and alcohol use, not only due to their ethnic minority status, prejudicial experiences and health disparity, but also their experiences of compromised educational and employment prospects (McCarthy, 2005; Fountain, 2006; Van Hout and Connor, 2008a). The older generations of Travellers strive to maintain a strong sense of ethnic identity, attachment and affiliation to their culture typified by adherence to traditional anti drug norms and practices. The protection of Traveller identity thereby has much to offer in terms of offering resilience to drug exposure, amidst increasing contact with pro drug using sedentarist sub-cultural norms. Older Travellers in particular are proud to be Travellers and this Traveller orientation is typified by strong sense of pride in their culture, cultural values, potent family bonds and group solidarity. A Traveller woman said “The more Travellers that want to help Travellers maybe we can deal with the problem”. However, cultural separation between Traveller groups and the sedentarist world exacerbates poor living circumstances, antisocial behaviour, criminal activity and problematic

drug use. Levels of problematic substance use among Travellers are additionally deemed a manifestation of psychosocial distress relating to inherent assimilatory struggles.'

And an excerpt from ***Paper 12*** entitled: ***'The Irish Traveller Community, Social Capital and Drug Use'***;

'The Traveller drugs risk environment within Irish society can be viewed as a 'social space' whereby a multiplicity of social, ethnic and cultural factors interact to discourage, facilitate and mediate forms of drug activity. The research supports previous literature in emphasising that the Traveller community in Ireland, as ethnic minority and existing within the mainstream 'settled' society experience increasing fragmentation of cultural values, discrimination, social exclusion and marginalisation (Binchy, 1994; Ni Shuinear, 1994; Clarke, 1998, Cemlyn, 2008). The dominant and underlying conflict occurs between the Traveller community and the 'settled' society (Griffin, 2002b). In the wider sense of social capital, this separation between the Travellers and 'settled' communities contributes to lower social capital, by compromising levels of institutional trust, wider community trust and reciprocity within 'settled' associational life'.

Thereby, the limited understanding and lack of Traveller research contributes to the reinforcement of distance between 'them' and 'us' and reflects the poor level of cultural understanding and acceptance in contemporary Irish society. In terms of the application of social capital, the Traveller groups also presented an interesting social phenomenon, in terms of the distinct and diverse nature of Gypsy Traveller cultures relating to Traveller education and home learning (see Jordan, 2001a; Jordan, 2001b; Bhopal, 2004; Derrington; 2007); the adoption of adult like roles at early ages (Smith, 1997a); the level of Traveller entrepreneurship based on traditional and opportunistic skills such as horse trading, tinsmithing and fairs (Okely, 1983) and perhaps most importantly in the context of inner trust and the presence of potent insular and wider family networks (Saunders *et al.*, 2000). Thereby, Gypsy Traveller perception of inner and outer boundaries of social and physical space for Gypsy Travellers remains contested and carries different symbolic meanings for Travellers than for the mainstream settled population (Kendall, 1997). In Ireland, this perceived distance from

the sedentarist population is gradually dissipating, and is contributing to increased Traveller feuding, a relinquishing of Traveller ethnic placement in society, and heightened prejudices in public discourse. Thereby, drug exposure and activity, whether consumption or dealing, represents an interesting paradigm for Traveller integration, selective assimilation or simply *'just contact'* within sedentarist Irish society. The restricted *'sense of Traveller belonging'* in dominant Irish discourse is the crux of the problem for Irish Travellers, and yet appears reinforced both by Travellers themselves and also the sedentarist population. Traveller ethnicity appears to restrict outer social capital perceptions, most fundamentally grounded in the lack of trust within the sedentarist world. Indeed, Traveller integration does not infer assimilation and cannot be equated with the homogenisation of ethnic minorities (Pavee Point, 2005). The process of assimilation whether by choice or enforced, therefore contributes to a relinquishing of Traveller social capital. One must endeavour to understand the inner and outer boundaries of Traveller existence, with empathy and an acceptance of Traveller cultural embeddedness within a culturally informed analysis of risk and resilience to drug use. ***Paper 11*** entitled: ***'Assimilation, Habitus and Drug use among Irish Travellers'*** additionally highlights the need for;

'A broader paradigm shift away from sedentarist frameworks in raising political and cultural awareness, acceptance, reduction of prejudice and ultimately preserving Traveller ideology have much to gain in protecting this ethnic minority from potential familial and ethnic fragmentation, dissipation of Traveller ethnicity and problematic drug use in contemporary Irish social structures.'

Stockdale *et al.*, (2007:1868) describes the presence of *'nested support systems'* which consist of layers of social networks providing social support, in order to attain community stability within the greater social structure, and indeed on an individual level to provide trust and inter personal relationships. Such a premise appears quite applicable to the disparate existence of Travellers within sedentarist Irish society, and is explained in the following excerpt from ***Paper 10*** entitled: ***'A Primary Care Service Framework for Travellers in Ireland: Results from a Consultative Forum'***;

'Research in Ireland and the United Kingdom indicates that Traveller health status is disparate when compared with the mainstream sedentarist population (Barry et al., 1987; Van Cleemput and Parry, 2001; Smart et al., 2003; Parry et al., 2004b; Parry et al., 2004c; Van

Cleemput et al., 2007; Cemlyn, 2008; Van Cleemput, 2009). Traveller housing, poverty, discrimination and marginalisation must be addressed in a broader perspective of social exclusion and inequality, and will hold the most promise for improvement of Traveller health status. This represents a movement away from consideration of Traveller culture and ethnicity in isolation and toward the process of community development. In the UK, community partnership and intersectoral collaboration between Gypsy Travellers and health care agencies are key factors in the success of Primary Care Health Service Frameworks [PCSF] (Smart et al., 2003; Cemlyn, 2008; Van Cleemput, 2009).'

Research also states that the wider community network can provide social support by way of advocacy, facilitation and sanctioning of routine and non routine activities, and thereby stimulate positive social capital within a community cohesive approach (Robert, 1999; Ziersch et al., 2005; Carpiano, 2006; Friedman et al., 2007). ***Paper 10*** entitled: ***'A Primary Care Service Framework for Travellers in Ireland: Results from a Consultative Forum'*** describes how the use of Traveller peer led advocacy, training and education can provide initial connection between the sedentarist community and Traveller groups, and thereby improve interpersonal and institutional trust between the *'itinerant'* and *'sedentarist'*.

'The involvement of the Travellers themselves in local needs assessments and the potential of the Primary Health Workers for Travellers [PCHT] cannot be underestimated in presenting the ideal link between the Traveller and the Primary Care team setting, whether private or public, in terms of advocacy, education, administration, community training and political lobbying for Traveller health related needs, and ultimately improving Traveller quality of life, life expectancy and health status. 'The core value of achieving equity in Primary Care provision remains central to equality of participation, access, health status amidst the recognition that Traveller communities require an empowered, innovative and inclusive approach to provision, planning and implementation (Kelleher, 2005). However, Traveller led PHCT projects must not be used in isolation to deal with Traveller health disparity. Whilst showing promise they may

further exclude the Travellers in the preservation of their cultural identity until such time as the Primary Care Teams advocate a culturally accepted method of treating Travellers within current health care provision (Kelleher, 2005; Murphy, 2005).'

Similarly, Bartkowski and Xu (2007) describe the association between religiosity and social capital, and that of reported drug use, suggesting that the positive interaction with religion, school and families can stimulate positive adherence to conventional morals and social codes. Indeed, churches and religious organisations can provide the thread which holds the community together (Chaves and Tsitsos, 2001; Wuthnow, 2002; Beyerlein and Hipp, 2005) and community interaction within these organisational links can provide emotional support and yield positive mental health and sense of belonging (Latkin and Curry, 2003). The Irish Travellers are deeply religious and indeed superstitious. Here follows an excerpt and quote from ***Paper 11*** entitled: ***'Assimilation, Habitus and Drug use among Irish Travellers'***;

'Thereby drug use remains a covert behaviour within the halting site, and most common in Traveller men and youth. Instances of home detoxification and use of religion to deal with problematic substance use were common, and replicate earlier Irish research by Fountain in 2006'.

"Sure we just locked the uncle in the caravan..and me ma and da prayed..me ma got the holy water...there's no point in asking the doctor to come..they don't come anyhow...we don't want no-one knowin' our business." (Traveller).

Social Capital and Housing

On wider social capital scale, land use studies have shown that neighbourhood design and proximity of housing affects the development, quality and levels of social interaction between residents (Leyden, 2003). Other studies indicate that multifamily housing development increase levels of social isolation and compromised interaction levels (Evans *et al.*, 2003). Bantchevska *et al.*, (2008) illustrate how social capital and the prediction of current life circumstances can contribute to homelessness and substance use, depression, sexual risk taking and delinquency. The centrality of homelessness remains evident within the Traveller communities with many reportedly

'feeling homeless' and **'without a sense of belonging'**. Sadly, the Traveller appeared to be drifting within contemporary Ireland, amidst coercive attempts by local authorities to house Traveller families and remove them from social visibility. Reports of residential harassment were high, with many Traveller families intimidated on the estates where they lived. According to Van Cleemput *et al.*, (2007), the reduced opportunity to live the Travelling lifestyle itself may cause a disparity in health status by way of compromised physical and emotional health. The health status of Travellers and Gypsies has been shown to be significantly less than those inhabiting houses (Barry *et al.*, 1987; Bunce, 1996; Van Cleemput, 2007:2009). Traveller families in Ireland are significantly less likely to own their home compared to the general household demographic (Treadwell *et al.*, 2008). Research in the UK and Ireland have emphasised how poor living conditions in the form of health and safety issues compound Traveller health disparity, with many sites situated near overhead powerlines, landfill areas, insufficient waste management, poor sanitation and a lack of electricity and running water (Barry *et al.*, 1987; Feder *et al.*, 1993; National Traveller Health Strategy, 2002; Smart *et al.*, 2003; Treadwell *et al.*, 2008). The possibility of harassment and real threat of eviction has also contributed to the acceptance of poor quality and transient halting sites in Ireland (Pavee Point, 2005). As previously outlined, poor mental health in the Traveller community is common (Barry *et al.*, 1987; Parry *et al.*, 2004b; Parry, 2004c) and attributed to the *'loss of traditional occupations and stopping places which undermines identity, substandard accommodation, poverty, and racism'* (Fountain, 2006:52).

Indeed, housed Travellers are often deemed as forfeiting their culture (Cemlyn, 2000; Morran, 2002). Indeed, Greenfields (2009) attest that the housing situation of Travellers in the UK, and similarly Treadwell *et al.*, (2008) in Ireland reinforce that Traveller housing remains a central area of discrimination and aggressive assimilation, and is the base cause of Traveller marginalisation, poor health, low educational uptake and unemployment. These variables are all individually supported by specific research studies (see Jordan, 2001a; Jordan 2001b; Bhopal, 2004; CRE, 2006; Smart *et al.*, 2003; Parry *et al.*, 2004b; Derrington, 2007; Van Cleemput *et al.*, 2007; 2009). There is sufficient evidence present to identify certain *'push'* factors which lead Traveller families to seek housing due to the inherent difficulties in the *'Traveling way of life'* (Niner, 2003). However, some UK Travellers report feeling confined with sites referred

to as 'prisons' or 'reservations', with many sites located away from residential areas, thereby increasing spatial segregation, harassment and overall disadvantage in terms of education, employment and health service access (Cemlyn and Clark, 2005). Culture shocks include 'isolation' and 'dislocation' from the extended Traveller family as most 'settled' housing is restricted to accommodating the nuclear family; whereas the extended Traveller family is a central focus of Traveller culture (Cemlyn, 2000; Parry et al., 2004b; Cemlyn, 2008). Here follows an excerpt and quote from **Paper 12** entitled: **'The Irish Traveller Community, Social Capital and Drug Use'**;

'Most Travellers commented on the inherent changes in Traveller 'way of life' and how levels of transience have been restrained and tempered by local authority efforts to house Travellers in group and local authority housing. These efforts have contributed to the dispersion of Traveller families and increased social anxiety, isolation and experiences of anti social behaviour in marginalised housing areas. The majority of Travellers described feeling socially excluded and highlighted the common practice of attempting to disguise their identities in order to avoid discrimination. Some Travellers commented that their identity contributed to an overall sense of hopelessness and inability to participate within their communities, and described their feelings of frustration relating to their attempts to both reject and accept 'settled' culture. This is evident within the following quote describing day to day life experiences for some Travellers;

"People judge Travellers on maybe 5 or 6 bad ones, and then the whole lot of them are getting judged, its like if one young fella goes down and he smashes all the windows, well people that were talking to him the next day, they might be blackened, and then it slowly goes out that they have a bad name, whether they've done it or not."

And an excerpt from **Paper 11** entitled: **'Assimilation, Habitus and Drug use among Irish Travellers'**;

'The Travellers described the isolation experienced within their communities, particularly when housed within local authority sites and attempting to maintain a sense of their culture, as they exist on

the peripheral of the sedentarist community. Experiences of large family networks divided and housed in different areas were common, and contributed to intense feelings of frustration and loneliness. Other Travellers commented on their sense of loss of transiency, in terms of their increasingly fragmented culture, restricted freedom and attempts to retain cohesive Traveller communities. The Travellers housed in local authority schemes described their sense of isolation from inner Traveller networks, and experiences of harassment within these housing outlets.'

*"Me house was sprayed with paint..get out f**** pikey (slang term for Traveller)...no-one spoke to me when I was going around me business..my kids are upset..they have no-one to play with..it's hard...but it's harder to go on the road". (Traveller)*

"You're living in the same community, but you're never part of it..people don't want ye around..so what are ye meant to do..hide?" (Traveller)

Indeed, Dallago *et al.*, (2009) underscore how neighbourhood attachment, social capital and perceived safety can potentially serve as risk and resilience to youth substance by way of contributing to the development of personalities, identities, groups and cultures, as young people become increasingly autonomous in the contemporary consumptive world. Shildrick (2006) also describes how the structural elements of neighbourhood contexts mould and shape youth identities. Research indicates housing guidelines and codes of provision should encourage optimal social interaction (Ahrentzen, 2003). The risk of substance abuse and indeed problematic substance disorder is exacerbated if housing is located in areas where there is a presence of drug related activity. As drug abuse is occurring within the Traveller family and extended groups of Travellers, it will become increasingly difficult for this not to have a serious impact on young Travellers, most particularly when confronted with this type of behaviour at close proximity, whether in the halting site, in caravans or among close relatives (see also Van Hout and Connor, 2008a). Here follows a quote from **Paper 6** entitled: '**Travellers and Substance Use- Implications for Service Provision**' and **Paper 7** entitled: '**Irish Travellers and Drug Use- An Exploratory Study**' respectively;

“Originally their cultural norms protected them from drug use, but as they become increasingly settled and involved in the settled community...their drug is increasing.” (Agency worker)

“You’re not in the same community, you’re living in it, but you’re not in it.”(Traveller)

“They try and settle in with the “settled” community and then if the “settled” ones are going to do it then the Travellers are going to do it, not saying that Travellers wouldn’t do it amongst themselves, they would.” (Traveller)

Rural families are also experiencing a fragmentation of traditional lifestyles and strong familial ties as Ireland has experienced economic growth, industrialisation and urban spread in the last decade. Such findings are of particular interest for both rural youth and parents experiencing great change in traditional rural communities in Ireland, whereby local authority housing schemes have been developed on agricultural land. In terms of substance use, social capital may also be reflected in the housing situation experienced by individuals, with results showing that living in a house or on a farm is associated with a lower rate of smoking, drinking and drug use (Glaeser *et al.*, 2002). Here follows an excerpt and quote from ***Paper 5*** entitled: ***‘Differentiated Normalisation and Drug Transitions among Rural Youth in Ireland’***;

‘Several community based workers questioned whether this recent increase in rural drug activity was due to changes in family structure whereby rural family units are dissipating in strength, due to both parents were working. In previous years, such agrarian families were bound to work on the land. This was deemed to have changed in correspondence with economic growth in Ireland.

A drugs worker said;

“Parents today both work.....this lead to less supervision of their children...who have now become the “latch key children” of previous urban years...rural families are playing catch up..the Celtic Tiger created a monster in terms of how destructive it has been for families..families don’t even sit down together for meals..things have really changed.”

Social Capital and the Family

The family environment can offer both protective and risk related mechanisms for substance onset, use and problematic use (Copello *et al.*, 2006). Thereby, the familial role in generating social capital cannot be underestimated in the form of support, relationships, communication, connectedness of parents, affective bonds with their children, investments in shared activities, parental participation in community institutions and clear delineation of acceptable and unacceptable forms of behaviour (McNeal, 1999; Wright and Cullen, 2001; Wright *et al.*, 2001). Positive social capital in the form of positive child parent relationship and school bonding have been much reported as deterring early onset of drug use in children. Research consistently indicates that substance misuse and problematic substance disorders run in families (Kroll and Taylor, 2009). Substance misusing families are characterised by above average levels of marital and family conflict, hostility and lower levels of family cohesion (Crome *et al.*, 2004). Aspects of family structure linked to drug use and substance use disorders include lower socio-economic status; domestic violence, early onset of children's substance use, parental death or divorce and larger family size (Crome *et al.*, 2004). However, McKegney (2003) argues that the restrictive focus on poverty as central to drug vulnerability in families' yields a simplistic view of social structure (see also Banwell and Bammer, 2006). However, poverty notwithstanding, research indicates that family structures characterised by father absence, both parents absent, or death of a parent(s) are associated with substance abuse (Sher *et al.*, 1997). Chaotic family situations common to single parent families exert a greater influence in predicting child and adolescent substance use than having family history of problematic substance use (Jenkins and Zunguze, 1998). In terms of family structure acting as a protective mechanism, two-parent households appear to offer greater resilience against substance abuse issues (Perrino *et al.*, 2002).

Indeed, a lack of parental involvement in terms of involvement, interest, supervision, emotional availability and encouragement has been associated with child and adolescent substance use (Gilramy, 2000). Kroll and Taylor (2009) identify the quality of parental relationship constructs as relating to levels of warmth, support, supervision and sanctions, and central to child and youth substance use. These factors represent an interesting paradigm for Travellers, who were characterised by strong family cohesiveness, control of young members and virtually non existent drug use, but

appear compromised by the contemporary changes in their housing situations, and dissipation of their culture. For rural parents experiencing a loss of supervision of their children, particularly in the summer seasons, this may indeed contribute to increased opportunistic and planned substance use. In addition, one cannot underestimate the contribution of sibling relationships for the Traveller and rural youth, in presenting a contextualisation of social normalcy of drug use. Older siblings can provide drug exposure, influence younger siblings to the initial experimentation of substances and subsequently they may engage in drug activities together (Chilcoat and Anthony, 1996). However, sibling relationships which are characterised by a strong bond, nurturance and lack of conflict may offer some resilience against problematic youth substance use and are optimal when coupled with strong parent-child bonding (Duncan *et al.*, 2000; Dishion *et al.*, 2002; Crome *et al.*, 2004).

In terms of Traveller ethnicity so characterised by potent family networks, the risk factors for problematic drug use related to the Traveller family are as follows: *'problematic drug use by parents; problematic drug use by siblings; problematic drug use by partner, family disruption, family conflict; family breakdown; poor communication with parents; family criminality; and inconsistent parental discipline'* (Fountain, 2006:59). For the Traveller family experiencing racism and levels of discrimination within the wider sedentarist community, this places the younger members at heightened risk of substance experimentation and potential problematic use. Family crisis and indeed violence within the Traveller home are worsened by the impact of substance and alcohol abuse on parents, relatives or older siblings. In addition, Traveller children are especially vulnerable to ill health and poor physical and cognitive development (Jordan, 2001a; Jordan, 2001b; Barry *et al.*, 1987; Lavery, 2002; Smart *et al.*, 2003). Sadly, the Traveller families reported experiencing high levels of child neglect, fear of social service intervention, domestic abuse, and large families. Here follows several quotes from **Paper 6** entitled: ***'Travellers and Substance Use- Implications for Service Provision'***;

"In other cases if the head of the household is absent or in prison, the Traveller woman present with high alcohol and prescription medication use." (Agency worker)

"Fathers with serious alcohol addiction and binge use- leading to increased violence in the home and financial difficulties for the

Traveller family. Alcohol causes depression...problems experienced exacerbate depression...GP's prescribing medication...risk of dependency and use in combination with alcohol." (Agency worker)

Family influence and also the close presence of extended family within the halting site suggests that drug use within the Traveller family may become less secretive over time, lose its sense of deviance and indeed may result in shared drug using activities, (such as prescription medication amongst Traveller women). Research shows that individuals with extensive social networks as indicator of the level of social capital they possess, experience greater levels of monitoring and control, than individuals with a small social network (Lundborg, 2005). This is contrasted in terms of the Irish Travellers who represent a socially excluded ethnic group, with small social networks in the form of extended families exercising great social control on their unmarried and young. Here follows several quotes from ***Paper 7*** entitled: ***'Irish Travellers and Drug Use- An Exploratory Study'***.

"Ye couldn't drink before ye got married, that was one thing you couldn't do, or smoke, never mind use drugs." (Traveller)

"If you're single no-one is supposed to know what you're doing, and if you have done something really wrong, your parents might say, you're not good enough or whatever, whereas if you're married anything goes, what you do in your own home is your business." (Traveller)

Lindström (2008) observed that men and women are influenced differently in their acquisition of social capital, behaviour in seeking relationships and maintaining social support and solidarity, and depending largely on the depth of exposure and psychological sensitivity within local communities. Research shows that women have a greater propensity to creating relationships, are more active in the community, and have a more sensitive and caring role in the community (Warr, 2006, Healy *et al.*, 2007; Kavanagh *et al.*, 2006a). Indeed, Measham *et al.*, (2001) describe how embodied gender specific roles surrounding drug practices conflict with social norms and moralities in contemporary society, with women existing on the peripheral of male drug culture and defined by their roles as home makers and mothers. Ettorre (1992) also describes the centrality of women's self worth as contingent on helping others and caring for others, and thus being depended on by others. In terms of the Traveller women who have little independence and voice within patriarchal Traveller networks

but yet assume the caring role in Traveller families, such individual interpretations of restricted social capital can contribute to depression, hopelessness and problematic substance use. The research supports earlier Irish efforts (Fountain, 2006) which indicated that Traveller women both old and young present with low levels of lifetime drug prevalence, due to lack of financial opportunity and strict levels of control on young Traveller girls and yet present with high levels of prescription medication abuse. In terms of gender, here follows an excerpt and a quote from **Paper 12** entitled: **'The Irish Traveller Community, Social Capital and Drug Use'**;

'The Traveller world is essentially patriarchal and characterised by early marriages within Traveller families and high levels of social control of women prior to marriage (Cemlyn, 2000; Morris and Clements, 2001; Parry et al., 2004b; Parry et al., 2004c; Helleiner, 2000, Griffin, 2002a, Griffin, 2002b). In contrast, Traveller boys assume adult like roles at an early age and experience less parental monitoring (Smith, 1997a; Smith, 1997a; Helleiner, 2000). 'However, like other ethnic groups, Traveller women experience dual racism and sexism (Helleiner, 2000, Griffin, 2002a, Griffin, 2002b)'. 'A Traveller woman remarked on the levels of dual discrimination and said, "We find it difficult as women to get education, training and employment, but it's much harder when you are a Traveller."

Thereby, for Traveller women existing in the traditional patriarchal system, the overall effect of poverty is far reaching and contributes to dual discrimination relating to gender, class and ethnic origin (Daly, 1988; Barry, 1996; Parry *et al.*, 2004b; Parry *et al.*, 2004c; Pavee Point, 2005; Van Cleemput, 2009). A form of dual discrimination of women by gender and as addicted bodies in drugs research has also been extensively discussed by Ettore (1992; 2004) with women frequently portrayed as more deviant, psychologically disturbed and addicted than their male counterparts, and thereby deviating from the norms of femininity and feminine gender roles in contemporary society. Research comments on the *'double deviancy'* of female drug consumption in a male dominated drug world (Denton, 2001; Banwell and Bammer, 2006). This represents an interesting quandary with Traveller women presenting with distinctive drug consumptive roles and practices when compared to Traveller men, and inversely the presence of dissipating illicit drug gender differences between rural boys and girls as recognised by the Irish HBSC studies (Nic Gabhainn *et al.*, 2007; Gavin *et al.*,

2008). Indeed, the Traveller woman's consumption of drugs appeared limited to prescription medication and alcohol, and deeply rooted in a lack of empowerment and coping skills. Traveller women in particular present to services with much higher levels of depression than the general population (Barry, 1996; Smart *et al.*, 2003). A Traveller woman said '**there's no other options for us as Traveller women..it's a man's world..and it's a settled world.**' Thereby, the social capital framework exemplifies the lack of independence that Traveller women possess as '*passive objects of power*' (see Neale, 2002:45) in their world. Indeed, Ettore (1992:70-76) proposed that alcohol and tranquillisers are viewed as '*good drugs*' inferring safety, social equilibrium and sanity within associational life, and most especially for women as passive and dependent consumers. Within this certain reflexivity of choice, Ettore (1992:126-128) argues for a distinction between '*dependence and addiction*' and '*dependence and subordination*' with such categorisation of drug use implying greater social acceptability of certain drug use in dependence /subordination and operating as a medium for attaining self determination, autonomy, social space and status, and within groups inferring positive value for female socialisation and subservience. In this way, Traveller woman appeared to experience subordination in drug taking and yet also acceptance and autonomy within normative Traveller female groups of prescription medication users. The Traveller women described using pills amongst each other, with only one or two women responsible for accessing the local general practitioner [GP] for scripts. The social capital interplay between alcohol use and prescription medication use underpins the Traveller women existence within strict patriarchal familial systems, with both substances used to stem feelings of anxiety and depression, and fuel the inner sense of Traveller women connectivity. It begs one to question whether these consumptive processes are indeed a form of self agency, or merely a response to social situation or environment. Wincop (2000) has also underscored the need for greater understanding of female structural factors in shaping the life course and destinies of female drug users. Within this context, one could see the emergence of a normative group context for dealing with the despair and marginalisation in day to day life course navigation for Traveller women. Indeed, one could draw some '*differentiated*' normalisation parallels when observing the inner practices of prescription medication use, however licit amongst Traveller women in terms of trying rates, exposure, social acceptability and moderated use. Thereby, the contextualisation of gender within dominant drug discourse needs to be mentioned in

within potential placement of drug normalisation within social capital (see also Measham, 2002; Ettore, 2004). One cannot discount the meanings, processes and symbols attached to masculine and feminine social, and indeed Traveller or rural ethnic or cultural capital within community associational life.

Equally, the closeness, love and support of the extended family with anti drug attitudes may act as a protective factor from drug initiation and problematic drug use. Traveller children and youth suffer a compromised life in terms of the social exclusion, discrimination, poverty and poor health experienced by the Irish Traveller community as a whole. This increases the risk of early drug initiation, and progression toward problematic substance use due to feelings of rejection, lowered self esteem, difficulties accessing training and education and friendships with the settled community. Therefore, an improved Traveller sense of sedentarist belonging, particularly for Traveller youth, whilst retaining their cultural identities may serve to detract from potential vulnerabilities to substance abuse, anti social behaviours and poor school attendance. Here follows an excerpt from **Paper 12** entitled: ***'The Irish Traveller Community, Social Capital and Drug Use'***;

'In this way, even in the advent of problematic drug use within Traveller families, Traveller family cohesiveness may bolster their perceptions of social capital relating to support, trust and solidarity. One might assume that therefore the Travellers possess great levels of social capital within their own communities and families, and not within dominant social discourse in 'settled' Ireland. However, this type of bonding capital can foster exclusivity within insular groups, thereby reinforcing the inner perspective of homogenous groups and their 'thick trust' within individual relationships, and reducing opportunities for the development of 'thick trust' within the greater social structure (Putnam, 2001).'

Thereby, the recognition of family and school social capital according to Wright *et al.* (2001:1) serves to situate substance use within a schema of informal social control, internal sanctioning and internalisation of pro social values and self esteem acquisition, and that ; *'family social capital produces the types of social and personal capital envisioned by Coleman, reduces delinquency across time, moderates the effects of misbehavior, and is associated with general positive effects across the life course.'*

Research indicates those individuals reporting greater perceived social capital often originate from family systems characterised by potent social support from family members (Tsutsumi *et al.*, 1998; McNeal 1999). Factors such as potent family networks, school and community bonding offer an unconditional resilience to drug use in young people (see Howe and Shill, 2000 who mention the ‘*spray-on*’ effect of social capital). It is therefore important to situate the entire family system and its relationships to other larger exo-systems such as the school, the neighbourhood, school and the community within a wider social understanding. Here follows an excerpt and a quote from ***Paper 11*** entitled: ***‘Assimilation, Habitus and Drug use among Irish Travellers’***;

‘Social conflict within inner Traveller organisation is also characterised by the existence of certain families and individual members of these families living in close proximity and yet in complete isolation from each other (Griffin, 2002a; Walsh and Krieg, 2007). The ethnic family as ‘a complex web of relationships that includes relations by blood, clan, tribe, and formal and informal adoption’ can offer potent support and cohesiveness (Waller et al., 2003:79). The Travellers observed a lack of boundary between ‘immediate’ and ‘extended’ Traveller family, with inter marrying relatively common in some Traveller groups. This sense of ethnic familialism acts as a strong protective mechanism against social exclusion, drug use and adverse life events commonly experienced by marginalised groups (Hoppe and Heller, 1975; Brook et al., 1998a; Brook et al., 1998b).’

Social Capital and the Educational Setting

Chung and Cheung (2003) describe the decline in effectiveness of support and guidance offered by social institutions as possible reason for the increase in youth drug and alcohol use, as social bonding and resources evaporate in modern society. Other social capital research explores educational attainment and bonding with the school, and the processes whereby the school reflects the youth’s norms, values and preferences with regard to behaviour such as drug and alcohol use (McNeal, 1999; Jæger and Holm, 2007). The school setting and the connectivity based on reciprocal trust in terms of urban influence thereby presents great potential for rural youth to

acquire social agency and status through drug behaviours within urban structures. In terms of levels of contact with drug users, rural and Irish Traveller youth may experience large networks of youth drug users within the urban school setting. Such networks serve to increase levels and choice of drugs available, even if youth drug use is somewhat opportunistic and spontaneous by virtue. These values whether mainstream or counter mainstream will be assumed by those children (whether rural or Traveller youth) engaging within groups of friends within the school as macro system, with great potential for deterrence and social accommodation of drug use within adolescent sub cultures.

However, Traveller children experiencing difficulties within the 'settled' philosophy in education may experience dual disadvantage relating to the lack of appreciation of their cultural needs and family harassment within the residential setting (Cemlyn, 2008). Griffin illustrated the traditional viewpoint of Traveller education in 2002b:93; *'formal education is valued, increasingly so, but there is also a feeling that there is no substitute for the education which comes with nomadism. Formal education is thought to hamper initiative and nerve'*. Here follows an excerpt and a quote from **Paper 7** entitled: ***'Irish Travellers and Drug Use- An Exploratory Study'***;

'Some Travellers commented on the relationship between poor educational attainment and drug use in Traveller youth and a Traveller male observed the need for community intervention';

"The person with no goal in life...you need to give him something..bring him down a different road."

Traveller children are still identified as particularly at risk within the school setting, with cultural dissonance affecting many Traveller children in their progression toward adult roles (Jordan, 2001a). Traveller youth often leave school early due to literacy issues, lack of understanding within the education system and levels of mobility (Jordan, 2001b; Van Hout and Connor, 2008a). According to the last Irish Census in 2006; 54.8% of Travellers left school at primary level, with 63.2% leaving school under 15 years of age (CSO, 2006). The formal educational setting may represent an additional threat for Traveller parents, in terms of negative assimilation experiences for their children, previous experiences relating to bullying, lack of teacher focus, lack of cultural acceptance, associated self exclusions and community vigilantism (Jordan, 2001a; Jordan, 2001b; Lloyd and Stead, 2001; Derrington and Kendall, 2004; Bhopal 2004;

Derrington, 2007). Indeed, some Traveller parents in this research observed; ***'leaving school early because they felt discriminated against and ridiculed, with many given a 'colouring book' in classes, instead of participating with the 'settled' children.'*** This has important implications for Traveller youth as they navigate urban school environments (see the following excerpts from ***Paper 12*** entitled: ***'The Irish Traveller Community, Social Capital and Drug Use'*** and ***Paper 13*** entitled: ***'Traveller drug use and the school setting: Friend or Foe?'*** respectively);

'Traditional Traveller culture places great value on normative behaviours and belief systems (i.e. anti drug philosophies), clearly defined gender roles and expectations regarding early adult markers pertaining to marriages, autonomy, role definition and financial independence, and the prioritisation of family based learning and traditional entrepreneurship. (Fountain, 2006). This traditional Traveller value stelsel clashes with the Gauje [sedentarist] formal education setting, with academic attainment seen as irrelevant to the Traveller world and contributing to poor literacy and early school leaving during childhood years (Kiddle, 2000; Reynolds et al., 2003; O'Hanlon and Holmes, 2004; Bhopal, 2004). It is seldom that Traveller family or home learning values of interdependence and independence are reflected within the dominant learned dependence sedentarist schooling approaches. This contributes to further institutional and social exclusion, overt negative stereotyping, disrupted learning, and compromised self esteem, early school leaving and high absenteeism (Jordan, 2001a; Jordan, 2001b). For nomadic families, formal schooling attempts are further compromised, contributing to parental condoned absences, discontinuance, high absenteeism and poor retention, thereby forming the basis of entrenched patterns of non transfer of Traveller children from primary to secondary level (Bhopal, 2004; Derrington, 2007).'

'The prime concern for Traveller parents is based on an inherent fear of the sedentarist world, potential dissipation of Traveller culture and fragmentation of Traveller families, and stems from personal prejudicial experience of schooling, or attempt to protect their culture,

where family and home education within the context of cohesive family networks serve a central role in the protection of their children from antisocial environments (Derrington, 2007). According to Kiddle (2000:266), the most frequently voiced Traveller attitude was 'I'll let them go to school to learn to read and write, but then they have to learn our way of life'. The act of sending their children to school and the potential exposure to psychosocial harm is often perceived by the Traveller community as 'a dereliction of parental duty' and as manifestation of group disloyalty (O'Hanlon and Holmes, 2004:29). The threat of the assimilatory process, however selective remains grounded in a fear of the acculturation of Traveller youth into mainstream youth culture, often perceived by Travellers as deviant and clashing with Traveller moral, sexual and behavioural codes (Levinson and Sparkes, 2006).'

And reinforced in *Paper 12*;

'Traditional Traveller culture offers resilience to drug use whereby social networks of older Travellers advocate abstinence and strive to regulate levels of deviant behaviour in Traveller youth within the context of strong family ties and support (Pavee Point, 2005; Fountain, 2006; Van Hout, 2009b). Drug use may be seen as an act to conform within certain groups, or in the creation of new space or new cultural capital (Bourgois, 2003; Scott, 2002). This may indeed be the case for Traveller youth in their conflicting attempts to retain their both their ethnicity, achieve youth status and assimilate within the school setting. '

The risk factors for problematic substance use related to education are: *'exclusion from school; truanting study; low school grades; attendance at 'special' school/lessons because of learning difficulties or challenging behaviour; and the protective factors offering resilience are; attachment to teachers, commitment to education, and educational attainment'* (Fountain, 2006:50-51). Although young Travellers may receive drug education material and life skills training at school; this may be haphazard due to issues relating to literacy difficulties, school timetabling and poor attendance (Jordan, 2001a; Jordan, 2001b). In addition, Travellers inexperience of a formal learning environment may also restrict the delivery and participation in youth drug

education (Jordan, 2001a; Jordan, 2001b). Due to their segregation from sedentary children, their experiences of discrimination at school and in the wider community, and their low literacy skills, Traveller youth are often most at risk for drug abuse and problematic substance use. The risk factor for problematic drug use and progression towards dependency in Traveller youth is closely related to their efforts to integrate, and the presence of potent social networks of pro drug using peers and siblings. This micro-system of emerging social values also represents an interesting paradox for the Irish Traveller community, as Traveller youth engage in formal education for longer periods than in previous years, thus introducing them to mainstream or indeed counter cultural values in their attempts *'to fit in'* with certain normative group collective actions, such as drug use. **Paper 7** entitled: *'Irish Travellers and Drug Use- An Exploratory Study'* also describes this reciprocity of inner trust between Traveller youth (see the following quotes);

"The young Travellers want to be part of the community especially now they are attending education for longer than in previous years and this leads them to be less aware of original Traveller cultural values." (Traveller)

"There are young fellas that are vulnerable to drugs, as well like eh, and eh, what I mean now is they are easily-led. There are young fellas out there that can be easily led. They want to be part of the gang or part of the group. Where there's other young fellas then that they wouldn't have anything to do with it like." (Traveller)

Hagan and Parker (1999) underscore the developmental role of poor educational attainment, socialisation within drug using peer groups and social crowds, and law abiding behaviours as negatively affecting the acquisition of positive social capital in youth. Youth drug and alcohol use may also contribute towards social problems such as poor school performance, attendance and retention (Sutherland and Shepherd, 2001). Finally, there are also higher reported prevalence rates for drug and alcohol use among juvenile offenders (Parry *et al.*, 2004a). However, school and youth training settings are dictated by similarities in student educational and social profiles, which can contribute to the fostering of similar pro or anti drug attitudes and behaviours (Jenkins, 1996; Headley, 2006). The measurement of peer drug use may therefore yield some representation of potential levels of proximal drug use clustering rather than the more distal environments such as school settings (Kandel *et al.*, 1992). Peer

structures contribute to drug exposure, access and consumptive trajectories (Sampson, 1997). Social capital recognition of positive leisure pursuits in free time is then also positively related to increased youth health enhancing behaviours (Hollander *et al.*, 2003). However, social capital measures relating to safety infer that young people are only likely to be part of a youth organisation or sports team, if their parents are supportive and perceive the local community to be safe (Longest and Shanahan, 2007). It was notable that the parents, both rural and Traveller commented on their sense of fear present in the surrounding residential areas, and this appeared centralised in a lack of child supervision. The lack of opportunity for some Travellers to integrate and '*play with*' with young people in the settled community may therefore offer some protection against drug initiation and use, and yet only if drug use is low within their own Traveller community. Similarly, research shows that peer rejection may also increase risk of a substance use disorder, due to feelings of social exclusion and isolation (Newcomb and Felix Ortiz, 1992). Such peer rejection in leisure is commonly experienced by many young Travellers in Ireland, who find it difficult to access sporting clubs and youth facilities, due to both experiences of discrimination and lack of suitable facilities in their areas (Van Hout and Connor, 2008a). This process of social exclusion can result in unstructured leisure time, increased levels of leisure boredom and opportunities to engage in risk taking behaviours.

Social Capital, Risk Neutralisation and Normative Group Settings for Drug Consumptive Behaviours

The supportive peer environment remains central to the emergence of substance using peer sub cultures (Brendro *et al.*, 2002). The certain '*entrenchment*' of youth within a deviant network (see Fast *et al.*, 2009) can potentially disturb school commitments, the fostering of positive leisure time hobbies, positive parent-child relations and discussions, and compromise the acquisition of social capital. For rural youth negotiating urban life, and Traveller youth attempting to selectively assimilate within sedentarist communities, these social capital tenets present a concerning view for later life and drug course trajectories. The risk environment whether for rural youth experiencing influx of drug activity within their communities or school based contacts with urban drug users, cocaine users in the course of their social lives or the assimilation of Travellers within sedentarist Irish society can be viewed as a social space with dynamic interplays of factors mediate and deter drug behaviours (see also

Rhodes, 2009). Fast *et al.*, (2009) describe the interplay between ‘push’ and ‘pull’ factors in the entrenchment of young people into a localised drug scene; with parallel research by Chris Derrington who also utilises these concepts to describe the situation of Travellers in the UK, as contextualised to describe the situational conflict and assimilatory struggle that Traveller parents have in negotiating the formal educational system. Push factors relating to the integration within a localised drug scene are understood to be centralised in proximity, availability, the desire for excitement, sense of belonging, independence and the occurrence of negative life events (Fast *et al.*, 2009). In many ways, rural youth, Travellers and cocaine users in this research portfolio fulfil these ‘push’ stipulations. One cannot discount the interplay of social circumstances relating to exclusion; family dispersion, and assimilatory stresses for young Travellers in potentially ‘pushing’ them toward the drug using element, and thereby providing them with an arena for status, integration, excitement and belonging (see also MacDonald and Marsh, 2002; 2004; Mayock, 2005; Fast *et al.*, 2009). Shildrick and MacDonald (2008) and Fast *et al* (2009) comment on the presence of youth transitions and risk trajectories shaped by life events or ‘critical moments’, social processes and localised drug scenes characterised by drug type availability, places for drug dealing and taking. This phenomenon can conjoin with the recognition that social capital and placement of individuals within localised community life operate within the wider and dynamic social discourse, as individuals strive to engage on a civic level, attain social space and agency and adhere to group boundaries.

This unique concept of youth drug use sub cultures needs further exploration in terms of individualisation, strategic negotiation of the adolescent life course, and social sanctioning for unacceptable forms of drug use. Social learning within groups contextualises drug using processes within normative and shared drug activities (Dawes *et al.*, 1999; Parker and Egginton, 2002; Husted, 2003). Varied levels of substance activity occurs within a variety of inner and outer bounded consumption in peer contextual dimensions identified as ‘best friendships, peer groups or cliques, and social crowds’ (Harter and Whitesell, 1996:762) and are associated with heightened patterns and social accommodation in recreational settings (Dornbusch *et al.*, 1999). In this research, the interplay between achieving a sense of belonging whether within proximal relations between friends and peer groups or indeed in a wider sense of ‘social crowds’ attested to the social capital tenets of ‘sense of belonging’, mutual

acquisition of resources, social agency and space in the context of drug activities. In this way, the rural navigation of urban normative drug use, the Traveller youth negotiation of sedentarist educational space and emergence of social cocaine use in Dublin night life indicate a filtering of drug activity into recreational lifestyles in Ireland. It was unclear whether the young people interviewed or the social cocaine users selected best friends and peer groups or socialised within a wider social crowds based on drug activity levels, with some indicating rather opportunistic use based on drug availability, and some reporting more concerted planned drug behaviour. Here follows an excerpt and quote from **Paper 5** entitled: ***'Differentiated Normalisation and Drug Transitions among Rural Youth in Ireland'***;

'Both service providers and rural youth were aware that locations for youth drug use were essentially random, where young people gathered and 'took what they could get'. There appeared to be a paradox between the spontaneous nature of these groups, and the individual level of planning to be present. It appeared that the peer setting, whether a collection of best friends or wider social crowd of young people was dominant in the prediction of drug activity, securing drug resources, contexts for drug use and the establishment of a drug taking career. Peer selection and peer socialisation processes were viewed as inter related by the drug users, as over time and with establishment of drug use in their free time, they would obtain a wider network of drug using peers. An addiction counsellor commented;

"Experimentation with drugs and alcohol helps the young person feel part of the group.....they feel a sense of belonging and makes them feel more adult like – substance use has become almost a normal rite of passage into adulthood."

The opportunistic use of drugs among the rural youth was observed as many users reported using drugs in social settings with no prior intention for using drugs (similar to Gourley's study on recreational ecstasy use in 2004 and Bahora *et al.*, 2009). However, one can infer some level of sub conscious planning was present and directly relate this to the youth reportedly ***'planning to be in the right place at the right time.'*** This can infer some level of support for the normalisation theory by highlighting the levels of drug exposure in day to day youth and recreational life course whether

deemed planned or opportunistic. It also illustrates the potency of social capital in the form of peer groups, networks and resource acquisition, in the establishment of early drinking patterns, initiation of drug use and drug experimentation within recreation time. Here follows a quote from **Paper 2** entitled: ***'An exploratory study of substance use among Irish Youth- A Service Providers perspective?'***;

"The location of the substance use is random, and that young people take what they can get, when and where they can get it...One might question how such groups are formed and is this drug use planned."

(Agency worker)

Group cohesiveness may bolster the drug user's perceptions of individual sense of belonging or membership to the group. Within this individual drug discourse, the access to extended resources and support is achieved by development of relationships and membership of certain social networks (Locher *et al.*, 2005, Lundborg, 2005). Dekovic and Meeus (2004) describe the process of peer selection as youth substance use preceding that of the peer context, with other research indicating the reverse, where young people experiment and consume drugs as a result of influential friends (Hussong, 2002). Indeed, Rose *et al.*, (2001) describe the labelling of '*social crowd*' membership, where '*social crowds*' serve as health and risk behaviour indicators, reputations or labels, with inherent stereotyping based on youth personalities and behaviours. This indicator of social capital reflects the striving to belong to a wider social structure in terms of socially accepted drug behaviours and attitudes, with '*social crowds*' typically involving less interaction than best friends or peer group membership, and thereby perhaps indicative of the greater drug normalisation thrust in contemporary Irish society. In this way, one can see the functioning of bonding and bridging social capital, where peer dimensions encourage conformity among members, in addition to shaping '*social crowd*' normative drug behaviours. However, the inner processes of peer relations remain potent with Moore (2002) describing the extent of substance use within social proximity by best friends as a strong predictive factor of youth substance use, in contrast to other distal predictors such as the average consumptive patterns within their identified '*social crowds*'. One can speculate on the influences of '*new*' sedentarist best friends as Traveller youth reportedly find their way in school '*social crowds*' and leisure environments, and traditional Traveller identity tempers over time.

The depth of integration and level of involvement within drug using peer contexts cannot be underestimated in terms of opening the doorways to drug availability, and cementing the establishment of drug use patterns and connectivity with other peer users. This creates a web of social reinforcement within group and localised contexts, and may solidify the normalisation movement away from 'so called' subterranean deviant cultures, and equally present fewer opportunities for individuals to encounter alternative views and pro-abstaining behaviours. Indeed, youth navigate their life course within a struggle of influences and choices between deviant and non deviant peers (Dekovic and Meeus, 2004; Fast *et al.*, 2009). Alternatively, the peer selection process may unfold over time such that individuals who have drug-using friends at every level of their peer structure may also have a longer history of drug use and may have invested more time and effort building trust, social status and agency within a peer context filled with drug-using friends. One must be aware that such social networks accumulate strength in numbers over time, and are influenced and facilitated by drug availability and opportunity for experimentation in recreation time in their neighbourhoods, and thereby offer some level of support for differentiated normalisation theory within recognition of specific social and localised settings (see also Shildrick, 2002; 2006). In terms of the development of drug taking groups within such settings, this occurs in conjunction with the normalisation elements described by Parker *et al.*, (2002) (drug availability, drug trying, accepted use by abstainers, moderated use, cultural acceptance) and are cognisant of social change within the concept of miniaturisation of communities, and inherent struggles relating to civic engagement, reciprocity of trust, and mutual acquisition of space and agency. Van Hout and Connor (2008b) in previous Irish youth research on solvent use also observe this level of connectivity and trust among groups and social crowds of youth drug users, in providing exposure to drug use, mediating continued use, sanctioning forms of use and the acts of securing drugs. Bolin *et al.*, (2003) describes the reciprocal nature of such investments as direct utility of socialising, and indirect utility deriving from the broadened resource level from the acquisition of increased social capital in drug activity. Here follows an excerpt from **Paper 13** entitled: '**Traveller drug use and the school setting: Friend or Foe?**';

'Some older Travellers reported intense concerns about Traveller peer socialisation within antisocial youth crowds, the inner struggles of Traveller youth to 'deny their identity and fit in', and attempts of

Traveller parents to curb this form of assimilation by increased parental monitoring, “ I won’t let my young fella take the school bus..I walk him meself...you don’t know what they do be doing on that bus”. Another Traveller parent said “I won’t let my daughter take the school tour..I don’t want her mixing with those girls...they’re smoking and drinkin..and messin’ with the boys.”

Indeed, the rural youth may have encountered the development of such new pro drug locales in the course of urban contact and in their own rural areas, with some describing the presence of a ‘***runner hanging on a telegraph wire***’ to indicate the potential location for a drug deal. This phenomenon was also mentioned during the cocaine research, and was observed by the researcher on several occasions in both research areas [Dublin; South East Ireland]. Here follows a quote relating to cocaine use in ***Paper 14*** entitled: ‘***A Community Perspective of Cocaine Use in Ireland.-A Brief Exploratory Study***’;

“You know where to get drugs, any drugs when you see a shoe hanging on a telegraph pole, that’s where you’ll see them dealing. The shoe tells you where to go....” (Taxi Driver 1)

The accumulation of resources, networks and values within the acquisition of social capital defines the concept of ‘*mutual extraction*’ (Pilkington and Sharifullina, 2009:251) and may be readily applied to the processes of drug seeking, taking and dealing as Irish Travellers, rural youth and cocaine users navigate modern social capital frameworks based on both reciprocity of trust, but also informal social and economic connectivity. This concept can be applied to describe emerging drug exposure and activity during leisure time (i.e. youth drug use and cocaine use) or indeed as potential form of entrepreneurship, relating to the reciprocal relationship between drug users and dealers. Fitzgerald (2009) in his qualitative work on drug dealing with a localised risk environment observed that drug dealing and drug use can be a central feature in the development of local economies and normative group settings, with a subsequent merging of roles between drug users and dealers. In relation to bonding social capital, the norms of reciprocity, levels of associational engagement and trust have great impact on processes of mutual extraction or acquisition of resources. In this sense, influx of drug dealing within rural, Traveller and indeed middle class sedentarist communities presents with greater self perceived social capital for those engaging in

this deviant act, and poorer social capital for those communities experiencing disorganisation, instability and resulting compromised social control (Sampson *et al.*, 1997; Kawachi *et al.*, 1999b; Kubrin and Weitzer, 2003; Messner *et al.*, 2004; Salmi and Kivivuori, 2006; Friedman *et al.*, 2007; Boyce *et al.*, 2008; Winstanley *et al.*, 2008). The research base is inconclusive in terms of social capital outcomes and crime rates (Katz, 2002; Osby, 2008). Some community research on social capital illustrates that greater levels of resources and activities for residents (i.e. positive leisure resources, significant role models etc) can reduce negative social capital and levels of criminality and other risk taking behaviours such as drug use (Youngblade *et al.*, 2006). In terms of drug use as illegal and covert activity, one can surmise the presence of bonding and bridging processes of social capital, whereby restricted social capital characterised by a lack of social connections, mobility and limitations on freedom can contribute to drug activity in communities. Bridging social capital is harder to apply due to the limited foresight of drug active individuals in close social relationships, and additional potential for exclusion and stigma of problematic drug use. Here follows an excerpt with quote from **Paper 13** entitled: ***‘Traveller drug use and the school setting: Friend or Foe?’***;

‘The recent influx of drug activity within Traveller families is evident, with an agency worker commenting “I can see strangers coming into the Traveller halting site....Traveller children are being exposed to an awful element of society within their own homes, never mind at school...it’s very difficult for Traveller parents to protect their children from it..”

One can question the interpretation of drug use in relation to crime or illegality, in particular when considering that such activities may actually bolster the perceptions of social capital for those engaging in it. It should also be mentioned that such varied levels of inner and outer social capital, may act in beneficial or positive ways depending on how these groups perceive the actions (Lovell, 2002). This has certain implications for the inclusion of the normalisation debate with the social capital framework when discussing drug exposure and behaviours within peer groups, networks and ‘*social crowds*’ in localised drug risk environments. Therefore in this context, greater social resource acquisition in the form of Traveller, rural or middle class community integration and development of associational relationships can also pose an individual and community threat in the form of drug exposure, drug use and drug dealing networks. Drug dealing represents an interesting development in the form

of positive and indeed negative social capital dependent on the relationships based on mutual extraction, the acquisition of monetary and social resources, and is thereby not limited to normative frameworks for behaviour in drug using groups. Merton (1938) describes such processes of social capital acquisition as relating to social status and wealth when social access is restricted or denied, can also take formation via illegitimate means (i.e. drug dealing) and thereby incur inner normative acceptance of retreatist behaviours where education and employment are rejected. Fountain's (2006:53) research on Irish Travellers and substance use noted that, '*a feature of Traveller culture is that income generation focuses on self-employment, occupational flexibility, entrepreneurialism, and economic adaptation*'. Drug dealing may therefore represent positive social capital and potential avenues for income in a life characterised by unaccountability, poverty and discrimination, particularly among Traveller young males, and therefore realise a somewhat positive perception in the eyes of some Traveller groups. Here follows an excerpt from **Paper 11** entitled: **'Assimilation, Habitus and Drug use among Irish Travellers'**;

'Drug dealing within the Traveller communities is reportedly increasing and represents the potential acquisition of resources, social space, agency and status during the assimilation process. Drug dealing was recognised by the younger Travellers as a lucrative diversion of economic activity from scrap metal and horse dealing, the utilisation of their nomadism, relative unaccountability and also an inherent fear of purchasing from sedentarist strangers. Other Travellers in contrast reported buying their drugs only from members of their own families and in halting sites suggesting a 'closed door mechanism', and again reflecting the inner and outer boundaries of Traveller ethnic identity. The separated social worlds of the Travellers and the sedentarist community may thereby exacerbate the invisibility of problematic drug use and heightened drug activity within the Traveller groups, making it increasingly difficult to control, quantify and address.'

Here follows an excerpt and several quotes from **Paper 12** entitled: **'The Irish Traveller Community, Social Capital and Drug Use'**;

'Some Travellers commented that drug use was coming from within their own communities, in terms of exposure, availability,

opportunities to purchase and consume drugs. Drug dealing was reportedly based on entrepreneurship of some Travellers to a market opportunity, and as control method to 'keep drugs within themselves'. Some Travellers commented that the Traveller way of life in terms of its transiency and unaccountability was ideal for 'drug trafficking', whilst others rejected the idea of drug dealing within their communities. The following quotes illustrate how Travellers perceive these local drug economies to affect them;

"People give out about it but the drugs are too easily available to them, and it's only going to get easier to get them";

"There are some people making big money out of drugs. They're going to be around for ever, you are never going to get away from them people."

For rural youth there appeared to be a quandary insofar that they perceived the purchase of drugs, as signifying a potential loss of control, or indeed as representing potential problematic drug use or addiction and this appeared to be a collective norm in terms of controlled action inferring safety by abstaining from purchasing and instead **'freeloading from friends'** within opportunistic peer contexts. This social phenomenon carries important connotations with Parkers normalisation theory pertaining to controlled youth drug use and negative connotations regarding addictive behaviour. It may indeed have been typical of the rural hesitation to ascribe to or *'feel safe'* within urban consumptive decision making practices. Here follows an excerpt and several quotes from **Paper 1** entitled: **'Drug and alcohol use among rural Irish adolescents- a Brief Exploratory Study'** and **Paper 5** entitled: **'Differentiated Normalisation and Drug Transitions among Rural Youth in Ireland'**;

"I wouldn't start paying for that..I wouldn't know when to stop..and then I would have a real problem..it's better just to take a drag from my friend or half a banger [E]." (16 year old Female).

'This apparent lack of interest in individual purchasing was linked to the perceived safety of 'free' drug use within the peer setting, and was deemed to minimise the illegal effect of drug use and create a distance between the rural youth and drug use as underground criminal activity.

Drug taking can be audience controlled and occur primarily due to insecurity, fear and loss of social support in group situations. One might think of vulnerable youth in the peer drug using setting; or indeed the entrenchment of young people via the aforementioned '*push factors*' into localised drug scenes (Fast *et al.*, 2009). Indeed, particularly for rural and Traveller youth, and those using cocaine, drug consumption may serve as mode of expression and heighten efforts at socialising (Parker *et al.*, 1998; Reid *et al.*, 2000; Measham and Shiner, 2009) with some research connecting certain socially acceptable drugs to greater levels of self esteem and social skills (Scheier and Botvin, 1998). Drug taking which is classified as thrill or pleasure seeking behaviour is characterised by sensation seeking or risk pursuit, and most commonly in the situation of boredom or the need for challenge (Kloep and Hendry, 1999). However, concern for problematic drug use remains with research indicating greater potential risk for those with a personality profile typifying over-confidence, delayed gratification, risk and sensation seeking behaviour (Ter Bogt, 2002). One can speculate if this was the case for the middle class cocaine user who, otherwise law abiding, senses drug activity as hedonistic and cathartic to offset the tedium of working life. Indeed, one must remember or perhaps accept that the majority of drug users do so, because of their own individual subjective experiences of pleasure associated with drug use (O'Malley and Valverde, 2004). Additionally, the element of pleasure itself contained in drug consumptive practices cannot be discounted, in the sense of the drug outcome, potential inner group feelings of safety and reduction of drug perceived harm. Lastly and perhaps quite contextualised in contemporary society consumptive behaviours, the process of calculated risk differs from irresponsible risk taking in that the individual engages in a cost benefit rational decision making process, whereby the risk is considered and accepted in order to reap the reward (Rodham *et al.*, 2006). Research observes that individual rational decision-making regarding youth scripting of risk and drug consumption is associated with levels of individual autonomy, individual cost benefit assessment and internal controls (Mayock, 2002; 2005; Allaste and Lagerspetz, 2002; McAllister and Makkai, 2003).

Within this portfolio of work, the most applicable method of risk neutralisation involved the comparison of drug risks similar to those accepted by the majority or indeed the local population (Peretti-Watel, 2003). Within the understanding of social connectivity and greater drug exposure in day to day associational life, one must be aware that in

the context of '*neutralisation*' (Gullestad, 1996), each individual may deviate at some point in their lives. Neutralisation proposes that deviant behaviours are not so distinguishable from the norm, with many so called deviants still adhering to conventional societal norms, but temporarily discarding or neutralising these norms (Peretti- Watel, 2003). By focusing on social capital in its illustration of potent social relationships, networks and bonds, this process of selective neutralisation appeared present for both the drug using youth and the '*law abiding*' cocaine users. Indeed, Maycock and Howat (2007:861) in their study on anabolic steroid use in Australia demonstrate how social capital within the drug using subculture assisted in the neutralisation of risk and facilitation of '*the distribution of illegal anabolic steroids, entry into illegal drug use, reinforced continuation of that drug use and inhibited cessation. The subculture of the dealing network introduced new users to the drug and provided the users with the skills and resources to overcome the social controls which may have inhibited or reduced use.*' In terms of drug using literature, Becker (1953) explored this concept in relation to the justification of cannabis use from the user's perspective in order to '*bend*' the risk and reinforce the drug use within group sub cultures. Such neutralisation strategies are defined as both behavioural and cognitive in changing actions and attitudes, and are observed by Becker in 1963 (see '*The Outsiders*') as functional in dealing with cognitive dissonance or tension in conflict with societal norms. This was supported by youth observations in **Paper 1** entitled: '**Drug and alcohol use among rural Irish adolescents- a Brief Exploratory Study**;

***"I just did it cos me friends were all smoking ...sure why not...there wasn't anything else to do at the time."*(17 year old Male);**

***"We were all outside my house..it was summer time...we just sat in the grass and smoked a joint...no-one knew."* (17 year old Male);**

***"All my friends were smoking..I wanted to know what it was like..I felt a bit sick...my head was spinning..nearly had a 'wobbler [a faint]'"* (16 year old Female).**

However social capital theory can also attempt to explain how after a certain level of risk behaviour whether criminal or otherwise is engaged in by a proportion of the community, this behaviour accelerates and incidence rates increase. Rock (1973:84) described this redefinition of deviant activities so that '*certain kinds of deviancy may, indeed, become normalised that they are no longer managed as deviant*'. The concept of the drug career is much debated and central to the acquisition of identity, autonomy

in drug seeking and consumptive behaviours, social status and agency, with such characteristics hinging on individual and group relationship within community life. In this way, the movement away from subterranean deviant sub cultures toward normative drug using groups in contemporary Ireland represents some elements of social isolation from mainstream society, or at least some degree of 'cocooning' of inner drug behaviours within such groups. In addition, Peretti-Watel (2003:27) described a level of stigmatisation whereby risk is transformed to blame, and acts 'to draw a border between the stereotyped 'them' (risky people) and 'us' (safe people)'. In this instance, the deviant group is 'otherised' whereby the attribution of the risk action is aimed at the individual's personality and not their environment. This may well be the case when considering the dual discrimination of Traveller addicts, both from within their families and communities, but also within the dominant drug discourse. One would question whether such a concept is applicable to the rural youth encountering urban levels of drug use, or Travellers as they negotiate assimilation within Irish society. According to **Paper 13** entitled: ***'Traveller drug use and the school setting: Friend or Foe?'***;

'Traveller youth drug use is rising in terms of drugs chosen and diverse patterns of use [poly substance use, intranasal cocaine use, inhalation and intravenous heroin use, with groin injecting increasingly common].'

And an excerpt from **Paper 13** entitled: ***'Traveller drug use and the school setting: Friend or Foe?'***;

'The Traveller community is traditionally bound by fear of drugs and potent anti drug values, and until recent times have been somewhat protected from exposure to drugs by limited contact with 'settled' communities. However, this closed nature, particularly in the event of problematic drug use leads to inherent difficulties in accessing treatment, and frequent attempts to deal with the problem within a closed family setting. A Traveller mother said;

"Traveller families try to hide one of their own is using drugsyou'd never think one of your own would be taking drugs."

A Traveller man said;

"The Travellers need to open up and talk...-break the silence....Travellers are too proud....they are carrying the shame of it

but not talkin' about it....they are embarrassed and ashamed..". A Traveller woman said "I got married very young at 17...got caught up in alcohol addiction....the drink brought me to places I didn't want to go..brought shame to my family..and let down..I nearly died..I didn't know there was any rehab centres..didn't know how to get help..tried the pledge [religious oath] but it never worked..my sister told me I had fell by the wayside..my mother didn't want to know me."

Miller (2005:247) describes several risk neutralisation strategies namely; 'scapegoating, self-confidence and risk comparisons'. Research describes 'scapegoating' as a rational response to the structural and social components of the risk infused environment (Albert, 1999). Interestingly, Mayock's work on Irish youth scripting of risk describes the presence of youth autonomy in decision making and rejects social factors in the prediction of their entry and internalisation within local drug scenes (Mayock, 2002; 2005). This was supported in the rural youth research who also described elements of self determination in navigating drug led decision making, and thereby the strengthening of their social position within drug taking groups. 'Self-confidence' describes a psychological component relating to 'unrealistic optimism' which reduces perceived potential for harm in comparison to ones peers, and whereby the risk taker distinguishes themselves by their individual trust in their capacity to avoid or control risk (Miller, 2005:247). Such self belief may be overly individualistic and is situated within a wider social structuration of the risk environment. However, Rhodes and Cusick (2000) propose that risk neutralisation strategies are also employed because of the influence of reciprocity and trust in power relationships of social capital in influencing risk taking decision making (see also MacPhail and Campbell, 2001). Here follows a quote from ***Paper 14*** entitled: ***'A Community Perspective of Cocaine Use in Ireland.-A Brief Exploratory Study'***;

"There's some fear of getting caught with coke,... but they have it snorted in a second ... and this results in complacency, particularly in the pubs.... It is very difficult to monitor the personal user;... we focus on the house raids." (Drugs Squad)

Reyna and Farley (2006) suggest that such cost benefit forms of risk decision making increases levels of risk taking, within the confines of cultural and social norms. This leads one to speculate on the dimension of the normalisation theory relating to

consumerism and social accommodation of drug use. One cannot discount the influence and interplay between drug discourses within the broader social consumptive processes in contemporary society (see Lundborg, 2005; Friedman *et al.*, 2007; Bailey, 2005). Jones (2004) describes the modern socio cultural world whereby consumption is fundamental to the leisure experience in terms of creating social image, status and agency for youth. According to Parker (2005) the social acceptance of moderated or controlled substance use is common among drug abstainers, especially young people who have friends' who use drugs on a recreational level. This was true in the research on rural youth, and to a lesser extent, the social cocaine users, but had not yet emerged within the Irish Traveller community. There remained a deep suspicion and abhorrence of illicit drug use among the older Travellers. One questions whether the process of selective assimilation and governmental attempts at homogenisation of the Travellers, as ethnic minority in contemporary Ireland, will assume the consumptive influences of normalisation of drug use, as they integrate and assimilate within the dominant sedentarist community context. In light of this, perhaps most importantly is how the attitudes of abstainers develop over time, in response to increasing levels of acceptable forms of drug use in society. One must remember that although anti-drug attitudes can have a protective effect, such attitudes are dynamic and may temper over time, in response to shifting cultural values, open and closed group networks, and transactional discourse (Parker *et al.*, 1998). Sharland (2006:250) describes youth drug use as typically '*short-term, experimental and soft*' whilst acknowledging that risk taking and risk exposure are inextricably linked. Social capital literature also describes the alignment of health attitudes and behaviours over time (Duncan *et al.*, 2002), as deviant behaviours such as drug use lose their deviancy over time, become somewhat internalised within communities and thereby at some level attain '*differentiated normalisation*'. Here follows an excerpt from **Paper 5** entitled: '***Differentiated Normalisation and Drug Transitions among Rural Youth in Ireland***';

'Adolescent attitudes and knowledge pertaining to drug use have also become liberalised and perhaps somewhat normalised, with research suggesting those in late adolescence are appearing accepting of drug use among their peers, even if they themselves are abstaining (Wagner et al., 2002). Wibberley and Price (2000:161) also comment on "the individuals right to choose a certain behaviour is considered, by some, to override the perceived `wrongness' of that choice of

activity (more so for cannabis than for amphetamine or heroin). In so doing, recreational drug use within social crowds and groups of young people becomes a form of leisure activity and loses the deviant sub cultural element (Evans, 2002). Cieslik and Pollock (2002) identified that youth drug users partaking in recreational drug use did not define themselves as drug users, by way of consuming drugs as part of their leisure lifestyles in addition to sports, relationships, shopping and holidays.'

Sharland (2006:252) commented on the need to understand youth risk behaviours, from the perspective of adolescents as; '*agents of their own lives, pursuing their own trajectories, situated within their own social, material, cultural and relational worlds*'. In addition to achieving a greater understanding of the risk environment through day to day lived experiences, neo liberal forms of public discourse have also proposed autonomous decision making as responsible for individual self care, and therefore the minimisation of harm. Youth themselves appear to have a '*sophisticated view*' of drug use in terms of their own and peer abilities to make choices, consume and act strategically in the course of day to day youth life (Graves et al., 2005:388). Hereby, drug use occurring during the leisure context becomes '*controlled loss of control*' with modern culture advocating control or moderation within socio structural constraints of age, gender, ethnicity and class (Measham and Brain, 2005). In terms of rural youth drug use and indeed middle class cocaine consumption, one may speculate that for only a small minority of individuals does alcohol and drug use operate as a coping mechanism, and instead appears centralised in subterranean social group activity. In this way, drug use operates as social medium whether for rural youth in their free time or social cocaine users within middle class socially conforming circles. Here follows an excerpt from **Paper 5** entitled: '**Differentiated Normalisation and Drug Transitions among Rural Youth in Ireland**';

'Recent studies on youth drug use have focused on the development of sociological approaches to understand drug transitions within a cultural context, whereby the original idea of peer pressure as thread between drug use and youth culture, has been replaced by the normalisation debate encompassing 'recreational drug use as one expression of consumerism in youth lifestyles' (Pilkington, 2007b:374). This concept of normalisation of youth drug use was

been extensively debated and has occurred in light of unprecedented trend increases in worldwide prevalence measures of youth drug use (Parker et al. 1998, 2002; Measham et al., 1994; Shiner and Newburn, 1997, Egginton and Parker, 2002, Wibberley and Price, 2000, Duff, 2003a, Cheung and Cheung, 2006).'

Indeed, the main reasons for youth drug use contained a recreational element and were quoted in ***Paper 1*** entitled: ***'Drug and alcohol use among rural Irish adolescents- a Brief Exploratory Study'***;

"Nothing else to do"; "Sure there's nothing wrong with hash"; "Everyone's doing it"; "It's a buzz" ; "Sure all my friends are doing it"; "I relax"; "It helps me chill out, when my parents get on to me." (Rural youth)'

The social capital literature in the aforementioned sections, describes that norms for substance use are reinforced within the social network, whereby socially isolated individuals have a greater likelihood to smoke, drink and use drugs. In terms of rural youth or cocaine users in middle class Dublin, the reverse appeared to ring true, with the presence of peer using groups appearing to reinforce the collective acceptability of alcohol and drug use. Hereby, the acquisition of entry to certain social networks such as drug using groups, and therefore social capital, may vary (Glaeser *et al.*, 2002). This appears applicable to the middle class cocaine user, who otherwise conforming has obtained entry to and security within a sub culture of recreational weekend cocaine use. Indeed, the social cocaine users represented large groups of weekend middle class groups generally conforming to societal norms and not socially marginalised or isolated. One might question whether this is due to the inner processes of social cocaine use with users exhibiting informal control mechanisms amongst themselves in terms of the level of cocaine consumed, combined use with alcohol and preferred mode of use (commonly intranasal). The cocaine users appeared to be creating their own sense of agency and space within the context of nightlife and socialising (see the following quote from ***Paper 14*** entitled: ***'A Community Perspective of Cocaine Use in Ireland.-A Brief Exploratory Study'***).

"There is a perception that these recreational cocaine users are looking for the risk, the sensation, and wish to appear fearless and unpredictable." (Prison Liaison)

Thereby, attempts to conform to perceived drug normalisation may also be seen as attempts to seek recognition or status within groups by so called illicit means or the creation of new space or new cultural capital (Bourgois, 2003). In relation to group normative behaviours and actions, Coleman (1994:258) uses the term *'closure'* to illustrate the intricate social links, which provide a guaranteed uniform adherence to certain norms. Social networks regulate levels of risk pursuit and deviant behaviour, with social groups disseminating norms for such collective and individual behaviours with costly sanctions for those who deviate (Bolin *et al.*, 2003). How these norms for risk taking are established and engaged with depend on the group level of openness or closure, and the level of close relationships within these networks in order to minimise conflicting norms and instead present with uniformity. Thereby, the ability to operate a *'parallel life'* with drug use (see Moore and Miles, 2004) confined within recreation time and self moderated by inner group sanctioning appeared to be coinciding within a greater social shift in the social accommodation of drug use within Irish society. Here follows several quotes from **Paper 14** entitled: ***'A Community Perspective of Cocaine Use in Ireland.-A Brief Exploratory Study'***;

"Cocaine users are often able to disguise their cocaine use and function normally, and only some will present with severe dependency and associated difficulties. There are so many normal people taking cocaine at the weekend, it only becomes a problem when they can't get to work on a Monday and things start to slide from there." (Drug Counsellor)

"Those using cocaine recreationally have never used heroin and do not classify themselves as drug users." (Drug Counsellor)

Within certain similarity, resilience to drug and alcohol use may be viewed as attempt to counteract dominant values (Bottrell, 2007). Fountain (2006:33) acknowledged that Travellers were aware of certain levels of drug activity within their networks, but deemed it a taboo subject and strongly stigmatised. Here follows an excerpt and several quotes from **Paper 11** entitled: ***'The Irish Traveller Community, Social Capital and Drug Use'***;

'The majority of Travellers whilst acknowledging the presence of drug activity in close proximity observed that this was rarely discussed between Traveller families. 'The Traveller narratives presented a fear

of addictive use, whether in terms of appearing like a 'junkie', 'bringing shame on the family' or stigma related to accessing mental health and addiction services [usually situated together in Ireland]. A Traveller man remarked;

"You would never hear of drugs among Travellers, going back I'd say even ten years, but now it's a big thing."

'Older Travellers commented on their traditional values and potent social sanctions for drug use. They appeared to be fearful and suspicious of all drugs and deemed all drugs as equally harmful. This reflects the older generational resistance to acculturation and is supported by previous Irish research reporting that drug taking carries great stigma and shame for the community, and is a sensitive and 'taboo' topic to discuss for Travellers (Fountain, 2006:33).'

"Ye couldn't drink or smoke before ye got married,...never mind drugs, we didn't know about it." (Traveller)

"I hate them drugs..am afraid every day them kids go to school..we never had this before..they come back and they don't tell me nothing..Travellers have it hard enough without trying to deal with this." (Traveller mother)

Here follows an excerpt and a quote from **Paper 6** entitled: **'Travellers and Substance Use- Implications for Service Provision'**;

"The mix between the settled community and Travellers has transcended and has broken down the barriers between settled and Traveller, particularly in the case of young people." (Agency worker)

The Irish Travellers in their separation from the 'settled' community appear to experience heightened levels of contact with cigarette and alcohol use, and in recent years increased drug use, as a result of close proximity of halting sites to marginalised communities and subsequent internalisation of problematic substance use within close Traveller family networks. Here follows several quotes from **Paper 7** entitled: **'Irish Travellers and Drug Use- An Exploratory Study'**;

"It used to be hash but in the last maybe year or two everyone is taking coke, every second person you meet is going to get a bag of coke. It starts of with hash and then it gets to coke, slowly going up, going up. I don't think its anything more serious than that." (Traveller)

***“Ya see life circumstances come into it too, it does really, because if your living with someone that takes that stuff its your everyday life looking at them, eventually your going to end up doing it like.”
(Traveller)***

Parker *et al.*, (1998) observed that normalisation of youth drug use, in terms of prevalence, drug exposure, normative use and social sanctioning in the recreational context may fluctuate along the life course. Child and youth drug use is dependent on opportunity and availability (Novins and Baron, 2004), with sequential progressions relating to prior alcohol or tobacco consumption (Kandel, 2002), with a large majority simply growing out of drug use and a small minority developing problematic substance use (Kandel *et al.*, 1992). The service providers commented on the general lack of future considerations of drug use among young people in general and said in **Paper 5** entitled: ***‘Differentiated Normalisation and Drug Transitions among Rural Youth in Ireland’***;

“Youth live for the moment..in their minds its just part of life..and part of free time...none of them think they will develop a problem..drug use is seen as a social activity..not a coping mechanism or criminal act.”

Those young people abstaining from illicit drug use in **Paper 1** reported being afraid of potential health consequences related to drug use including; ***“addiction”***; ***“paranoia”***; ***“loss of mental skills”*** and ***“fear of overdose”***. Other consequences included; ***“fear of losing friends”***; ***“becoming a recluse”***; ***“exhibiting strange behaviours”*** and ***“not being able to finish school”***. Even the younger Travellers appeared to recognise such bounded consumption indicating their experiences of assimilation within dominant social discourse and quoted in the following **Paper 7** entitled: ***‘Irish Travellers and Drug Use- An Exploratory Study’***;

“No 15, 16, 17 year old I know has a serious drug problem. Serious is like ecstasy, Hash is just a buzz, weed is just a buzz, to relax you like, It’s more like older people that take serious drugs.” (Traveller young male)

***“Some Traveller young fellas are taking them and more Traveller young fellas don’t take them. You can’t tar them all with the one brush” and; “I don’t know of any Traveller girl taking drugs.”
(Traveller)***

Some of the older members of the rural youth reported a reduction of illicit drug use over time, with reasons reported including (see the following quotes from **Paper 1** entitled: **'Drug and alcohol use among rural Irish adolescents- a Brief Exploratory Study'** and **Paper 5** entitled: **'Differentiated Normalisation and Drug Transitions among Rural Youth in Ireland'** respectively);

"I couldn't be bothered";" me head was wrecked on drugs";" I prefer to drink now."

"I just didn't bother trying again...it wasn't for me..I don't really like smoking anyway.."(17 year old Female);

The role of the chosen substance in the individuals' regression or progression to other substances cannot be underestimated in terms of stimulating factors such as peer norms for use, peer drug using sub cultures, availability, and opportunities for use, cultural use and attitude, which may well explain progressive patterns of licit and illicit drug use (Hussong, 2002). Li *et al.*, (2002), indicates that frequency of substance 'offering' relates to greater youth uncertainty in maintaining abstinence. In the rural and Traveller youth research, many youth reported having been offered cannabis, which contributed to heightened perceptions relating to safety, and linked to the lack of exposure to heroin which was greatly feared as the **"dirty drug"**. Contemporary media discourses on drug use and exposure to drug availability in the course of day to day life can indeed reduce perceived harmfulness of certain drug use (Parker, 2003; Bailey, 2005). Both users and abstainers recognise a hierarchy of drugs in relation to harm or risk (see Ettore, 1992; Hussong, 2002). According to Mayock in 2001a, dominant drug consumptive beliefs and attitudes appear to be risk assessed in relative terms and grounded in diverse circumstances and social settings affecting potential harm. Here follows several quotes from **Paper 2** entitled: **'An exploratory study of substance use among Irish Youth- A Service Providers perspective?'** and **Paper 14** entitled: **'A Community Perspective of Cocaine Use in Ireland-A Brief Exploratory Study'** respectively;

"Hash or cannabis is no longer special and is socially acceptable. This may be due to this being widely available and often smoked by parents or older siblings"; "Cannabis is as safe as cigarettes and sure everyone smokes a joint." (Agency worker)

“Sure the pub owners don’t care:... these lads will drink more on cocaine, so why not turn a blind eye?”(Drugs Worker)

Jørgensen et al., (2007:554) describe youth alcohol and drug users developing their ‘own lay harm-reducing initiatives’. Some rural youth commented that they didn’t want ***“to look like a junkie”*** and exercised informal controls on their drug and alcohol consumption so as not to appear ***“out of control or a complete mess”***. This fear of outward loss of control was underscored in the rural youth interviews. Indeed, this view also appeared central to the youth consumption of ***‘bangers and yokes’*** [ecstasy] and typified their drug choices as relating to control and to a large extent ***‘hazard management’***. This is similar to research by Shildrick (2002) on illicit drug youth cultures in the UK and who reported anti-ecstasy views stemming from media coverage surrounding several publicised fatalities. Here follows several quotes from ***Paper 2*** entitled: ***‘An exploratory study of substance use among Irish Youth- A Service Providers perspective?’*** and ***Paper 7*** entitled: ***‘Irish Travellers and Drug Use- An Exploratory Study’*** respectively;

“Young people think they can give up before it becomes a problem.”
(Agency worker)

“There is nobody that can’t fall into the trap, There’s so many different levels of drug abuse, there’s the surface and everyone knows (*) is doing drugs, and then beneath the surface, there’s people with plenty of money, and they’re partying and they’re doing coke, and ya don’t care about them and ya only care about (****) that got into trouble cos he’s a drug addict, and that goes for Settled community as well.”***
(Traveller)

“People are under the impression that we’ll say, eh, eh, (*) is a drug addict down the road and I know cos I seen him, but there’s nothing to say the (****) neighbour wouldn’t be one either, and he could hold down a very good job and have a very good car. He could be from the upper class, he could be Joe Blogs son, dya know what I mean, there’s no discrimination against who can get hooked.”*** ***(Traveller)***

The fear of addiction appeared pervasive throughout the research, with varying degrees of fear ranging from intense fear of addiction by the old Traveller fraternity, fear of uncontrolled drug use by the rural youth, and relatively low levels of fear reported by the cocaine study. This may be applied to certain levels of stigma attached

to drug use, in terms of addiction, uncontrollable use and the peripheral problems experienced by the social networks around the problematic user. The rural youth drug users reported that subsequent patterns of drug use were established within groups of peers, were improved by older peers providing information on “**how to get a better buzz**” and how to control their drug combinations to get a more pleasurable experience. This social setting and reasoning for drug use from both an individual and group level in their possession of social capital is supported by Becker (1963:30,51) who observes how ‘*individuals were able to use a drug for pleasure only when they had learnt to conceive of it as a substance that could be used for pleasure*’. This normative thrust pertaining to sanctioned and acceptable forms of drug behaviours appeared common throughout all research cohorts, and incurred greater restraint on drug consumptive behaviours in the operation of reciprocal relationships, group sanctioning and social norms. Similarly, **Paper 5** entitled: ‘**Differentiated Normalisation and Drug Transitions among Rural Youth in Ireland**’ observed this normative form of drug use among rural youth;

‘Infrequent recreational drug use was most common, with moderated drug use supported and encouraged by peers, with some rural youth stating;

“It is a grand buzz..but you wouldn’t want to be completely mashed...no-one wants to see you completely off your face..the lads wouldn’t like that..we just smoke some blow to chill out..we wouldn’t use anything else..I wouldn’t consider coke or E.” (17 year old Male);

“Sure you can see them off their heads in the nightclubs...I wouldn’t like to look like that..chewing their jaws..sweating..” (17 year old Female)’.

In addition, the threshold between social or recreational cocaine use and that of problematic cocaine use is inherently difficult to disentangle (Bellerose *et al.*, 2009), with controlled use very much situated on social conditions and reinforcers for use (Reinarman *et al.*, 1994). In the case of cocaine users, these groups collectively perceived cocaine to be a safe drug of choice, enabling them to drink more alcohol, easy to use, and once deemed under certain control, not harmful or ‘**just plain recreational**’. Here follows an excerpt and a quote from **Paper 14** entitled: ‘**A Community Perspective of Cocaine Use in Ireland.-A Brief Exploratory Study**’;

'Evidence suggests that social cocaine users do not see themselves as needing to access treatment for their cocaine use, and also that they view the existing treatment services as being 'for the real junkies'.'

"The perception is, if they are not injecting it's ok, as long as they're not seen as the local junkie!" "sure even someone's parents are using coke at the weekend and they are in their forties...everyone's at it, its no big deal , just a treat at the weekend. People have so much more money now, with the Celtic Tiger and all, it's often cheaper to club together and get some gear [drug supplies] for the weekend." (Drug Treatment Services).

Lastly, the researcher wishes to draw attention to the explanation and understanding of normative influences within dynamic social capital processes as contributing to the prediction and understanding of consumptive drug trajectories over time (Galea *et al.*, 2004; Winstanly *et al.*, 2008). The concept of '*habitus*'² (Bourdieu, 1990) is useful in understanding such decision making processes over time and when considering socially situated practices of drug use within the risk environment, and is defined as socially acquired dispositions in relation to practices, habits, tastes and behaviours, which are reproduced iteratively, and often unconsciously, through everyday practices. ***Paper 11*** entitled: '***Assimilation, Habitus and Drug use among Irish Travellers***' explores the theoretical concept of habitus in understanding Traveller assimilation within sedentarist Irish society and influx of drug activity within these closed communities.

'The concept of habitus (Bourdieu, 1990) may offer some added illustration and comprehension into Traveller assimilation over time and the negotiation of emerging drug risk environments within the newly encountered sedentarist world and their own inner Traveller

² Bourdieu (1990:53) defines habitus as '*systems of durable, transposable dispositions, structured structures predisposed to function as structuring structures, that is, as principles which generate and organize practices and representations that can be objectively adapted to their outcomes without presupposing a conscious aiming at ends or an express mastery of the operations necessary in order to attain them. Objectively 'regulated' and 'regular' without being in any way the product of obedience to rules, they can be collectively orchestrated without being the product of the organising action of a conductor*'.

networks. Habitus offers an explanation as to how social actions are predicted over time, whereby such actions are deemed to be transferred in an unconscious manner through generations and seen as reflecting class practices (Jenkins, 1992). According to Bourdieu (1990) the comprehension of the power relations within social fields and in turn within the local habitus is essential to predicting community and individual behaviour.

'Bourdieu (1977) also describes the influence of habitus as limiting the options which individuals possess whether through cultural influences and generational precedents.'

'Bourdieu (1984) described distinct consumption practices in social groups in terms of meaning and expression, and reflected in perceived risk, strategic decision making and sanctioned or condoned forms of behaviour within certain cultural norms. Consumption patterns and modes of drug use are part of habitus which become unconscious reflexes over time.'

As prevalence data is indicating the establishment of certain youth and social drug use trends over time, this may flag the presence of 'new' habitus formation as Irish society changes, and indeed in the form of insular localised drug using groups. One can surmise the operation of social capital tenets in these drug use settings, in terms of individual learning, group and individual support, feelings of solidarity, catharsis, trust and camaraderie in the acquisition of social agency, status and space. Many of the users did not negotiate drug use as a result of social or peer pressures and commonly reported taking charge of their own substance use in a rather reflexive manner within certain normative relationships and networks. Mayock (2002; 2005) reported similar research findings in Ireland and described the presence of contextual and reinforcing peer influences in drug taking transitions. Research also supports that most abstainers in early adulthood have drug-using friends (Fergusson *et al.*, 2003). This presents a certain level of bounded consumption in terms of both rural youth and cocaine users, in their efforts to remain 'normal' and yet in direct contrast with rural parents and older Travellers in their comprehension of all drugs as equally harmful.

Here follows an excerpt and a quote from *Paper 5* entitled: ***'Differentiated Normalisation and Drug Transitions among Rural Youth in Ireland'***;

'The fundamental aspect of normalisation of adolescent drug use is the presence of a certain level of acceptability of drug use within 'contemporary' youth identity and culture (Duff, 2003a). Most importantly this social phenomenon is characterised by so called 'sensible recreational' drug use, typified by social sanctions and norms for use, certain levels of drug related knowledge and engrained group dynamics, and cost benefit strategic consumerism practices (Cheung and Cheung, 2006). Excessive, frequent and addictive drug use is not condoned within many youth drug using groups and social crowds, with such users openly ostracised (Egginton and Parker, 2002). An outreach worker illustrated the transitions experienced by rural youth in terms of changing rural life with her comment;

"Drug use seems to be part of growing up now..kids are so familiar with it...celebrities and media reports are contributing to this ..those rural kids are trying to fit in..they don't want to be the 'country bumpkins' ..they want to be part of what they think is cool."

The service providers also commented on the brevity of drug taking careers for youth in general and said;

"Many young people experiment with drugs and alcohol and yet only a minority develop a serious issue with drugs, and this appears to be encouraged by a peer using group and a combination of risk factors relating to the individual and their family setting. For rural families experiencing drug use in their communities it's a worry, as they don't know what to look out for or how to deal with this issue."

Conclusion

Social capital is presented in this integrated research chapter as a resource relating to social networks within associational life in contemporary Ireland and illustrates how individual and collective actions relating to risk and drug use can be better understood within the sanctioning of the *'local social world'* of these research cohorts. One must note that individual navigation of the diverse range of aspects relating to social capital and substance use needs to be understood as a complex interplay between the

individual and social structures within the micro and macro system of contemporary discourse. Dominant drug discourses within both expert and lay epidemiology serve to expand the individuals view on such agency (Bailey, 2005). This discourse, as representation of reality plays a central role in the definition of socially, culturally and historically constructed concepts such as '*addiction*', '*dependence*', '*drug problem*' and '*drug use*' (Martin and Stenner, 2004:398). In this way, these concepts shape conduct and attitudes by functioning through communication networks in associational life by local discourses merging with expert discourses within contemporary society and shift movements toward '*normalisation*' of risk behaviours such as drug use (Bailey, 2005:536). This stance has important parallels to both the normalisation debate as formularised by Parker (1998, 2003; 2005) in terms of accepted and controlled drug use and consumerist approaches to social drug use in leisure time, and yet also with social capital and '*lived*' connectiveness, where normative relationships influence risk neutralisation, trust and resource acquisition, and guide the quest for social space and agency within certain locales (Shildrick, 2002; Shildrick and MacDonald, 2008). The integration of both submissive and constructive patterns within continuous self reflexivity serves to create a picture of current societal norms and values. Bearing in mind that social capital can then be viewed from the normative approach in predicting concerted action in drug use, and the competition, acquisition and transferral of resources within social fields, this portfolio aims to combine each approach in yielding a better understanding of individualisation, the negotiation of risk, management of harm and relationships with substance use, and intends to illustrate the inter relatedness between the individuals reflexivity, levels of social structures, normative social capital and governance in describing such risk behaviours and the responsiveness to cultural learning, habituation and identity development. Drawing on the concept of habitus and Bourdieu's work within a wider understanding of social capital and dominant discourse, one can thereby achieve a greater understanding of cultural logics and social practices pertaining to Traveller ethnicity, rural youth subterranean cultures and middle class values and habituation in the continual reproduction, normalisation and naturalisation of action schemas in newly encountered drug scenes. The final chapter shall conclude by discussing the main thematic threads of this research portfolio within the chosen theoretical frameworks and the potential contribution this body of work makes to both research and drug policy.

Chapter 4. Conclusion

Parker *et al.*, (1998) argued that the post modern society has created greater emphasis on consumption amidst globalisation, and restructuring of gender and class relations, with resulting extension of 'youth' lending itself to normalisation of drug use in leisure time (see also Shiner and Newburn, 1999; Duff, 2003a;2003b; McCambridge and Strang, 2004). The normalisation of socially accommodated drug use within the recreational context in this collection of Irish works stems from structural changes in the micro risk environment, and interplays between dominant drug discourses, economic and political influences on development of drug use social settings and groups. In this way, potent factors surrounding housing, neighbourhood disorganisation, families, schools and communities affect the filtering of drug use, drug consumptive patterns and community norms within rural Ireland; the Traveller communities and inner city Dublin. The social capital framework thereby provides an insight into the structural nature of normative drug use within the lay discourses of associational life in Ireland, amidst the presence of informal social controls relating drug choices, consumptive practices and so called acceptable use. This portfolio of work seeks to contribute to the field of drugs research in terms of creating greater comprehension and indeed recognition of social and cultural capital aspects of drug taking within the modern day risk environment, with specific focus on the normative structure of micro systems of societal connectivity. Hereby, the concept of social capital in providing a greater comprehension of drug use within contemporary society, can suggest that; *'the notion of social capital as a natural by-product of a self-regulating economy and its institutions needs to be reconsidered in the context of local configurations of capital and social relations as well as their cultural and normative context'* (Pilkington and Sharifullina, 2009:252). These sub cultures are deemed heterogeneous, with theories of social and cultural capital offering an insight into individual choices, attempts to achieve recognition, discourses and reflexes in the possession of prestigious cultural capital and counter acting shifting societal values. The research portfolio identifies several significant social capital tenets concerning the community, family, school and peer contextualisations as proving useful to discussing the normalisation theory of youth drug use within contemporary Irish associational life. Each of these social capital constructs represents potential forms of social control, acquisition of social agency and legitimatisation of certain drug consumptive

behaviours. Contemporary familial relationships have changed in Ireland, with growth in dual parent employment patterns, and non parental child care, with the research base pointing to a restricted grounding in quality and depth of family relations, and school bonding in association with drug use initiation and thereby contributing to a movement away from the consideration of family and social deprivation based structures (Friedman *et al.*, 2000, Wright *et al.*, 2001; McKegney, 2003; Crome *et al.*, 2004).

Furlong and Cartmel (1997:109) observe; *'The paradox of late modernity is that although the collective foundations of social life have become more obscure, they continue to provide powerful frameworks which constrain young people's experiences and life chances'*. Young people in their negotiation of Irish associational life are increasingly faced with new emerging drug scenes and drug consumptive decisions. Measham and Shiner (2009: 502) in their critique of the normalisation theory *'agree that normalisation is best understood as a contingent process negotiated by distinct social groups operating in bounded situations'*. MacDonald and Marsh (2001:383) underscore the need for greater understanding of the youth drug trajectories as bounded *'by the surrounding opportunity structure'* within local associational life. Shildrick (2006) also observes the influences of neighbourhood structural factors in stimulating youth transitions and identities. Within a localised viewpoint, research by Wikstrom (2002:7) describes such *'perceptions of alternatives and the process of choice'*. Shiner and Newburn (1996:24) argue that key factors in responses to risk and risk taking behaviours, constitute routine and familiarity and quoted *'it is the automatically at hand knowledge about the world that offers them rough but sufficient rule of thumb for typical behaviour in typical situations.'* One questions whether this can be applied to the rural youth or indeed the Travellers with potent familial networks and anti drug norms. Thereby, the potential development of drug cultures within each research settings contribute to the differentiated normalisation theory advocated by Shildrick in 2002. Attempts to understand drug consumption from a cathartic, hedonistic or group connective perspective using social capital theory has much to offer in terms of comprehending the effect of leisure boredom, frustration and other situational factors leading to the use of drugs in young people, recreational cocaine use by otherwise law abiding individuals and indeed ethnic minorities such as Irish Travellers encountering assimilatory stresses. Drug taking may offer the individual a

certain level of self actualisation, a development of autonomy and control within the wider discourse of maturation or crossing of cultural, social, exclusionary and urban-rural dichotomies. One must attempt to understand individual cost-benefit negotiation processes in the consumption of drug decision making as then situated within the social micro environment and indeed the particular locality. Such observations can be integrated within the model of habitus, in terms of predicting behaviours and risk related responses in terms of modern societal change (Bourdieu, 1990). Rhodes (1997a; 1997b) underscored the need for understanding habituation in the understanding of risk perception and drug use, with social norms varying in terms of the hierarchy of risk. Indeed, Fast *et al.*, (2009) underscore the presence of personal and structural settings in dictating youth risk taking behaviours and indeed the avoidance of risk itself. The concept of hierarchical risk is interesting when one considers the older Travellers and to a lesser extent rural parents' labelling of all drugs as equally harmful, in contrast to the youth acceptance of recreational cannabis use and cocaine use within insular middle class circles. There is a paradox contained within these clusters of habitual drug users over time, as drug use can also present a risk of withdrawal and isolation from the broader societal framework as drug use becomes more ingrained and possibly more destructive. Thereby, this research seeks to place the individualisation of risk decision making surrounding drug use, within a greater contextualisation of the individuals' social agency, status and power resources. The crossing of boundaries in terms of social actions and agency, routine or considered alternatives, can then be readily applied to the world of drug taking, and indeed within the social capital conceptualisation.

Social capital offers us some explanation of reflexivity within localised social networks and '*sites of mutual extraction*' within normative processes of social cohesion impacting on group and individual drug use (Pilkington and Sharifullina, 2009:259). The concept of social networks within a broader framework of social capital are central to the individual's negotiation of drug risk taking behaviours (Maycock and Howat, 2007; Shildrick and MacDonald, 2008; Pilkington and Sharifullina, 2009). Such networks and groups are culturally and locally constructed and contain elements of trust and mistrust, cooperation and conflict, support and dishonesty. The individual and the group opinions of drug use and the structured and unstructured settings, in which such drug use occurs, are then indicated as key variables in the organisation of drug use

practices and cultures (Rhodes, 2002). Shared feelings, experiences and senses of belonging common within such groups of drug users may change, particularly in this case of rural youth negotiating urban associational life in the ever decreasing presence of a rural–urban dichotomy in modern Ireland; the filtering of social cocaine use within Irish night life, and in Travellers existing on the periphery of sedentarist discourse. Social integration, connections and relationships within the micro level of social capital thereby have much potential in the mediation, management and facilitation of drug use (Lovell, 2002; Boeck *et al.*, 2006; Pilkington, 2007a; Pilkington, 2007b). It is also inherently difficult to distinguish such particular values within the conceptualisation of social capital in the course of drug risk taking. Therefore, one must attempt to understand not only the presence of such inter related networks of individuals, but the values, norms and nature of these groups within a certain social and cultural embeddedness.

Measham and Shiner in 2009:502 reflected on normalization of youth drug use in how *'the original thesis underplayed the role of structural influences in favour of a rational action model of adolescent drug use'* and proposed a greater inclusion and recognition of the situated choice and structured roles played by agency and social structures. In terms of understanding why and how individuals navigate their social worlds, it appears that culture, resources and relationships and context assume a central position (France, 2000). Friedman *et al.*, (2007) advise the interpretation of the social capital networks as better served within a *'dialectic'* collective action of negotiations, norms and perceived social safety between inter related networks of individuals, friends, families and community members (see also Sampson *et al.*, 1997) operating within contemporary society , and that the reciprocal basis of trust and mutual obligations may not actually lower drug related risk taking in itself, and may therefore be limited to its expression in the form of an *'invention'* or institutionalisation of norms. Indeed, Furstenburg and Hughes (1995) described levels of social capital as the degree to which families, parents and children are embedded within a close unitary bond of perceived social protection, trust, mutual obligations and loyalty, and inherently stimulating the internalisation and growth of positive school bonding, legitimate conventional behaviours and positive social development (see also McNeal, 1999; Wright *et al.*, 2001). However, it remains that neighbourhood norms however and which way they develop, have a central place in the occurrence of the drug

normalisation debate. The understanding of neighbourhood level norms remains clouded and underpinned by social processes, the dissemination and exchange of information, social control, sanctioning (Musick *et al.* 2008) and defined by collective efficacy as *'linkage of cohesion and mutual trust with shared expectations for intervening in support of neighborhood social control'* (Sampson and Raudenbush, 1999:612). Most studies have focused on the proximal inter social structures such as friends, peer groups and social networks, perceptions, attitudes surrounding friends substance use or indeed the demographic aspects of neighbourhoods in predicting youth drug risk taking (Lindström, 2003;2004;2005; Kim *et al.*, 2006; Winstanley *et al.*, 2008). Indeed, young people may misperceive substance prevalence in their locality and indeed local norms for use, or simply engage in substance use as normative phenomenon of *'growing up'* (Ennett *et al.*, 1997). Schroeder *et al.*, (2001) comment on the greater interplay of social influence provided by individual relations within the micro environmental analysis rather than the greater macro environment. In this way, although drug using patterns may prevail in a certain neighbourhood (or even a certain ethnic group as was the case for Travellers) social capital in the form of normative group behaviours and social control may curtail the effect of dangerous consumptive practices and thereby underpin Parkers normalisation theory, and indeed *'differentiated normalisation'* within certain localised settings (see Shildrick, 2002).

Lupton and Tulloch (2002:115) describe a hierarchy of power dynamics in social capital whereby certain groups control *'social space and culture'*, and therefore mediate and influence risk taking behaviours such as drug use, and within this premise, drug use becomes a method of achieving social *'kudos'* and acceptance within groups. This may be very much the case relating to both rural adolescents attempting to *'fit in'* with urban peer groups, and also Traveller youth assimilation, and Traveller drug dealing within such habituations. Networks of friends, peers and families act as social capital resources in the facilitation of drug taking decisions, the sense of safety, belonging and inclusion within drug using subcultures (Morrow, 2001; Mayock, 2005) and development of drug taking identities (MacDonald and Marsh, 2001; Maycock and Howat, 2007; Fast *et al.*, 2009). The potential exclusionary effect cannot be discounted for some groups, in this case the Travellers, who would experience dual levels of social isolation as Travellers and as addicts. One would question whether the Irish Traveller ethnic identity shall remain salient over time, particularly in the course of

Traveller youth negotiation of the 'settled' community, its shifting cultural capital, resources, changing networks and low life expectancy of older Travellers. This contrasts with the rural youth, so typical of contemporary youth consumptive risk navigation, with greater potential for belonging to a diverse set of networks whether, drug using, rural or urban, and greater reflexive optimism for controlling risk and difficult situations. One must therefore realise that drug behaviours however normative can operate as an inherent part of the life course, and mediate the acquisition of social capital, agency and status. The uncertainty and reflexivity of the drug using or abstaining culture, within personal, individual and group dialogues, and responses to environmental, cultural and societal structures must be recognised in the negotiation of social capital resources and collective actions.

Indeed, social capital is dichotomised between positive and negative outcomes in the contemporary literature with recognition that strong social capital bonding is central to negative social behaviours such as organised crime, racist groups and sectarianism. Building on the positive-negative dichotomy of drug use (see Cheung and Cheung, 2003), Maycock and Howat (2007) underscore the need to view social capital as representing something positive for the group involved; in terms of entry into deviant sub cultures; the loss of deviant connotations over time, and methods of ensuring covertness of drug activity within the group. Social capital as non discriminatory construct facilitating the initiation, operation and maintenance of each sub cultural drug group, whether socially identified as negative or positive as per the inner or outer boundaries of social structures is centralised in a sense of belonging and trust (Maycock and Howat, 2007; Pilkington and Sharifullina, 2009; Fitzgerald, 2009). Thereby, the connotations of social capital dichotomised to represent either positive or negative health outcome may not be useful in the contemporary risk infused societies. Indeed, Parkers normalisation theory described young drug users in Britain as functioning within the mainstream culture and being "*well-adjusted and successful goal-oriented, non-risk taking young persons who see drug taking as part of their repertoire of life*" (Parker, 1997: 25). This statement is interesting when one ponders the influx of cocaine into Irish social life, once driven by alcohol, and conversely the existence of Travellers within sedentarist Irish society and certainly not operating within the mainstream dominant culture. Traveller drug use appeared rather central to coping with life, and not readily applicable to the normalisation theory as the vast majority

were unemployed, illiterate, experiencing great poverty, financial and domestic troubles and life crisis, and so their drug use could not represent the so called leisure time consumptive activity. The recreational practices of normalised use of drugs as typified by "*the occasional use of certain substances in certain settings and in a controlled way*" (Parker, 2005:206) was considered within an exploration of social situatedness in drug activity contextualisations for the research cohorts involved. This view is corroborated by Duff (2005:162) who described such consumption as "*perceived and sometimes tolerated as an embedded social practice*". In terms of the tenets of the normalisation theory, according to Moore and Miles (2004), it is important to recognise the potential homogenisation of this approach, in some ways '*tarring all with the same brush*'. This builds on the '*differentiated normalisation*' theory (Shildrick, 2002) and underscores the need to understand normalisation as providing some insight to Irish drug use for these cohorts within a bounded sense of sub cultural system (see also Aldridge, 2008). Interestingly, this potential homogenisation theme reoccurred often in the Traveller narrative analysis, and most often in terms of negative stereotyping and prejudice. Perhaps we must not forget the original definition and use of the normalisation definition, and instead utilise it to draw parallels within a bounded sense of operating within contemporary social structures.

One must underscore the theme of '*non problematic drug use*' in this portfolio of work. The researcher recognises the potential for problematic use, and loss of control among those particularly at risk (i.e. the Travellers) or indeed in the case of excessive cocaine consumption, but essentially calls for a greater understanding of the methods of how this bounded sense of drug use has emerged both in terms of initiation decision-making, entrenchment within drug using sub cultures and pro active methods of adjusting and curtailing use. Research by Shiner and Newburn (1997) and Shildrick (2002) observe that contemporary users do not identify themselves as the typical '*junk*' with a compromised sense of life course navigation and irresponsibility. This phenomenon is central in the drug choices made in this body of work, and very much dependent on availability, perceived prevalence of use within immediate and wider social circles, socially accommodated use and the desensitisation of potential harm by reinforcing infrequent or opportunistic use, and thereby did not signify a loss of control or potential addiction, all of which infer some conformation of Parkers normalisation theory. According to Parker (2005), drug use stigma is minimal in the case of the

social drug user, but obvious social sanctions occur in situations of loss of self control, the inability to contain drug use within leisure time, or in order to protect relationships, educational and employment status. This is especially applicable to the social cocaine users and youth drug users not willing to appear '*out of control*' and is indicative of Coleman's description of '*closure*' as intricate social links guaranteeing uniformity in terms of drug use social regulations (Coleman, 1990). In terms of potential escalation of recreational drug use leading to problematic use, one must be aware of individual risk and resilience factors, varied drug trajectories and '*slippage*' from social to dependent or problematic drug use (Parker *et al.*, 1998; Egginton and Parker, 2002;). However, the very definition of drug risk as '*problematic*' behaviour versus '*problem*' behaviour creates difficulty in terms of responsive social policy and governance for drug use, and is very much under the influence of broader social change (Sharland, 2006) and indeed contemporary drug discourse (Bailey, 2005). Issues in distinguishing such definitions of drug use are linked to shifting orthodoxies, roles and identities within the concept of micro and macro social capital in modern society (Martin and Stenner, 2004; Sharland, 2006). The concept of alcohol as underlying foundation to this normalisation concept must be addressed, and used to target emerging drug trends within certain clusters of drug users, and minimise potential for '*slippage*' toward problematic drug use. One may speculate that excessive drinking among youth typifies the world we live, characterised by fast pace, social strain and stress (Eisenbach Stangl and Thom, 2009). Such alcohol use is not only of serious public health concern but also has an impending effect on potential drug experimentation and further incorporation into poly substance using repertoires (Parker, 2003). This may be particularly the case in terms of cocaine use and its potential for dependency, certain vulnerable youth and the Irish Travellers, who experience of many of the psycho-social risk factors identified as contributing to problematic substance use.

In conclusion, social capital was used to situate drug activity within localised Irish associational life in terms of the centrality of two functions; the function of uniformity and control within a normative network of individuals, and the function of a potential resource lending itself to reciprocal obligations and loyalties (Coleman, 1990:110). Kawachi *et al.*, (1997:1491) describe how the '*resource social capital*' in terms of group dynamics, social networks and relationships between individuals, and the '*normative social capital*' represent key values, norms and collective actions which provide a

dimensional analysis of social capital. Bourdieu (1986) however, places greater emphasis on the capacity of social capital to yield resources, power and influence to certain individuals and groups at the cost of others. Interestingly this lends itself to a certain generalisation of group normative behaviour within some situations, and not in others, and yet also presents opportunities to claim social space and status, as is the case with drug dealing. Most importantly and illustrating the development of drug using sub cultures, Veenstra (2000) illustrated how individuals within certain networks interrelate according to common normative rules, sanctions and incentives, which coordinate their actions and ensure consistence. This body of work emphasises social capital as a situational resource relating to open and closed group drug networks whether rural youth, cocaine user or Irish Travellers, and how such collective actions can be understood within the '*local social world*' of these groups of individuals and their drug consumptive practices. Such peer group social capital realises both pro and anti substance use norms and behaviours dependent on uniform sanctions of the '*local social world*', and the varying experiences of group members relating to drug activity within a broader cultural framework of transactional and collective understanding. One must be aware of the potential separation between structural social capital in terms of '*closure*' and in its capacity to create links between groups, resources and networks (see Boeck *et al.*, 2006). Bonding social capital is typified by inward looking and restricted networks such as family and friends, where normative frameworks for risk behaviours such as drug use or drug dealing exist and may present some restriction in terms of choice, power and opportunity. This can operate in both ways, either stimulating drug activity and associational settings within the group context or also by reducing any freedom or choice to operate otherwise, as is the case in '*habitus*' (Bourdieu, 1990). Dynamic social capital represents a broader contextualisation of effect, characterised by community support, relationships and choice, in the transitions to '*bridging social capital*' as dictated by dominant drug discourse (Boeck *et al.*, 2006).

Thereby, social capital as '*heuristic device*' (Halpern, 2005) can provide some understanding not only as potential risk resilience mechanism, but also as to how individuals negotiate risk decisions within certain social structures and settings. The individual perception of self is fundamental in understanding access to networks, groups and structural opportunities for change, most especially within groups traditionally excluded and attempting inclusion, and thus experiencing limited choice

and levels of reflexivity in life course navigation. This research underscores the need to utilise social capital as a resource within a dynamic and multifaceted social framework which acts to influence drug pathways and trajectories within the contemporary life course. Thereby, the question of conforming law abiding individuals under influence of dominant cultural changes relating to the accommodation of licit and illicit drug use was explored within both the wider social capital analyses but also within the context of collective action in the '*local social world*' in modern Ireland. Indeed, the contemporary changes in identified risk factors for problematic drug use relating to Irish family set up, marginalisation, parental substance use, poverty and low formal education bond, coupled with that of increased drug exposure in leisure time, can potentially result in greater numbers of youth experiencing drug problems.

Erickson and Hathaway (2010) call for greater research efforts disentangling the normalisation theoretical threshold in terms of substance choices, risk perceptions, harms and social situatedness of drug trajectories across a broad spectrum of cultures, populations and life courses in contemporary society. Ettore (2004) underscores the need for greater understanding of the cultural shaping of drug consumption within every day life, within a sense of distinct, bounded social space dictated by gender, ethnicity and class inequalities. One cannot discount that it is the immediate environment which stimulates the initiation and progression of drug taking trajectories (Kendler *et al.*, 2003). The emergence of drug use within Traveller communities, rural communities, and increased social accommodation of cocaine use, contributes to the dissipation of traditional anti drug norms and values whereby traditional '*grids*' bow to the social influences of changing times. Thereby, the very understanding of the '*risk*' environment is fundamental to reducing and controlling the diffusion of drug related harm (Rhodes *et al.*, 1999a; Rhodes *et al.*, 1999b; Rhodes *et al.*, 2005; Fitzgerald in 2009, Erickson and Hathaway, 2010). Indeed, according to Miller (2005), the neutralisation of risk, once traditionally described as deviant risk, has now emerged as element of discourse, in how institutional and governments strive to manage and control risk behaviours in their societies. Measham and Shiner (2009) on their commentary on the normalisation theory state that risk behaviour and choice cannot be solely targeted by informative methods of harm reduction, and attention must focus on certain social and cultural embeddedness. This represents a movement away from the potential sensationalist and homogenisation of social normalcy of drug use, and raises

questions for the successful utilisation of harm reduction interventions, with non problematic drug use still carrying with it a potential for risk and harm, however common the '*maturing out*' of drug use is (Hammersley, 2005, Aldridge, 2008; Pederson, 2009, Van Hout and Ryan, 2010 forthcoming). Therefore, risk prevention interventions must identify and consider all elements of the dynamic risk environment and contingencies for dealing with eventualities existing within such systems, amidst regular critical appraisal of '*lay epidemiology*' developing over time. This signifies the importance of developing an understanding of the complex and interrelated reasons behind drug use within each '*local*' risk environment in the realisation and admission that individual risk neutralisation tactics exist to justify certain behaviours such as drug use (Miller, 2005).

One cannot underestimate the importance of the lay '*voices*' in the exploration of the concept of risk and drug use, and the power relations in decision making and drug use, in terms of social environments, peer crowds and cliques, the balance of being '*in*' or being '*different*' and consequences relating to risk taking behaviours. Targeted and successful drug prevention must be increasingly driven by the science of risk and vulnerability within the complex and competitive social environment of changing social encounters with drugs (Jones, 2004). Research acknowledges that drug use has a '*localised*' flavour and can take place within distinct and normative social contexts which sanction excessive consumption, messy or uncontrolled drug use (Gourley, 2004; O'Malley and Valverde, 2004; Slavin, 2004; Fast *et al.*, 2009; Bahora *et al.*, 2009). Bantchevska *et al.*, (2008) underscore the need for greater ecological understanding of the social and structural environment, with great potential for changing risk behaviours through structural interventions, and indeed the manipulation of bonding and bridging social capital indicators grounded in trust, relationships with friends, peers, siblings and families, community integration and civic engagement. Imbalances between bonding, bridging and linking capital can further isolate some social groups, and contribute to reinforced disempowerment and marginalisation, and thereby incur a potential for problematic substance use. In this way, more effective strategies can be devised to avoid '*victim blaming*' and provide an inclusive and community based approach (Thom and Bayley, 2007). In terms of the research cohorts within this portfolio, one could suggest that interventions and drug policies which create community bonding, whether between urban and rural populations, the

Irish Travellers and the 'settled'; and to a lesser degree relating to cocaine use, can strive to achieve certain levels of population health improvement, whether by reducing drug exposure, or increasing drug education, brief interventions, family and community support. As social capital within the neighbourhood context develops very slowly over time, one could advocate a multilevel approach to drug prevention, whereby combined community, family and individual interventions attempt to address the myriad of identified risk factors for problematic drug use in communities (Boyce *et al.*, 2008). In this way, the findings on social capital in this portfolio of published work are relevant to drug policies and interventions whereby the role of civic participation and empowerment in schools and communities, parental roles and development of reciprocal level of trust may serve to moderate group norms for substance taking behaviour. According to Brown and Scullion (2009:4) '*exposing issues such as power, difference, gender, and status is an inextricable part of research and should guide all research endeavours.*' Thereby, the reflexive post modern society needs to engage in open ended, critical debate and the examination of perception of risk, the social construction and management of risk taking behaviours within a wider social framework.

'There is not, and there can never be, a risk-free environment, an idea which is widely understood by the lay public.'

(Frankel *et al.*, 1991 in Bunton *et al.*, 1995:85)

Paper 1. Van Hout, M.C (2009). Drug use among rural Irish adolescents- a Brief Exploratory Study. *Drug and Alcohol Today*, Volume 9, Issue 1, 20-26.

Abstract

Semi structured interviews were undertaken with a random sample of 220 students from schools and youth training centres within a rural area of the South Eastern region of Ireland. The results show that against the backdrop of rising drug use prevalence, the attitudes towards drug use of both adolescent users and abstainer have become more liberal and '*normalised*'.

Key Words

Adolescents, Rural Youth, Drug use, patterns and perceptions of risk.

Background to Research

In Ireland there is increasing concern over the public health implication of the substantial social transformation in relation to the normalisation of adolescent drug use in recent years (NACD, 2007a). Irish adolescents report the highest incidence of 'binge drinking',³ and an increasing prevalence of lifetime use of any illicit drug (NACD, 2007b). Recreational substance use is also becoming increasingly accommodated into the social lives of young people indicating a controlled and sanctioned ability to use drugs and continue to attend school, employment and college (Headley, 2006). While Irish drug policy has gradually progressed toward a broader and more differentiated focus of drugs and their use, the challenge facing such policy makers is in keeping up with young people's increasingly varied knowledge of drug related issues and drug taking practices (Kilpatrick, 2000). Irish youth drug use which originated in marginalized or sub deviant groups has now emerged as a social situation where drugs appear to be increasingly accessible and more widely used (Mayock, 2002).

The social context and setting of adolescent drug use is pivotal for the development of drug cultures and practices. This setting for drug use describes individual and group subjective interpretations of use, similarities of drug related knowledge, pro drug using attitudes and the settings in which drug use occurs (Hussong, 2000). Young people's knowledge of drug use is acquired largely through personal experience and routine social interaction with pro-drug using peers (McAllister and Makkai, 2003; Graves *et al.*, 2005). This socially distributed information plays an influential role in their decisions regarding drug experimentation and practice, as does the perceived health and legal risks involved in experimenting with illicit substances (Stormshak, *et al.*, 2004). Other research has illustrated the evolution of norms and patterns of use, with regard to quantity and drug type (Measham *et al.*, 2001). Drugs are ranked according to perceived risk (Anthony and Petronis, 1995), and risk taking behaviour is determined by lifestyle and family characteristics, supportive peer groups, drug availability and community norms. According to the National Advisory Committee on Drugs in Ireland there is a clear need for research into the experimental and recreational drug use

³ There is no standard definition of binge drinking, but the British Medical Association suggests that "in common usage, binge drinking is now usually used to refer to heavy drinking over an evening or similar time span - sometimes also referred to as heavy episodic drinking. Binge drinking is often associated with drinking with the intention of becoming intoxicated and, sometimes, with drinking in large groups."

common among adolescents, and in particular outside of the urban context of Greater Dublin.

Methodology

Semi structured interviews were undertaken with a random sample of 15 – 17 year olds (***n=220***) attending schools and youth training centres within a rural area in the South Eastern region of Ireland. The school type included vocational, secondary in disadvantaged area, secondary in non- disadvantaged area, youth training centre and private schools.

Procedures

Parents were given an information leaflet and asked to sign a consent form accepting the content and confidentiality of the research. The interview schema was piloted on a small sample of students in another area. All interviews were coded to ensure confidentiality and participants gave informed consent for audio recording.

Data Analysis

The thematic analysis of the interviews consisted of generating *'a list of key ideas, words, phrases, and verbatim quotes; using ideas to formulate categories and placing ideas and quotes in appropriate categories; and examining the contents of each category for subtopics and selecting the most frequent and most useful illustrations for the various categories'* (Zemke and Kramlinger, 1985). These themes were then collated and transcribed.

Results

The first three months of the research involved spending afternoons with the adolescents selected in a variety of social settings such as after school clubs, in conjunction with the school completion programs, at youth centres and games clubs. The central concern of the researcher was one of gaining access to informants and establishing trust before conducting interviews.

In relation to reported drug use, less than a quarter of the sample reported drug use and a large proportion of these were boys. The majority of those who had never tried a drug consisted of mostly younger individuals in the sample and this was gender balanced. The reasons quoted for *'not'* experimenting with drugs included ***“My friends do it but I couldn't be bothered”;*** ***“It doesn't interest me”;*** ***“Drugs are dangerous- I have seen what drug use can do”;*** ***“I am afraid of getting***

addicted”; **“You can control drink but you can’t control drug use”;** and **“My friend had a bad experience with ecstasy”**. Some did remark that they would be afraid of their parent’s reaction if they were caught. However, in relation to drug availability and ease of access, nearly the entire sample had been offered an illicit drug at some stage, both at school and in their area, and this was most commonly hash or cannabis. Approximately half of the entire sample of both drug users and abstainers had friends currently using illicit drugs. Both users and abstainers commented; **“Sure I see it every day in my estate”;** **“The guards (police) don’t come near my estate, they are afraid”** and; **“You’d see them robbing out of shops and mugging old people, to pay for drugs”**. This visibility of drug related activity appeared to occur more commonly in more urban areas but was increasingly noticed by rural adolescents in their towns.

In relation to purchasing illicit drugs, a minority of adolescents **“clubbed together”** in order to purchase larger amounts and the remainder were most commonly given it for free by friends or older siblings. In relation to how they accessed their drugs, the adolescents commented; **“It would take one phone call to get what I wanted”;** **“It would take me 20 minutes in school to get some”;** **“The dealer kept ringing me up to ask if I wanted more”;** **“They’d sell it to anyone, they don’t care who you are”** and; **“All you have to do is look for the runner hanging up on the telegraph wire and you know where to go”**. The majority of adolescents felt that the drug problem in their area would escalate in the future. Particularly the younger ones in the sample reported feeling intimidated by youths hanging around on the streets and areas of known drug use (e.g. at local river banks, in parks). In some cases, the presence of needles on the ground was reported. Others noticed burnt lumps of hash at school, speed and cocaine in the toilets at nightclubs and the look of drug using individuals at night.

For those reporting illicit drug use, the average age for *first time drug use* was about 13 years, and less than half of illicit drug users began using drugs between the ages of 10 and 15 years. In all cases the drugs were given for free. Drug users reported that *first time drug use* was not a conscious decision and rather that the opportunity presented itself within a peer setting. Nearly all of drug users **first** took them out of curiosity, out of boredom and because their friends were doing it. The settings for first time use was

included; at a house party, in a field, in a lane and in a nightclub. Less than half of drug users reported a negative experience, like ***“I fainted”*** or ***“I had to go home, I was sick – I took 3 ecstasy tablets”***. Interestingly, this did not deter them from wanting to try again, as they felt supported by their friends and were confident that the following occasion for drug use would be more pleasurable. Cannabis was almost always the first illicit drug used, accompanied by alcohol in three quarters of all cases and by cigarette smoking in half. Other illicit drugs mentioned included ecstasy and amphetamine.

Over half of the illicit drug using sample reported subsequent drug use with a time lapse of several weeks; the remainder reported no further drug experimentation. Their reasons for *not* pursuing further drug use included; ***“Couldn’t be bothered”***; ***“My parents will kill me”***; ***“I didn’t like it”***; ***“The opportunity didn’t happen again and I didn’t have any friends who had some”*** and ***“I prefer to drink alcohol, I get a better buzz”***. Subsequent illicit drug use was not planned and occurred in a sporadic and spontaneous fashion. Similar to first time drug use, almost all of those reporting continued drug use did not buy their own drugs and on these subsequent occasions were given it by friends or siblings. The most common illicit drug of choice for adolescents was cannabis which was perceived as a ***“safe drug”***. The adolescents indicated a fear of the more serious forms of illicit drugs such as cocaine, speed and heroin, and were aware of the local group of heroin users in their area. They were afraid by the appearance of these individuals. They commented that subsequent illicit drug use occurred in a controlled fashion and resulted in a better experience. This appeared to be due to increased drug knowledge and support provided by the peer group. The adolescents were unsure as to whether they chose their friends based on pro drug using attitudes and behaviours or whether their friends were drug using anyway. About half of the drug using sample reported drinking alcohol in combination with drugs during occasions of subsequent drug use. The main reasons for subsequent drug use included; ***“Nothing else to do”***; ***“Sure there’s nothing wrong with hash”***;***“Everyone’s doing it”***; ***“It’s a buzz”***; ***“Sure all my friends are doing it”***; ***“I relax”***; and ***“It helps me chill out, when my parents get on to me”***. In terms of their drug using experiences, the drug users commented that the drug experience improved with practice and they appeared to ***“self medicate”*** with regard to drug types and poly drug using, based on information provided by the peer group. Half of the

sample reporting illicit drug use had taken more than one substance within an 8 hour period, with the most popular response combination being alcohol and cannabis.

In terms of the negative or less pleasurable effects of drug use, drug users commented on their perceived negative sides to drug use and quoted as follows; **“Fear of addiction”**; **“I won’t let myself get that far”**; **“I felt sick and fainted”** and; **“I had to go to hospital”**. Some of the adolescents commented that they didn’t want **“to look like a junkie”** and exercised informal controls on their drug and alcohol consumption, so as not to appear **“out of control”**. The majority of illicit drug users did not regret their decision to experiment and saw themselves as drug using in five years time. Some of the older members of the sample reported a **“maturing out of”** illicit drug use, with reasons reported including; **“I couldn’t be bothered”**; **“Me head was wrecked on drugs”** and; **“I prefer to drink now”**. This cessation of drug use appeared to occur during their 17th year and in conjunction with the development of other interests, relationships and career goals. Some of those currently abstaining from illicit drug and alcohol use, on the other hand, reported that they might start in the future. Only a small percentage of the total sample was worried about the legal consequences of illicit drug use and commented **“Sure they wont catch me smoking a joint, I’ll just throw it way”**;**“ Sure even if you do get caught, nothing would happen”**; **“Id be more afraid of being caught drinking under age than with a joint”** and; **“I wouldn’t touch any of them dirty drugs”**. The adolescents reported a lack of vigilance in terms of schools and Gardai (Irish Police) in controlling the supply of drugs in their areas, and the majority were not concerned about the potential for arrest.

Discussion of Research Findings

It has been argued that adolescents are most sensitive to changes in the availability and cultural acceptability of drugs (Biederman *et al.*, 2000; Novin and Barron, 2004). Research indicates that while socio-demographic characteristics mediate perceptions of drug prevalence (Parker *et al.*, 1998; Measham, 2002; Stormshak *et al.*, 2004), most adolescents (in the UK at least) experience a high level of exposure to a drug taking peer culture (Hyde, 2000; Wagner *et al.*, 2002), resulting in the normalisation of drug use, increased experimentation, possibly at earlier ages, poly substance use, binge use and the development problematic patterns of use (Measham, 2002). In support of these observations, the majority of adolescents interviewed in this study reported that

illicit drug use in their community had become more visible and most commonly took place outside or in public places. It is possible that neighbourhoods and schools may provide access to substances, provide resources that facilitate the likelihood of use, present community norms for substance use or non use, or have physical or social characteristics that may promote or interfere with substance use (Lambert *et al.*, 2004). Both abstainers and users were aware of drug use in their community and commented on the ease of which to locate illicit drugs if needed. In addition, most had been offered drugs and were aware of drug and alcohol use within their immediate circle of friends. The adolescents in this study also reported that those currently abstaining might use drugs in the future, and this typifies the increasing normalisation of drug use among Irish adolescents. The majority of adolescents felt that the drug problem in their area would escalate in the future and were often intimidated on the street by drug dealing and drug using individuals. This is similar to research by Tobler *et al.*, (2000) who found that adolescents often felt unsafe in their communities due to groups hanging around the shops, 'junkies' or drunks on the street.

Parker *et al.*, (1998, 2002) has argued that experimentation with drugs must be viewed as one of the developmental tasks of early adolescence. This leads one to question is drug use during adolescence just part of normal growing up? Experimentation and a dynamic pattern of use/cessation have been found to be much more common than excessive or problematic use in adolescents (Comeau, 2001). It appears that many adolescents experiment with drugs and yet only a small percentage (through individual combinations of individual risk and protective factors) actually develop a problematic disorder or even progress towards more serious forms of drug use. The adolescents in this research reported controlling the levels of their drug use in order not to lose control or appear addicted. This shows a certain social acceptability of 'moderated' drug use among young people, as previously indicated by Mayock in 2002. The most common combinations of substances reported in the interviews were alcohol and cannabis and alcohol and speed. It is most notable that adolescents tend to use a variety of drugs rather than one or two preferred drugs during the course of their maturation and that this occurs most commonly in relation to the availability of substances (Esteban, *et al.*, 2006). In terms of other drugs used, there appeared to be little awareness of substances such as mushrooms, ketamine, poppers and LSD. Some of the adolescents interviewed reported previous regular solvent abuse as children, such as

sniffing petrol, glue, permanent markers and aerosols and also the sporadic use of parental prescription drugs such as sleeping tablets and valium, with the age of initiation for this averaging at 10 years. Some studies suggest that the risk for progression from alcohol, cannabis, and/or inhalants to other illicit drugs (e.g., cocaine, heroin) increases over the first four and a half years after initiating substance use, and then diminishes in subsequent years (Novins and Baron, 2004; Headley, 2006). However, when compared to adolescents who initiate substance use with alcohol only, adolescents who initiate substance use with cannabis or inhalants are more likely to progress to use other illicit drugs (Dornbusch *et al.*, 1999). Examination of the relations between the different substances suggests that alcohol use precedes the use of cannabis, and cannabis precedes the use of other illicit and more serious substances (Kaplow *et al.*, 2001). In addition, volatile solvent use has been suggested as a gateway phenomenon among younger adolescents, as research has shown that children who abuse solvents are more likely later to proceed to other illicit drugs (Hawkins *et al.*, 2002). Research also suggests that adolescents tend to use a variety of drugs whether in combination or otherwise rather than one or two preferred drugs during the course of their maturation and that this is very dependent on the accessibility of substances in their area (Novins and Baron, 2004). This appeared to be the case, with drug used reported to be opportunistic in terms of drug used and reliant on availability.

Less than a quarter of the sample of adolescents interviewed reported drug use and a large proportion of these were boys. An analysis of demographic risk factors suggests that age and gender can predict the development and course of substance abuse patterns in youth (Brooks *et al.*, 2006). Research also suggests an association between gender and perceptions of drug related harm, with girls tending to perceive drug use as far riskier than their male counterparts (Engels and Ter Bogt, 2001). Research suggests that boys are more likely to engage in early experimentation and more severe substance use (Weinberg, 2001a; Weinberg, 2001b; Hussong, 2002). Adolescents, whose peer group present with pro drug using attitudes and drug using practices, will conform rather than jeopardise their affiliation with that group (Elliott *et al.*, 2005). Peer groups also facilitate the development of certain attitudes about drugs, provide drugs, and provide the social contexts for drug use, and share norms and values relating to the acceptance of such behaviour (Headley, 2006). The

adolescents were unsure as to whether they chose their friends based on pro drug using attitudes and behaviours or whether their friends were drug using anyway. The extent of substance use by adolescents' best friends has been a stronger predictor of adolescents' substance use than have such predictors as the average substance use within their social crowds (Moore, 2002) and substance use by peers who attend adolescents' schools but who were not reported by adolescents as friends (Taffel, 2001). Substance use by best friends and by *clique* members each contributes to the prediction of adolescent substance use (Parker *et al.*, 2001; Esteban *et al.*, 2006; Gilramy, 2000).

Opportunism also had some part to play in levels of drug use for those reporting drug use. It appeared to be quite common that the adolescents would ensure that they **“were in the right place at the right time”** and this appeared to be linked to the fact that they rarely had to purchase the drugs mostly cannabis, and depending on opportunity and availability; amphetamine and ecstasy. This is similar to other research which states that most young people secure their drugs through social networks of friends and acquaintances connected to small time dealers (Measham *et al.*, 2001; Parker *et al.*, 2002). Other adolescents commented that it was often cheaper and easier for the adolescent to purchase cannabis for a night out or after school, than to get served in the public house or liquor store.

The adolescent reporting drug use commented that their friends gave advice and information on safety issues and on the effects of the drugs. According to Parker (2002) and Gourley (2004) initial fears regarding potential dangers from drug taking are challenged and minimised by the reassurances of those engaging in drug use with little negative effect. Such interaction with peer users and ongoing participation in a drug-using subculture was reported to persuade the **“beginner”** that drug use can be safe and enjoyable. The fact that individuals wish to continue interacting with a pro drug using peer group is often a major influencing factor in users' perceptions and opinions of drug use, and has a peripheral effect on their current or future drug related behaviours (Esteban *et al.*, 2006). It is through the course of this social experience in drug-using groups that users acquire *the* norms, values and shared understandings surrounding drug use practices, patterns of use and perceptions of their friends drug use (Parker *et al.*, 2001; Parker, 2003). This may relate to how drugs are used,

different combinations, settings and sanctions for use. Informants moderated their drug intake so as not to appear “*out of control*” or before “*school exams*,” in addition to restricting use to particular settings where drug using friends were present. Other research has illustrated the presence of rules regarding bounded consumption in youth drug use (Measham *et al.*, 1994; Measham, 2002). The adolescents interviewed were selective as to who they would use drugs with, what combinations of substances they would take and in what type of social setting. Other research has noted the rejection of certain drugs, despite the presence of opportunities for use (Brooks *et al.*, 2006). The ‘*practice of selective drug avoidance*’ has been reported on previous research on youth drug use, and typically involves using some drugs and rejecting others (Mayock, 2002). Young people may avoid certain or all illicit substances according to their perceptions of harm, while others seek to reduce potential drug related harm by regulating their drug intake (Stormshak *et al.*, 2004). Informants confirmed findings of previous research (Mayock, 2002), that drugs have ‘*a pecking order*’ of perceived risk, with drugs such as heroin (“*the dirty drug*”) as the top end of the scale and cannabis at the other. Sensible, occasional, and recreational drug users, particularly users of cannabis, appear to be accepted rather than ostracised by those abstaining (Elliott *et al.*, 2005). Adolescents in this research appeared unconcerned with regard to their peers drug use and most particularly cannabis use. This is similar to research by Zapert *et al.*, in 2002 who reported that cannabis use is increasingly perceived to be a ‘*safer drug of choice*’. However, whilst cannabis has already met the normalisation criteria of availability, trying and use rates and cultural accommodation in Ireland and other European countries, it may take some time before other drugs are viewed in a similar manner (Elliott *et al.*, 2005). This has important repercussions for youth drug prevention tactics.

The dynamics of substance use and its progression toward problematic use or addictive disorder is influenced by the individual circumstances, personality, and drug related knowledge and attitude of the young person (Weinberg, 2001a; Weinberg, 2001b; Hawkins *et al.*, 2002; Graves *et al.*, 2005). Mayock (2002) has also reported that young people often indicate significant modification or control of their drug intake in terms of drugs used and drug taking habits during the mid- to late teenage years suggesting a ‘*maturing out of regular drug use*’. Some of those reporting previous drug use stated that they did not pursue further drug experimentation, and attributed this to

relationships, sports and career goals. In contrast, the current drug users interviewed did not appear to have any fear or concern of future mental or physical health risks, and were only afraid of “**appearing**” drug addicted. This is similar to previous studies which have also identified norms of drug using conduct and social sanctions that define moderate and acceptable use, condemn compulsive use, limit use to settings conducive to the drug experience and routinise or control use (Esteban *et al.*, 2006). There also appeared to be a certain lack of fear among all adolescents surrounding legal consequences for possession of drugs due to the lack of policing in schools and in their neighbourhoods. In terms of future drug taking decisions, the majority of current drug users saw themselves as drug using in five years time. This future drug using information has important implications in terms of targeted drug education interventions for *both* drug users, and those at risk of commencing drug use careers. This transient drug taking behaviour and attitude toward drug use appears to occur as a result of ever increasing social accommodation and normalization of drug use within adolescent culture.

Paper 2. Van Hout, M.C (2009). An exploratory study of substance use among Irish Youth- A Service Providers perspective? *Journal of Ethnicity in Substance Abuse*. Volume 8, Issue 1, 99-111.

Abstract

This research aimed to provide a qualitative perception of Irish youth substance use according to youth and drugs service providers in Waterford, Ireland. Semi structured interviews were conducted with a self selecting sample of community, law enforcement and drug services (*n=42*). The research provided detailed knowledge about levels of youth substance use involvement and gaps in regional service provision. The results suggest that adolescents' attitudes and substance using practices have become more liberal and indeed more '*normalised*', and that drug services may be aiming at a '*transient target*' of drug and alcohol taking patterns within the rural context. Successful and proactive programs of service delivery must therefore incorporate the complexity of adolescent regional culture, perceptions of risk and maturational processes.

Key Words

Adolescent Drug and Alcohol use, Service Providers, Prevention

Background to Research

The prevalence and patterns of drug and alcohol usage has experienced a dramatic change during the past decade in Ireland, and has become increasingly varied in relation to age, location, drugs of choice, drug use practices, drug availability, accessibility and price (Moran *et al.*, 2001a). National and regional surveys of youthful groupings indicate an increased use of a wide range of illicit substances and suggest that substance use is increasingly a feature of Irish adolescent culture (NACD, 2007a). Irish youth drug use which originated in marginalised or sub deviant groups is now an emerging social situation where drugs appear to be increasingly accessible and more widely used (Mayock, 2002). Young people's knowledge of drug use is acquired largely through personal experience and routine social interaction with pro-drug using peers (McAllister and Makkai, 2003). This socially distributed information plays an influential role in their decisions regarding drug experimentation and practice, as does the perceived health and legal risks involved in experimenting with illicit substances (Stormshak, *et al.*, 2004).

Substance abuse not only has a negative impact on economic and social development but also impacts negatively on the family unit, the health sector, and law enforcement (Parry *et al.*, 2004a). Adolescent substance use may potentially contribute towards compromised health and well-being of the individual. In addition research has highlighted the presence of a relationship between co-occurring adolescent substance use and co-morbid psychiatric disorders, such as conduct and mood disorders (Gilramy, 2000). Adolescent substance use may also contribute towards social problems such as poor academic performance, absenteeism, truancy and early school drop out (Sutherland and Shepherd, 2001). Finally, there are also higher reported prevalence rates for substance use among juvenile offenders (Parry *et al.*, 2004a). In light of these varied and serious implications for public health and social order, while Irish drug policy has gradually progressed toward a broader and more encompassing focus of drugs and their use, the challenge facing current policy makers in Ireland is in designing regional and culturally appropriate interventions in response to varied drug prevalence trends.

Methodology

Research Aim

The aim of this qualitative research was to explore the views, perspectives and concerns of agency workers and service planners who had direct knowledge and/ or experience of substance use and of the youth drug scene in Waterford, Ireland. There was specific focus on uncovering information pertaining to the availability of certain drugs, local youth drug markets, the youth social setting, peer influences, levels of risk perception, drug related knowledge, attitude towards drug and alcohol use, patterns of youth drug and alcohol use and issues regarding service delivery (Mayock, 2002).

Research Design

Semi structured interviews were conducted with a self selecting range of agency workers including drug service providers, an Garda Siochana (Irish Police), youth workers, drug counsellors, probation and welfare officers, juvenile liaison officers, health service executives, treatment services, community drugs initiatives, outreach, child protection, school completion officers, home school liaison, hospital personnel (A and E), regional data coordination, youth organisations, addiction counsellors and other key informants in Waterford, Ireland ($n=42$). The interview schema followed National Advisory Committee on Drugs, Ireland research guidelines and was piloted on a small sample of service providers in another region not partaking in this study. The interviews lasted approximately 30 minutes and were coded to ensure confidentiality. Participants were able to withdraw at any time. Interview transcripts were read at the end of the interview and the interviewee was asked for clarification or elaboration if necessary.

Data Analysis

All interviews were transcribed using thematic analysis which reported on the issues surrounding adolescent substance use and also aimed to identify areas of similar and contrasting opinions relating to this topic (Zemke and Kramlinger, 1985). Not all interviewees discussed the same themes and this was dependent on their type of contact with adolescents. Therefore the typicality of their responses cannot be determined or indeed generalized. In addition, the results are not presented in terms of percentage allocation to type of agency worker in order to avoid identification and ensure anonymity.

Results

The majority of the service providers interviewed responded that substance use for the age group 15 to 17 years was on the increase in the last five years, and that they felt that the numbers of over 18 years accessing drugs and community services was relatively stable. In general, most service providers felt that such increased patterns of drug and alcohol experimentation was due to increased access to a wider variety of substances at all ages, that substances are more socially acceptable (i.e. hash and cannabis), that adolescents today have more disposable income (pocket money, part time employment) and that the prices of substances were reducing (i.e. ecstasy, cocaine). A home school liaison officer commented; ***“The part time job and the increased pocket money due to both parents working.....the compensation of lack of quality time (and lack of supervision) with their kids, causes increased opportunity to engage in drug taking and drinking behaviours”***. Several community drugs workers questioned; ***“Is this increase in adolescent substance use a product of greater information regarding the appropriate services or is this due to greater numbers of young people experimenting, and leading to dependency related issues?”*** From a medical admissions perspective, a Hospital Liaison Officer noted that accident and emergency admissions for young people, both minors and those in early adulthood appeared to be on the increase, in terms of relating to substance overdose and accidents.

According to a community drugs worker, ***“Those young people experiencing pro drug using influences within their estate...this may increase their perception of normalization of drug use and may result or contribute to increased experimentation”***. In relation to more serious substance use and in particular drug use, school completion officers and youth workers remarked that within those communities or families presenting chaotic peer and home life, that adolescent substance use was often a coping mechanism for crisis or indeed a form of sibling modelling for older brothers and sisters experimenting with alcohol and drugs. From a law enforcement perspective, a probation and welfare officer commented; ***“Is this greater availability of drugs due to greater detection and seizures or is this an indicator that illicit drugs are more widely available in every community in Ireland?”*** The majority of service providers and other key informants also observed that such drug and alcohol taking patterns had resulted in increased public order and

possession offences in those areas. The following comment was made by a juvenile liaison officer; ***“In some marginalised areas there may be increased opportunity to participate in delinquent acts, including substance use”***.

According to a juvenile liaison officer, most young people were aware of drug using friends and classmates, and purchased their drugs through social networks of friends and acquaintances connected to small time dealers. This was supported by a comment from a youth worker; ***“young people from all backgrounds know a variety of avenues to get drugs and other substances”***. The community drugs service providers were aware of this and commented; ***“It makes economic sense for the young person to deal in drugs and groups of friends often club together in securing larger amounts at subsequent discounted price”***. Several community drugs workers did question the purity of drugs available now, as compared to five years ago in Ireland. One addiction counsellor questioned; ***“Has the quality of drugs dropped or has the tolerance increased? In respect of Ecstasy the quality has reduced and young people need to take more, to get the same buzz.”***

The main reasons for substance experimentation and subsequent use observed by those working closely with adolescents included; ***“Boredom”***; ***“lowers inhibitions and raises self esteem”***; ***“to feel good,” “because its there”***; ***“it’s cheaper than cans of beer and easier to get”***; ***“friends are using”***. Most school completion officers reported having experience of students presenting with symptoms of weekend use at the start of the week, and some also suspected daily use during break times at school. As the students matured it was increasingly common to see them coming to school with ***“hangovers”*** on the Monday morning. The majority of service providers also commented on the prevalence of alcohol abuse at a young age and that this occurred particularly as the local public house was of great significance as social outlet in Ireland. Many questioned the common social acceptability of drinking in current Irish culture, and indicated that this substance use was ***“the real problem”***, both in terms of the devastating impact on health, finances and relationships, but also as typified within the Irish treatment statistics where the majority of clientele were admitted for alcohol related disorders. The addiction counsellors reported that in general Irish young people report a far more positive perception of alcohol than other drugs, and while they

seem to be aware of the harmful consequences of alcohol use, these do not appear to impact significantly on their drinking behaviour.

Interestingly, the use of alcohol as first substance used was generally observed by the service providers to occur within the home setting (either with or without the presence of parental supervision) and not out on the streets, and most often around the time of a family party or religious gathering. Some youth workers reported that young people often report **“sipping”** out of the drinks cabinet when their parents were at work, whilst others reported their parents giving them a drink. The social setting observed for both drug and alcohol use thereafter was most often during unstructured leisure time after school or during break times and in the summer holidays and occurred in fields or on streets. Other community drugs workers reported that the practice of **“ditch drinking or field drinking”** was very common among groups of young people. According to addiction counsellors, the patterns of current alcohol use were reported as weekly in older individuals and more sporadic amongst younger adolescents. This appeared to be due to ease of access to public houses, liquor stores and supermarkets. Youth workers remarked that it was easier for girls to purchase alcohol, as they often looked older than their actual age. Older adolescents particularly males were reported to often drink alcohol on occasions such as; **“winning a sports match, a family gathering, a twenty first party”**.

According to the regional data coordination unit, **“Many adolescents experiment with drugs and alcohol and yet only a small percentage (perhaps through combination of individual risk and protective factors) actually develop a problematic disorder or even progress towards more serious forms of drug use”**. Similarly, according to those in addiction services; increased levels of experimentation during adolescence are present as common behaviour during adolescence, without subsequent development of problematic disorders or development of habit. However, those working in hospital and mental health services quoted; **“Many young people especially those at risk do experience problems associated with dependence or problematic drug use (e.g. increase in tolerance, withdrawal symptoms, and attempts to curtail use)”**.

The service providers commented on the prevalence of poly drug use patterns, meaning **“Combinations of substance taking within a certain period of time”**. The most prevalent combinations included;

- Alcohol and Cannabis (most common);
- Cannabis and Ecstasy;
- Alcohol and Cocaine;

A typical comment from a youth worker was; **“At age 10 to 12 years experimentation with alcohol, solvents and cigarettes begins, at ages 14 to 18 years the adolescent mixes substances such as alcohol, hash, ecstasy and cocaine in an opportunistic manner and around the ages of 18 to 20 years they would generally settle for one substance of preference.”**

The community drugs workers reported on the emerging trend of increased cocaine use, their concern for prescription drug abuse, most common among males aged 10 to 14 years, and solvent abuse among younger children and teenagers. Sniffing aerosols appeared to be most common amongst girls aged 12 to 14 years, as evidenced by the presence of aerosol canisters behind the local youth centre according to several youth workers during the interviews. An outreach worker commented; **“The concern is growing that solvent abuse / experimentation fast-tracks into future substance abuse”**. According to youth workers, the pattern of prescription drugs occurred most commonly in among adolescents who stole from their parents and grand parents’ medicine cabinet. In addition those working closely with the Travelling community reported high levels of prescription drug abuse among youthful members due to literacy difficulties and also the perception that such medications **“can keep the young people under control”**.

The majority of the service providers interviewed felt that the general age of initiation for alcohol and drug use for adolescents was between the ages of 10 and 12 years, with males often experimenting earlier than females. Most of the service providers remarked that **“first time substance use starts as spontaneous activity and becomes planned and regular”** whilst others observed that **“first time drug use is actually subconsciously organised”**. In addition the majority commented that young people first take drugs; **“Out of curiosity”**; **“out of boredom”** and **“because their friends were doing it”**. In relation to first time drug experimentation, a community

drugs worker remarked; ***“By the age of 15 to 16 years, they are collectively enjoying drug use, even if the first time is a negative experience typified by getting sick, feeling unwell. The presence of the peer group is dominant in stimulating continued drug use, whether planned or spontaneous, providing the context and setting for drug use and the securing of drug resources”***. Some youth workers observed that the collection of drug and alcohol using adolescents appeared rather opportunistic; ***“The location of the substance use is random, and that young people take what they can get, when and where they can get it...One might question how such groups are formed and is this drug use planned”***. Others commented that adolescents would gravitate toward the pro drug and alcohol using group and make sure to be present at situations and settings with the potential occurrence of substance taking. The community drugs workers and youth workers commented in the interviews that peers often give advice and information on safety issues and on the effects of the drugs.

The majority of the service providers agreed that the negative first time drug experience was not a deterrent to subsequent attempts, because the peer group would reinforce and teach the first time drug users what to expect and how to deal with it. The youth workers felt this was due to the affiliation and support provided by the substance using peer group, in its potency to facilitate further substance taking attempts. According to the community drugs workers it appears to be quite regular that the adolescent would ensure that they ***“were in the right place at the right time”*** and this appeared to be linked to the fact that they most often did not purchase the drugs themselves. It appeared that peer groups and social groups facilitate the development of certain positive attitudes about drugs, provide drugs, information on how to use drugs, provide the social contexts and sanctions for drug use. In the course of interviews, the following remark was made; ***“The experimentation with drugs and alcohol provides the young person with a sense of belonging to the group of friends, and becomes almost a normal rite of passage into adulthood”***. All service providers stated that they had clients ranging from daily use to experimental weekend use, and they found that many weekend users were controlling their substance use to some extent based on drug related information provided by the peer group and also in fear of appearing to be addicted or ***“having a problem”***. Some outreach workers observed that the adolescents were unafraid of drug use but did not

want to appear like the **“local junkie”**. The majority of service providers also noted that in general the adolescent would **“grow out”** of their drug use by their early twenties, and that few full blown addictions had presented at less than eighteen years. The addiction counsellors commented that **“As users grow older they tend to move out of the drug scene and seek other leisure activities.”**

According to the youth and community drugs workers, drugs have **“a pecking order”** in relation to perceived risk for adolescents, with drugs such as heroin (**“the dirty drug”**) as the top end of the scale and hash/cannabis at the other. Some community drugs workers reported concern for heroin use and quoted; **“Heroin is being smoked with the perception among young people that it isn’t a dirty drug then”**. A child protection worker commented on the general perception among adolescents that; **“Hash or cannabis is no longer special and is socially acceptable. This may be due to this being widely available and often smoked by parents or older siblings.”** The general perception was one of; **“drinking is ok, sure my parents drink, hash is safe enough, it’s like smoking a fag and other drugs are dangerous”**. The probation officers commented that the perceived risks of drug use added to the thrill contained in the drug taking experience for the clientele that they were dealing with.

The youth workers and addiction counsellors felt that in general, adolescents had no concept of the future or their mortality, and that they did not display any fear of health consequences as quoted by these key informants echoing their client group’s thoughts; **“Young people really live for today”**; **“Young people think they can give up before it becomes a problem”**. Those directly involved with adolescent juvenile offenders quoted; **“Drug use in young people is often not a criminal activity but a social one”**. In relation to service provision, the majority of the service providers interviewed stressed the need for an overall holistic approach and improved networking between multi disciplinary agencies representing youth work, family support, outreach, drug education and aftercare. They recommended increased training at ground level for all community and drugs workers, in light of new trends in youth drug use and increased prevalence of drug and alcohol use among all adolescents. A service provider commented **“Services are old and need to aim or cater for youth, not adult”**. They also observed the gaps in drug education in schools (i.e. that due to

timetabling not all students were facilitated), drug awareness programmes (the need for more information in Youth Centres, General Practitioners, Health Agencies and resources, and that such targeted work needed to expand from the ground, especially youth facilities (i.e. open at night and at weekends) and resources (i.e. more Parent to Parent Courses) within communities. Those working closely with young substance abusers questioned the harm reduction versus abstinence ideal ***“Is abstinence a reality for the young person?”***

The majority of those service providers interviewed agreed that the regional adolescent addiction centre needed to expand into a National Service in Ireland. Youth and outreach workers remarked on the long waiting time needed to enter this addiction centre and the lack of suitable aftercare, particularly needed as the adolescent returned to the old home and peer environments containing all the same stimuli and reinforcers for drug and alcohol use. Those having worked in adolescent counselling services commented on the ***“false sense of security”*** within such residential addiction treatment, and that upon return to home post treatment that this was not ***“the reality of life”*** for the adolescents. One addiction counsellor observed; ***“A young substance abuser told that when he returned home after treatment that the dealer was back at the door, and threw a freebie in the letter box”***. The addiction counsellors commented that young people often required longer periods in residential treatment than adults to produce similar positive outcomes and were often not ready to make any changes in their lifestyle. Others working in the area of treatment and counselling questioned ***“Are those addiction counsellors specifically trained with adolescents in mind?”*** Those Addiction counsellors working closely with young substance abusers found this client group ***“defensive and difficult to engage with”*** and were ***“often presenting with a range of other difficulties”***. In their opinion ***“drug use is a symptom not a primary presenting problem”*** and they questioned whether it ***“is a phase or is it an addiction”***. Some addiction counsellors stressed the need for clarification regarding the presence of mental health condition or substance addiction, which often resulted in misdiagnosis and inappropriate treatment plans.

Discussion

Adolescent substance use occurs across a broad range of social backgrounds and affects the physical, mental and psycho-social maturational development of the young

individual (Brooks *et al.*, 2006). The dynamics of substance use and its progression toward abuse is influenced by the individual circumstances, personality, attitude, substance availability, and drug related knowledge of the young person (Engels and Ter Bogt, 2001). Recent population surveys and treatment data in Ireland have reported the general level of substance use is increasing among young people, particularly those under 18 years in Ireland countries (NACD, 2007a; NACD, 2007b; NACD, 2007c; HSE 2007). However, one must note that forms of data relating to such treatment and community statistics of adolescent substance use may only represent *'the tip of the iceberg'*, as many adolescent users do not access such services, and may partake in regular or experimental substance use, which may not lead to problematic drug disorder.

Literature on substance use suggests that an increase in rates of drug use may be associated with increased consumerism (Parker *et al.*, 2002), economic growth (Graves *et al.*, 2005), changes in parenting patterns, or a decrease in the importance of religion and the opportunities for educational achievement (Silbereisen and Kracke, 1997). The service providers commented on the increasing availability of alcohol and drugs for young people in the Waterford region. It is adolescents who are most sensitive to changes in the availability and cultural acceptability of drugs (Novins and Barron, 2004). In response, it appears that young peoples' attitudes and substance using practices have become more liberal and indeed more *'normalised'*, and that drug services are programming for *'transient targets'* in respect of drug and alcohol taking patterns among youth. Research indicates that even those young people reaching late adolescence or early adulthood will appear fairly drug wise and increasingly willing to acknowledge the different types of drug use and drug user even if they haven't themselves experimented with substances (Wagner *et al.*, 2002). Successful and proactive programmes of regional service delivery must therefore incorporate the complexity of adolescent culture, maturational processes, perceptions of risk and regional differences.

In examining causes of substance misuse it is important to discriminate between experimental, recreational and dependent use, as these exert a potent affect on the attitude and control of the individual over the substance. These divisions are important in order to design specific interventions for each stage of substance use, in relation to

drug education and prevention, treatment and family support. Education and prevention programmes must be designed to reflect the multiple reasons for substance experimentation and use in the young person. Parker *et al.*, (2002) suggested that substance experimentation may well be an inherent part of adolescent development. The consequences of failing to intervene early and not providing age-appropriate substance abuse and indeed timely mental health treatment are substantial and long-term. The service providers commented on the common prevalence of underlying mental disorder, the use of substances as coping mechanism and the difficulties in treating adolescents not ready to change. Evidence indicates that poly substance use in adolescence may predict potential problematic disorders and also mental health difficulties in young people (Pirisi, 2003).

It is possible that *'neighbourhoods provide access to substances for use, provide human and economic resources that support or diminish the likelihood of use, present community norms for substance use or non use, or have physical or social characteristics that may promote or interfere with substance use'* (Lambert *et al.*, 2004: 206). Services must strive to identify potential settings for use within the youth free time context, implement programmes using peer led education and research in order to utilize the strength of peer influence and norms for use, and drug education targeting perceptions of risk. Research indicates that the risk for initiating use of any substance accelerates in early adolescence in relation to the strength of the peer group and peaks at age 18 years (Graves *et al.*, 2005). It is important to provide information on the dangers of substances, while at the same time building on the individual's confidence and skill's process with a peer and family setting (Jeynes, 2002). Research suggests that individuals may change their attitudes after exposure to new experiences such as drug and alcohol experimentation (Measham, 2002). Becker (1963) illustrated the importance of learning in relation to drug taking practices and attitude, noting that the experience and effects of the selected drug was mediated and facilitated by a subculture of experienced users, and that this increased the sense of support for the new user.

In relation to recommendations for improved regional service planning, the cross section of service providers interviewed, emphasised the need for clear delineated treatment pathways for adolescent substance abuse, drug education in schools and for

parents, improved policy documentation and increased funding for all areas of youth and drug service provision. Some indicated that access at community service level needed to improve for both parents and young people, particularly in relation to education, support and information for parents, youth diversion interventions for young people and activities for young people in the community. In addition law enforcement efforts must be intensified in order to reduce the availability of drugs in general and the vending of alcohol to those under age, in public houses and also supermarkets. Alcohol is by far the most commonly used drug among young people in Ireland as evidenced by population surveys and treatment statistics (NACD, 2007b; HSE, 2007). Others highlighted the need for adolescent specific treatment and intervention programmes and improved aftercare support for those returning to old environments post treatment. It appears that current Irish drug initiatives assume similarities in drug use prevalence and profile, regardless of geographic location or socio-demographic grouping and without taking particular rural or urban characteristics into consideration. It is therefore of vital importance to develop local polices, and drugs services in response to identified local needs in order to target interventions in accord with local youth drug use norms and practices.

Conclusion

The social and cultural contexts of these young people's lives clearly need to be acknowledged in the National Drugs Strategy 2009-2016, within a range of regionally specific policies and interventions aimed at reducing the likelihood of serious and damaging forms of drug and alcohol use among young people. It is imperative that Irish people more aware of the risks associated with drug taking, the nature of drug misuse, the impact of substance abuse on the family unit, financial impact and the supports and services which must exist to minimise harm and provide timely outreach and support.. A multi-stranded approach is therefore seen to be most successful and focuses on involving the mainstream health services, parents, and youth, social and community services to devise comprehensive drug prevention interventions.

Paper 3. Van Hout, M C (2009). An Illustrative Picture of Irish Youth Substance Use. Letter to the Editor. *Journal of Alcohol and Drug Education*. Volume 53, No 1, April, 7-14.

Dear Editor,

This letter shall describe recent exploratory research in Ireland, which was undertaken in order to provide a '*snapshot*' of the perspectives of youth, community, addiction, educational and health service providers, in terms of youth substance use and current service provision.

Drug and alcohol prevalence trends and patterns of use in Ireland have become increasingly diverse in terms of drug type, poly substance use, drug availability and demographics of users. National prevalence surveys indicate increasing drug and alcohol use among young people and suggest that substance use is increasingly accommodated into adolescent lives and culture (NACD, 2007a). Ireland is ranked as the highest among the thirty five European countries in terms of the number of adolescents who regularly binge drink and second highest for reported general drunkenness, with Irish school-going students showing a higher than average prevalence of lifetime use of any illicit drug (EMCDDA, 2007). Such patterns of youth substance use were traditionally confined to marginalised communities or vulnerable youth, but are now increasingly common in both urban and rural locations across Ireland (Mayock, 2002). Parker *et al.*, (2002) have proposed that experimentation with substances must be viewed as part of early adolescent life course negotiation. However in terms of public health and social harm, youth substance use and indeed problematic use potentially contributes to compromised health and well-being, difficulties in maturation and to a wide host of problems for the individual in terms of '*academic difficulties, declining grades, absenteeism, truancy, and school drop-out*' (Sutherland and Shepherd, 2001:446).

Prevalence patterns of youth substance use are most commonly characterized by '*acute local variation and clustering of trends*' within the national setting (NIDA, 1995). These small numbers of drug users such as adolescents are usually hidden within general surveys and are thus difficult to understand in terms of '*their backgrounds,*

lifestyles and the social contexts in which they consume their drugs' (NIDA, 1995; Rhodes, 2000). Current Irish research lacks a social profile of adolescent drug and alcohol use, particularly in terms of such regional and indeed local clustering of trends. It is hoped that this research will add to the current research base on youth substance use in Ireland and also guide the implementation of proactive and timely community and youth interventions.

In terms of research methodology, interviews were undertaken with a self selecting sample (based on availability, **n=78**) of youth, community, addiction, educational and health service providers in the South Eastern region of Ireland, which covers 13.5% of the State area and represents 20% of the national population. One must note that in order to provide complete anonymity, it is not possible to provide detailed information regarding percentage breakdown of these individuals, as due to the regional context of the research, some may be identifiable. The interview schema was used in a previous study by Mayock in 2002 and included the following themes; the prevalence of adolescent substance use; drug activity in the area; reasons for substance experimentation; alcohol use; drug use; initiation of drug use; first time experience; reasons for not continuing; subsequent drug use and the peer context for reinforcement; current drug use; adolescent attitude and meaning of drug use; maturing out of drug use; risk perception of drug and alcohol use; drug information and service provision and treatment for adolescent substance abuse. Interviews lasted on average 45 minutes, were audio taped with permission and participants were allowed to withdraw at any stage. As themes arose, they were explored in a '*lengthy conversation piece*' (Simons, 1982: 37). Therefore the research is firmly grounded in the information gained. The qualitative nature of the research meant that although the researcher had a list of themes to guide data collection, not all participants discussed a particular issue, and were encouraged to raise their own. Therefore, the typicality of these perceptions and experiences cannot be assessed (Fountain and Griffiths, 2002). Transcripts were read several times at the end of each interview to allow the researcher to revise and develop an understanding of the '*themes*' of responses, and also to allow the interviewee to elaborate or clarify their response. All interviews were analysed thematically, according to the themes that most consistently arose and that were pertinent to the research aims. This consisted of generating '*a list of key ideas, words, phrases, and verbatim quotes; using ideas to formulate categories and placing ideas*

and quotes in appropriate categories; and examining the contents of each category for subtopics and selecting the most frequent and most useful illustrations for the various categories' (Zemke and Kramlinger, 1985).

The research yielded an '*illustrative picture of Irish youth substance use*' in terms of substances used, the potency of the peer and family setting for use, gaps and deficits in targeted service response. Most interviewees felt that youth drug and alcohol use was increasing and of greater concern, due to higher levels of experimentation across all age groups and genders, with increased potential for the development of problematic use. Drug use among young people in Ireland has also increased due to greater levels of youth disposable income (pocket money and part time employment), greater freedom or lack of parental monitoring (both parents working, single unit families), increased drug availability (urban and rural) and increasing normalisation of drug and alcohol use within neighbourhoods. Drug activity, both using and dealing was deemed to be common both in communities, schools and within groups of young people. Such increasing contact with drug use, whether within peer groups or social crowds was reported to increase normalisation of drug use within the adolescent sub culture. One must note the potency of the school context in addition to the neighbourhood context in providing access to drugs, raising positive attitudes or norms to drug use and peer drug taking. Some service providers commented on heightened levels of teacher supervision necessary at schools in order to prevent drug dealing and drug taking during recess. In addition youth substance use, both licit and illicit was observed to be increasingly common for those young people experiencing family crisis, home disorganisation and stress. In this context substances are used as form of stress coping mechanism and have greater potential for progression toward problematic use.

In terms of alcohol use, most service providers commented on the increasing social accommodation of drink within Irish culture and common acceptability of drinking to excess. Young people in Ireland are usually introduced to alcohol at a young age, whether by parents or older siblings and friends, and usually within the context of a family celebration or public house. The service providers voiced concern both in terms of binge drinking and also as alcohol may provide the context for further drug experimentation. In addition, others commented on parental alcohol abuse and older siblings in encouraging alcohol use among younger adolescents. Some reported that

binge drinking often takes place outside and during summer holidays or weekends when parental monitoring is low. It appeared that the unstructured leisure context was providing opportunity to experiment with alcohol and other drugs, particularly in areas with poor youth and leisure facilities. It was observed that those young people actively involved in after school activities or sports did not experiment with or use drugs and alcohol to the same extent as those youth with higher levels of leisure boredom and stress.

Young people were observed to purchase their drugs, most commonly hash or cannabis, ecstasy and amphetamine in groups, thus indicating the potency of social networks among young people and the peer setting for use. It appeared to be most commonly within the context of the best friend network or close peer group, but as the substance abuse becomes problematic, the young person would gravitate to wider social networks or social crowds in order to avail of drug availability. The service providers commented that drug and alcohol use was often part of adolescence in terms of gravitating toward the peer group and away from the family, and that such behaviours were also facilitated by high levels of leisure boredom, low parental monitoring, part time employment and lack of positive free time activities. In general drug and alcohol use was deemed to occur in fields, on the streets and at friend's houses. The increasing levels of substance use at weekends, was evidenced by behavioural and cognitive difficulties at school. Those working with particularly vulnerable or at risk young people observed the prevalence of solvent use at a young age and also increasing prescription medication abuse.

Most young people were observed to present with positive attitudes to alcohol use, and facilitating attitudes to peer drug use, both in terms of those using drugs and abstaining. This was of direct concern with regard to increasing perceptions of peer use and the potential for increased experimentation as a result. The service providers commented on the strength of the peer group whether best friend or group of friends or peers, in providing the user with drugs, knowledge of drug taking and how to improve the experience and norms for use. It appears that young people's attitudes to drug use and drug related knowledge are becoming increasingly normalised and accommodated into the adolescents '*rite of passage*'. It was reported that young people would often

portray high levels of drug awareness and knowledge, and also appear willing to accept peer drug use even if they themselves are abstaining.

Drug use was reported to present at ages 10 to 12 years with alcohol as most common precursor to drug initiation. Some remarked that boys were likely to experiment at earlier life stages than girls, but other service providers commented that girls were now presenting with increased levels of experimentation. In general it was reported that young people do not perceive their substance use to be of any risk to them, and that often the risk adds to the thrill of drug taking itself. It appears that negative first time experiences would not deter the young individual from using again, and that such drug decisions are stimulated and encouraged by the strength of the relationship with the peer group, in terms of learning new drug taking behaviours, attaching meaning to the drug experiences and providing the context for drug use. In terms of patterns of use, it was observed by those working closely with young substance users, that internal sanctions for use were present which served to control levels of drug taking and combining, certain ways to behave and levels of drug use. It appears that young substance users do not want to appear either addicted or out of control, and that youth substance use is increasingly a social activity and not a criminal one. In addition, there is a reported '*hierarchy*' of drugs in terms of potential harm and social accommodation within youth culture, with heroin at the top of the scale and cannabis/hash at the lower. Of some concern was the perception by some young people that heroin was safe if smoked and not administered intravenously. Most young people deemed cannabis to be as safe as smoking cigarettes, and were not concerned with any future health impact.

In terms of the varying nature of youth drug and alcohol use, education and prevention programmes, it was emphasized that such initiatives must be designed to reflect the multiple reasons for substance use in the young person. According to Parry (1998:13), '*interventions should be designed for the particular communities they are meant to reach, that is, generic programmes may not be effective. Life skills programmes should be designed to address the attitudes of young persons towards drug and alcohol use, specifically attempting to modify adolescents' perceptions regarding the positive consequences of substance use and to introduce less risky alternative activities which are also likely to lead to positive outcomes*'. As regards drug and

alcohol awareness, it was reported that misinformation or lack of information could undermine investment in current harm reduction programmes and had the potential to also contribute to the stigmatisation of the individual drug user and his or her family. This was observed to occur due to lack of implementation of drug education at school and community level, causing poor levels of drug related knowledge in some cases in addition to poor or lack of timely support for families suffering from drug and alcohol abuse in the home. It was also observed that interventions were short lived and that drug educational campaigns must be sustained over a prolonged period of time in order to have maximum impact on the target audience, particularly in relation to timetabling constraints, levels of school absenteeism and age appropriate intervention planning (Van Hout and Connor, 2008c). Other recommended elements for potential success included the targeting of drugs of first use, information and help for parents, teachers, and sports coaches, and the maintenance of a consistent message through the coordination of media efforts with other initiatives in schools, youth groups and communities.

However in contrast, service providers remarked on the '*maturing out of substance use*' for most young people by middle twenties. Other service providers directly involved with youth addiction counselling and treatment observed that for the most part, young people experiment with both drugs and alcohol and that few progress along the addiction continuum toward dependency and problematic disorder. This appeared to coincide with the development of other interests, relationships and career aspirations. Only a small percentage would seek treatment for problematic substance use. The assessment of adolescent alcohol and drug abuse is a complex task, which was reported to be regularly inhibited by lack of professional knowledge regarding maturational level of the young person, and the severity of their substance dependency. In addition, criteria for diagnosing alcohol and other drug abuse or dependence among adolescents were reported to be often derived and practiced from adult models of addiction. This emphasised the need for specific adolescent assessment and appropriate adolescent interventions. The apparent younger age of initiation into drug misuse and potential development of dependency has created a corresponding need for the development of multi component treatment types, catering specifically for the needs of young people less than 18 years of age. It was recommended to introduce some leniency in the drying out period prior to admittance

to residential addiction treatment as this was often impossible for parents to achieve without targeted outreach support

It was commented that young substance abusers were often not ready to change or comply with counselling when referred by juvenile courts and that this was a drain on the addiction services. It was reported that young substance users were often defensive and difficult to engage with and therefore required specific and measured responses. However in terms of mental health most reported concern at the potential negative impact that early and destructive substance use has on the individual's maturation in terms of physical, social and psychological health. The consequences of failing to intervene early and not providing age-appropriate substance abuse and indeed mental health treatment are substantial and long-term. Lastly, such adolescent focused treatment initiatives must also include supportive and timely family therapy, outreach support and community integration phases for those attempting to access treatment and also post treatment. Some commented on the issues raised for the young person upon return to old situations and stimuli post residential treatment. There appears to be a great need for improved aftercare support for those young addicts post treatment.

In order to devise and implement successful youth orientated drug education and treatment programs, it was universally stated that policymakers need to recognise the local nature of youth drug use in the South East of Ireland. Due to funding and staffing restraints, most current Irish programmes assume similarities in drug use prevalence and the factors that contribute to it, regardless of geographic location in the area. The identification of local factors pertaining to adolescent drug and alcohol use, and understanding how services can encourage or discourage drug use is of practical importance. Local multi-agency service providers must incorporate existing information from multiple sources (i.e. treatment data and research such as this) to study the development and growth of adolescent substance use and related problems. Perhaps most importantly, adolescents' attitudes have become more liberal and somewhat '*normalised*' towards alcohol and drug use. As a result current prevention campaigns may be aiming at a '*dynamic target*' of culturally and regionally held youth opinions relating to substance use. Research such as this, then becomes vital in creating

networks of health professionals and using combined information to target and programme for young people.

The research provides a key insight into the opinions, thoughts and knowledge relating to youth drug and alcohol use from the viewpoints of the service providers themselves, in relation to their varied levels and types of contact with young people. One must note that such information can only be perceived as '*perceptions*' from the viewpoints of these service providers and therefore are limited insofar as representing anecdotal evidence. However, the information garnered in this study is useful in presenting the regional situation and guiding resources for timely drug and alcohol prevention strategies and community initiatives. In light of the information provided in this '*snapshot of service provider's perspectives of youth substance use*', it is recommended that a multi disciplinary approach is deemed to offer most success in terms of involving individuals, health services, parents, schools and local communities in dealing with youth substance use trends.

Paper 4. Van Hout, MC (2009). Youth Alcohol and Drug Use in rural Ireland- A Parents View. *The International Electronic Journal of Rural and Remote Health Research, Education, Practice and Policy*. Online.

<http://www.rrh.org.au/articles/showarticlenew.asp?ArticleID=1171>

Abstract

Introduction

Drug availability is increasing throughout all areas of Ireland, as a result of a certain convergence of rural and urban cultures in the last decade of economic growth and prosperity. Rural Irish youth may now experience heightened risk for problematic alcohol and drug use due to increased exposure to drugs, urban contact with peer drug users, unstructured recreation time and poor parental monitoring. Rural parents may perceive their children to be less at risk, and often struggle more than their urban counterparts to identify and respond to their children's alcohol and drug use. The aim of this research is to provide an exploratory account of rural parents' perspective of alcohol use and illicit drug use among youth in Ireland:

Methods

A convenience sample of parents with adolescent children were selected at a parent teacher evening at 3 rural schools, through facilitation of the school completion officers (34 mothers and 21 fathers, *n=55*). Semi structured interviews were conducted which included questions relating to the parents' perception of youth drug and alcohol use, both in terms of recreational and problematic use in their communities, levels of drug availability, risk perceptions, settings for adolescent substance use, service provision and drug information; and not necessarily with regard to their own children. Following transcription of the interviews, a content and thematic analysis was conducted in order to identify areas of similar and contrasting opinions, whereby various formulations were compared and contrasted in order to ground the information firmly in the data garnered.

Results

The research suggested parental concern with regard to increased rural drug exposure within local rural communities. The majority of parents were aware of youth alcohol but concerned about all drugs, not aware of specific differences in terms of drug related risk and had difficulty comprehending harm reduction principles. Most parents

recognised the need for greater parental monitoring, awareness of free time accountability, improved parent-child discourse, and visibility of services.

Conclusion

Contemporary rural Ireland is influenced by dominant social changes in terms of the normalisation of alcohol and drug use within youth sub cultures, with increased fragmentation of traditional rural family norms and values, emerging acceptability of alcohol and drug use within recreation time and widespread availability of alcohol and drugs. The research highlights a need to target rural parents within the community development approach in order to provide drug education, service visibility and family support for those families experiencing problematic substance use.

Key Words

Perceptions, Parents, Rural Youth Drug and Alcohol Use.

Introduction

European prevalence surveys present a rising trend of illicit drug use among Irish youth when compared to other European countries (EMCDDA, 2007). Irish youth present with high rates of '*binge drinking*', in addition to increased lifetime use of any illicit drug (Mongon *et al.*, 2007).. Treatment surveys also show that the general level of youth drug use is rising with earlier ages of initiation, alcohol as primary substance of use and poly substance use increasing (HSE, 2007). Drug use appears to be gravitating towards all areas of Ireland and is clearly no longer limited to urban or marginalised areas (An Garda Siochana, 2007). This has occurred within the last decade of the '*Celtic Tiger*', a period of economic growth and prosperity in Ireland, resulting in greater consumption levels of alcohol and drugs, and increased acceptance of '*so called recreational drug use*' within free time and social settings. Such shifts in contemporary social discourse has prompted heightened risk of youth drug use within rural areas due to widespread drug availability, increased contact with peer drug users, whether at school or in leisure time, and an overall emergence of normalisation of youth drug use in terms of the selection of '*safer*' drugs and '*acceptability of controlled use*' on a social level within adolescent sub cultures (Parker *et al.*, 1998).

According to Galvan and Caetano (2003) rural communities were previously characterized by strong familial ties within an independent rural and family culture separated from the mainstream societal forces, and somewhat protected from urban problems such as crime and drug use. In recent times with reduced dichotomy between urban and rural areas, rural areas are reporting the development of unique rural youth drug using cultures and heightened drug availability (Hall *et al.*, 2008). Previous research by Quine *et al.*, (2005) indicated that rural youth may experience certain risk factors for problematic alcohol and drug use in terms of the level of their isolation within rural agrarian communities, compromised education and employment prospects, limited opportunity within the recreational context, and poor awareness of health and community services. Other research states that youth in rural areas are also more likely to initiate alcohol and drug use at an early age to external variables, such as leisure boredom, availability of substances and poor parental monitoring (Gordon and Caltebiano, 1996). Protective factors offering rural adolescents resilience to drug initiation and experimentation include potent family networks, strong anti drug values and reduced levels of contact with drug using peers. However applicable such

risk or protective factors are, these mechanisms are increasingly compromised, as contemporary Ireland navigates the modern consumerist society characterised by normalisation of drug and alcohol use within youth sub cultures and negotiation of individual strategic risk taking behaviours in adolescence. Youth exposure to risk in the course of daily life and increased acceptability of drug and alcohol use in free time, coupled with poor parental awareness, may in some cases explain reasons for rural youth presenting with problematic alcohol and drug use (Wilson and Donnemeyer, 2006).

In terms of measuring parental awareness of their children's alcohol and drug use, Bierut and Fisher (2008) report that in general parents are unaware of their children's substance use and found that for more serious forms of drug use such as cocaine, parental awareness is even lower. Parents of children with problematic substance use often present with a somewhat normalised view of drug use, and overestimate their own level of parental monitoring, when compared with parents of non drug using children (Cohen, 1995). Williams (1999) identified an age correlated discrepancy and reported that greater levels of parental awareness of their children's use of substance use occurred with parents of older adolescents (16-18 years). In terms of rural youth substance use, research suggests that rural parents often struggle more than their urban counterparts to identify and respond to their children's' alcohol and drug use, significantly underestimate the level of their child's drug and alcohol use and perceive their children to be less at risk (Beirut and Fisher, 2008). It may be the case that rural parents have little or no contact with the concept of drug use and limited to the media interpretations, or contact with urban social structures experiencing drug activity and therefore appear isolated from mainstream societal trends in youth drug use. Research suggests that rural parents commonly defer the onus of responsibility on health professionals and public health campaigns in deterring youth drug and alcohol use, focus on the potential role of professionals and the media in offering resilience for youth drug use and therefore reduce their own perception of their importance in providing drug education and prevention for their children (Hermida *et al.*, 2003). The aim of the research is to provide an exploratory account of rural parents' perspective of alcohol use and illicit drug use among youth, in order to illustrate their thoughts, experiences, fears and opinions regarding recent increases in drug use and availability in rural Ireland.

Methods

Research Design

Semi structured individual interviews gathered information on the rural parents' experiences of adolescents' alcohol and drug in Ireland. A convenience sample of parents with children aged 12 to 18 years were selected at a parent teacher evening at 3 rural schools (34 mothers and 21 fathers, *n=55*). A gatekeeper (school completion officer) for each school facilitated the initial introduction and contact with the parents. To ensure voluntary participation, the participants were given an information sheet explaining the aims and objectives of the study, signed consent, assurance of confidentiality and were made aware of their right to refuse to participate, and to withdraw from the interview if they so wished.

Ethical approval was gained by the Research and Ethics Committee at Waterford Institute of Technology, Ireland. The interview schedule had been piloted on an urban school in a previous study, and followed NACD guidelines for Research (NACD, 2002). The researcher chose individual interviews in order to optimise on research information garnered, as levels of suspicion and stigma relating to drugs was significant among these rural parents, with possible constraints on forthcoming information within a focus group setting. These semi structured interviews included questions relating to the parents' perception of youth alcohol and drug use in their communities, in terms of recreational and problematic use in their communities, levels of drug availability, risk perceptions, settings for adolescent substance use, service provision and drug information; and not necessarily with regard to their own children. The qualitative nature of the research meant that although the researcher had several questions to guide the discussion, not all parents commented on particular issues, and were encouraged to explore their own ideas, thoughts and opinions. The interviews lasted approximately $\frac{3}{4}$ of an hour, were coded and audio taped. All data files were stored on a private computer with password protection and were destroyed after 3 months. The transcripts were read several times and categorised by the researcher in order to progressively bring out the main themes. This consisted of generating *'a list of key ideas, words, phrases, and verbatim quotes; using ideas to formulate categories and placing ideas and quotes in appropriate categories; and examining the contents of each category for subtopics and selecting the most frequent and most useful illustrations for the various*

categories' (Zemke and Kralinger, 1985:35,89). The thematic analysis using Nvivo was then conducted in order to identify areas of similar and contrasting opinions, whereby various formulations were compared and contrasted in order to ground the information firmly in the data garnered, and identify categories for presentation of research findings.

Results

The thematic analysis resulted in identification of three main themes in relation to what rural parents are experiencing in terms of; “**parental estimations of rural youth drug and alcohol use**”; “**patterns of rural youth drug and alcohol use**”, and “**drug education and treatment provision**” in the area.

Parental Estimations of Rural Youth Drug and Alcohol Use

The parents were aware of increased patterns of drug and alcohol experimentation among rural youth from their communities and felt this was due to increased access to a wider variety of substances at all ages (*i.e. alcohol and cannabis*), and most usually within the context of school and friends and that rural youth have more disposable income than previously (*due to pocket money, part time employment*). Some parents commented on the difficulty of continued monitoring necessary to curb such substance use, given the reinforcers for use at school, after sports matches and in towns;

“Its very hard..they are given an early introduction to drinking...as if its macho to get drunk...the girls are the worst...much easier for them to get served...and what can you do...if they're all going out ..how can you say no”.

“Sure they are drinking after school, and at those teenage discos...it's not hard for them to alcohol in the supermarket...or take drugs in the fields.. it's very hard to control”.

“These kids can go drinking in the fields and no one would ever know...it's impossible to know where they are every minute of the day”.

Most parents were aware of increasing normalisation of drinking and also cannabis use among young people, due to local newspaper reports, teenage discos, after sports celebrations, twenty first parties and ease of purchasing alcohol at local shops. The majority of parents agreed that; “**There is a drug problem in your area, which has**

recently occurred". It would suggest that the youth were faced with increasing acceptability of substance use within their school setting, which was then brought home to the rural community. Most parents were aware of drug activity in their rural community, and commented on **"the individuals dealing on the street"** and also within the proximity of urban suburbs, the incidence of several students **"smoking joints at school"**. The parents in general placed blame on the urban setting and its increasing drug problems. Some believed in the presence of a drug dealer in encouraging first time drug use among their children and were not as aware of the presence of peer groups in initiating substance use; **"there's this one guy selling drugs to the young people in our locality"**. Older rural parents were more cautious and commented that the youth would be coerced by a **"criminal or drug dealer"**. Other parents were aware that drug use was common at school and commented; **"I am sure they all get their drugs together...there's a few lads at the school who have been suspended for dealing...there's no real control though and it worries me"**. However, other parents were not aware of drugs being available or being used by individuals in the community and commented on their ignorance to this social problem among their youth; **"I wouldn't know how to recognise any sort of drug related activity, to be honest"** and **"Sure we never used drugs; I wouldn't even know what it looks like"**.

Patterns of rural youth drug and alcohol use

In terms of drug and alcohol taking patterns, the majority of parents in this study were aware of varying levels of drug and alcohol use in terms of experimental, sporadic, regular and abusive and commented that such degrees of substance use were dependent on the young individual's circumstances in terms of vulnerability, stress, opportunity and peer pressure. However all voiced concern as to how such behaviours can begin at a young age and rapidly escalate towards problematic use. The parents observed that the following substances were most prevalent among adolescents; **"Alcohol; Tobacco; Cannabis; and Amphetamine"**.

In general, the parents voiced concern as to the increasing levels of alcohol drinking among young people, the increasing normality of alcohol use within Irish society and also increased levels of hostile and aggressive behaviours among youth at night. They observed a pattern of frequent and heavy youth drinking within the rural communities

and felt this was due to the pervasiveness of alcohol use and excessive drinking within Irish culture. A parent quoted; ***“this appears to be the case in many Irish families and is reflected in Irish history and culture...Irish people drink to socialise, celebrate and commiserate”***. A concern highlighted by parents was that adolescents appeared to be drinking for no particular reason other than it being a Saturday night; ***“It’s shocking, you can see them drunk at 1 and 2 in the morning at the weekends”***. The parents commented that they often gave their children the first alcoholic drink most commonly during a family celebration such as Christmas, or if they had gone out to lunch on a Sunday. Most parents were regular drinkers and commented

“sure there’s no where else to go on a Saturday night other than the pub around here, going into town is too far...there’s not even a cinema or bowling alley”.

Other parents purchased their alcohol in the super market and drank at home; ***“it’s very cheap to buy alcohol in *****, and now with the smoking ban it’s more comfortable to drink at home”***. This point is interesting given that some parents observed that they allowed alcohol use within the home; ***“at least I can supervise and it’s a safe environment..there’s nothing wrong with having a drink”***. Most parents were not aware that their children would have access to their liquor cabinets when they were at work or unavailable and only some were aware that young people would often ***“go ditch drinking”*** in the summer holidays. The majority of rural parents with older children were not concerned about their teenagers drinking alcohol ***“as long as it is in moderation”***. This was perhaps due to their acceptance of drinking and previous histories of drinking during childhood. Other parents commented that ***“it seems to be normal practice for youngsters nowadays to go drinking after the match or go to discos at an earlier age”***. One parent commented ***“there’s this groups of lads, and they go drinking after the matches on a Sunday...and even the coach gets drunk”***. Some parents were also unclear as to whether ***“drinking alcohol when you are a teenager can lead to increased opportunity to use drugs and develop a problem”***.

Most notably the parents were aware that first time drug use most commonly occurred within the peer settings or also due to sibling influences. However, the parents were unaware of when the crucial time for vulnerability to drug use could be; ***“I’d be hoping***

it wouldn't ever happen". The majority of parents were aware that cannabis use is increasingly common among young people and most were concerned as regards the potential hazard; *"the kids nowadays think it's a safe as smoking a fag"* and *"I'd be worried about the effect this (cannabis) has on his schoolwork"*. The most common reasons for substance experimentation quoted were; *"Friends are doing it"*; *"School peers"*; *"Curiosity"* and *"Boredom at weekends and holidays"*. The three most common settings for use from the parent's perspective were; *"parties, in public places such as in the local cinema and on the street, and at friends houses"*.

The majority of parents were aware of the potential of the peer group in determining the level of their teenagers substance use;

"I'd be hoping their parents would have talked to their kids about drugs and drinking, and I try to make sure my child doesn't mix with kids in trouble...but I don't always know, that's for sure".

The parents were concerned as to the influence of the urban setting (i.e. school, friends etc) in terms of providing the opportunity to experiment, coupled with a lack of positive leisure time activities in their rural areas, often leading to increased levels of deviant behaviours. The majority of parents voiced their concern of a lack of suitable activities and facilities for young people in these rural areas. It appeared that youth with urban contacts (i.e. sports, activities in the towns) had greater opportunity for substance use, due to increased levels of availability and greater opportunity to congregate in groups of young people. Some parents commented that they were happy to let their teenagers visit other friends at weekend, even if they were uncertain about the level of supervision, *"at least he/she isn't on the streets"* and *"I really couldn't tell you if her friends do drugs or drink..I suppose most of them would drink"*. Other parents remarked that it was also difficult to accommodate their children and the potential of activities on offer in the town due to cost, work commitments and family commitments. *"Sure I can't be watching him all the time...its hard to keep track of them and their mobile phones"*. In relation to the teenage discos, most parents agreed that this was often not suitable for young adolescents due to insufficient supervision and the potential for alcohol and drug use on site. The parents were conscious that drug and alcohol experimentation occurred most often during weekends and summer holidays, when it was difficult to monitor and supervise their children;

“They grow up so fast nowadays ..It’s hard to keep a hold of them”. This appeared to be a factor in the case of some parents, who reported they were often busy with chores on the farm and away from the home when their teenagers would return from school. Some mothers remarked ***“it’s very hard especially if we are working to make sure they are supervised all the time”.*** However the parents often felt under duress to allow their child to go to such a disco as all the other friends were going too. ***“What can I do, if they are all going, the best I can do is bring them, collect them and hope for the best”.***

Most of the parents were worried about their children experimenting with drugs and to a lesser extent alcohol, and had not experienced the symptomatology of problematic substance use. Interestingly, these rural parents were not as concerned about alcohol use in older teenagers, and did not deem this to be harmful if not taken in excess. In terms of perceptions of drug related risk, the majority of parents were aware of cannabis use but were concerned about all drugs in general and were not aware of specific differences in terms of drug related risk. The parents were suspicious of harm reduction advocacy in schools and commented; ***“taking drugs is wrong, how can they tell our youngster its ok..or here’s some information on how to do it safely”.*** All parents recorded the following concerns relating to their child using alcohol and/or drugs; ***“Overdose”***; ***“Accidents”***; ***“Crime”*** ***“Becoming addicted”***; ***“Letting the family down”***; and ***“Not being able to finish school”***. However, most were aware of families who had experienced youth substance abuse.

Drug education and treatment provision in the area.

The majority of parents identified the need for increased drug information for parents and also greater parent support for those experiencing a child with problematic substance use. The parents also remarked on their difficulties in identifying possible substance use in their children and stressed the need for ***“open communication”*** with their children during late childhood and adolescence. The rural parents in this case appeared to take some form of solace in their attempts at parental monitoring even though many observed this role to be difficult. ***“its very hard to be their friend and encourage them to talk to you, and also at the same time trying to control their behaviours”*** and ***“it’s a catch twenty two situation”***. Some older rural parents were less aware as to the services available to young people in the event of drugs crisis and

reported that they would seek advice from the local priest, the school principal, local policeman or their general practitioner. The parents were not as aware of local community based drugs services; ***“there’s nothing out here for us, if we need help, we don’t really know which road to take”***. In addition for some parents, there appeared to be some concern as to who they would contact due to the stigma attached to drug use, particularly within their families and the rural community.

Discussion

In order to accurately estimate prevalence patterns of youth substance use, researchers must be aware of *‘acute local variation and clustering of trends’* within the national setting (NIDA, 1995:90). Youth drug users, and in particular those within the rural contexts may not be represented within such prevalence surveys and therefore present with specific variations terms of *‘their backgrounds, lifestyles and the social contexts in which they consume their drugs’* (NIDA, 1995; Rhodes, 2000:25) Ethnographic research such as this may provide an illustration of the meanings and interpretations of rural youth alcohol and drug use from the rural parents point of view, and yield useful information in terms of guiding national and regional drug strategies.

The rural urban dichotomy- an emerging drug market?

There is a lack of research exploring the variations between urban and rural drug and alcohol use in Ireland (Wilson and Donnemeyer, 2006). During the course of this research, it became apparent that the differences between urban and rural Irish youth are minimal, and strengthened due to increased contact with urban peers within the school and sporting settings, against emerging normalisation of youth drug use and individualisation in modern Irish social discourse. Emerging youth drug using sub cultures within rural areas are increasingly common, in light of rural areas providing new markets for the over supply of drugs in Ireland. This has occurred in recent years as a result of increased commercialisation, growth and materialistic society, which has repercussions in terms of greater drug activity in urban and rural areas, widespread drug availability and consumerist society approaches to drug use in recreational time. In turn, the traditional protection offered by strong family values, bonds and open discourses within the rural context has been compromised, as urban values are assumed. It appears therefore that one can no longer discuss urban versus rural differences in drug and alcohol use patterns, and instead illustrate how rural

communities are now experiencing changing social capital in the course of individualised youth negotiation of alcohol and drug taking strategic decisions.

Rural Drug Exposure, Peer Normative Settings and Social Accommodation of Drug Use

Research indicates that contemporary youth experience a high level of exposure to a drug taking peer culture when growing up, and most especially within the school or urban context (Parker *et al.*, 1998). This has important implications for these research findings, where parents were increasingly concerned about the level of influence which the school, peer and urban settings provide, in terms of drug dealing within groups of friends, in recreational contexts and within schools. Research shows that particularly vulnerable youth (for example, those that don't *'fit in or who want to fit in'*) whose peer group present with pro drug using attitudes and drug using practices will mostly conform rather than jeopardise their affiliation with that group (Sharland, 2006). This may be the case for rural youth in their attempt to negotiate urban youth culture and integrate within social crowds and peer groups. Peer groups present a potent influence in the facilitation of development of certain attitudes about drugs, the social contexts for drug use, and norms and values relating to the acceptance of such risk behaviour (Gordon and Caltabiano, 1996).

The parents were aware of cannabis use among youth, and commented on the rising social accommodation of this drug. This indicates the influence of the dominant social discourse within modern Irish society, where recent research has indicated cannabis attaining normalisation criteria in terms of social accommodation of use, perceptions of safety and widespread availability (Parker *et al.*, 1998), and also prevalence surveys indicating no difference in socio demographic variables among cannabis users in Ireland (NACD, 2008a). It is interesting that while the parents noted the use of cannabis as most common among youth, they did not categorise other drugs in relation to potential harm or risk. This finding has important implications for the success of harm reduction advocacy in schools, and the dissemination of such material in rural communities and families.

Perhaps most relevant to this discussion is the potency of the unstructured leisure setting for rural youth in providing a context for alcohol and drug use within a peer

setting. Some research suggests that in more isolated communities or among rural youth with heightened leisure boredom and poor parental monitoring, there may be increased opportunity to participate in deviant behaviours and substance use can become a socially accepted, normative behaviour within that setting (Gordon and Caltebiano, 1996). It appears that rural youth may experience both high levels of unstructured leisure time in rural lifestyles, increased contact with alcohol in the course of family and sporting activities, and increasing levels of contact with drug using peers at school. However, one must note that such a development is not unique to rural communities, with Parker *et al.*, (1998) reporting that in future years the non drug taking group will most certainly be the minority, regardless of rural or urban context. The rural parents were concerned with regard to compromised efforts to supervise holidays and after-school activities, and efforts to maintain open discourse with their children. Research has shown that parents who are absent or show little involvement with their children are more likely to have children who experiment with alcohol and other drugs (Cohen, 1995). Traditional rural values may appear increasingly fragmented as contemporary rural lifestyles, family networks and parent-child relationships shift within modern social capital in Ireland.

Alcohol and Rural Irish Culture- a cause for concern?

Perceptions of drug and alcohol use are strongly influenced and mediated by the individual's experience of use and their social demographic characteristics (Hermida *et al.*, 2003). This research presents an interesting dichotomy in terms of the social acceptance of alcohol use among rural youth, in contrast with a global fear of drug use and difficulties in comprehending harm reduction advocacy from the parents' perspective. Alcohol drinking for older teenagers during adolescence may be accepted or tolerated by rural parents as a result of cultural normality of youth drinking in rural Ireland. Alcohol is by far the most commonly used substance in Ireland (Mongon *et al.*, 2007). Research has reported that in general youth indicate a far more positive perception of alcohol than other drugs, and while they seem to be aware of the harmful consequences of alcohol use, these do not appear to impact significantly on their drinking behaviour (Graham *et al.*, 2006). This has interesting repercussions within Irish society characterised by worrying trends of excessive drinking among youth. Only some parents were aware that the family provides a learned context for social appropriateness, in so far that a family that regularly uses alcohol and/or other drugs is

sending a message of normality and acceptability of that behaviour to their children. This appeared to contradict rural family norms for drinking and socialising while using alcohol. Evidence also suggests that parents who buy and supply adolescents with alcohol are contributing to the increased risk of adolescents engaging in binge drinking and consuming more alcohol on a given occasion (Oh *et al.*, 2003). These findings are of concern for rural youth, not only in light of widespread alcohol use but also in terms of the possible progression toward drug experimentation when drinking when in contact with peer drug users.

Implications for Rural Outreach and Service Provision

In terms of future directions for policy, the research points to a need for increased visibility of health and addiction services within these rural areas, the development of targeted rural drug prevention programmes, family drug education, support and outreach. As early experimentation with alcohol and possibly cannabis, appears to be a foundation to future problematic drug issues in early adulthood, it is important in terms of targeted education and prevention tactics to determine which factors are most likely to contribute to rural children's early initiation of substance use and target these in drug education and rural family interventions. Rural parents need to be educated in terms of the potential of alcohol in predicting the pathways to possible drug experimentation, the importance of parental supervision, open discourse with their children, and recognising problematic substance use in their children.

Conclusion

Irish youth drug use is emerging as a socially constructed and normative phenomenon, whereby a choice of drugs is increasingly available, widely used and converging between urban or rural contexts, and not limited to marginalized, deviant or vulnerable youth. The research presents an '*anecdotal snapshot*' of what rural parents currently experience in terms of youth alcohol and drug use, and is therefore not representational of the rural Irish population. It suggests heightened parental concern with regard to excessive youth drinking, cannabis use and increased rural drug availability within local communities and schools. In terms of drug and alcohol related knowledge, rural parents often experience difficulties in understanding the prevalence of youth drinking, and in recent times drug use, and fail to comprehend differences in potential hierarchies of risk relating to specific drugs. However, the rural parents

recognised the need for greater parental monitoring, improved parent-child relationships and discourse and greater awareness of free time accountability. Services in these areas need to become more visible to all members of the community, and particularly for rural families experiencing problematic substance use. In order to guide resources, future research efforts must attempt to create discourse between rural youth, parents and service providers in order to aid in the development of rural family and rural youth centred interventions within greater youth policy directives.

Paper 5. Van Hout, MC (2010). Differentiated Normalisation and Drug Transitions among Rural Youth in Ireland. *Drugs: Education Prevention and Policy*. In press.

Abstract

Prevalence surveys in Ireland indicate an increased trend of youth drug use with rural areas reporting comparable drug availability and prevalence of use to urban settings (Currie *et al.*, 2008). Few studies have explored the contexts and meaning of drug use on rural youth transitions in terms of increased drug prevalence, recent influx of rural drug activity, normative tolerance of recreational drug consumption and fragmentation of traditional rural communities. Qualitative interviews were conducted with **220** young people (15-17 years), and **78** service providers in a rural area of Ireland, in order to yield contextualised narratives of their experiences of drug use and achieve a wider exploration of processes, drug transitions and realities of rural youth. The thematic analysis of the research described varied pathways, attitudes and typologies of rural youth drug use, ranging from abstinent, recreational, and moderated to maturing out. The research suggests support for a '*differentiated*' normalisation theory (see Shildrick, 2002) in terms of consumerist and normative rural youth drug use transitions in their negotiation of risk within integrating rural and urban dichotomies. In conclusion, it is recommended that drug education programmes need to situate localised rural drug taking behaviours within a wider understanding of rural community life.

Key Words

Rural youth, normalisation, drug transitions

Background to Research

In recent years, Irish youth indicate high incidence rates of *'binge drinking'* in Europe, coupled with increased lifetime use of any illicit drug (Currie *et al.*, 2008; Hibell *et al.*, 2009). Adolescent treatment data also indicate that the general level of youth drug use is rising with earlier ages of onset (HSE, 2008). Such trends indicate that the social accommodation of alcohol and drug use is increasingly part of youth culture, and no longer confined to vulnerable individuals and marginalised urban areas (Mayock, 2002). There is a dearth of research on variations between rural and urban youth drug use, and few attempts to analyse youth transitions in how drug use becomes essentially a consumerist activity and central to the integration of rural youth within urban youth cultures (Wilson and Donnemeyer, 2006; Martino *et al.*, 2008; Hall *et al.*, 2008). Rural agrarian communities were traditionally defined by a certain independent and self sufficient culture, within their isolation from urban society (Galvan and Caetano, 2003). Economic growth during the *'Celtic Tiger'* in Ireland has now led to an influx of new drug markets and heightened exposure to drug activity. There appears to be increasing fragmentation of traditional cohesive rural family structures, with the growing emergence of social and affordable housing schemes in rural areas. Such compromised social structures have led to further clustering of single parent, teenage parent, unemployment and a certain vulnerability to drug use within these areas (Van Gundy, 2006).

Recent studies on youth drug use have focused on the development of sociological approaches to understand drug transitions within a cultural context, whereby the original idea of peer pressure as thread between drug use and youth culture, has been replaced by the normalisation debate encompassing *'recreational drug use as one expression of consumerism in youth lifestyles'* (Pilkington, 2007b:374). This concept of normalisation of youth drug use has been extensively debated and has occurred in light of unprecedented trend increases in worldwide prevalence measures of youth drug use (Parker and Measham, 1994; Measham *et al.*, 1994; Parker *et al.*, 1998; Shiner and Newburn, 1997; Parker *et al.*, 2002; Egginton and Parker, 2002; Wibberley and Price, 2000; Duff, 2003a; Cheung and Cheung, 2006). However, such drug prevalence surveys of youth commonly emphasise *'lifetime use'* which contributes to misleading media reports of youth drug consumption, and leads to speculation of the normality of such social behaviours within youth culture (Shiner and Newburn, 1997).

In terms of the urban-rural context for adolescent drug use, Parker *et al.*, (1998) comment that in future years, and most certainly in urban metropolitan areas, the non drug trying group will become the minority. The fundamental aspect of normalisation of adolescent drug use is the presence of a certain level of acceptability of drug use within '*contemporary*' youth identity and culture (Duff, 2003a; Duff, 2003b). Most importantly this social phenomenon is characterised by so called '*sensible recreational*' drug use, typified by social sanctions and norms for use, certain levels of drug related knowledge and engrained group dynamics, and cost benefit strategic consumerism practices (Cheung and Cheung, 2006). Excessive, frequent and addictive drug use is not condoned within many youth drug using groups and social crowds, with such users openly ostracised (Egginton and Parker, 2002).

Adolescent attitudes and knowledge pertaining to drug use have also become liberalised and perhaps somewhat normalised, with research suggesting those in late adolescence are appearing accepting of drug use among their peers, even if they themselves are abstaining (Wagner *et al.*, 2002). Wibberley and Price (2000:161) also comment on '*the individuals right to choose a certain behaviour is considered, by some, to override the perceived `wrongness` of that choice of activity (more so for cannabis than for amphetamine or heroin)*'. In so doing, recreational drug use within social crowds and groups of young people becomes a form of leisure activity and loses the deviant sub cultural element (Evans, 2002). Cieslik and Pollock (2002) identified that youth drug users partaking in recreational drug use did not define themselves as drug users, by way of consuming drugs as part of their leisure lifestyles in addition to sports, relationships, shopping and holidays. This paper reports on recent ethnographic research, which explored drug exposure and drug use transitions among youth in a rural area of Ireland experiencing economic growth and recent influx of drug activity.

Methodology

Prevalence surveys contain regional clustering of drug users and present with specific variations terms of '*their backgrounds, lifestyles and the social contexts in which they consume their drugs*' (Rhodes, 2000:25). The initial descriptive research was undertaken as part of self funded doctoral research and approved by the Ethics and Research committee at Waterford Institute of Technology, Ireland in 2005. It aimed to

illustrate the varying experiences, meanings, patterns of drug use, and transitions relating to youth drug use in a rural area in Ireland, and used triangulation of data from youth and service providers to provide a wider focus and enhance research material garnered. This research paper aims to further conceptualise these research findings within the normalisation theoretical framework (Parker *et al.*, 1998; Parker *et al.*, 2002).

Research Design

The fieldwork commenced with semi structured interviews with a sample ($n=78$) of youth, community, addiction, educational and health service providers in the rural area. The interview schema was based on the following key themes; *'the prevalence of adolescent substance use; drug activity in the area; reasons for substance experimentation; drug use; initiation of drug use; first time experience; reasons for not continuing; subsequent drug use and the peer context for reinforcement; current drug use; adolescent attitude and meaning of drug use; maturing out of drug use; risk perception of drug and alcohol use'*. The second phase of fieldwork commenced following a pre development phase of several months, where the researcher engaged with the sample in after school and recreational activities, and involved qualitative research using semi structured interviews with a random sample of 15 – 17 year olds ($n=220$) attending schools and youth training centres within the rural area. This was done in order to develop trust, familiarity and develop relationships in order to optimise on the retrieval of research material. The interviews were composed of themes regarding drug use patterns, peer contexts, drug using experiences, attitudes to drug use, perceptions of risk, and levels of drug related knowledge.

In order to ensure voluntary participation, the participants were given an information sheet, a verbal instruction as to the aims of the research, parental consent (if applicable), and were ensured of their right to refuse to participate, or to withdraw from the interview if they so wished. Interviews were allowed to develop whereby participants were allowed to discuss and explore their own ideas and attitudes relating to particular themes. Therefore the generalisability of their responses in terms of rural youth drug use cannot be guaranteed, but remain grounded in the information yielded.

Data Analysis

A phenomenological approach using content and thematic analysis was conducted in order to identify and present areas of similar and contrasting opinions, relating to rural youth drug use. The transcripts were analysed using Nvivo and aimed to progressively develop the main themes and generating *'a list of key ideas, words, phrases, and verbatim quotes; using ideas to formulate categories and placing ideas and quotes in appropriate categories; and examining the contents of each category for subtopics and selecting the most frequent and most useful illustrations for the various categories'* (Zemke and Kralinger, 1985:35, 89). The narratives were mapped into five dynamic stages of drug use, in terms of abstinence, infrequent drug use, moderated recreational drug use, problematic drug use and maturing out of drug use.

Results

Drug Activity in rural communities, mapping rural youth illicit drug use and normalisation debates

This research, notwithstanding the difficulties encountered in achieving research participation from youth, provides a unique insight into contemporary Ireland post Celtic Tiger, and the processes of youth drug use within a rural community. In terms of the research sample of youth (115 males and 105 females) a clear majority reported no experience of illicit drug use. This was gender balanced and primarily the younger cohorts of 15 and 16 year olds. However, the majority were aware of peer drug users, drug use at school and drug activity in their local areas. Those who reported ever trying a drug were primarily infrequent or moderated recreational drug users, and a smaller minority were now abstinent. None reported problematic drug use. In terms of the additional triangulation of information from service providers, the interviews were designed to present a current picture of rural youth drug use in terms of drug exposure, prevalence, normative behaviours and consumerism, in addition to a dynamic picture of youth drug use transitions, pathways and changes in behaviour over time. The results shall be presented in accordance with four main themes pertaining to the normalisation theory namely; increased drug activity in rural areas; prevalence of rural youth drug use; normative tolerance of youth drug use; and consumerism, risk and rural youth drug use.

Increased Drug Activity in Rural Areas

In terms of the development of new drug markets, increasing urbanisation offers potential pathways for drugs to influx rural communities and most importantly in this research by way of traffic between rural and urban youth. The majority of rural youth commented on the increasing prevalence of illicit drug use among young people, in terms of drugs of choice, peer use and earlier ages of initiation leading to the establishment of drug taking careers. An older youth commented;

“Sure we never had a drug problem at school..all I wanted to do was play sport and have a drink after the match with my friends..things have changed...the younger lads are smoking hash in the fields now..it’s so easy to get. You can get it at school..on the bus...the lads in the village” (17 year Male).

Most youth were aware of drug use among their peer groups and in wider social networks of youth. Most were concerned that levels of drug activity would escalate in the future, particularly the older participants who commented on the changes in their communities in the last 3 years. Some reported feeling intimidated by ***“lads hanging around smoking”*** outside school and in urban areas when they waited for the school bus. Others noticed drug using paraphernalia in the school recess grounds such as papers and burnt lumps of hash.

Service providers were aware of heightened drug activity at schools and observed increased avenues for drug dealing within rural settings. They commented on the subsequent increase in youth drug use in rural areas, due to increased drug availability, access to a wider variety of both licit and illicit drugs, emerging social acceptability of drug use within youth peer groups, greater levels of leisure time and disposable income, and reducing prices of common drugs such as ecstasy and hash. Other service providers commented on the impact of such heightened drug exposure within rural communities and questioned whether this was contributing to the perception among rural youth, that drug use is widespread among their peers, and is an acceptable form of recreational activity. Several community based workers questioned whether this recent increase in rural drug activity was due to changes in family structure whereby rural family units are no longer as cohesive, with both parents were working. In previous years, such agrarian families were bound to work on the land. This was deemed to have changed in correspondence with economic growth in Ireland. A drugs worker said;

“Parents today both work.....this lead to less supervision of their children...who have now become the “latch key children” of previous urban years...rural families are playing catch up..the Celtic Tiger created a monster in terms of how destructive it has been for families..families don’t even sit down together for meals..things have really changed”.

Other service providers emphasised the role of traditional risk mechanisms in terms of chaotic family life, parent and sibling substance using in the home, poor parental monitoring, poor school bonding, drug using peers and unstructured leisure pursuits. Protective factors were deemed to include strong family networks, parental supervision and presence of anti drug using peers.

Prevalence of Rural Youth Drug use

Less than a quarter of the rural youth reported ever trying a drug and these were mostly boys. The majority of those who had never tried a drug consisted of mostly younger individuals in the sample and this was gender balanced. For those reporting abstinence, the reasons quoted for ‘***not***’ experimenting with drugs included

“I couldn’t be bothered, even though some of my friends do it”. (16 year old Female);

“I am not bothered about it... I don’t feel the need...it doesn’t interest me at all”. (15 year old Male);

“I am afraid of getting addicted ..I think drugs are dangerous...aren’t they?” (15 year old Female);

“I prefer to drink alcohol...I wouldn’t like to mess with drugs...drinking is ok with me”. (17 year old Female).

About half of the sample had friends currently using both licit and illicit drugs. The majority did not deem cigarettes and alcohol to be a form of drug use. Licit drugs included prescription medication such as D5’s and D10’s (tranquillisers), solvents and night sedation. A small amount of the older members of the sample had experimented with solvents, but the majority had ceased when it became possible to get alcohol. Most of those who had experimented with solvents were current drug users, with cannabis as primary drug of choice. Illicit drugs used were primarily cannabis or hash, and followed by ecstasy and amphetamine. The average age for ‘***first time drug use***’ was about 13 years, within an age range of 10 and 17 years. It appeared that the age

of experimentation was dependent on opportunity, curiosity and drug availability, with the following reasons reported;

“I just did it cos me friends were all smoking ...sure why not...there wasn’t anything else to do at the time”. (17 year old Male);

“We were all outside my house..it was summer time...we just sat in the grass and smoked a joint...no-one knew”. (17 year old Male);

“All my friends were smoking..I wanted to know what it was like..I felt a bit sick...my head was spinning..nearly had a “wobbler”. (16 year old Female).

The service providers reported the reasons for rural drug use were often linked to urban influences in terms of clusters of urban school friends using and offering drugs such as cannabis. They commented that rural youth drug use was similar to national youth trends in terms of infrequent use and dependent on local availability, with few rural youth presenting with problematic use. However, most voiced concern as to the potential for increased problematic drug use in rural areas and current lack of support networks for rural clients. It was particularly interesting that no rural youth reported problematic use, or the need to seek help from services. A youth worker commented;

“At age 10 to 12 year they start to try alcohol, solvents and cigarettes, and usually secretly within the family home, around 14 to 18 years thy start to mix substances together like alcohol and hash, and sometime cocaine, and then around 17 or 18 years they grow out of drug use or settle for one substance of choice, usually hash...only a small few develop problems in their twenties”.

An outreach worker illustrated the transitions experienced by rural youth in terms of changing rural life with her comment;

“Drug use seems to be part of growing up now..kids are so familiar with it...celebrities and media reports are contributing to this ..those rural kids are trying to fit in..they don’t want to be the “country bumpkins” ..they want to be part of what they think is cool”.

The service providers also commented on the brevity of drug taking careers for youth in general and said;

“Many young people experiment with drugs and alcohol and yet only a minority develop a serious issue with drugs, and this appear to be encouraged by a peer using group and a combination of risk factors relating to the individual and their

family setting. For rural families experiencing drug use in their communities it's a worry, as they don't know what to look out for or how to deal with this issue".

The rural drug users reported that the first time they tried a drug it was given ***"for free"*** and was not a conscious decision; rather the opportunity presented itself within a peer setting. Cannabis was cited in all cases, and in some cases combined with alcohol. Other drugs currently used included ecstasy and amphetamine, and this was confined to older drug users who were going to pubs and nightclubs. Drug use did not occur alone. Some reported a negative experience such as vomiting or feeling dizzy, but this did not deter the majority from trying again at a later stage. Those currently abstinent said;

"I just didn't bother trying again...it wasn't for me..I don't really like smoking anyway..". (17 year old Female);

"I just didn't have the opportunity again..I wouldn't say I would do it again..but I don't know...some of my friends smoke hash..maybe some other time I will try again". (16 year old Male).

Normative Tolerance of Rural Youth Drug Use

Some service providers described first time drug use as a spontaneous and collective activity which then became planned and regular over time, and dependent on drug availability within peer groups. Others observed that drug use is subconsciously organised on an individual and group basis. This was reciprocated by the drug users who reported that by ***"being in the right place at the right time"*** they were able to experience and consume drugs, which indicated to the researcher a certain amount of forethought in presentation within peer drug use settings. Both service providers and rural youth were aware that locations for youth drug use were essentially random, where young people gathered and ***"took what they could get"***. There appeared to be a paradox between the spontaneous nature of these groups, and the individual level of planning to be present. It appeared that the peer setting, whether a collection of best friends or wider social crowd of young people was dominant in the prediction of drug use activity, the securing of drug resources, contexts for drug use and the establishment of a drug taking career. They were uncertain as to whether they selected their friends based on friends drug use attitudes and drug taking careers, or

whether their friends were drug using anyway. Peer selection and peer socialisation processes were viewed as inter related by the drug users, as over time and with establishment of drug use in their free time, they would obtain a wider network of drug using peers. In this way, drug use became an inherent part of their youth lifestyles with drug use particularly common during weekends and summer holidays and taking place in fields where isolation was ensured. An addiction counsellor commented;

“Experimentation with drugs and alcohol helps the young person feel part of the group.....they feel a sense of belonging and makes them feel more adult like – substance use has become almost a normal rite of passage into adulthood”.

The drug users reported that subsequent patterns of drug use were established within groups of peers, were improved by older peers providing information on ***“how to get a better buzz”*** and how to control their drug combinations to get a more pleasurable experience. Infrequent recreational drug use was most common, with moderated drug use supported and encouraged by peers, with some rural youth stating;

“It is a grand buzz..but you wouldn’t want to be completely mashed...no-one wants to see you completely off your face..the lads wouldn’t like that..we just smoke some blow to chill out..we wouldn’t use anything else..I wouldn’t consider coke or E”. (17 year old Male);

“Sure you can see them off their heads in the nightclubs...I wouldn’t like to look like that..chewing their jaws..sweating..” (17 year old Female).

In terms of the potential hazardous effect of drug use, the rural youth, both abstainers and drug users commented on a ***“fear of addiction”*** and ***“looking like a junkie”***. As a result, the drug users exercised informal controls on their drug use and when probed by the researcher, described controlling combinations such as alcohol, hash and ecstasy, and the norms of the peer group dictating what the level of consumption would be. As most were sharing within groups, this appeared to somewhat minimise excessive or poly drug use. The service providers were aware of the potency of the peer group in enforcing norms for use based on socially distributed information between experienced and novice drug users, sanctioning for unacceptable and ***“out of control”*** use.

Consumerism, Risk and Rural Youth Drug Use

Most rural youth remarked on the ease of purchasing drugs, whether they reported drug use or were currently abstaining, with most having been offered a drug, usually cannabis at some stage. They said;

“All you have to do is talk to the right lads at school..there’s a gang of them..they can get you whatever you want..I never bought drugs..I just smoke some of my friends...if I started buying blow I wouldn’t know when to stop...my friends usually get some for the weekend”. (15 year old Male);

“If you really don’t know where to get some..you just look for the runner on the telegraph pole..that’s in town that is..but those lads would frighten me...I don’t like that”. (17 year old Male);

“We just get the blow at school..even if you didn’t want to know..they are hanging around in the break times...we don’t have break times in the yard anymore..the teachers have found out..lads were smoking in the lunch hour”. (15 year old Male);

In terms of the actual act of purchasing the drug, a minority of rural youth ‘**clubbed together**’ in order to purchase larger amounts with some rural youth commenting;

“One phone call is all it takes”. (17 year old Female);

“You don’t have to ring a dealer in town..sometimes they are hanging around after school..I just ask my friends for some”. (16 year old Male);

In contrast other rural youth commented;

“I wouldn’t start paying for that..I wouldn’t know when to stop..and then I would have a real problem..it’s better just to take a drag from my friend or half a banger [E]”. (16 year old Female).

This apparent lack of interest in individual purchasing was linked to the perceived safety of “**free**” drug use within the peer setting, and was deemed to minimise the illegal effect of drug use and create a distance between the rural youth and drug use as underground criminal activity. Rural drug users were also not afraid of the legal consequence of consuming drugs and said;

“Sure a joint you smoke in a few minutes..if someone comes along you just throw it away”. (16 year old Female).

In relation to the perception of risk relating to drug purchase and the consuming of drugs, the rural youth were aware of a hierarchy of risk with cannabis at one end and heroin as most serious form of drug use. This was supported by opinions from the service providers who described drug **“pecking orders”** which were socially dictated and accepted within groups of youth. A service provider commented on the apparent social accommodation of cannabis use in Ireland;

“Hash or cannabis is no longer special, its widely available and used by older and younger people..the general perceptions is that it is as safe as smoking a fag”;

“It appears that although there was an experience of risk relating to the fact that drug use is illegal, the risk was minimised by the use of “safer” forms of drug use, such as hash”.

The majority of rural youth were not negative towards drug use in general, and felt this was an individual choice. Those abstaining were unsure as to whether they would experiment in the future and said;

“Sure I don’t know...never say never..I might if I feel like it...right now I have no interest..I like the odd drink”. (16 year old Female).

The service providers commented on the general lack of future considerations of drug use among young people in general and said;

“Youth live for the moment..in their minds its just part of life..and part of free time...none of them think they will develop a problem..drug use is seen as a social activity..not a coping mechanism or criminal act”.

The service providers reported most rural youth presenting with irregular and experimental use, and most **“growing out”** of drug use in early adulthood. However, the majority of current drug users intended to continue, with others reporting abstinence in line with the development of other interests and other relationships.

Discussion

There is a certain merging of rural and urban cultures, as a result of increasing urbanisation in Ireland, with many new towns situated in areas previously rural and agricultural. Rural isolation may have previously hampered drug availability, but does not offer such resilience in contemporary Ireland, with resiliency factors compromised in light of changing rural families and westernised values affecting youth lifestyles

(Schoeneberger *et al.*, 2006). Research indicates that most youth today experience some level of exposure to drugs and peer drug taking during the course of adolescence, independently of socio demographic characteristics (Stormshak *et al.*, 2004). This contact with drugs and drug use contributes to the perceived normalisation of drug use, increased opportunities for experimentation, earlier initiation ages, poly substance use, and the development of problematic patterns of use (Pilkington, 2007a). However, normalisation of youth drug use is essentially an argument regarding the prevalence of drug use among youth, with national surveys indicating that drug use during adolescence has become a statistical probability (MacDonald and Marsh, 2002). One must note that the normalisation debate focuses on the increased prevalence of social drug use among adolescents, and not the normalisation of drug dependency and addiction (Cheung and Cheung, 2006). The additional recognition of normative frameworks acting to condone and sanction moderated patterns of youth drug use and the emergence of youth consumerist cultures facilitating recreational use form the framework for this theory. Research suggests that drug use within youth cultures is increasingly common and indeed normal for most youth to have tried a drug such as cannabis, and to a lesser degree a more serious form of drug use, such as cocaine or amphetamine (Wibberley and Price, 2000; Parker, 2003). Cannabis use appears to be gaining ground in Ireland, with high prevalence rates for cannabis reflecting the increasing normalisation of cannabis use across all socio-economic groups (NACD, 2008a). This has important implications for the normalisation debate in terms of prevalence and relating to a hierarchy of risk perception and acceptance, with personal experience of a certain drug contributing to a lower perception of risk (Wibberley and Price, 2000).

Parker (1997:24) has suggested '*normalisation means that those who do not take drugs accept those who do, and accept that drugs are around . . .*'. Most rural youth had contact with drug users and were not opposed to drug use, whether in peer groups or wider social networks, whereby some remained abstinent but did not discount future drug use, others tried once or twice, and the remainder engaged in infrequent, rather opportunistic drug use, and also in moderated drug use. Additionally, the majority did not view alcohol and cigarettes as form of drug use and supports previous Irish research on youth drug use transitions (Mayock, 2002). Members of the older cohorts reported maturing out of drug use in the advent of new relationships, loss of interest

and preference for alcohol use. In this way, the research attempts to yield an illustrative profile of rural youth drug transitions, and lends greater support to the theory of '*differentiated*' normalisation of youth drug use (Shildrick, 2002), as rural youth gravitate toward different pathways for drug use. Sharland (2006:250) in her discussion of young people and risk taking behaviour commented on youth drug use as typically '*short-term, experimental and 'soft*' whilst acknowledging that risk taking and risk exposure are inextricably linked. Parker *et al.*, (1998) observed that such normalisation of adolescent drug use may fluctuate as this '*cohort*' of young individuals mature and develop along the life course, with particular concern for rising drug prevalence and early drug initiation. Research suggests that in rural and isolated communities, there may be increased leisure time to devote to deviant behaviours such as drug and alcohol use, and over time such recreational use may become a socially accepted normative form of behaviour (Allaste and Lagerspetz, 2002).

Similar to Parker *et al.*, (1998), the rural drug users commented that with the support of their peer group, their drug taking experiences improved in terms of knowing how to define the pleasure, norms for use, techniques and camaraderie and that this social atmosphere gained importance in their lives over time. The interaction and drug use within such social contexts in leisure time convinces the inexperienced drug user that such activity is enjoyable, safe and self reinforcing (Allaste and Lagerspetz, 2002). Perhaps supporting the normalisation theory, in order to emphasise recreational, infrequent drug use and not dependency or addiction, some of the drug users commented that they didn't want "***to look like a junkie***" and exercised informal controls on drug taking practices in terms of poly drug taking and amounts, so as not to appear "***out of control***". Wibberley and Price (2000:1969) also observe that individuality, acceptance and personal decision making is somewhat '*tempered*' by normative limits on levels and combinations of usage. Research has also observed the rejection of certain drugs, within a certain opportunistic context (Botvin *et al.*, 1998). The '*practice of selective drug avoidance*' has pointed to a rational type of individualist decision making process in the consumption of drugs and appears influenced by both normative acceptance of risk and atmosphere (Mayock, 2002).

Conclusion

The concept of normalised drug use among youth has been related to a wider social change in terms of transient communities and increased youth consumerism (Cheung and Cheung, 2006). This paper aims to shed light on the normalisation concept not only based on youth drug prevalence but particularly concerned with transitions in youth cultures and the place of drug use within rural contexts. This emerging open-mindedness to drug use among rural youth is certainly promoted by the heightened exposure to drugs in rural locations in Ireland, and stimulated by a growing '*willingness*' to experiment, consume and develop identities. The role of consumption has integrated recreational drug use within rural youth identity in leisure time, and therefore no longer carries a deviant connotation. Drug education and prevention tactics must therefore understand rural youth not as victims of economic growth in urban Ireland but rather locate their drug use patterns, practices and transitions within the context of their '*local social world*'.

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Paper 6. Van Hout, M C (2010). Travellers and Substance Use- Implications for Service Provision. *International Journal of Health Promotion and Education*. Volume 48, Number 2, 36-41.

Abstract

Introduction

The Traveller community as ethnic minority experience many risk factors for problematic substance use relating to their life circumstances, which include; '*peer pressure, stress, anxiousness, family crisis, community or neighbourhood disorganisation, sibling use, parental use, sensation seeking behaviours and depression*' (Fountain, 2006:16,47). The extent of Traveller drug use remains unknown due to the lack of ethnic identifiers in reporting systems and a lack of Travellers accessing services (Pavee Point, 2005).

Research Aim

The research aimed to yield an anecdotal presentation of Traveller substance use from the perspectives of drug, social, law and community service providers in Ireland.

Methods

The research was qualitative in design and consisted of semi structured interviews with service providers (***n=45***) in order to generate a more comprehensive picture of current dominant perceptions of the '*experiences and issues relating to drug and alcohol use among Travellers*'.

Results

The research findings indicated that drug and alcohol use in the Traveller community in Ireland is increasing in terms of excessive alcohol use, certain drugs used and patterns of problematic substance use. Travellers have poor awareness of potential risks relating to substance use and most are using drugs and alcohol in order to deal with boredom, depression and poverty. Travellers were reported to be difficult to engage with in terms of addiction treatment, due to issues with group work, literacy and family crisis.

Conclusion

It is vital to consider the needs of the Travellers and their reported substance use in the development of proactive, culturally specific and supportive drug prevention and treatment protocols.

Key Words

Travellers, Drug Use, Culturally appropriate Services, Discrimination, Drug Education

Introduction

The prevalence of drug use in Ireland has increased over the last two decades, in terms of drug availability, drugs used and patterns of use (NACD, 2007a). As a minority grouping, the Irish Traveller community experiences many of the risk factors for problematic drug and alcohol use exacerbated by social exclusion, poor mental health and poverty, and identified to include; '*peer pressure, stress, anxiousness, family crisis, community or neighbourhood disorganisation, sibling use, parental use, sensation seeking behaviours and depression*' (Fountain, 2006:16,47). However, the somewhat excluding nature of the Traveller culture and values can offer some resilience to drug use, due to the presence of supportive families, high levels of parental control and positive social networks (Blighe, 2001, Fountain, 2006). There are concerns however, of the prevalent levels of poor mental health and depression, coupled with increasing problematic drug and alcohol use among the Traveller community (McCarthy, 2005). Alcohol abuse among Traveller men is increasingly common. Travellers are reported not access services in the event of problematic drug and alcohol use, instead choosing to deal with the issues themselves (Fountain, 2006). Instances of home detoxification are common in this community. In addition due to the lack of ethnic identifiers in national drug prevalence surveys it is not possible to accurately estimate levels of drug use within the Traveller community in Ireland (Fountain, 2006).

Methodology

Research Aim

The research aimed to yield an anecdotal presentation of Traveller substance use from the perspectives of drug, social, law and community service providers in Ireland.

Research Design

The research was qualitative in design and consisted of semi structured interviews with service providers (***n=45***) in order to generate a more comprehensive picture of current dominant perceptions of the '*experiences and issues relating to drug use among Travellers*'. The emphasis was on assessing key informants, which were the individuals working in the Traveller community and also within the community and drugs context, that were deemed well positioned to detect '*new*' or recent developments in the lives of Travellers, relating to their levels of drug knowledge,

attitude to drug use, levels of drug use, awareness of services available,, experiences of drug and community services and their approaches to drug treatment.

The researcher compiled a list of agency workers and following initial contact explaining the research objectives, an interview was arranged. Snowballing from these initial contacts identified further potential interviewees and the sample was based on availability or self selection. The sample comprised representatives of Traveller organisations, primary health care workers, , community workers, addiction counsellors , probation and welfare, youth diversion programmes, juvenile liaison officers, county development, An Garda Síochána (Irish Police), youth workers, social inclusion projects, social workers, child protection, family support workers, outreach workers, health care workers, drug service workers, housing officers and local authority planners. All interviews were taped with permission and coded to ensure confidentiality.

Data Analysis

The themes analysis of interviews (Nvivo) reported on the issues surrounding Traveller drug and alcohol use, but also aimed to identify areas of similar and contrasting opinions according to the varied perceptions presented. One must note that in order to provide complete anonymity, the research does not engage in an in depth analysis according to job type, does not provide detailed information regarding percentage breakdown of these individuals and therefore, the typicality of these individual perceptions, thoughts and experiences cannot be assessed (Fountain, 2006).

Results

The agency workers commented that drug and alcohol use among Irish Travellers has increased in terms of excessive alcohol use, types of drugs used, patterns of substance use in the last five years. This may have occurred due to increased contact and efforts to integrate with the settled community. The settled community is providing a context for both alcohol and drug use. The following comment was made ***“Originally their cultural norms protected them from drug use, but as they become increasingly settled and involved in the settled community...their drug is increasing”***. Alcohol is increasingly abused by Traveller men and single Traveller women. Travellers are also stereotyped by the media as having major alcohol related

issues, particularly relating to funerals, weddings and other religious celebrations. An agency worker said ***“Drinking most commonly takes place at funerals and weddings with high levels of alcohol being consumed particularly among the Traveller men”***. It was reported that there appears to be a certain level of acceptance of alcoholism and not drug use, as if excessive alcohol use is part of ***“normal”*** Traveller culture. However, the agency workers also commented on the increasing pervasiveness and destructiveness of alcohol abuse in Irish society. An agency worker said ***“Alcohol needs to be dealt with in Irish society never mind as part of Traveller culture”*** and ***“There is little difference now between the Traveller community and the settled in terms of alcohol abuse”***. Some described the negative effect of problematic alcohol use; ***“Fathers with serious alcohol addiction and binge use- leading to increased violence in the home and financial difficulties for the Traveller family. Alcohol causes depression...problems experienced exacerbate depression...General Practitioner(doctor) prescribing medication...risk of dependency and use in combination with alcohol”***.

The agency workers observed a marked increase in drug use among Irish Travellers in the last two years. In terms of drug type and availability, drugs such as hash, amphetamine and ecstasy are increasingly available to Travellers with the following comment made ***“Drugs, a lot of them are at it, hash, and they’re taking their coke and just you know it’s very easily got”***. Most agency workers were concerned about such new levels of drug dealing and this divergence of economic activity for the Traveller community; ***“Entrepreneurship..drug dealing..a new way to make money”***. The ease with which Travellers move around coupled with their nomadic lifestyle was reported to create the opportunity for drug dealing. In some areas, it was reported that some Traveller families are in control of drug dealing and presenting with extremely violent gang type behaviours, as evidenced by the following comment ***“They are starting to engage in gang type behaviours..They’d remind you of the mini mafia”..Some have been threatened by confrontational demands for money..and the violence is increasing due to alcohol and cocaine abuse”***.. Others commented ***“Drugs are endemic in Ireland, from national to local levels. It’s also a lucrative way of making money, especially for those such as the Travellers experiencing unemployment”***. In other areas Travellers were not reported not to be dealing in drugs. Some agency workers said; ***“There’s also negative stereotyping of***

Travellers that they are dealing in drugs, however this is not reflected in our regional law enforcement statistics” and; “There are low levels of dealing amongst some Traveller communities..the circles of use stay within themselves..there are some levels of suspicion regarding obtaining drugs from the settled community”. An agency worker commented *“Those that are dealing in illicit drugs are not abusing drugs themselves..They are clever enough to control their own substance use ...they are driven by the money”.* Some commented on the contrast between the well off Travellers who are drug dealing, and the extreme poverty experienced by other Traveller communities and sites.

Most agency workers commented on the prevalence of poly substance use with common combinations including; *“Alcohol and hash/cannabis; Alcohol and Benzos; Benzos and Solpadine; Solpadine and alcohol; Cocaine and alcohol; Redbull and Anadin; Zanadol and Coke; Anadin and Coke and Painkillers and Alcohol”.* Hash, cocaine and ecstasy appear to be on the increase particularly for Traveller men and youth, and prescription drugs are increasingly abused by Traveller women. There appears to be some anecdotal reports of heroin (smoking), crack cocaine and also cocaine. Traveller males in their 30's and younger are using drugs such as hash, ecstasy and amphetamine regularly and males over 40's are using primarily alcohol. Agency workers also noted concern for young Traveller men in relation to problematic substance use, with older Travellers (above 40 years) commonly using only alcohol. Marked differences relating to gender and age are present, with very low levels of Traveller women using illicit drugs. This was observed by the agency workers to be due to lack of opportunity to purchase illicit drugs, as the Traveller male traditionally controls the household income and high levels of chaperoning among the younger Traveller females. Prescription medication such as night sedation and valium are increasingly abused by Traveller women and sold within the Traveller community.

The reasons for substance use were observed to be similar to the *‘settled’* community but in most cases worsened by the problems experienced by the Traveller community, such as unemployment, poverty, discrimination, poor mental health, domestic violence and stress. Drug and alcohol use was identified by the majority of agency workers as an escape from the reality of their problems within the constraints of settled society and

were as follows; ***“Majority use substances in order to cope with problems and boredom”*** and; ***“Traveller substance use is more than a coping mechanism .It is a set of circumstances”*** and; ***“Escaping from alienation/wanting to be accepted/drowning sorrow”***. The most common perceptions of risk were reported to include health impact, legal consequences for possession/intent to supply and potential financial and family consequences. The following observations were made; ***“They appear to be quite aware of risks..”*** and; ***“There is little perception of risk relating to drug or alcohol use; only when there is an addiction do they acknowledge a problem”***. Several agency workers also commented on the difficulties which arise due to poor mental health both in relation to dual diagnosis of mental and drug related disorders; ***“Dual diagnosis of mental health and drug disorders very common”***.

In relation to how Travellers deal with problematic substance use, in most cases, the agency workers felt that the Travellers would try to deal with the problematic use themselves and within their own community before attempting to access services. The following comments were made; ***“There is a certain innocence around drug use – they don’t talk about it..”*** and; ***“2 out of 3 Travellers sort themselves out by taking the pledge or attempting home detox”*** and; ***“Some instances of home detox attempts as they don’t like outsiders..they try to solve everything from within and as a last resort will access services”***. The agency workers also commented on the use of religion in order to deal with addiction; ***“Sometimes they go to Medjurigorie”***. It was reported that some Travellers would abstain during lent, but these are reportedly mostly the older Traveller men. ***“Alcohol – the pledge is still very powerful among the Traveller community –strong effect. Superstitious faith particularly among the older”***. The prevalence of abstinence as the only solution amongst Travellers was also reported to clash with the objective of harm reduction adopted by some drug education agencies and health promotional materials.

The majority of Travellers accessing treatment services were reported to be male and presenting with alcohol addiction. The following observation was made; ***“Traveller women don’t access treatment services only Traveller men”***. This is particularly of concern in relation to reported levels of prescription medication abuse within the Traveller female population. The agency workers concerned with this facet of service delivery also commented on the lack of ethnic identifiers in drug treatment systems and

that in most cases Travellers (in all cases male with exception of 1 female) attended sporadically and usually one or twice. It was reported that in most cases the Travellers were usually difficult to engage with and were reported to only initiate treatment in the case of court referral, impending court case or child protection issues. The following observations were made; ***“Referrals to treatment are only in the case of GP, court or probation work..often not coming from the Traveller in question themselves which makes it harder to engage with them. Often disappear after the court case”***. Other commented on difficulties engaging with Travellers in treatment settings; ***“Commitment and motivation for treatment are problematic..Travellers are difficult to engage with a lack of commitment for treatment ...problems attending appointments and lack of understanding form counsellors..”*** and; ***“Travellers need greater support at treatment levels-there’s often very little direct support given and therefore they commonly attend once or twice and then drop out....They promise more than they can deliver”***. In addition to issues accessing treatment and engaging with the addiction counsellors, it was observed that Travellers find it difficult to work within groups as is common practice in residential treatment, and also in relation to committing to the residential treatment in its entirety. Those delivering counselling commented; ***“They need one to one interventions as they don’t work well in groups as they feel stigmatized”***.and; ***“Used to living in a caravan..very hard to commit to treatment in a residential; centre.claustrophobic...their world is outside of the caravan..”*** Some commented on the cost involved in urine screening deterred Travellers from attending and also problems relating to female nursing staff conducting urine analysis with Traveller men. In relation to the delivery of addiction treatment which commonly involves the use of written informational materials and logbooks, some agency workers commented that they had to read this information to their Traveller clientele and explain in depth, leading to delays in providing addiction counselling. The following remarks were made; ***“Treatment – literacy difficulties in reading the written work...i.e. keeping a journal ..Adds a layer of difficulty.. don’t read or understand written material and don’t see themselves as having a problem. Time intensive provision is needed, no point in giving drug educational leaflets.12 step programme in writing... Take time to read drug material to Travellers and explain.In this context the use of shock ads may have some value for Travellers or even films describing addiction.”***

It appears from this research that both Traveller organisations and mainstream drug services report that Travellers are under represented, in terms of those accessing counselling and residential treatment services. It is of vital importance to create ethnic identifiers and reporting systems throughout all community and drugs related services in order to quantify accurately the numbers of Travellers accessing treatment and education services. An interagency approach involving all relevant community based, Traveller and drugs services was deemed necessary to improve and develop a cohesive structure of support for Irish Travellers. Services must expand to include out of hours and weekends, in order to fully serve those most vulnerable and provide timely and reactive support. Ethnic monitoring of drug treatment and service numbers is necessary in order to quantify those currently accessing services and measure improvements in years to come. Some agency workers commented;

“A multi layered approach is necessary..not just drugs interventions but also sports/health/leisure/accommodation/training and employment” and ;“Travellers need timely help – when they decide to access they need it straight away, not weeks later. 30days clean is unrealistic..services are 9-5 not weekends.”

Other agency workers reported on the need for dedicated Traveller outreach, with a specific remit for drug and alcohol use. ***“Their own community is the key to successful drug prevention trust is paramount..Travellers do not want to attend segregated services.”*** The agency workers stressed the need for greater efforts made at targeting Traveller men, women and youth, with specific drug educational material and interventions for these age and gender categories in terms of substances used. ***“We need programmes specific to Travellers, designed by Travellers and implemented by Travellers..”*** There is a need for Traveller trained addiction counsellors, in order to engage with and support those Travellers experiencing problematic use and addiction. In addition, there must be some female Traveller trained addiction counsellors particularly in light of the severe lack of Traveller women accessing services. Other agency workers observed the common discriminatory experiences for Travellers and stressed the need for increased training for community, law enforcement, health and addiction services regarding Traveller culture. ***“Suspicion of the addiction counsellor who appears as authoritarian figure cultural training is vital for all staff..need to understand where they come from” and; “Traveller women won’t see a male counselor..There needs to be a voice for***

Traveller women experiencing problematic substance use” and “A Traveller will listen to another Traveller”. In terms of treatment residential detoxification must attempt to accommodate Travellers, due to difficulties for Travellers in attending residential treatment programmes, comprehension of written materials and commitment to treatment. There is also a mismatch in relation to addiction versus mental health services with some Travellers experiencing dual problems with high levels of depression in combination with drug/alcohol dependency.

“Travellers have special needs which include high levels of mental health disorder against a background of the problems they experience.”

Discussion

Illegal drugs, such as cannabis, ecstasy and more recently cocaine appear to be increasingly available across urban and rural areas throughout Ireland (NACD, 2007a, NACD, 2007b). This increasing pervasiveness of drug use in Ireland has appeared to have some peripheral effect on the Irish Traveller community who experience a myriad of risk factors for substance use so typically experienced by marginalized communities (Quinn, 1999). The exposure to risk factors in the relative absence of protective factors exacerbates the likelihood of such problem behaviours occurring in vulnerable individuals and minority groups experiencing social exclusion (Kilpatrick, 2000).

The Traveller cultural values and norms, close knit family and social networks may have some positive effect in reducing drug related instigation and harm (Fountain, 2006). However, drug use can pose a serious threat on the strength of Traveller culture in inhibiting risk factors, and is increasingly causing a fragmentation of Traveller culture (Joyce, 2002). This can also occur due to increasing sedentarisation of Traveller families in settled housing programmes, within marginalized areas with high levels of drug use and availability. Kenealy (2006) suggested that Travellers fear that their young people learn more about drugs when they interact with settled people and therefore their cultural base is weakened.

In addition one cannot under estimate that the neighbourhood environment or community setting may have some predictive effect in the initiation of substance use by providing exposure to and access to substances available and substance-using peer groups (Parker *et al.*, 2002). The Traveller community can provide close proximity and

access to substances available, and this can increase likelihood of use coupled with increasing normalisation of substance use among that group.

There is a certain lack of information on Travellers lives and experiences, due to the somewhat hidden nature of their lives in combination with levels of suspicion from settled or mainstream communities (Quinn, 1999, Kenealy, 2006). The agency workers reported an increase in drug availability and drug use within the Traveller community, and observed that this was due to increasing efforts to integrate with the settled community, high levels of boredom due to unemployment and poor mental health. However, there appears to be a genuine fear of drugs within the Traveller community particularly among older Travellers and Traveller parents, as a result of increased drug availability in their communities. This new exposure to drugs has also led to new ways of generating income for the Traveller community, and also an increased concern in terms of violence, criminal behaviours and drug abuse. It appears that the traditional Traveller culture is dissipating and is no longer offering protection to drug related risk factors (Joyce, 2002).

The levels of drug and alcohol involvement among the Travellers in this research presented a varied continuum in terms of prevalence, age and gender of users. Although lower than national trends, drugs use trends are similar (NACD, 2007a; NACD, 2007b). Alcohol abuse remains a serious cause for concern for both the general Irish population and also among the Traveller community (Pavee Point, 2004). It appears that Traveller women both old and young present with low levels of lifetime illicit drug prevalence, due to lack of financial opportunity and strict levels of control on young Traveller girls. Traveller men report increasing levels of alcohol abuse and illicit drug use. In contrast, Traveller women are increasingly reporting licit drug dependency in terms of night sedation, pain killers and anti depressants. This problem is twofold insofar that literacy and educational difficulties are impacting on appropriate use of this medication, and some General Practitioners are over prescribing to the Travellers. This is of concern in terms of co morbidity where the Traveller community commonly present with poor mental health, which is now exacerbated by increased levels of both licit and illicit drug abuse.

These research observations are supported by research indicating that Travellers are increasingly concerned about the impact of recreational and problematic drugs use on their children, families and communities, and most are willing to discover the appropriate response for their community (Pavee Point, 2005). In terms of attempts to deal with problematic use, these research findings are similar to the National Advisory Committee on Drugs report in 2006, which identified that in many cases the Traveller community's response to problematic drug use within their community or family includes *'perhaps indicating their lack of drug education can include, for example, some dangerous and overly-optimistic practices such as 'home detoxes' and hoping that parent telling children not to use drugs will prevent them from doing so'* (Fountain, 2006:74). The agency workers reported that the Travellers were unable to comprehend a harm reduction approach, instead adopting an *'all or nothing approach'*. Denial of drug use and problematic use is often present (accompanied by secrecy and shame among those who do have a problem), and Travellers also commonly have an unrealistic expectation of a *'quick fix'* (Pavee Point, 2004). In terms of Travellers accessing treatment services, these were reported to be primarily male, difficult to engage with, often only accessing treatment in the event of a court order, and compounded by literacy issues and difficulties attending group therapy. According to Fountain in 2006:93, the barriers to effective treatment for Travellers experiencing addiction is *'that it is geared to majority needs and culture; no minority members delivering services; and mistrust of confidentiality'*. There is an underlying perception among Travellers that drugs services are discriminatory, either from the service itself or from the clients (McCarthy, 2005; Fountain, 2006). In many cases, the agency workers were unsure as to whether services should attempt to provide integrated provision or that regional policies must offer segregated services to cater for the Irish Traveller community and any other ethnic minority. The agency workers indicated a greater need for culturally appropriate training in order to reduce such experiences of discrimination and social exclusion for those Traveller clients accessing their services.

Conclusion

It appears that the Irish Traveller community most commonly present with problematic alcohol use, and only in recent times with drug related issues. However, due to heightened risk of problematic substance use linked to their life circumstances, poor levels of drug awareness, difficulties accessing relevant services, experiences of

discrimination from health service staff, and committing to residential treatment and group counselling, it is necessary to devise culturally appropriate support mechanisms within community and drugs services, in order to proactively manage this social issue within the Traveller community.

Acknowledgement

The research was funded by the Western Regional Drug Task Force, Ireland. The opinions expressed in this article are of (the researcher) and are not necessarily those of the Western Regional Drugs Task Force.

Paper 7. Van Hout, M C (2009). Irish Travellers and Drug Use- An Exploratory Study. *Ethnicity and Inequalities in Health and Social Care*. March, Volume 2, Issue 1, 42-49.

Abstract

The challenge for drug and health promotion services is to keep up to date with the dynamics of drug use patterns and trends both nationally and within certain groups (Kilpatrick, 2000). The Irish Traveller community present with lower but similar levels and patterns of drug use than the general population, but are particularly vulnerable to early onset of drug use and problematic substance use relating to their life circumstances. Risk and protective factors relating to drug use for the Traveller community are described as interrelated deficits in the following areas: *'education, health, employment, accommodation, previous and current drug use, involvement in the criminal justice system, family, social networks and the environment including social deprivation, community disorganization and neighbourhood disorganization'* (Fountain, 2006:16,47).

The research aimed to provide an explorative account of the issue of drug use in the Irish Traveller community. The research consisted of focus groups (***n=12***) of Travellers (***n=57***) with a gender balance (47/53%) based on self selection and volunteerism. The focus groups (4-5 individuals) were predominantly peer-accompanied where a Traveller guided the facilitation of the Traveller focus groups and were also gender based. The focus groups incorporated the following key themes relating to the Travellers and drug use; Traveller culture and drug use, drug availability and dealing, gender differences in drug use, types of drugs used, reasons for drug use, levels of drug related knowledge, attitude to drug use, drug taking contexts and patterns, problematic drug use in the Traveller community, drug awareness, perceptions of risk and experiences of drug treatment and community services.

The Travellers indicated increased drug availability in recent years. Some members of their community were dealing in and using drugs, as a result of unemployment, lack of education, depression, and increasing contact with the settled community. This has lead to a fragmentation of Traveller culture. Traveller men are at heightened risk of substance dependency in terms of increased contact with drugs such as cocaine,

speed, hash and ecstasy. In contrast Traveller women reported prescription medication abuse. The Travellers described a fear of problematic drug use within their communities coupled with concern in terms of discriminatory experiences with health and drug services, lack of awareness of current service provision and the lack of culturally appropriate drug education material and addiction counselling.

Key Words

Travellers, Drug Use, Culturally appropriate Services, Discrimination, Drug Education.

Implications for Practice

In order to fully respond to the issue of increasing drug and alcohol use among the Traveller community, targeted, integrated and culturally appropriate community and drug service provision must be developed (Pavee Point, 2004). It is therefore vital to consider the needs of the Travellers and their reported drug use in the development of such proactive, culturally specific and supportive drug prevention and treatment protocols. The implications for practice include;

- The need for targeted outreach for Traveller communities in order to create awareness of services available.
- The need for culturally specific material in drug educational content.
- The need for improved service experiences for those Travellers attempting to seek help and treatment.
- The need for flexible treatment modalities in terms of group versus individual and residential addiction treatment.
- Improved systems of ethnic identifiers in drug prevalence data, services and treatment statistics.
- The inclusion of Travellers in guiding drug education and training in health education.

Introduction

Drug use is of increasing public health concern in Ireland in terms of widespread use of both licit and illicit substances (NACD, 2007a; NACD, 2007b). The challenge for drug and health promotion services is to keep up to date with the dynamics of drugs used within groups and communities (Kilpatrick, 2000). The Traveller Community in Ireland is identified '*as people with a shared history, culture and traditions including, historically, a nomadic way of life on the island of Ireland*' (Joyce, 2002, see Irish Traveller Movement, www.itm.ie). This ethnic minority present with lower but similar levels and patterns of drug use than the general population, but are particularly vulnerable to early onset of drug use and problematic substance use relating to their life circumstances. Risk and protective factors relating to drug use for the Traveller community are described as interrelated deficits in the following areas: '*education, health, employment, accommodation, previous and current drug use, involvement in the criminal justice system, family, social networks and the environment including social deprivation, community disorganization and neighbourhood disorganization*' (Fountain, 2006:16,47). However, due to the somewhat isolating nature of the Traveller culture and values, this ethnic group also experience some protective factors offering resilience to drug use such as supportive families, high levels of parental control and positive social networks (Stormshak *et al*, 2004, Fountain, 2006). There are concerns however, of the increasingly prevalent levels of poor mental health and depression among this ethnic group, coupled with increasing risk of problematic drug use for these individuals. In terms of Travellers accessing community, health and addiction services, the most commonly reported barriers include '*that it is geared to majority needs and culture; no minority members delivering services; and mistrust of confidentiality*' (Fountain, 2006:93). In terms of drug educational efforts, there are also difficulties in the dissemination of health promotional material, due to difficulties in literacy issues and comprehension of material, often requiring direct assistance from health professionals.

Research Methodology

Research aim

The research aimed to provide an explorative account of the issue of drug use in the Traveller community in the West of Ireland.

Participants

This qualitative research consisted of focus groups (n=12) of Travellers (**n=57**) with a gender balance (47/53%). The sample consisted of 12 locations in the counties of Roscommon, Mayo and Galway in Ireland and was based on self selection and volunteerism. The research commenced following several months of engaging with the researcher, in order to garner trust and optimise on number of research participants.

Research Design

The focus groups (4-5 individuals) were predominantly peer-accompanied where a Traveller guided the facilitation of the Traveller focus groups and were also gender based. This was based on recommendations from the Irish Traveller Movement [ITM] (2003) in order to facilitate the creation of relationships between the researcher, the agency facilitating the focus groups and the Traveller community; and to aid in future dissemination of drug and health related information within the community. The focus groups were guided by the following key themes relating to the Travellers and drug use; Traveller culture and drug use, drug availability and dealing, gender differences in drug use, types of drugs used, reasons for drug use, levels of drug related knowledge, attitude to drug use, drug taking contexts and patterns, problematic drug use in the Traveller community, drug awareness, perceptions of risk and experiences of drug treatment and community services. Confidentiality was stressed prior to conducting the focus groups, focus groups were allocated a code in order to ensure anonymity and participants were able to withdraw at any stage.

Data Analysis

All focus groups were coded, audio taped and transcribed. A thematic analysis (Nvivo) of the focus groups explored the information gained within the context of these '*lengthy conversation pieces*' and aimed to illustrate areas of similar and contrasting opinions (Simons, 1982: 37, Zemke and Kramlinger, 1985). Not all interviewees discussed the same themes and this was dependent on their experience of drug use within their halting site or community setting. Therefore the research findings cannot be generalized and yield a '*snapshot*' of the Travellers and their experiences of drug use within their community.

Results

The Irish Travellers spoke about their culture with great concern that the Traveller culture was **“dying out”**. There appears to be a genuine fear of drugs within the Traveller community particularly among those Travellers who are older and those who are parents. Some Travellers reported that drug taking is a sensitive and **“taboo”** topic to discuss, due to their difficulties in understanding drug use from a cultural and age perspective. From the Travellers perspective, the discrimination which Travellers face in all aspects of life was widely regarded to encourage early onset of drug use and also exacerbate current problematic drug use. Some observed a certain isolation within the settled community and said **“You’re not in the same community, you’re living in it, but you’re not in it”**. In terms of unemployment and difficulties in accessing training, the Travellers commented on this negative effect in their lives often leading to depression and highlighted the link between this and future drug use; **“If you have no education and no skills, you more than likely have no job, then kids that have no opportunities, they seek and opportunity and an easy way out. Some kids take the drugs for their own use and they take extra and are selling it to their friends, and it’s like a skill, like a job.”** Others remarked; **“So if they ain’t got jobs and they ain’t got work, the best thing is to go and get drugs and get high”** .

There was immediate recognition by Travellers within urban groups that there are visibly **“more drugs”** in urban areas over the last 2 years. The Travellers associated the increase in availability of drugs in their towns, possibly due to these towns **“getting bigger”**, and more people moving into the town, **“who may be bringing”** in drugs. A Traveller commented **“Its like every town I suppose, there’s drugs in every town and, ya know, this place is riddled with them like, that’s to be honest about it like, dya know what I mean.”** According to the Travellers, there appears to be the presence of both drug users and dealers within the Traveller’s own circles and halting sites. The Traveller groups observed that they are aware that drug-taking and dealing takes place in all communities, and that it is often hidden **“better”** in more affluent lives; **“There’s people like that are taking drugs and nobody knows about it”**. Therefore in most instances the drug use is commonly coming from their own community and not the settled community as context for introduction, facilitation of use and opportunity for drug dealing. The Travellers reported that drug dealers are known to them as both members of their own community and also within the settled

community, as evidenced by a Travellers comment ***“Most towns would probably have a dealer”***. A Traveller said ***“A lot of people are making a living out of it and destroying someone else’s life”***. The lack of activity by the Gardai Siochana (Irish Police) in arresting drug-dealers and preventing drug dealing was highlighted as an important issue in combating drugs within the Traveller community. Other Travellers were concerned that these drug dealers were recruiting young Travellers to act as ***“runners”*** and also introducing them to drugs such as hash, ecstasy and cocaine.

The Traveller groups were very conscious to outline and emphasise that drug-taking is most definitely not a part of life for all Travellers, but that it is an issue for some individuals, and families, as within the settled community; ***“In the biggest population of Travellers, I wouldn’t think that you would get 50 of them doing drugs.”*** The Traveller groups outlined that ***“ecstasy, speed, hash and cocaine”*** are the most commonly used drugs within the Traveller community. The Traveller groups identified that illegal drug-taking was most prevalent among young Traveller men, and least common in Traveller women both young and old. The Travellers outlined that it is mainly single Traveller men who are involved in drug-taking and drug dealing, while there are a small number of married Traveller men involved. However some Travellers did describe drug-taking as ***“a stop gap when you’re single”***. There were also several comments made by the Traveller women in relation to marriage and possible positive effect this has on health risk behaviours such as drug use and excessive drinking; ***“If you’re single no-one is supposed to know what you’re doing, and if you have done something really wrong, your parents might say, you’re not good enough or whatever, whereas if you’re married anything goes, what you do in your own home is your business”*** and; ***“If you were single it would be harder for you cos you would have to keep it quiet, or they mightn’t be able to get married”*** . In relation to the lower drug taking rates among Traveller women, the Travellers themselves attributed this to the fact that young Traveller women/girls do not have much freedom or disposable income, and therefore do not have the opportunities to purchase illegal drugs.

Prescription medication such as night sedation and valium is commonly used and sold within the Traveller community. Some Travellers outlined their concerns that depression was increasingly common and prescribed drugs are being misused within the Traveller community, particularly among Traveller women, and their concern in

relation to the potential of problematic prescription drug abuse; ***“Isn’t there an anti-depressant now that people are kind of getting hooked on, I think it’s called D10”*** and; ***“I think that there are people just going in there and getting them, and pretending they are being depressed and that, and maybe getting them and selling them on”***. In some cases it was reported that Traveller women are trying to control their children with antidepressant medication and valium. This was due to literacy difficulties and misinformation and appeared to be occurring coupled with high levels of mental and conduct disorder amongst Traveller children.

These reasons for drug experimentation and subsequent use were described by the Travellers as primarily relating to curiosity, depression and the peer group setting; ***“Didn’t know what it was”*** ; ***“Depression is one of them*** and ; ***“There is young fellas that are vulnerable to drugs, as well like eh, and eh, what I mean now is they are easily-led. There is young fellas out there that can be easily led. They want to be part of the gang or part of the group. Where there’s other young fellas then that they wouldn’t have anything to do with it like.”*** In addition, the Traveller parents commented on their fears of drug use among their children and said; ***“They might feel let down, they might be having problems at home, or “the whole world is against me I might as well do it anyway”*** and ; ***“It seems to be the ones that aren’t working, left school about 16 or 17 and they’re getting their dole, it seems to be higher in them that the ones that are working, but I don’t know why.”*** .

The Travellers recognised that there are probably Travellers within their communities who are using drugs, both young and old, who may be in need of ***“help”*** due to problematic substance use. Some Travellers outlined that they were aware of those using drugs in their communities but were not as aware of many Travellers who may have a ***“drug problem”***. Other Travellers commented on the strength of rules and sanctions for drug use within their communities in previous years and said; ***“Ye couldn’t drink before ye got married, that was one thing you couldn’t do, or smoke, never mind use drugs”***. The Travellers reported a lack of comprehension and fear of the potential escalation of drug use both in terms of progression to harder and more serious forms of drug use and also in terms of excessive or binge use. The Traveller groups also discussed the impact of problematic substance use on themselves and their loved ones, highlighting their beliefs that drug-taking has both

significant causes and consequences in terms of **“knock on effect”** and also denial of the existence of a problem with a substance; **“Ya see life circumstances come into it too, it does really, because if your living with someone that takes that stuff its your everyday life looking at them, eventually your going to end up doing it like”** and; **“And Travellers don’t realise the dangers of it and a person won’t admit to going to Rehab, a Traveller won’t admit it because they won’t admit they have a problem.”** .Some Traveller groups noted that drug-taking can lead to having people owing money, and having dealers **“after them”** for money owed. The following remarks were made in the course of the focus groups; **“Some people can cope with it and get out of it, but more doesn’t, some people commit suicide over it”** and; **“Bills coming through the door, then you’re getting put out of your house, then your somewhere else, the rent goes up you cannot pay that”**. Such drug use and indeed problematic drug use would often result in domestic abuse, child neglect and financial difficulties. The Traveller groups acknowledged that within their community, drugs are seldom discussed among Traveller families, who do not have drug use/addiction within their immediate family. In particular there would be attempts to hide or disguise levels of drug addiction within the Traveller family due to the stigma attached to drug use. The Traveller family will generally attempt to deal with the drug user and their problem within the family first, often with the help of wider family networks (uncles, cousins etc.), talking to the person, trying to get them to stop **“doing what they are doing”**.

In relation to drug awareness training which some of the Traveller focus groups participated in, the majority of Travellers felt that it was not suitable for a Traveller group, as it was not based on their values and beliefs in terms of harm reduction advocacy; **“We had someone in here talking about drugs before and we actually thought by the way that she was talking that drugs were good, what we took from that session was its ok to take drugs and don’t drink”** and; **“With drugs you can’t be non-judgmental, you’re either for them or against them”** and; **“She should have been told before she came in here really is that would have been the way we are about drugs, that we don’t find drugs as being good, ye know, that we don’t agree with that, maybe she would have came across differently then.”** The Travellers reported finding it very hard to come to terms with the current harm reduction approach and called it, **“the safe use of drugs”**. In relation to drug

education and their children, the Traveller advocated the use of shock tactics in deterring their children from drug experimentation and made the following comments; ***“If they were shown something, the harm that it does”*** and; ***“I know someone who is off it ten or twelve years. They are the people that should be talking to young people about it because they understand.”*** Other Travellers advocated the use of recovering or ex addicts in the delivery of drug educational material and youth ***“It would be good if they brought in a recovering drug addict, to tell their story of how it affected them and all that, because a person going in that never took drugs before, they’re not going to know”*** and; ***“They should do that in secondary school, and aim it the whole way through school. Sure they could have someone come in and they might never see that person again, it would go out of their head, I think it should be certain times of the year come into certain classes and keep it going the whole way through so they remember what you have been saying.”*** The Travellers felt that drug education and awareness for Travellers is vital and that opportunities for Travellers to participate in drug education should be developed within communities. The groups felt that drug awareness programmes should be delivered on a gender and age basis (Traveller men, women, and young people) and within established Traveller groups in order to build on present levels of trust and relationships.

In relation to the situation for Travellers who may have a ***“drink or drug problem”*** the Travellers discussed how someone might access a service or the possible reasons for not accessing a service and made the following comments; ***“Drugs is like a sickness, and why would you hide it?”*** and; ***“Travellers don’t really go for, say, “I’ve got a drink problem and I need help like”, I think its more they don’t want people poking in their business, it would be embarrassing, they probably wouldn’t say anything. And for the rare few that would, they’re nothing for them.”*** and; ***“if somebody did come out and say that they were on hard drugs they would a lot of people upset with them.”*** There appeared to be the identified need that Travellers must be able to access treatment services in confidence due to feelings of shame, denial and fear; ***“Some people might not want to walk in because it could be you neighbour that’s working in there, could be somebody that you know from going to the schools and stuff like that, one of the other parents working there”***. Most Travellers commented that the General Practitioner was most commonly the first port

of call for those needing help and commented; ***“Well what we would think is the first person you would see if you have a drug problem is your own doctor and he would put you onto somebody”***. Other Travellers reported feeling embarrassed to visit their General Practitioner in times of drug related difficulty.

The Traveller groups suggested that there is a lack of information on drug services within their communities in terms of access and timely support and said; ***“such services need to be out and about with information on drugs, and what their service has to offer”***. The Travellers highlighted that while they feel while they are aware that there are Travellers who are facing drug problems in their lives, in their area, the current level of service provision, and service provision structures, are not designed to meet the needs of those Travellers who may be trying to access ***“help”***. The Travellers highlighted that it is common practice for them to hide their identity in order to avoid being discriminated against, particularly in the case of attempting to gain employment, accessing health services, and addiction counselling. Many of the Travellers involved recounted negative experiences both in accessing services, but also in relation to the settled people, who operate those services and also those accessing with them. Most Traveller groups highlighted that negative experiences within services could possibly prevent an individual or family seeking help or support at another stage.

In addition, some Traveller groups were not aware of what services were available to them and what services were appropriate to access in terms of mental health or drug related disorder. Many of the Travellers commented that services were only accessible during office hours and not at weekends, and remarked that often when a Traveller had made a decision to enter treatment this had to be acted on immediately. The following comments were made; ***“Well we can’t do it today, and I only work from 9 till 5, and I’m on holidays, and today is a bank holiday”***. ***You tell that to a drug addict, he doesn’t even know what day it is, don’t mind that it’s a bank holiday, or she for that matter. So I think that the services should be, when they’re prepared to take the help, that’s the time to grab them.”*** A Traveller said ***“Travellers and settled people, anyone that needs help”***. The Travellers felt that treatment services should make themselves more visible to the Traveller community,

and outreach also to highlight their role and services available ***“somewhere to go, have a chat, a drop-in centre.”***

The Traveller groups recognised that drug misuse is a community issue and as such members of the Travellers community should be provided with training in order to help members of their own community. An ***“outreach element”*** is vital, which would involve a Traveller worker being ***“on-site”***, meeting families, young people and providing information and developing opportunities for Travellers. The following quotes were made; ***“I don’t think the services know what they need to know about Travellers, about Traveller culture or what way Travellers do things, because they haven’t got Travellers with them, they’ve got know Traveller worker with them and say well I’ll go to these Travellers and speak to them”*** and ***“At least if there was a Traveller they could say, I know what the situation is, I know how they have to live, I know from their background and being of the same background they would pretty much get it.”*** The Travellers suggested that developing services for Travellers which promote Traveller culture and expression would serve as drug prevention methods also as they would provide a place to belong, a sense of identity. The Travellers remarked on the need to integrate services and cater for all; ***“talk to you and not at you”*** and ***“Travellers and settled people working together....has to come from everyone.”***

Discussion of Results

Whilst drug use among the Traveller community is increasingly present, this remains at a lower level than the general Irish population (Fountain, 2006). There is a certain lack of information on Travellers lives and experiences, due to the somewhat hidden nature of their lives in combination with levels of suspicion from settled or mainstream communities (Quinn, 1999, Kenealy, 2006). This research attempts to provide an insight into drug use and issues surrounding drug use within the Irish Traveller community. The Traveller community was traditionally protected from drug use due to their nomadic lifestyles and limited contact with the settled community. However, in recent times Travellers are experiencing greater levels of contact with the settled community in terms of housing projects, community outreach and education. As a result increasing levels of problematic drug and alcohol use have been reported (Fountain, 2006).

Joyce (2002) also reported an increasing fragmentation of Traveller culture causing increased vulnerability to problematic drug use in the Traveller community. In terms of their lifestyles the Travellers experience a myriad of risk factors for substance use so typically experienced by marginalized communities (Quinn, 1999). The Travellers reported a fear of drugs in general, coupled with concern that their culture was increasingly dissipated in terms of offering protection from drug use. In addition, problems accessing education, employment and other community services were reported to increase susceptibility to drug experimentation and problematic use. There appears to be a certain level of shame, denial, and fear of drug use within their community. This is similar to Fountain (2006:33) who reported that *'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'*

According to Parker *et al.*, in 2002, the perceptions of access to drugs or drug availability are strongly influenced and mediated by the individual's personal experience of drug use, their community context for norms of use and their socio demographic profile. The Travellers reported increased availability of drugs within their communities. Drug dealing, drug use and increased access to drugs for the Traveller community are becoming a serious issue due to increased levels of mobility and location of halting sites within urbanised areas (Power, 2004; Fountain, 2006). The drugs most prevalent for using and dealing were hash, ecstasy, amphetamine and cocaine, and were primarily used by Traveller men. This is similar to national drug prevalence trends (NACD, 2007a; NACD, 2007b).

The reasons for substance use were observed to be similar to the *'settled'* community but in most cases worsened by the problems experienced by the Irish Traveller community, such as unemployment, poverty, discrimination, domestic violence and stress. In addition, high levels of mental disorder and depression were resulting in increased levels of prescription medication abuse, particularly among Traveller women. Denial of problematic drug use was reported to be present (accompanied by secrecy and shame among those who do have a problem), and the Travellers reported attempting to deal with such problems within their own families, rather than accessing services. Other Traveller research reports that Travellers also commonly have an

unrealistic expectation of a '*quick fix*' (Pavee Point, 2004). Such fear of drug use has also led to difficulties for the Travellers to comprehend the current harm reduction methods of drug education.

The discrimination and exclusion that Travellers experience in the course of their daily lives is often not directly visible to national policy and regional/local service providers (Blighe, 2001; Fountain, 2006). The barriers to effective treatment for Travellers experiencing addiction is '*that it is geared to majority needs and culture; no minority members delivering services; and mistrust of confidentiality*' (Fountain, 2006:93). There is an underlying perception among Travellers that drugs services are discriminatory, either from the service itself or from the clients (McCarthy, 2005; Fountain, 2006). This was also reported by the Travellers in terms of not availing of community services due to issues regarding discrimination, lack of awareness, lack of culturally appropriate material, literacy difficulties, problems engaging with the '*settled*' counsellors and lack of timely support. There is a need for targeted outreach for Traveller communities in order to create awareness of services available. In terms of service experiences, anti discrimination and cultural training for professionals and the inclusion of Travellers in guiding drug education and training in health education was deemed vital. The Travellers also commented on the need for flexible treatment modalities in terms of group versus individual and residential addiction treatment.

Conclusion

The Irish Traveller community is reported to be under represented in drug education, prevention, community and treatment services (O'Brien, 2005). This has occurred due to difficulties in accessing services, experiences of discrimination, lack of education and lack of ethnic identifiers in reporting systems. According to Pavee Point (2005), in order to fully respond to the issue of increasing drug and alcohol use among the Traveller community, targeted, integrated and culturally appropriate community and drug service provision must be developed across Ireland. It is therefore vital to consider the needs of the Travellers and their reported drug use in the development of such proactive, culturally specific and supportive drug prevention and treatment protocols.

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Paper 8. Van Hout, MC (2010). Alcohol Use and the Traveller Community in the west of Ireland. *Drug and Alcohol Review*. January, Volume 29, 59-63.

Abstract

Introduction and Aims

The Irish Traveller community as ethnic minority is vulnerable to problematic alcohol use, due to social exclusion, discrimination, lack of awareness and difficulties in engaging with addiction treatment protocols.

Design and Methods

This research yielded an exploratory account of Irish Travellers and alcohol use according to the perspectives of the Travellers and key service providers in the west of Ireland, within the context of a large scale study on Travellers and substance use. The research consisted of 12 peer accompanied focus groups of Traveller men and women ($n=57$) and 45 semi structured interviews with a self selecting sample of key service agencies. The research themes related to Traveller culture and alcohol use, gender differences, reasons for consuming alcohol, attitude to alcohol use, problematic alcohol use, levels of alcohol harm related knowledge, perceptions of alcohol related risk and experiences of addiction services. A thematic analysis of the information garnered guided this comparative analysis.

Results

The Traveller community, and in particular Traveller men are presenting with increasingly problematic alcohol use, due to dissipation of their culture and their experiences of marginalisation, discrimination, depression, illiteracy and poverty. Difficulties engaging with law enforcement, community health and addiction services compromise their efforts to deal with this problem and home detoxification attempts are common.

Discussion and Conclusions

Services must aim to take into consideration the cultural needs of Travellers and provide appropriate educational materials, peer education programmes and flexible treatment approaches for those Travellers experiencing problematic alcohol use.

Introduction and Aims

Treatment statistics consistently report alcohol as primary substance of misuse in Ireland (HSE, 2007). National drug policy and regional services must diversify in terms of the dynamics of substances used, and most particularly among at-risk groups such as the Traveller community (Kilpatrick, 2000). Traveller culture once offered some resilience to substance misuse, in terms of strong family networks and anti drug attitudes (Joyce, 2002). The Traveller community as ethnic minority experience many risk factors identified for problematic substance use. Their lives are typically characterized by poor educational attainment, unemployment, compromised housing conditions, criminal activity, domestic violence, child welfare issues, poor health and experiences of discrimination in the community (Fountain, 2006). This has led to increasing levels of alcohol abuse and problematic drug use, and occurs in conjunction with the merging of Traveller communities with ‘*settled*’ or mainstream communities. .

Due to the lack of ethnic identifiers in reporting systems and difficulties accessing the Traveller communities, there is a dearth of national and regional information regarding the Travellers and levels of substance use. National prevalence surveys indicate that male Travellers exhibit higher levels of alcohol use, than females, and that the Traveller community report lower levels of drug use (McCarthy, 2005; Fountain, 2006). However, the Traveller community is reported to be under represented in health, community and treatment services, due to lack of awareness, mobility, discriminatory experiences and difficulties in engaging with treatment protocols (O Brien, 2005).

According to Pavee Point (2005) which is ‘*a partnership of Irish Travellers and settled people working together to improve the lives of Irish Travellers through working towards social justice, solidarity, socio-economic development and human rights*’ (see www.paveepoint.ie), the appropriate response to increasing substance use among the Traveller community must incorporate targeted, integrated and culturally appropriate drug service provision across Ireland. The research was part of a large scale regional needs analysis in the west of Ireland conducted in order to guide the National Drug Strategy 2009-2016. This needs analysis aimed to uncover the needs and feelings of Irish Travellers, Traveller culture and substance use, problematic substance use and experiences of health, community and addiction services, in order to identify gaps in services, guide resources and give recommendations for improved service provision.

Design and Methods

The research provided an exploratory account of Irish Travellers and alcohol according to the perspectives of the Travellers and key service agencies in the western region of Ireland (counties Galway, Mayo and Roscommon).

1. *The Travellers*

A predevelopment research phase of several months was conducted in order to build trust and commitment among the Traveller population in the west. This yielded optimal information about levels of alcohol use, attitudes to alcohol, current patterns of alcohol use, motives for use, perceptions of risk, and experiences of addiction services. The 12 focus groups contained 3-9 individuals of similar age and gender within the counties of Mayo, Roscommon and Galway and were Traveller peer-accompanied, whereby a Traveller guided the facilitation of the Traveller focus groups. The focus groups were composed of Traveller men and women who volunteered to partake from a random sample of halting sites in each county ($n=57$).

	Total	Traveller Men	Traveller Women	Under 20 years
Galway	36	14	14	8
Mayo	4	4	0	0
Roscommon	17	1	8	8
Total	57	19	22	16

An information sheet outlined the aims, methods and confidentiality of the research project and was verbally explained to all participants. Participants were encouraged to ask for clarification during the course of the focus groups, to raise their own issues and were allowed to withdraw if necessary.

2. *Service Providers*

The interviews with agencies ($n=45$) were conducted in order to generate a more comprehensive picture of current dominant perceptions of the '*experiences and issues relating to drug use among Travellers*'. The researcher contacted all relevant agency workers in the west and the resulting sample was based on availability, with a response rate of 66%. The sample included representatives of Traveller organisations, primary health care programmes, addiction services, county development, probation and welfare, juvenile liaison, An Garda Siochana (Irish Police), youth services, social welfare, family support, and community services. These individuals were deemed well positioned to detect '*new*' or recent developments in the lives of Travellers, in relation

to their levels of alcohol related knowledge, attitude to alcohol use, levels of drug and alcohol use, experiences of addiction services and approaches to addiction treatment. In order to provide complete anonymity, it is not possible to provide detailed information regarding percentage breakdown of these individuals.

3. Data Analysis

The information was transcribed and collated by the author. The thematic analysis (Nvivo) explored the information gained within the context of illustrative conversation segments and presented areas of similar and contrasting opinions. The analysis is therefore strongly grounded in the research information garnered.

Results

It appears that the Irish Traveller community most commonly present to services with problematic alcohol use and only in recent times with drug related issues. The agency workers commented that the introduction to alcohol most commonly occurs within the Travelling community, although the increasing contact with the settled community in terms of housing, employment and education are providing avenues for excessive alcohol use, increased opportunities for drug experimentation and problematic drug use. Most agency workers commented on the prevalence of poly substance use with the following common combinations with alcohol; ***“Hash/cannabis; Benzodiazepines; Solpadine; Cocaine and Prescription medication”***.

The agency workers observed that alcohol remains the primary substance of choice within the adult Traveller community and is increasingly abused by older Traveller men and single Traveller women. Alcohol use was identified as a coping mechanism in order to deal with increasing fragmentation of their culture, experiences of discrimination, difficulties gaining employment, lack of positive leisure opportunities and poverty with agency workers observing; ***“Majority use alcohol in order to cope with their problems.”*** and; ***“Escaping from alienation and wanting to be part of the community they live in”***. Travellers are also stereotyped by the media as having major alcohol related issues in terms of excessive alcohol use, violence and public order offences, particularly relating to feuds, funerals, weddings and religious celebrations. An agency worker said ***“Drinking most commonly takes place at funerals and weddings with high levels of alcohol being consumed particularly among the Traveller men.”***

The agency workers commented on the increasing pervasiveness and destructiveness of alcohol abuse in Irish society. The lack of ethnic identification in health systems, similarities in Traveller surnames and poor engagement of Travellers with services, has compromised estimations of the proportion of Travellers seeking support for alcohol abuse. An agency worker said ***“Alcohol needs to be dealt with in Irish society never mind as part of Traveller culture”*** and ***“There is little difference now between the Traveller community and the settled.”*** They described the negative effect that problematic alcohol use has on Traveller families; ***“in other cases if the head of the household is absent or in prison, the Traveller woman present with high alcohol and prescription medication use.. Mothers are seen as the key role model in the Traveller community”*** and; ***“Fathers with serious alcohol addiction and binge use- leading to increased violence in the home and financial difficulties for the Traveller family. Alcohol causes depression...problems experienced exacerbate depression...General Practitioners (Doctors) are over prescribing medication...risk of dependency and use in combination with alcohol...”***

In relation to alcohol use and the Traveller community, the Travellers themselves highlighted several important issues. Most Travellers described the extensive discrimination in gaining access to pubs and hotels, leading to binge drinking in halting site, fields and caravans. A Traveller male observed; ***“it would be the odd time that we would get into the pub, Travellers you see have a lot of problems getting served in the pubs, so that would be a big thing too about going to the pub, and this is why we would be drinking at home”***. The Travellers felt that alcohol was very accessible to ***“all”*** Travellers (including minors) due to its low cost, ease of purchasing and accessibility in off-licences and supermarkets. In relation to the opportunity to purchase large amounts of alcohol cheaply, the following remark was made; ***“look at Lidl’s (supermarket) there, you get the drink there very cheap, off-licences now at the weekends, they do these deals, you get 24 bottles of Bud for 20 euro.”*** (Traveller Male) The older Travellers also noted their concern that young Travellers are drinking alcohol in an attempt to ***“fit in”*** with their settled peers, and said; ***“I can be really honest with you that 14, 15 ,16 years old are getting somebody to get it for them in the off-licence, and drinking it up back alleys, or go to somebody’s house and they would know that the parents wouldn’t be there and they would***

be drinking it” (Traveller Male Youth) and; “it’s cheap, and if their friends are doing it they are going to do it” (Traveller Female) and; “The same as everything else really, like yer just going to go and do it, like I know myself, when I was 15 or 16 it was always drinking, there was nothing else to do. It was quicker to go and get a bottle of cider than it was to go and get a team set up for football, or do anything like that.” (Traveller Male).

The Travellers attempted to illustrate the position of alcohol and the issue of problematic use within the Traveller community. There appears to be a certain level of acceptance of alcoholism, as if this is part of **“normal”** Traveller culture. In terms of alcohol related harm; **“There is little perception of risk relating to drug or alcohol use; only when there is an addiction do they acknowledge a problem” (Traveller Female)** and; **“If I don’t get caught what’s the problem” (Traveller Male Youth)**. Some Travellers suggested that while they are aware of Travellers who may have a **“drink problem”**, others would be ashamed to admit that they have a problem with alcohol or even acknowledge the negative impact alcohol use is having on their families. The Travellers remarked; **“Probably ashamed to admit that they have a problem” (Traveller Male)** and; **“You would know more alcoholics now than you would expect...it’s accepted.” (Traveller Female)** In addition, some Travellers commented that whilst they recognised the negative impact of alcohol abuse on themselves, and their families, they found that due to high levels of boredom, depression and stress that they were unable to curb their alcohol use. The agency workers described problematic alcohol use among the Traveller community characterised by excessive drinking in terms of units and type of beverages consumed and remarked; **“Their alcohol use patterns are more destructive than in the settled Irish population”**. In addition, high levels of domestic violence, assault and damage were reported to occur as a result of excessive Traveller drinking.

Both agency workers and Travellers described the Irish Traveller culture as traditionally very religious and that religious celebrations are often the context for heavy drinking and drug use. The Travellers reported they would often pray and visit the local priest to try to deal with the problem of substance abuse within their family. Some agency workers illustrated that some Travellers would abstain during Lent (40 day period before Easter), but that these were reportedly mostly the older Traveller men; **“Alcohol**

– the pledge is still very powerful among the Traveller community –strong effect. Superstitious faith particularly among the older”. The agency workers described instances of home detoxification without medical support and other attempts to deal with the problem within the Traveller family and said; “The difficulties arise for Travellers who by nature of their culture advocate abstinence in the case of problematic alcohol and drug use.....this clashes with the current service advocacy of harm reduction principles”.

In relation to the situation for Travellers who may have a **“drink or drug problem”** the Travellers discussed how someone might access a service or the possible reasons for not accessing a service and said; **“Travellers don’t really go for, say, “I’ve got a drink problem and I need help like”, I think its more they don’t want people poking in their business, it would be embarrassing, they probably wouldn’t say anything. And for the rare few that would, there’s nothing for them.” (Traveller Female)** According to the agency workers, almost 100% of Travellers accessing treatment services were reported to be male, presenting with alcohol dependency, only attending once or twice and usually in the advent of a court case.. In terms of gender differences, the following observation was made; **“Traveller women don’t access treatment services... only Traveller men.”** This was deemed due to Traveller culture often preventing Traveller women from leading independent lives. The agency workers described Traveller women as hampered by lack of financial ability, family commitments and engaging in low levels of alcohol use.

In terms of improving service provision for Travellers experiencing problematic substance use, both Travellers and agency workers reported on the need for culturally appropriate alcohol education, peer led training protocols, increased Traveller outreach and family support. Both cohorts emphasised the need for increased visibility in terms of service awareness and after care support systems for those Travellers engaging in treatment. The Travellers commented; **“responses need to come from everyone in the community...that’s us the Travellers, the Traveller organizations and drugs serviceswe need to know where to go for help ... where there’s a friendly face and someone who understands...someone to listen to me.” (Traveller Male)**

Discussion and Conclusions

Alcohol abuse remains a serious cause for concern nationally and also among the Irish Traveller community. Alcohol and indeed drug use among ethnic groups like the Traveller community is usually hidden and dynamic in nature. The prevalence of problematic alcohol use among this minority is therefore difficult to estimate in national prevalence surveys, due to lack of ethnic identification and poor service utilisation (EMCDDA, 2007; NACD, 2007a). The levels of alcohol abuse among the Travellers in this research are presented a varied continuum in terms of patterns of use, reasons, gender differences and other causative factors. It appears that Traveller women present with low levels of alcohol prevalence, due to lack of financial opportunity, family commitments and strict levels of control on young Traveller girls. In contrast, Traveller men and youth were reported to engage in increasing levels of alcohol abuse and drug experimentation.

Alcohol abuse can have many potential negative consequences over time, including health and emotional problems, lower social competence, and problems with school or employment (Hopfer *et al.*, 2003). This appears to be particularly the case for the Traveller community who experience many risk factors coupled in terms of mortality and co morbidity of alcohol dependency and mental health disorders (Fountain, 2006). For the general population, a small number of individuals will experience problems associated with their alcohol use, or will go on to develop dependence and problematic disorders (Hussong, 2002; Kelly *et al.*, 2002). However, in light of the fact that the Travellers experience a myriad of risk factors for problematic alcohol use relating to their social situation, their levels of problematic alcohol use and in recent times drug use is of public health concern. This has occurred due to increasing levels of contact with the '*settled*' community in terms of housing in marginalized communities, drug availability and experiences of social exclusion.

It appears that Traveller culture is dissipating and has compromised resilience against alcohol and illicit drug use. The barriers to accessing health services for Travellers experiencing problematic substance use are; '*that it is geared to majority needs and culture; no minority members delivering services; and mistrust of confidentiality*' (Fountain, 2006:93). National drug policies ignore reality of the Traveller community in terms of their alcohol and drug use and their experiences of services. While policy

emphasis is on abstinence, ground level services adopt a harm reduction approach. This is difficult for the Traveller community to comprehend and is evidenced by attempts to achieve home detoxification without medication, and dealing with substance abuse within themselves. Services must take into consideration the needs of Travellers in terms of their life experiences, their culture, illiteracy, feelings of discrimination and difficulties engaging with treatment modalities. In summation, the research is intended to provide an illustrative account of Travellers and alcohol use, cultural beliefs, problematic alcohol use, levels of harm related knowledge, and experiences of services. The study findings cannot be generalized the limited sample sizes and regional context. Future research is necessary to further explore new communities in Ireland against increasing alcohol and drug use in Ireland.

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Paper 9. Van Hout, MC (2010). Travellers and Substance Use in Ireland- Recommendations for Drug and Alcohol Policy. Policy Paper. *Drugs: Education, Prevention and Policy*. In press.

Abstract

The Irish Traveller community was traditionally protected from drug use by distinct traditional anti drug norms and potent family networks within their '*separateness*' from the 'settled' community. Estimations of Traveller substance use remain clouded due to lack of ethnic monitoring in drug reporting systems, and poor service utilisation by Travellers. This paper draws on a Traveller and substance use regional needs analysis in Ireland, which comprised of **12** Traveller focus groups and **45** interviews with key stakeholders. Drug activity in terms of both drug dealing and drug use among Travellers is increasing in recent years (Van Hout, 2009a). Traditional resiliency factors are dissipating in strength due to increased Traveller housing within marginalized areas experiencing drug activity and increased levels of young Travellers encountering youth drug use within school settings, by way of their attempts '*to fit in*' and integrate with their '*settled peers*' (Van Hout, 2009a). Fragmentation of Traveller culture is occurring as Travellers strive to retain their identity within the assimilation process into modern sedentarist Irish society. Treatment and outreach policies need to protect Traveller identity by reducing discriminatory experiences, promoting cultural acceptance with service staff and addressing literacy, implementing peer led approaches and offering flexible therapy modalities.

Key Words

Ethnic minority, Culture, Travellers, Drug Service Provision, Drug Policy

Introduction

The Traveller Gypsies

Gypsy Traveller groups are identified as small indigenous nomadic groups, who have been part of Irish and British society for several centuries (Cemlyn, 2008). Available literature remains cloudy with variations in self definition and contextual differences present in generic terms such as 'Gypsies' and 'Travellers'. Due to the prevalent levels of Traveller Gypsy illiteracy, their history has incurred great misrepresentation (Fraser, 1995) and continued debate prevails on the *'unspoken assumption that the validity of Gypsy/Traveller culture is up for definition and approval by the majority population'* (Ni Shuinear, 1994:73). The Gypsy Travellers comprise several distinct groups, namely; English Romani Gypsies, Irish Travellers, Roma from Central and Eastern Europe and 'New Age' Travellers in their third or fourth generation (Earle *et al.*, 1994). The Traveller community have been recognized within the United Kingdom and Ireland in the last two hundred years and are described by Joyce (2002 see Irish Traveller Movement, www.itm.ie) 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, historically, a nomadic way of life on the island of Ireland'*. The Traveller community remains a minority of the Irish population (0.6%) (CSO, 2006).

The Irish Traveller community preserves their identity as ethnic nomadic group in Ireland by reinforcement of their choice of *'separateness'* from the *'settled'* society (Pavee Point, 2004). Hostility and prejudice of the *'itinerant way of life'* remains present in Irish society, and are exacerbated by the very reinforcement of the distinct Traveller culture, limited opportunities for interaction, lack of reciprocal trust and labeling of Travellers as criminals (Cemlyn, 2008). According to Helleiner (2000) Irish Traveller culture and identity are consequential to oppression, exclusion and media conditioning of anti Traveller discourse. Within Traveller public discourse, levels of human rights denial range from denial of their ethnic minority status to intense socio political exclusion, with Traveller children taken into state care, enforced sterilization of Traveller women, imprisonment and evictions (Cemlyn, 2008). In terms of current national strategies and policy provision, the social exclusion experienced by Travellers in Ireland is often not directly visible, however visible the issue may be in terms of

poverty, marginalisation, almost total unemployment and poor educational and health status (Blighe, 2001).

Traveller housing remains a central area of discrimination and medium for enforced assimilation (Clark and Greenfields, 2006). *'Push'* factors such as poor health, threat of eviction and dispersion of Traveller family networks have led some Traveller families to seek housing due to difficulties in maintaining the *'Travelling way of life'* within contemporary sedentarist society (Niner, 2003; Clark and Greenfields, 2006). The restrictions posed by housing only the nuclear Traveller family, result in experiences of *'isolation'* and *'dislocation'* from the wider Traveller family network (Cemlyn, 2000; Morris and Clements, 2001; Parry *et al.*, 2004b; Parry *et al.*, 2004c; Cemlyn, 2008). Travellers in housing may deny their culture and identity in order to avoid community harassment (Thomas and Campbell, 1992), and yet also experience problems within their own networks for *'forfeiting their culture'* (Cemlyn, 2000; Morran, 2002). For those Travellers choosing to relinquish their Traveller sites, there is little cultural and tenancy support, with many Traveller families *'failing'* quite quickly and reverting back to transient and semi permanent site residency (Clark and Greenfields, 2006). This fundamental lack of tenure and security serves to reinforce poverty, marginalisation and conflicts between Travellers and *'settled'* authorities, and also increase spatial segregation, vigilantism and overall disadvantage in terms of health, education and training services (Van Cleemput, 2007).

Travellers and Substance use

Illicit drug use is no longer confined to high risk and marginalized areas, and more vulnerable groupings and prevalence data indicates increasing recreational use within Irish (NACD, 2008a; NACD, 2008b; ADRU, 2009). The lack of ethnic identifiers in drug and treatment statistics serves to cloud any estimations of the extent of Traveller alcohol, licit and illicit drug use in Ireland. However, some qualitative studies have taken place in recent years, which indicate that although the prevalence of drug use in the Irish Traveller community is increasing, it is not yet at the level of the total Irish population (Fountain, 2006; Van Hout, 2009b). Research shows that Traveller men exhibit higher levels of both alcohol and hash, ecstasy and amphetamine use, than Traveller women (McCarthy, 2005; Fountain, 2006). Excessive alcohol use among Traveller men and unmarried Traveller women is common and remains an impending

problem in terms of its contribution to poverty, domestic violence, child neglect, possible progression to drug experimentation and worsening relations with the 'settled' community. In terms of Traveller women and drug use, research suggests a worrying trend of licit drug use in the form of prescription medication dependency with inappropriate use often the result of illiteracy, over prescribing from general practitioners, and general poor mental health (Fountain, 2006; Van Hout, 2009a). Opiate use is less common but increasing in terms of both inhalation and intravenous use, with many Traveller encountering heroin during custodial sentences (McCarthy, 2005; Fountain, 2006; Van Hout, 2009a).

The Traveller community was traditionally protected from drug use by traditional anti drug norms and potent family networks and reinforced within their marked inner boundaries from the 'settled' community (Pavee Point, 2005). Research shows that the Traveller culture remains deeply suspicious and fearful of drug use, with older Traveller viewing all drugs equally harmful (Fountain, 2006; Van Hout, 2009a). However, in recent times, and in the advent of increased Travellers seeking local authority housing, and the location of group housing sites close to marginalized areas, the risk of drug exposure and experimentation remains high (Pavee Point 2004; Van Hout, 2009a). Traveller youth are perhaps most at risk, when confronted with sibling, peer and familial drug use whether in the course of schooling, or within their halting sites, or housing areas (Van Hout and Connor, 2008a).

In terms of community, health and drug service access, Travellers often report discriminatory experiences, difficulties in entering referral networks, feelings of compromised confidentiality and general lack of cultural acceptance from service staff and professionals (Cemlyn, 2008; Van Cleemput, 2009). The Department of Health and Children [DoHC] (2002:4) in Ireland has recognised the conflict between efforts at Traveller sedentarisation in conflict with Traveller identity and has recommended that '*attempts to make Travellers behave like non-Travellers could be inappropriate and a model should be used that recognizes their own health concepts*'. In terms of problematic substance use, attempts to deal with dependency within the Traveller community are common, and directly resulting from stigma of addiction, shame and lack of education (Pavee Point, 2005). Drug awareness, service utilisation and engagement within treatment protocols remain poor, whether in terms of seeking drug

educational material, attending counselling and residential treatment, and serves to compound the emerging issue of drug use within the Traveller community. The aim of this paper is to present the findings of a funded regional needs analysis on Travellers and substance use (see WRDTF, Van Hout, 2009a) within a policy context, and yield a series of recommendations for improved service provision for this ethnic minority group in Ireland.

Methodology

There is a lack of research on the Gypsy Traveller community due to methodological issues of mistrust, hostility towards researchers, restricted access and compromised sampling due to lack of participation and poor literacy (Hedican, 2005). The research was conducted in 2008 and took place in the western region of Ireland, namely counties Mayo, Roscommon and Galway (see WRTDF, Van Hout, 2009a). The Irish census (2006) recorded 22,369 Travellers in Ireland; with 938 in Mayo, 308 in Roscommon and 3,113 in Galway. The initial exploratory needs analysis research aimed to achieve greater comprehension of alcohol and drug use within this hidden population in terms of awareness, attitudes, patterns of use, prevalence, reasoning, drug activities, engagement with services and risk perceptions in relation to Traveller cultures, day to day experiences and associational life within 'settled' Irish discourse (see WRTDF, Van Hout, 2009a). Therefore, the aim of this paper is to present the service related findings within a framework of policy recommendations for improved service provisions from both the Traveller and key stakeholder perspectives.

Research Design

The research comprised of several phases, whereby semi structured interviews with key stakeholders and key informants ($n=45$) were conducted prior to engaging with the Traveller groups in each county. These individuals were identified as individuals working with the Traveller communities (Traveller organisations and Traveller Primary Care Projects) and also within the addiction, health, housing, youth, law enforcement, family support and social welfare contexts and recruitment was based on an initial listing of contacts and some degree of internal snowballing. The interviews aimed to discuss and explore issues relating to Traveller alcohol and drug use, levels of drug awareness, experiences of Traveller service engagement and guidelines for improved service provision. Prior to conducting these interviews, the researcher explained the

aims and objectives of the study and ensured confidentiality. The participant was encouraged to explore the themes of the interview schema and discuss additional issues if they so wished.

Following this phase, the researcher engaged with the key Traveller liaison workers from identified support organisations in each county about the research aims, so that these workers could begin to brief their Traveller cohorts around the research. Once the ‘*gatekeeper*’ in each site (2-3 per county) were identified and recruited, a lengthy pre development phase of several weeks commenced whereby the researcher engaged with the Travellers on an informal basis. This pre development phase aimed to develop trust, facilitate optimum research participation and give the Traveller a sense of ownership and voice during the course of the research, and was conducted in accordance with recommendations for pre development work from Pavee Point National Traveller Centre, Dublin (Pavee Point, 2005).

The last phase of research comprised of Traveller focus groups and was peer accompanied in order to optimise on Traveller representation, whereby a Traveller Research Accomplice (TVA) co facilitated the focus group discussion and assisted in the recruitment of research participants. Focus groups were selected in order to obtain group perspectives and responses to certain consensus beliefs and group behaviours (Daly *et al.*, 2007). The aim of the focus groups was to examine the Travellers experiences of problematic substance use whether themselves or within their family networks and issues relating to their engagement with community, drug and health services. The 12 focus groups (3-5 individuals) were gender specific and composed of Traveller adult men, women and youth (*n=57*). The researcher did not seek any demographic data relating to age or educational status (see Table below).

	Total	Traveller Men	Traveller Women	Under 20 years
Area 1	36	14	14	8
Area 2	4	4	0	0
Area 3	17	1	8	8
Total	57	19	22	16

Prior to commencing the focus group, the researcher and Traveller research accomplice (TVA) explained the aims and objectives of the study, ensured

confidentiality and other ethical considerations. Participants were allowed to ask for clarification or withdraw if they so wished. Information was re read to the focus group upon completion in order to reinforce the information garnered and avoid any misrepresentation.

Data Analysis

All interview and focus group data was coded and fully transcribed. A content and thematic analysis of the data using Nvivo was conducted in order to compare and contrast the varied formulations of research participants' perspectives. The triangulation of data from both Traveller and key stakeholder viewpoints was used to optimise on research validity in the first instance, and secondly to identify key areas for the presentation of research findings.

Ethical Considerations

The Traveller Ethics, Research and Information Working Group was established by the Department of Health and Children in 2002 as a sub-group of the Traveller Health Advisory Committee and its terms of reference set standards of conduct for this research. The confidentiality of records and data generated by the research was protected at all times. The protection of informant's identities was a priority through out the research, and therefore it is not possible to engage in a detailed regional or service type debate.

Results

The Travellers were anxious to emphasise that their opinions were applicable to both the Traveller communities where they lived but also within a wider community context, with the majority willing to share their observations and issues affecting their families. Within this context, the majority were not willing to admit to direct contact with drugs or drug use within their families. As mentioned, the needs analysis report and the descriptive research with Travellers and drug use explored the impact of drug use within the Traveller communities in the west in terms of prevalence, trends, patterns and social contexts of use (see WRDTF, Van Hout, 2009a). Therefore, the results shall be confined to presenting the Traveller focus groups and stakeholder interview perspectives on Travellers experiences of problematic substance use and service provision for drug dependency.

The Travellers discussed the emergence of drug activity within their communities and observed an increase in recent years. Some Travellers spoke about drugs within their close family networks and in halting sites, and others did not acknowledge drug activity close to home. The inherent fear of drugs and suspicion relating to drug use was evident in the older Travellers. This was observed to a lesser extent in younger Travellers, with the majority of Traveller youth willing to discuss drug use within their recreation and school settings. The perception of all drugs equally dangerous or hazardous by the older Travellers did not sit well with current harm reduction measures within the community, and also contributed to a great sense of shame within the family with a problematic substance use issue. A Traveller woman quoted the following in relation to such an instance;

“I don’t think so, I don’t even know how a Traveller would go about it, I think they just wouldn’t say anything cos they wouldn’t want anyone in their business, and they might not think there is any help there cos there is nothing in this town for Travellers, let alone for a Traveller with a drug problem, and there’s no Traveller in any of these services...they might not bother cos they would think, they’re not going to know my life, or know what it’s like for a Traveller.”

Drug Awareness

In light of poor drug and alcohol awareness, the Travellers recognised this and recommended a greater focus on Traveller peer training in order to disseminate drug educational material, thereby circumnavigating literacy issues, compromised outreach efforts by **“settled people”**, and also aiding the development of Traveller guided referral networks and support during treatment. The Travellers spoke about the success of the Primary Care projects for Travellers whereby a Traveller woman was trained to be a community health worker (like Traveller Health Visitor in the UK), and used to **“create a bridge”** between the Traveller community and relevant services. The majority felt that this would be useful for the dissemination of drug educational material, assist Traveller access to general practitioners (GP) and referral networks to addiction and mental health services. The majority of Travellers recognised the gender differences in substance use, with many male adult Travellers and male youth engaging in excessive alcohol use and illicit drug use (most commonly cannabis, ecstasy and cocaine), in contrast to the prevalent use and abuse of licit medication among Traveller women. In this way, the Travellers emphasised the need for gender

based peer led educational models, and highlighted the need for Traveller male orientated project. Traveller men were not engaging with local training projects. A Traveller male observed;

“Travellers want to hear it from another Traveller..and that goes for meself..I wouldn’t listen to a settled person..and I wouldn’t listen to a woman either..if you want information you get it from your comrades.”

The key stakeholders, and particularly those working on the ground with the Traveller communities in each area, observed the need for improved outreach and support, increased receptiveness for GP home visits, the use of brief interventions offering advice for alcohol and drug use, and peer education for both Traveller men and women. Some stakeholders observed the inherent threat of Traveller youth socialisation into peer drug and alcohol use within the school setting, and ***“in effect bringing the problem home.”*** Other stakeholders pointed to the need for literacy training, development of other mediums such as art, multi media, sport and drama for drug education within the ***“sense of ownership for Travellers.”*** A key stakeholder observed;

“The problem and the solution comes from within the Traveller community itself..they will dictate how they deal with it..whether with closed doors or with us.”

Seeking help for problematic substance use

Both Traveller organisations and mainstream drug services asserted that Travellers are under represented in terms of service numbers attending counselling and residential treatment. Most key stakeholders identified the need to incorporate ethnic identification within health service reporting systems in order to accurately estimate levels of problematic substance use among the Traveller community, and promote client retention within current service systems. Some stakeholders described the difficulties in engaging with Travellers relating to large families present during visiting hours, with Travellers commonly attending once or twice and usually in the event of a court case or child welfare issue. These stakeholders felt that this was a draw on current resources. Other issues included the lack of postal address for appointment cards, the prevalence of similar surnames, and swopping of mobile phones within close family networks, and compromised service efforts to track health records. An inclusive

and supportive approach was therefore advocated by the stakeholders, particularly within the community and addiction sector, in order to integrate the Traveller community within local prevention and treatment service delivery. It was hoped that this would promote acceptance of ethnic minorities like the Travellers, reduce discriminatory experiences, improve on ethnic monitoring systems and heighten cultural knowledge within service protocols. A key stakeholder said;

“Travellers accessing services need to be reassured they will be treated just like everyone else..at least that’s what I try..I can’t speak for my colleagues.”

The Travellers observed common discriminatory experiences from both health service staff and adjunct staff such as receptionists and porters. In addition, some Travellers commented that addiction services were often located within the mental health hospitals which led to those with problematic drug use to seek help outside of their region. This was deemed necessary to avoid shame and ***“the whole community knowing your problem”*** but led to problems in attending after care and other therapies. Other Travellers, most notably, Traveller parents observed the lack of service visibility and said

“I just don’t know where to go..I couldn’t go to my GP..I might meet someone I know.”

Other Travellers observed a lack of timely assistance, with most services restricted to operating during the week, and leading to an overuse of A and E services for emergency detoxification. A Traveller woman said;

“There should be a service that you can grab the person when the person wants help, and is prepared to accept help.....I have asked this question before in centres and I was told that such a service couldn’t exist, it would be impossible and I think the reason why they are giving that answer is, they (other services) don’t want to be in danger of anything new coming into the scene, because the new thing could be the thing that will take their comfort away, and even though it might be the way forward, it might be the thing to do because what they are doing at the minute doesn’t seem to be working. If something isn’t working for you why not try a new way?”

Cultural Acceptance

The majority of Travellers emphasised the need for greater acceptance and understanding of their culture within current service provision, with some indicating the lack of assistance for those with literacy difficulties, issues relating to medical card provision, GP registration and lack of permanent address, lack of Traveller representation in health service materials, and overall negative feelings from health professionals. A Traveller man observed his difficulties engaging with his addiction counsellor and said;

“sure I couldn’t read the stuff he gave me..I couldn’t do the logbook for him and so I gave up..”

A Traveller woman described her experiences of addiction services and said;

“the GP had given me this stuff ..to make me feel better.. life is hard you know..the d10 or something like that..sure I couldn’t make out the instructions ..I just took them when I felt I needed it. I didn’t know they were like them drugs..it’s hard..I wasn’t able to go to me counsellor much..the children were always there.”

Those stakeholders working in the addiction field pointed to the difficulties for Travellers to attend counselling sessions in terms of group sessions with ‘settled’ individuals, issues engaging with residential treatment modalities and aftercare. In some instances, health professionals were unaware they were treating Travellers for co morbid mental health and substance related disorders. A key stakeholder said;

“The Travellers don’t usually stay in treatment..they come once or twice..often trying to deal with detox themselves at home..they don’t like group work..I support they can’t relate to the ‘settled’ people...they have a need for understanding of where they’re coming from..and the issues they deal with in day to day life..it represents a whole other ball game in terms of understanding their pathway to drug use..”

Other key stakeholders observed the lack of cohesiveness between community, Travellers, social welfare and probation services, and exacerbated by prevalent levels of Traveller transiency between these sectors and within the western region itself. Some observed the need for greater prison outreach support, family support for those experiencing homelessness and domestic violence. In conclusion, the key stakeholders emphasized the need for inter agency networks involving all relevant

community-based, Traveller and drugs services in order to create a cohesive and visible structure of support for Travellers.

Discussion

Research methodologies among hidden or socially excluded groups such as Travellers are generally compromised by issues relating to access, the necessity for lengthy pre development work to garner trust, recruitment procedures based on participant volunteerism and potential ethical issues regarding stigma and potential stereotyping (Matthews and Cramer, 2008). While generalisability was not the primary goal, the researcher still sought to obtain a diverse group of stakeholders and key informants in order to achieve the maximum variation in experiences and yield a representational '*snapshot*' of the situation for Travellers in Ireland. The predevelopment phase whilst used initially to gain access and garner trust with the Traveller communities was also used to forge links between the Travellers and the communities around them, through the expressive medium of this research by way of discussing issues impacting on them and disseminating information and health service contacts after the focus group sessions. Interestingly, the presence of '*gatekeeper*' bias was experienced when accessing the Traveller services, where Traveller workers displayed strong protective views of their client groups, in terms of the research approach, levels of access secured and potential misuse of research information. Conversely, the interviews with key stakeholders also raised the issue of cultural awareness and acceptance for them within the course of their daily lives.

Drug use in Ireland remains increasingly diverse, with lifetime drug use of particularly cannabis on the increase (NACD, 2008a; NACD, 2008a; ADRU, 2009). Although the new National Drug Strategy 2009-2016 is responding to these varied drug needs and clustering of drug users, the challenges remain for regional and local drug service providers to attend to the needs of Travellers, who as ethnic minority in Ireland remain on the peripheral of society. The question remains whether this is by choice or by necessity. Travellers remain at risk of problematic substance use, with research indicating that Traveller health is significantly poorer than those in the mainstream society (Van Cleemput *et al.*, 2007) and inherently linked to the restricted opportunity to live '*the itinerant way of life*'. Poor mental health and co morbidity with substance abuse in the Traveller community is common and attributed to the fragmentation of

Traveller identity, poverty, threat of evictions, domestic violence, overall lack of life opportunity and discriminatory discourse within Irish society.

In summation, in order to provide positive, inclusive and culturally appropriate service provision for Travellers, there must be a certain level of co operation between the Travellers and the services around them. In this way, Traveller involvement in drug prevention and treatment service delivery can inject reciprocal trust, highlight cultural beliefs and practices, reduce stigma, discrimination and harassment, and improve service access and referral pathways. Dedicated and peer led educational models can then be used to target specific groups of drug users within the Traveller community, address levels of excessive drinking and prescription medication abuse within halting sites.

Services must introduce and develop ethnic identification and monitoring systems in order to track trends and guide appropriate service resources allocations. Cultural training for all levels of service remains a priority. Within an operational context in order to retain clientele within addiction services, there needs to be a greater emphasis on appointment reminders, use of letters or texting, public health nurse visits and Primary Care Traveller worker supports. For those Travellers experiencing problematic substance use and needing intervention, services must offer a cohesive structure of support within an all hours remit. Flexible and individual modes of residential treatment may offer a solution for those Travellers experiencing difficulties in adhering to lengthy programmes, whether by allowing them to access these therapies daily, or by offering childcare and family support for the spouse. The development of a Traveller addiction training course on par with that of the Primary Care Traveller worker scheme offers optimum potential in relation to having Travellers '*listen to*' Travellers, and thereby creating Traveller community responsibility to contain and address the emerging issue of drugs within their lives.

Conclusion

The inherent struggle of Gypsy Travellers to retain their cultural identity without submitting to the dominant culture continues (Cemlyn, 2008). One can recognize the continued '*othering*' of Gypsy Traveller rights within the dominant social discourse in Ireland. The research points to a somewhat segregated Traveller led approach to

dealing with and addressing problematic substance use in the Traveller community, within a wider structure of improved cultural acceptance within health and addiction services. These recommendations were submitted to the National Drugs Strategy 2009-2016 (see Appendix 1 of that document).

Acknowledgement

The research was funded by the Western Regional Drug Task Force, Ireland. The opinions expressed in this article are of (the researcher) and are not necessarily those of the Western Regional Drugs Task Force.

Paper 10. Van Hout, MC (2010). A Primary Care Service Framework for Travellers in Ireland: Results from a Consultative Forum. . *Community Practitioner Journal*. May, Volume 85, Issue 5, 25-28.

Abstract

The Travellers in Ireland continue to experience health disparity, cultural fragmentation and a lack of visibility in health service provision. The research aimed to explore factors impacting on Traveller health and experiences of Primary Care Services from the perspectives of key Traveller Health stakeholders in Ireland. This pilot study was designed as initial consultative forum using a single focus group ($n=13$) in order to yield specific recommendations for the development of a designated Primary Care Service framework [PCSF] for Travellers. A thematic analysis of the narratives identified the following key areas of interest, namely; recognition of Traveller culture and ethnic identity; emerging issues in Traveller Health; Traveller consultation in the establishment of area Primary Care clinics; role of the Primary Health Care Traveller worker [PHCT] and recommendations for improved Traveller utilisation within a Traveller '*sensitive*' Primary Health Care service framework. The research recognised the importance of Traveller community consultation in the design of Primary Care Service framework within each local needs analysis. Thereby, the promotion of Traveller advocacy, visible access and referral pathways can be achieved, with Primary Health Care Project for Traveller [PHCT] workers acting as a '*bridge*' between Travellers and the designated area Primary Care Team.

Key Words

Travellers, Primary Care, Health Inclusion

Background

The Irish Travellers are a small indigenous group, typically nomadic, who have been part of Irish society since the Middle Ages, and are defined as '*a community of people commonly so called who are identified (by themselves and others) as a people with a shared history, culture and traditions, including, historically, a nomadic way of life on the island of Ireland*' (Kelleher, 2005:5). Travellers in Ireland are not recognized officially as minority ethnic group but maintain their identity as an ethnic nomadic group in Ireland, by choice and reinforcement of their detachment from the '*settled*' community. Limited opportunities for interaction between Travellers and the sedentarist population exacerbate the negative perception of Traveller culture and fuels institutional discrimination (Fountain, 2006). Poor housing conditions for Travellers in Ireland, amidst coercive assimilatory government efforts remain fundamental to Traveller health disparity, poor educational outcomes and high unemployment (Treadwell *et al.*, 2008).

The health status of Travellers and Gypsies in the United Kingdom have been shown to be significantly worse with greater self reported symptoms of ill health than other UK-resident, English speaking ethnic minorities and economically disadvantaged white UK (Parry *et al.*, 2004b). Research shows that the average life expectancy of Travellers in the United Kingdom is lower than the general population, particularly amongst men; with Traveller families recording one of the highest birth rates in the EU and yet experiencing high levels of infant mortality, high still birth rates; high rates of babies with low birth weight and premature deaths of older offspring; some evidence of hereditary disease caused by consanguinity (Parry *et al.*, 2004c). Additionally, Travellers are also more likely to suffer from self reported anxiety, asthma, chest infections, heart disease, diabetes, stroke, cancer, disability, diarrhoea, infections and other health complications linked to compromised life circumstances (Van Cleemput and Parry, 2001; Van Cleemput, 2009).

In terms of Irish statistics on Traveller health, there is a lack of systematic data collection on Traveller health, and an absence of Traveller ethnic identification within current health service systems, with the most current research on Traveller health status conducted in 1987 (Barry *et al.*, 1987). The 1987 national study reported that life expectancy for Travellers was significantly lower than the national average (in

particular Traveller men); with high infant mortality (still birth and Sudden Infant Death) and high fertility rates among the Traveller groups contributing to its youthful demographic (Barry *et al.*, 1987). The study additionally reported heightened rates of utilization of obstetric services, with converse lower uptake of family planning clinics, lower rate of breast feeding and lower uptake of ante and post natal service care, lower uptake of child immunisation, developmental paediatric and specialist child health services (Barry *et al.*, 1987). Anecdotal evidence suggests a widening health gap between Travellers and the sedentarist Irish population (DoHC, 2002; Kelleher, 2005; Murphy, 2005; Fountain, 2006). In 2007, the All-Ireland Study of Travellers Health Status and Health Needs for both Northern Ireland and the Republic of Ireland commenced in order to provide baseline data on Traveller health status; assess health service provision and identify factors influencing Traveller mortality and health disparity. This study is due for completion in 2011 and will be used to inform the policy debate surrounding Traveller service provision.

In recent times, progress has been made in Ireland as a result of equality legislation, dedicated health policies and appreciation of Traveller culture, amidst greater lobbying efforts on the part of Traveller organisations seeking to tackle the issue of Traveller health status and the lack of culturally appropriate service provision. However, traditional health service provision in Ireland is designed to serve the mainstream society in terms of language, literacy, information and access to services, which contributes to further Traveller exclusion and lack of Traveller cultural acceptance (Murphy, 2005). The National Traveller Health Strategy in 2002 (DoHC, 2002:15) stated *'this Strategy re-affirms the right of Travellers to appropriate access to healthcare services that take into account their particular needs, culture and way of life'*. Thereby, the context of prejudice and discrimination experienced by Travellers is inherently relevant both to Traveller health status, and health service provision. However, according to the review of the National Traveller Health Strategy in 2005 (Murphy, 2005), the following deficits were still in existence in Ireland, namely; the lack of ethnic identification and data collection on Traveller health, a dearth of focus on Traveller psychiatric health, intellectual disability, substance use, gender differences and suicide, with continued problematic access to and uptake of health services, and the need for racism training for health service staff. On a positive note, improved culturally appropriate health promotion materials and programmes are emerging, with

the recognition of Traveller literacy issues leading to increased use of visual media to explain a variety of health topics, increased Traveller involvement in Traveller Health Units, recruitment of designated Traveller Public Health Nurses [PHN], and development of Primary Care Health Traveller Worker [PCHT]⁴, roles around Traveller peer led training and health education. This strategy recognizes the importance of a community development approach for dealing with Traveller health disparity, creating Traveller empowerment for community and individual health ownership, peer led services, development of new roles for Travellers as planners, service providers and promoter, and providing an accessible, equitable and Traveller sensitive health service (Murphy, 2005). Travellers have a right to access health services which consider their specific cultural needs, health practices and way of life (DoHC, 2002; Kelleher, 2005; Murphy, 2005).

Indeed, the Department of Health and Children DoHC, (2002:4) has recommended that *'attempts to make Travellers behave like non-Travellers could be inappropriate and a model should be used that recognizes their own health concepts'*. The Primary Health Care programme for Travellers [PHCT] are identified as the cornerstone of the *'Traveller Health – A National Strategy 2002–2005' Primary Health Care for Travellers'* (Kelleher, 2005) with such Traveller led programmes developed across Ireland in order to provide Traveller advocacy and address Traveller health needs. However, there is a growing need to ensure that these Traveller led PHCT projects are not used in isolation to deal with Traveller health disparity. Whilst showing promise they may further exclude the Travellers in the preservation of their cultural identity until such time as the Primary Care Teams advocate a culturally accepted method of treating Travellers within current health care provision (Kelleher, 2005; Murphy, 2005). The United Kingdom [NHS] has a dedicated Traveller Gypsy Service Primary Care framework [PCSF] (2009) with central focus not on providing separate services for Travellers and Gypsies, but rather presenting a series of components for ensuring that these communities can utilize similar high quality mainstream Primary Care Services. In Ireland, even with the presence of efficient and community oriented PHCT projects, the development of such a protocol within the Primary Care setting is hugely urgent. The research aims to present an exploratory account of stakeholder perspectives of Traveller needs relating

⁴ The Primary Health Care Traveller worker is always a member of the Traveller community.

to Traveller health and Primary Care provision in Ireland, and was conducted as pilot consultative forum for the identification of guidelines for a Traveller Primary Care Health Service Framework [PCSF] in Ireland.

Methods

Research Design

A single focus group of all national Traveller Health Unit stakeholders (***n=13***) representing each Health Board area was conducted. Thereby the sample was deemed representational of all areas, with the stakeholders having contact with Travellers in the course of their work on a national level, with some of Traveller ethnicity (***n=6***) and therefore well positioned to detect recent developments in the lives and health outcomes of Travellers. The researcher facilitated the focus group, which was guided by a structured schedule based on identified issues relating to Traveller physical and psychosocial health; cultural beliefs surrounding health; life circumstances; Primary Care needs, experiences, access, cultural acceptance and utilization; and potential considerations for the development of an Irish Traveller Primary Care Service Framework [PCSF]. The focus group was audio taped with permission of the participants.

The Traveller Ethics, Research and Information Working Group [TERIWG] was established by the Department of Health and Children [DoHC] in 2002 as a sub-group of the Traveller Health Advisory Committee. Its terms of reference set the standards of ethical conduct for this pilot study, and namely that the research participants were informed fully about the purpose, methods and intended possible uses of the research; were informed as to what their participation in the research entailed and what risks, if any, are involved; that the confidentiality of information supplied and the anonymity of respondents would be respected at all times; that participation was entirely voluntary, free from any coercion and that withdrawal was possible at any stage; and lastly that the independence and impartiality of researcher would be clear throughout the research process. In order to protect the identities of the participants, the research does not engage in an area debate.

Data Analysis

Following transcription, a content and thematic analysis of the narratives garnered using the qualitative package Nvivo was conducted. This consisted of generating ‘a list of key ideas, words, phrases, and verbatim quotes; using ideas to formulate categories and placing ideas and quotes in appropriate categories; and examining the contents of each category for subtopics and selecting the most frequent and most useful illustrations for the various categories’ (Zemke and Kramlinger, 1985). A certain level of synchronic reliability was achieved, whereby two or more perspectives between the narratives were in relative agreement. The analysis mapped the narratives relating to Primary Care service provision for Travellers in terms of emerging issues in Traveller Health and life circumstances; recognition of Traveller culture and ethnic identity; Traveller uptake of Primary Care clinics, the role of the Primary Health Care Traveller worker [PHCT] and recommendations for Primary Care Service Framework [PCSF] for Travellers in Ireland.

Results

The stakeholders recognized that Traveller tradition, nomadism and Traveller held beliefs surrounding health are fundamental to addressing the issue of Traveller health disparity, achieving health equity and culturally sensitive responses to Primary Care services. The majority observed that health disparity of Traveller communities continued in spite of service and PHCT efforts to engage with the Traveller communities. The lack of up to date ethnic identification in health systems and general practitioner records was deemed to compound issues of health tracking (i.e. immunisation, appointments, transience) in Ireland. Emerging Traveller health needs relating to disability, mental health and drug dependency were deemed to incur certain levels of stigma and shame within the Traveller community, with Travellers often seeking to address those needs in another Health Board area (in order to avoid recognition and avoid discrimination).

“Primary Care teams and Primary Health Care Traveller worker (PCHT) need to link ..especially in the case of drug treatment and counselling for depression or suicidal thoughts...the stigma will limit what services are accessed.. Travellers are very private..they wouldn’t tell the Primary Health Care Traveller worker [PCHT] if they thought they would have to access services where other Travellers known to them are.”

Other needs common to the Travellers were the issues relating to poor uptake of immunization programmes; poor uptake of ante and post natal services and issues relating to domestic violence. It was felt that localised Traveller knowledge surrounding health and cultural practices needed to be recognized and built on, in terms of highlighting and targeting services to cater for these specific needs in each Health Board area.

“The GP network needs information- the local staff is vital...building everything into this Primary Care team would help Travellers.”

In terms of the level of Primary Care Traveller cultural acceptance, some stakeholders described difficulties for Travellers in engaging with Primary Care team professionals, difficulties in recruiting Primary Care professionals onto ***“Integrated Traveller and Primary Care”*** days, and the general need for race and cultural awareness training for Primary Care staff. Some stakeholders observed a lack of visibility of Traveller health needs in written health educational leaflets. Other stakeholders observed the need for the Primary Care team to meet the Travellers in their own settings (caravan bay; halting site or group housing project), in order to observe and understand the reasoning behind cultural health traditions (i.e. immunization; alcoholism), within an overall recognition of the life circumstances of this ethnic group. Many Primary Care staff had little or no contact with Travellers in the course of their day to day life which was deemed to increase levels of suspicion and discrimination. Others felt that if the PHCT worker had a designated space in the Primary Care clinic, that discriminatory instances could be reduced for Travellers, and indeed highlight the important role of this Traveller worker within the team of Primary Care professionals.

‘Travellers need to feel they belong..whilst Travellers hear it best from a Traveller..at the same time they need to feel an appreciation of where they come from and what they are dealing with in life.’

In terms of Primary Care uptake, it was identified that general practitioner lists are problematic in terms of the current and ***‘only’*** mechanism of entry for Travellers into the Primary Care setting, and were contributing to overuse of Accident and Emergency services by Travellers in local hospitals.

“Historically, private clinics didn’t treat Travellers fairly”

“Travellers are entitled to access and not just GP lists”

Some stakeholders felt that private or geographically based Primary Care clinics could contribute to further exclusion of Travellers, particularly in the case of some general practitioners over subscribed with Travellers, or refusing to take Travellers, and the unavailability of required specific services in certain areas where Traveller communities clustered (i.e. physiotherapy, speech and language therapy, disability services and addiction treatment). Other stakeholders commented that geographic establishment of Primary Care teams could offer greater health equity for Travellers and said;

“The general practitioner [GP] list has often 80% Travellers...to maintain continuity of treatment, geographic lists are better located to deliver equity for Travellers and ensure confidentiality.. Travellers won’t go if they think other Travellers could find out their problems.”

Some Traveller PHCT programmes had dual registration of Travellers in terms of the local general practitioner and also the Primary Care team in the case that this was separate, in order to achieve some equity of care.

“You need dual registration of GP and Primary Care settings...just to ensure equity..and the right care”

Most of the key stakeholders commented on the general lack of communication between the Primary Care service settings and the Traveller community in terms of poor referral systems; difficulties in securing appointments; lack of clarity for some Travellers in terms of their rights to explanation of medication and treatment pathways; and overall unsatisfactory Primary Care service experiences.

“There’s a lack of community consultation, outreach and networking between each other and between the Traveller groups.”

“Sometimes they can’t get an appointment, sometimes the Public Health nurse [PHN] just doesn’t follow up.. there’s no relationship between them [Primary Care staff] and the Travellers.”

The majority of stakeholders observed the need to empower the Traveller community to take ownership and responsibility for their own health, and reflected that this could only occur via the mediation of the PHCT. It was felt by the stakeholder group that PHCT worker (a Traveller themselves) has the potential to act as a **“bridge”** between the Traveller community and the designated Primary Care Team in each locality. The role of the PHCT worker needs to be viewed as professional or semi professional, and expanded in order to provide outreach to needy Travellers, assist in the case of

illiteracy, aid in access, referrals and post care tracking, and additionally act as advocate for Traveller rights and needs surrounding their health, within a confidential setting. Local needs assessments involving both the PHCT as facilitator, and improved cohesion between the Primary Care team and the Traveller families would additionally help create an initial benchmark of Traveller need.

“Travellers should be in the network with the Primary Care Team..the Primary Care delivers..but you need a team involving the Primary Health Care worker for Travellers (PCHT) to help with appointments, referrals and advocacy..the current infrastructure is weak..”

“There’s a unique selling point here..the Primary Health Care worker for Travellers (PCHT) needs to be seen as a potential contribution to the community, especially for localized needs assessment... Travellers need to be consulted for these needs assessments otherwise they won’t be catered for..the Census data needs to be used within a wider policy framework.”

The stakeholders highlighted the following key themes for the development of an effective Traveller Primary Care Service Framework [PCSF] designed to meet the needs of Travellers, namely; the establishment of local Traveller needs analysis, improved health data records and tracking of Travellers; active partnerships and consultative forum between Travellers and Primary Care staff; the development of bridging initiatives using the Primary Health Care for Traveller [PHCT] worker to raise Travellers’ awareness of Primary Care services, act as outreach and advocate in improving access, utilisation and referral care pathways; the inclusion of specific services targeted to emerging Traveller health needs (i.e. disability, mental health and addiction); and mandatory cultural and racism awareness training for all Primary Care staff. Lastly, general practitioner registration whether within a private Primary Care setting or based on a geographic Health Board list should be as unobtrusive as possible, and take into consideration communication, registration, tracking and comprehension difficulties within an empathetic considerate approach.

Discussion

The research provided an exploratory consultative account on potential methods of recognizing current Traveller health needs, incorporating Traveller culture, improving Traveller uptake of services and service experiences into the design of a dedicated Traveller Primary Care Health Service Framework [PCSF] in Ireland. Research in

Ireland and the United Kingdom indicates that Traveller health status is disparate when compared with the mainstream sedentary population (Barry *et al.*, 1987; Van Cleemput and Parry, 2001; Smart *et al.*, 2003; Parry *et al.*, 2004b; Parry *et al.*, 2004c; Van Cleemput *et al.*, 2007; Cemlyn, 2008; Van Cleemput, 2009). Factors such as housing, poverty, discrimination and marginalisation need to be addressed in a broader perspective of social exclusion and inequality, and will hold the most promise for improvement of Traveller health status. This represents a movement away from consideration of Traveller culture and ethnicity in isolation and toward the process of community development. In the UK, community partnership and intersectoral collaboration between Gypsy Travellers and health care agencies are key factors in the success of Primary Care Health Service Frameworks [PCSF] (Smart *et al.*, 2003; Cemlyn, 2008; Van Cleemput, 2009).

Travellers in Ireland require specific consideration within the Primary Care setting due to their ethnicity and culture, different perceptions of health, disease and care and their distinct health and disease problems when compared to the mainstream sedentary society. Barriers to Primary Care access reciprocate previous UK research (Smart *et al.*, 2003; Van Cleemput *et al.*, 2007; Van Cleemput, 2009) and include the refusal of some general practitioners to register Travellers, experiences of discrimination, lack of treatment continuity and overall lack of cultural awareness, empathy and understanding in treating Travellers. Geographic establishment of Primary Care clinics, whether public or private, remains a concern in terms of general practitioner refusal to subscribe Travellers, or indeed the over subscription of Travellers in certain private or indeed public Primary Care clinics. Emerging health needs such as drug dependency, suicide and developmental disabilities need to be catered for, in a safe and secure setting free from confidentiality concerns and stigma. A collaborative approach between the Traveller groups and the Primary Care team is advised in order to optimise on local knowledge of Traveller needs, give a voice to Travellers in the planning and implementation phases, reduce racism and negative service experiences for Travellers, heighten cultural awareness among the health professionals, improve access and referral, and increase Primary Care service visibility in each geographic area where Travellers reside. In this process, the Traveller community is empowered to address their own diverse health needs through improved advocacy, representation

within both the community and Primary Care setting and consultation in management of culturally accepting Primary Care service frameworks.

Conclusion

The Traveller community in Ireland are a distinct cultural group presenting with inherent health disparity (Kelleher, 2005) different health problems and cultural beliefs surrounding care perspectives, than the mainstream sedentarist population (Barry *et al.*, 1987; DoHC, 2002; Murphy, 2005). The core value of achieving equity in Primary Care provision remains central to not only equality of access, but also to equality of participation, health outcome and the recognition that Traveller communities require an empowered, innovative and inclusive approach to provision, planning and implementation (Kelleher, 2005). The involvement of the Travellers themselves in local needs assessments and the potential of the Primary Health Workers for Travellers [PCHT] cannot be under estimated in presenting the ideal link between the Traveller and the Primary Care team setting, whether private or public, in terms of advocacy, education, administration, community training and political lobbying for Traveller health related needs, and ultimately improving Traveller quality of life, life expectancy and health status. This pilot project involved an initial consultative forum of national stakeholders, with these exploratory findings contributing to the development of a Primary Care Service Framework [PCSF] for Travellers and lobbying document for the Irish Department of Health and Children in 2009. However, one must note that the research is limited by the small scale nature of the sample, potential power differences and dynamics of individuals in the group, and varied ethnic/non ethnic appreciation of the Traveller culture. Future research efforts in 2010 intend to sample the Traveller communities themselves, the Primary Health Workers for Travellers [PCHT] and Primary Care Teams in each Health Board area, to further develop and explore the need for the development of a national set of guidelines for an improved Primary Care Service Framework [PCSF] for Travellers.

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⁵ Pavee Point, National Travellers Centre, Dublin, Ireland was established in 1983, comprises Travellers and members of the majority population and is a non-governmental organisation committed to human rights for Irish Travellers.

Paper 11. Van Hout, MC (2010). Assimilation, Habitus and Drug Use among Irish Travellers. *Critical Public Health*. In press.

Abstract

The Travellers in Ireland maintain a strong sense of ethnic identity, attachment and affiliation to their culture against rising assimilatory efforts by governments and policies. The Traveller community is at increased risk of problematic substance use, as consequence of marginalisation, social exclusion and health disparity. The aim of the research was to explore the assimilation process within the context of Traveller habitus and heightened drug activity within Traveller communities, once virtually non-existent. Qualitative research using 12 gender specific focus groups with Travellers (*n=57*) was conducted (see WRDTF Van Hout, 2009a). This initial descriptive drugs research was plotted against a selective assimilation theoretical framework, using the concept of habitus in exploring the recent advent of drug activity within Traveller associational life. Traditional anti drug Traveller culture is diminishing in potency, as families become fragmented and Traveller youth assimilate within educational settings, and over time one would question if drug use among Travellers will replicate or even exceed that of the “*settled*” population, given the marginalisation and discrimination they experience. Young Travellers are experiencing contradictory drug norms and values in their assimilatory experiences of cultural and social change, with the sedentarist world presenting normative contexts for drug activity. The level of Traveller attachment to both Traveller and sedentarist values, and development of new action schemas in Traveller habitus will predict Traveller negotiation of the risk environment, as this ethnic group strive to retain their culture within the dominant sedentarist Irish society.

Background to Research

Introduction

The Irish Traveller community is identified “as people with a shared history, culture and traditions including, historically, a nomadic way of life on the island of Ireland” (Joyce, 2002, see www.itm.ie) and existed in Irish society since medieval times (Binchy, 1994; Ni Shuinear, 1994; Clarke, 1998). Due to prevalent levels of Traveller illiteracy, Traveller history has been annotated by non Gypsies (Gaujos), with great consequent misrepresentation (Fraser, 1995) and debate on the ‘*unspoken assumption that the validity of /Traveller culture is up for definition and approval by the majority population*’ (Ni Shuinear, 1994:73). Boundaries of group definition vary amongst themselves, as some Travellers travel and others have relinquished the nomadic way of life (Liegeois, 1994; Liégeois and Gheorghe, 1995). Liegeois (1987: 53) observed that ‘*nomadism can also be ‘more a state of mind than an actual situation*’ but remains a central part of Traveller ethnic identity, with a recent study by Parry *et al.*, (2004b) reporting that the majority of Travellers were transient at some point in their life course and that many maintained the desire for themselves and their children to return to the ‘*itinerant way of life*’. Several identified characteristics are currently present in relation to the diverse nature of Traveller cultures, which relate to Traveller economies based on family entrepreneurship in response to local opportunities (Okely, 1983; Webster and Millar, 2001; Clark, 2002); the gradual erosion of nomadic lifestyles (Cemlyn, 2008), the centrality of strong Traveller family and extended family networks (Kiddle, 1999; Saunders *et al.*, 2000) and Traveller based forms of education where children assume a central and responsible role at an early age (Smith, 1997a; Smith, 1997a).

The perception of social and physical space for Travellers remains contested and carries different symbolic meanings for Travellers than for the sedentarist population (Kendall, 1997; Smith, 1997b; Hancock *et al.*, 1998; Saunders *et al.*, 2000). The Traveller community reinforce their identity as ethnic nomadic group in Ireland by choice of separateness from the sedentarist society. Griffin (2002a:69) quoted in his study on Irish Travellers; ‘*although Travellers resent being separated from non Travellers, many I knew valued the separation, providing they could cross the border on their own terms, when they chose*’. The limited opportunity for interaction between Travellers and sedentarist society contributes to hostility, prejudice of the ‘*itinerant way of life*’ and indeed labeling of Travellers as criminals (Ni Shuinear, 1997; Stonewall,

2003; Fountain, 2006; Cemlyn, 2008). The very reinforcement of Traveller rights, values and cultural traditions as distinction between their culture and '*way of life*' and that of the sedentarist population have resulted in a lack of tolerance and inclusion both within individual, public and political discourse (Blighe, 2001; Pavee Point, 2005). Nomadism remains a threat to dominant sedentarist economic and political ideologies in contemporary Irish discourse (McVeigh, 1997).

The reduced opportunity to live the Travelling lifestyle itself may cause a disparity in health status by way of compromised physical and emotional health (Van Cleemput *et al.*, 2007). Traveller housing remains a central area of discrimination and aggressive assimilation (Clark and Greenfields, 2006). Traditionally Travellers were accommodated on sites located on common land or land that was generally recognised as '*de facto transient*' site (Court, 1985). There is sufficient evidence present to identify certain '*push*' factors which lead Traveller families to seek housing due to the inherent difficulties in the '*Travelling way of life*' (Niner, 2003; Clark and Greenfields, 2006). For those Travellers making the choice to move from sites, there is little agency support in terms of cultural and tenancy difficulties, with many Traveller families '*failing*' quite quickly and reverting back to site residency (Clark and Greenfields, 2006). Lack of security and threat of eviction contribute to reinforce social exclusion and tensions between Travellers and authorities (Van Cleemput, 2007; Treadwell *et al.*, 2008). Housing remains culturally alien to the Traveller community with culture shocks including '*isolation*' and '*dislocation*' from the extended Traveller family, as sedentarist housing is restricted to accommodating the nuclear family; whereas the extended Traveller family is a central focus of Traveller culture (Cemlyn, 2000; Morris and Clements, 2001; Parry *et al.*, 2004b; Cemlyn, 2008). Other Travellers report feeling confined with sites referred to as '*prisons*' or '*reservations*', with many sites located away from residential areas, thereby increasing spatial segregation, harassment and increasing overall disadvantage in terms of education, employment and health service access (Hyman, 1989; Kenrick and Clark, 1999; Morris and Clements, 1999; Cemlyn and Clark, 2005).

Traveller children housed in local authority settings may experience dual disadvantage relating to the lack of appreciation of their cultural needs in the school setting, family harassment and community vigilantism within the residential setting (Cemlyn, 2008).

The formal educational setting represents a fundamental assimilatory threat for Traveller parents, in terms of cultural dissonance, discriminatory experiences for their children, bullying, lack of teacher focus, lack of cultural acceptance, associated self exclusions, potential contact with anti social youth behaviour, crime and community vigilantism (OFSTED, 1999; Jordan, 2001a; Jordan, 2001b; Lloyd and Stead, 2001; Derrington and Kendall, 2004; O'Hanlon and Holmes, 2004; Power, 2004). Traveller youth often leave school early due to literacy issues, lack of understanding within the education system, poor attendance and levels of transience (Jordan, 2001b). In some instances Travellers deny their own identity in order to avoid community hostility with housed Travellers are often deemed as forfeiting their culture (Cemlyn, 2000; Morran, 2002).

Illicit drug use has moved from the initial high risk marginalized areas, and more vulnerable groupings towards widespread recreational use within society in Ireland (NACD, 2008a). The Traveller community, as an ethnic minority presents with lower levels of drug use than the sedentarist population in Ireland, with Traveller men reporting higher levels of alcohol and drug use (Noonan, 1998; Hurley, 1999; Pavee Point, 2005; Fountain, 2006; Van Hout and Connor, 2008a; Van Hout, 2009a; Van Hout, 2009b; Van Hout, 2010). Traveller women both old and young present with low levels of lifetime drug prevalence, due to lack of financial opportunity and strict levels of control on young Traveller girls and yet present with high levels of prescription medication abuse (Pavee Point, 2005; Fountain, 2006; Van Hout, 2009a; Van Hout, 2009b; Van Hout, 2010). Cannabis remains the most commonly used illegal substance for both Travellers and the population of Ireland as a whole (Hurley, 1999; Pavee Point, 2005; Fountain, 2006; NACD, 2008; Van Hout and Connor, 2008a; Van Hout, 2009a; Van Hout, 2009b; Van Hout, 2010). There are also some reports of opiate use amongst Travellers with this type of drug dependency on the increase in terms of both smoking and intravenous use (Hurley, 1999; McCarthy, 2005; Fountain, 2006; Van Hout and Connor, 2008a; Van Hout, 2009a; Van Hout, 2009b; Van Hout, 2010).

Irish research suggests the presence of protective mechanisms whereby the traditional Traveller culture and cohesive family networks may offer resiliency to drug initiation and use (McCarthy, 2005; Pavee Point, 2005; Fountain, 2006; Van Hout and Connor, 2008a; Van Hout, 2009a; Van Hout, 2009b; Van Hout, 2010). However, the Travellers

remain particularly at risk of problematic substance use due to poverty, compromised living conditions, poor mental health, unemployment, poor educational attainment, crime and social exclusion (Hurley, 1999; McCarthy, 2005; Pavee Point, 2005; Fountain, 2006). Of most significance, is that the risk of potential drug use and abuse is exacerbated if Traveller accommodation is located in marginalised areas where there is a presence of drug related activity, and indeed the presence of clusters of pro drug using peer groups in the school setting (McCarthy, 2005; Pavee Point, 2005; Fountain, 2006; Van Hout and Connor, 2008a; Van Hout, 2009a; Van Hout, 2009b; Van Hout, 2010). This has occurred due to increased '*settled housing*' projects for Travellers and increased educational retention, and therefore increasing contact with drug users, drug use norms and availability of drugs within their communities (O'Brien, 2005; Pavee Point, 2005). On the flipside of this increased sedentarisation of the Traveller community, drug abuse is increasingly occurring within the Traveller family and extended groups of Travellers, with this type of behaviour occurring at close proximity, whether in the halting site, in caravans, local housing schemes or with close relatives (Pavee Point, 2005; Fountain, 2006; Van Hout and Connor, 2008a; Van Hout, 2009a; Van Hout, 2009b; Van Hout, 2010).

Research on ethnic groups offer limited insight into how ethnic minorities experience drug and alcohol related problems, particularly those assimilating within the dominant society (Weaver, 1999; McNulty *et al.*, 2009). The consequences of assimilation over time and contact with the host culture may include the adoption of cultural patterns, and dominant elements of the host culture in terms of normative behaviours such as cigarette smoking (Wiecha, 1996), drug use (James *et al.*, 1997; Greenman and Xie, 2008), alcohol use (Kitano *et al.*, 1988). The selective assimilation theoretical framework offer us much in the recognition of both positive and negative assimilation trajectories, varied levels of cultural adaptation, and in exploring the relationships between ethnic generations, acculturation and substance use (Portes and Rumbaut, 2001; McNulty *et al.*, 2009). Some research posits that selective acculturation, ethnic preservation and family cohesiveness may offer some resiliencies to such risk behaviours in the dominant culture (Zhou and Bankston, 1994; Nagasawa *et al.*, 2001). The presence of community solidarity and connectiveness may provide a filter for normative risk taking behaviours such as drug use, and indeed reinforce the retention

of positive cultural identity (Denner *et al.*, 2001). Thereby, the concept of habitus⁶ (Bourdieu, 1990) may offer some added illustration and comprehension into Traveller assimilation over time and the negotiation of emerging drug risk environments within the newly encountered sedentarist world and their own inner Traveller networks. The aim of this article is to explore emerging Traveller drug use using the aforementioned published data (Van Hout, 2009a; Van Hout, 2009b; Van Hout, 2010) within a contextualisation of the assimilation process for Traveller communities navigating sedentarist Ireland, and relating to their associational life experiences to Traveller habitus and the drugs risk environment.

Methodology

Research Considerations

Research on ethnic minorities must address the core principle of equity and if ignored will contribute to increasing '*cultural fragility*' of certain ethnic groups (Matthews and Cramer, 2008). Research among hidden groups such as ethnic minorities, and indeed drug users is exceptionally difficult with research methodologies often compromised by lack of access, the necessity for lengthy pre development work in order to garner trust, recruitment procedures based on participant volunteerism and potential ethical issues regarding stigma and potential stereotyping (Mathews, 1998). There is an absence of information on Irish Travellers lives and experiences, due to the invisible nature of their lives, in combination with levels of reciprocal mistrust and suspicion with sedentarist communities (Gmelch, 1996; Fountain, 2006). Research within the Traveller community is hampered by high levels of mobility, a lack of ethnic identification systems in health systems, limited access and poor literacy in completing surveys (Fountain, 2006). Challenges exist in order to adequately achieve a diverse sample of Travellers, with researchers perceived to be '*outsiders*' often relying on volunteerism (Helleiner, 2000).

⁶ Bourdieu (1990:53) defines habitus as '*systems of durable, transposable dispositions, structured structures predisposed to function as structuring structures, that is, as principles which generate and organize practices and representations that can be objectively adapted to their outcomes without presupposing a conscious aiming at ends or an express mastery of the operations necessary in order to attain them. Objectively 'regulated' and 'regular' without being in any way the product of obedience to rules, they can be collectively orchestrated without being the product of the organizing action of a conductor*'.

Research Design

This research was originally conducted as a regional needs assessment in the west of Ireland relating to substance misuse and the provision of services for the Traveller community (Van Hout, 2009a; Van Hout, 2009b; Van Hout, 2010). The researcher worked with key liaison workers in order to inform them about the research process and aims, so that they were able to brief the Traveller groups around the research (aims and objectives, process etc.). A certain level of '*gatekeeper*' bias was experienced within the Traveller services, whereby the Traveller workers displayed strong protective views of their client groups, in terms of the research approach, levels of access secured and potential misuse of research information. A pre development phase of several weeks was concerned with building relationships with the local Traveller Community and Traveller organisations, thus providing the researcher with a clearer understanding of the reality of appropriate access approaches and support needs. The aim of this phase was to build trust among the Traveller population and commitment to the research within a partnering approach with Traveller ground workers, which involved visiting and talking with members of the Traveller families, in order to facilitate the growth of a relationship between the researcher and the participants and thereby optimise on potential research retrieval, and reduce the perception that the researcher was an '*outsider*' to the community. This was also done in order to forge links with the Traveller groups post research completion, and give the Travellers a sense of ownership of the research.

Initial attempts to access the various Traveller halting sites were met with suspicion and certain levels of hostility. It was common for the Travellers '*to disappear*' when strangers entered their halting site, and for the researcher and Traveller worker to be met by an older Traveller man, and several barking dogs. Many meetings with the Traveller women and men were arranged and then '*apparently forgotten*' by the Travellers, when the researcher visited them. Time was taken to meet the Traveller women in the Primary Health Care Training for Traveller units, and this proved to 'open the door' somewhat. The primary aim was to examine the respondents' use of a variety of substances and attitudes to drugs; to investigate perceptions of the risks associated with substance use, drug use history; current drug use, peer relationships and peer drug use, family relationships, drug attitudes, motives for use/non use; knowledge of the local drug scene; social settings, experiences and circumstances

associated with the use of drugs and drug use services. This research phase was predominantly peer-accompanied where a Traveller guided the facilitation of the Traveller focus groups. The focus groups were composed of Traveller men, women and youth (aged 17 to 20 years) (n=57). The researcher aimed to maximise the number of focus groups containing 3-9 individuals of similar age and gender within each area (see Table 1).

Table 1. Focus Group and Area

	Total	Traveller Men	Traveller Women	17- 20 years
Area 1	36	14	14	8
Area 2	4	4	0	0
Area 3	17	1	8	8
Total	57	19	22	16

The researcher outlined the aims and objectives of the research and repeated this information verbally to the potential participants, at the beginning of each focus group session. All participants were encouraged to ask for clarification during all stages of the focus group. Participants were reminded that their participation was voluntary and that they could withdraw at any stage. The qualitative nature of the research meant that although the researcher had a list of themes to guide data collection, not all participants discussed a particular issue, and were encouraged to raise their own. All materials were tape recorded with permission and fully transcribed. The methodologies were conducted in accordance to standards set by the NACD's Guidelines on Good Research Practice – Research Ethics (2002). The confidentiality of records and data generated by the research and the protection of informant's identities was a priority through out the research. All research materials were securely stored and pass word protected.

Data Analysis

The research design contains some level of data transformation whereby, following the initial descriptive work, the researcher reflected within an iterative process of studying the research narratives and plotting them within the conceptual framework of frameworks of assimilation, habitus and the drugs risk environment. The theoretical frameworks which guided the groupings of interview data were essentially based on narrative analysis (Morse, 1998), whereby the Travellers discussed and explored their experiences of sedentarist society, their understanding of drug exposure within their

families and communities, risk perceptions, and drug activity by interpretation of their stories. The narratives were content and thematically analysed using Nvivo, according to themes which most consistently arose and were pertinent to the research aims. This consisted of generating '*a list of key ideas, words, phrases, and verbatim quotes; using ideas to formulate categories and placing ideas and quotes in appropriate categories; and examining the contents of each category for subtopics and selecting the most frequent and most useful illustrations for the various categories*' (Zemke and Kramlinger, 1985). A certain level of synchronic reliability was achieved, whereby two or more perspectives between the narratives were in relative agreement as to the situation regarding drug use within the Traveller social environment.

Results

Assimilation and Exposure to Drugs in the Traveller Community- A New Pavee?

Ethnic identity contains specific norms, distinct values and typical behaviours which are transmitted over generations within that culture (Kulis *et al.*, 2002). The Travellers strive to maintain a strong sense of ethnic identity, attachment and affiliation to their culture (McVeigh, 1997; Vanderbeck, 2005). The Traveller community represents an interesting ethnic group in terms of whether they experience '*same race racism*' or '*racism without race*' (Hedican, 2005). Helleiner (2000:101) quoted as follows '*I argue that Traveller culture and identity have been and continue to be produced out of sets of unequal social relations ... [that are] deeply structured by class, gender, and generation*'. Travellers typify a distinct inner/outer normative boundary within sedentarist society in terms of marked differentiation between co existence and non co existence. Gmelch (1996) emphasized that the Traveller claim for ethnic separateness lies in their culture and identity, rather than historical basis. Travellers exist as a marginalized group, which exacerbates their visibility as a social problem and yet also their invisibility within public discourse as ethnic minority (Cemlyn and Briskman, 2002).

The cultural separation between the ethnic minority and the dominant society is cited as contributing factor to poverty, unemployment, compromised health and drug use (Greenman and Xie, 2008). Ethnic identity has been found to be negatively related to drug use and pro drug using attitudes, and studies suggest that the protection of ethnic identity has much to offer in terms of offering resilience to drug experimentation and increasing contact with pro drug using community norms and drug availability

(Belgrave *et al.*, 2000; Brook *et al.*, 1998a; Brook *et al.*, 1998b; Townsend and Belgrave, 2000; Waller *et al.*, 2003; Brook and Pahl, 2005; McNulty *et al.*, 2009). The Travellers in this research were proud to be Travellers and this Traveller orientation is typified by strong sense of pride in their culture, cultural values and family bonds. However, there appeared to be an intense resistance to adopting sedentarist values and behaviours, and most particularly among older Traveller generations.

“I’ll always be a Traveller..they won’t ever take that away from me..I want me kids to understand the life” (Traveller)

“I won’t never be like a settled person..no way..[spat on the ground]” (Traveller)

However the stresses relating to assimilation can contribute to a loss of ethnic identity, fragmentation of traditional culture and norms often posing a risk for drug use and manifestation of psychosocial distress relating to difficulties assimilating between the ethnic group and cultural differences with the mainstream society (Brook *et al.*, 1998a; Brook *et al.*, 1998b; Kiddle, 1999; Kulis *et al.*, 2002; Waller *et al.*, 2003; Brook and Pahl, 2005; Walsh and Krieg, 2007). This is especially true for the Traveller community, who reported experiencing significant adversity in terms of the general lack of opportunity and high incidences of discrimination in their lives, and most particularly in terms of early school leaving, poor living conditions, large families, almost total unemployment and health disparity.

“I can’t get a job..the training centre tried to get me a job, but they don’t want to know ya, when they hear me name..” (Traveller)

This underlying level of racism on governmental, social and individual level has been present in Ireland for many decades (Clarke, 1998; Helleiner, 2000; Irish Traveller Movement, 2003; Pavee Point, 2005). It appears increasingly difficult to weaken Traveller prejudice within the sedentarist society or even garner a reasonable level of social inclusion for this ethnic minority. The Travellers observed a reciprocal and self fulfilling circle in terms of distrust and deep suspicion from both sides. The Travellers also commented on their will to remain among themselves.

“Sure we just want to be left alone you know..we don’t mean to bother no-one” (Traveller)

The Travellers described the isolation experienced within their communities, particularly when housed within local authority sites and attempting to maintain a sense

of their culture, as they exist on the peripheral of the sedentarist community. Experiences of large family networks divided and housed in different areas were common, and contributed to intense feelings of frustration and loneliness. Other Travellers commented on their sense of loss of transiency, in terms of their increasingly fragmented culture, restricted freedom and attempts to retain cohesive Traveller communities. The Travellers housed in local authority schemes described their sense of isolation from inner Traveller networks, and experiences of harassment within these housing outlets.

“Me house was sprayed with paint..get out f* pikey (slang term for Traveller)...no-one spoke to me when I was going around me business..my kids are upset..they have no-one to play with..it’s hard...but it’s harder to go on the road”. (Traveller)***

“You’re living in the same community, but you’re never part of it..people don’t want ye around..so what are ye meant to do..hide?” (Traveller)

Within their own culture and communities hidden tensions reportedly exist between variant families and groups, in addition to the greater sense of frustration within the sedentarist society. Social conflict within inner Traveller organisation is also characterized by the existence of certain families and individual members of these families living in close proximity and yet in complete isolation from each other (Griffin, 2002a; Walsh and Krieg, 2007). Some Travellers commented on the advent of drug related ‘**warfare**’; with many inter related Traveller families becoming involved without assent, and fearful of the consequences.

“The fighting comes from them settled thugs..we never had it like this before.....stabbings and shootings is part of Traveller life now..” (Traveller)

These observations are of distinct value in terms of the exploration of increasing drug use among the Traveller community, occurring as a result of coercive efforts on governmental level to house and situate Travellers within marginalized areas, thereby exacerbating drug related risk and reducing previous resilience offered by cohesive Traveller family values and anti drug Traveller culture. The ethnic family as ‘*a complex web of relationships that includes relations by blood, clan, tribe, and formal and informal adoption*’ can offer potent support and cohesiveness (Waller *et al.*, 2003:79). Extended family members within each Traveller network were perceived in the same way the sedentarist culture would view the immediate family unit. The Travellers also

observed the lack of distinction between 'immediate' and 'extended' Traveller family, with inter marrying relatively common in some Traveller groups. This sense of ethnic familism acts as a strong protective mechanism against social exclusion, drug use and adverse life events commonly experienced by marginalised groups (Hoppe and Heller, 1975; Brook *et al.*, 1998a; Brook *et al.*, 1998b).

"I just want to live with me family you know..I want the best for my kids..I don't want them growing up with nothing..life is tough you know..me mam and dad lived on the side of the road...the rain came in through the roof..we had nothing..I just wanted to get married and have something for meself you know..there's no other options for us as Traveller women..it's a mans world..and it's a settled world'. (Traveller)

One cannot underestimate the school and proximal community setting in terms of general socialisation, prediction and indeed normative presence of youth drug use (Dekovic and Meeus, 2004; Bottrell, 2007). Individuals reared in socially or economically disadvantaged environments are likely to experience a different range of peer choices than those reared in advantaged and privileged areas (Longest and Shanahan, 2007). This incurs a host of issues for Traveller youth who represent the greatest potential for assimilation by their level of contact with sedentary youth, and are additionally compromised by their Traveller background, social exclusion and marginalisation. The Travellers observed that the sedentary communities and schools were providing Travellers with access to drugs, resources that facilitated the likelihood of drug use, and introduced community norms for drug use. The risk according to the Travellers themselves appeared greatest for Traveller boys, as Traveller girls are chaperoned by older female relatives, thus buffering them from pro drug using norms at school. Traveller youth reported feeling excluded from after school activities and sporting clubs. One would also note that it is in unstructured leisure time that the risk for drug use is greatest (Collingwood *et al.*, 2000).

"I want to fit in..I ain't going to say I won't do it..if the lads are out there gettin' a buzz, whose to say I won't neither.." (Traveller youth)

Traditional Traveller values may therefore offer resilience against drug use in terms of potent anti drug attitude and anti drug norms within the family, the chaperoning of younger female members and also in terms of providing strong attachment and

bonding with those advocating abstinence. Older Travellers commented on their traditional values and potent social sanctions for drug use. They appeared to be fearful and suspicious of all drugs and deemed all drugs as equally harmful. This reflects the older generational resistance to acculturation and is supported by previous Irish research reporting that drug taking carries great stigma and shame for the community, and is a sensitive and ‘*taboo*’ topic to discuss for Travellers (Fountain, 2006).

‘Ye couldn’t drink or smoke before ye got married,...never mind drugs, we didn’t know about it’. (Traveller)

“I hate them drugs..am afraid every day them kids go to school..we never had this before..they come back and they don’t tell me nothing..Travellers have it hard enough without trying to deal with this” (Traveller mother)

Thereby drug use remains a covert behaviour within the halting site, and most common in Traveller men and youth. Instances of home detoxification and use of religion to deal with problematic substance use were common, and replicate earlier Irish research by Fountain in 2006.

“Sure we just locked the uncle in the caravan..and me ma and da prayed..me ma got the holy water....there’s no point in asking the doctor to come..they don’t come anyhow...we don’t want no-one knowin’ our business” (Traveller).

In this way, drug use is dually hidden, both from the ‘*settled*’ society and also within the inner boundaries of Traveller families. Some Travellers commented that although drug use comes from within Traveller communities whether from close family networks or in certain caravans, it was still not acceptable within their culture and therefore drug activity was not blatantly obvious. This reflects the Traveller assimilation process within Irish society however selective, is still dynamic in terms of its reflexive influence on drug related norms and community values. However, as drug use becomes more common place one might expect the traditional protective factors of close Traveller family networks and social control to contribute to the growing drug problem, in terms of parental and sibling drug use within close proximity in halting sites and group housing. Increased visibility of substances in the youthful Traveller community and indeed halting site among Traveller men, may thereby neutralize negative risk perceptions of certain drugs, and stimulate Traveller’ perception of normalization of drug use (see Parker *et al.*, 2002; Parker, 2005; Measham and Shiner, 2009). Drug dealing within the Traveller communities is reportedly increasing and represents the potential acquisition of resources, social space, agency and status during the

assimilation process. Drug dealing was recognised by the younger Travellers as a lucrative diversion of economic activity from scrap metal and horse dealing, the utilization of their nomadism, relative unaccountability and also an inherent fear of purchasing from sedentarist strangers. Other Travellers in contrast reported buying their drugs only from members of their own families and in halting sites suggesting a '*closed door mechanism*', and again reflecting the inner and outer boundaries of Traveller ethnic identity. The separated social worlds of the Travellers and the sedentarist community may thereby exacerbate the invisibility of problematic drug use and heightened drug activity within the Traveller groups, making it increasingly difficult to control, quantify and address.

Discussion

Traveller Habitus and Drugs in the sedentarist risk environment

The Irish Traveller community is at increasing risk of problematic drug and alcohol use not only due to their poor life circumstances, attempts to protect their ethnicity, culture and increased family fragmentation but also due to the '*inner versus outer*' struggle of assimilation within sedentarist Irish society. Griffin (2002a; 2002b) observed that the reinforcement of both individual and familial autonomy has resulted in a fragile sense of internal community identity and contributed to increased dissipation of traditional Traveller culture within greater social structures. Research indicates that indigenous groups with low reported drug use are those which are selectively acculturated, having adopted and merged both ethnic values with those of the dominant society (Oetting and Beauvais, 1991; Herring, 1994; Moran *et al.*, 1999; Brook and Pahl, 2005). It appears that cultural traditions and practices can simultaneously facilitate drug use and promote abstinence (Brady, 1995; James *et al.*, 1997; Belgrave *et al.*, 2000; Felix Ortiz *et al.*, 2001; Waller *et al.*, 2003). This process was described by the Travellers in the context of a supportive Traveller or sedentarist peer groups encouraging drug experimentation, or with the presence of a Traveller family member using drugs in close proximity in the caravan or halting site. Conversely strong Traveller family networks and close parent child relationships advocating abstinence acted as potential deterrent. The Travellers reported a clear sense of old Traveller values being replaced by those of the '*settled*' community among the youthful generation. Experiences of selective acculturation along the continuum of assimilation perhaps pose the greatest

risk for younger generations of Travellers who experience cultural confusion and cultural shame as they strive to integrate within schools and form friendships.

Habitus offers an explanation as to how social actions are predicted over time, whereby such actions are deemed to be transferred in an unconscious manner through generations and seen as reflecting class practices (Jenkins, 1992). According to Bourdieu (1990) the comprehension of the power relations within social fields and in turn within the local habitus is essential to predicting community and individual behaviour. Thereby, the concept of habitus may offer some illustration and insight into Traveller navigation of the risk environment in the potential retention of Traveller ethnicity and values, and particularly in the case of Traveller youth merging within the school setting. Bourdieu (1977) also describes the influence of habitus as limiting the options which individuals possess whether through cultural influences and generational precedents. On a negative note, this is inherently the case for Travellers in terms of lack of education, employment and life opportunity, and somewhat positively in relation to potent sense of familialism within inner Traveller networks, thereby offering support, solidarity and connectiveness in Traveller community life. Of note is that as Traveller culture is dissipating in its strength and also adapting somewhat to '*settled*' values and norms, this may result in distinct habitus evolving for younger generations of Travellers.

Habitus operates as a perceptual, classifying and objective structure, and additionally as a generative structure of practical action, where practice is produced by structure, and vice versa on a wider macro scale (Bourdieu, 1987). The Traveller environment as it meets the '*new*' sedentarist risk environment may yield an entirely new set of action schemas over time, and in response to heightened contact with drugs, whereby previous and traditionally held views and values may not come into play, and therefore represent potential assimilation and adoption of new stocks of knowledge around drug practices and consumption. The process of assimilation thereby offers the Traveller new, modified and existing action schemas based on knowledge and past experiences to deal with rational decision making experiences pertaining to drug use within the newly encountered subterranean drug cultures. Acculturated ethnic groups often present with similar drug prevalence trends of the dominant society, indicating a certain reflexivity of perception of drug related risk coupled with changes in normative frameworks for drug use (McNulty *et al.*, 2009). This may very well be the case for

Traveller youth as they navigate modern sedentarist associational life and subscribe to the understanding of drug use within a consumptive framework of accepted subterranean leisure values in post industrial society (see Matza and Sykes, 1961; Young, 1971; Cohen, 2002; Measham and Shiner, 2009).

These subterranean cultures are deemed heterogeneous, with theories of social discourse offering an insight into individual drug choices, attempts to achieve recognition, discourses and reflexes in habitus, assimilation and counter acting shifting societal values (Bourdieu, 1987; Bourdieu, 1999; Cohen, 1971; Cohen, 2002; Willis, 2003). Bourdieu (1984) described distinct consumption practices in social groups in terms of meaning and expression, and reflected in perceived risk, strategic decision making and sanctioned or condoned forms of behaviour within certain cultural norms. Consumption patterns and modes of drug use are part of habitus which become unconscious reflexes over time. As habitus is deemed to limit certain responses to risk situations, the question remains, whether inherent Traveller abuse of alcohol and now in recent times of drugs, is a reflexive action or partially reflexive in the selective assimilation process, to the under current of frustration, tension and discrimination in Traveller lives. Within the dominant sedentarist discourse, is this new drug taking behaviour a response to stress, boredom and depression, or are the wider forces of Traveller social circumstance predicting such behaviours? Drug activity within the Traveller community may be therefore seen as attempts to seek recognition or status within groups by so called illicit means, the creation of new space or new cultural capital and when applied to the older Traveller generations, resilience to drug and alcohol use may be viewed as attempt to counteract dominant values. However, these social shifts remain a threat in terms of potential for drug abuse, as drug using members of Travellers families will inadvertently influence members of their own family over time, even in the context of previous fear of drug use within the halting site.

Conclusion

The lack of data pertaining to Travellers in Ireland occurs in light of predominant assimilationist approaches in the development and implementation of national and international policies, and reflects an ideology that for many governments the approach of ignoring the Travellers will result in the '*problem*' disappearing (McVeigh, 1997, Noonan, 1998, Morris and Clements, 1999, Irish Traveller Movement, 2003). One

must note that for Travellers, integration does not infer assimilation and '*social inclusion and social integration should not be equated with the homogenisation of minority ethnic groups.* (Pavee Point, 2005). Lack of Traveller institutional trust remains strong as consequence of aggressive sedentarisation in Ireland, where attempts to coerce Travellers to behave like non-Travellers continue and policies ignore their individual values, beliefs and concerns. The uncritical sedentarist perspective where Traveller cultural identities are perceived to be criminal, pathological and deviant continues (see '*othering*', Cemlyn, 2008).

Their experiences of a myriad of identified risk factors for substance use, in the relative absence of resilience is explored in this article within the contextualisation of assimilation, reorganisation of Traveller habitus and the identified clash between older Travellers resisting '*settled*' values and Traveller youth integrating within sedentarist communities. The assimilation process yields an interesting quandary in the context of Traveller drug use, which traditionally low and virtually non-existent, has now in recent years increased although still at a lower level than the general population in Ireland. Drawing on the concept of habitus and Bourdieu's work, one can achieve a greater understanding of cultural logics and practices pertaining to Traveller ethnicity within the wider social discourse, and how habitus represents the continual reproduction, normalisation and naturalisation of action schemas in the newly encountered sedentarist drugs risk environment. Further research is necessary to explore this process within the context of drug education and prevention planning for Travellers, particularly as segregated programming in Ireland is most common, coupled with a distinct lack of Traveller advocacy in the National Drugs Strategy 2009-2016. This represents a distinct political movement away from consideration of Traveller culture and ethnicity in isolation, and toward an inclusive community development focus for addressing drugs in Ireland. A broader paradigm shift away from sedentarist frameworks in raising political and cultural awareness, acceptance, reduction of prejudice and ultimately preserving Traveller ideology have much to gain in protecting this ethnic minority from potential familial and ethnic fragmentation, dissipation of Traveller ethnicity and problematic drug use in contemporary Irish social structures.

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Paper 12. Van Hout, MC (2010). The Irish Traveller Community, Social Capital and Drug Use. *Journal of Ethnicity in Substance Abuse*. Volume 9, Issue 3, July, 196-202.

Abstract

The Irish Traveller community experience severe marginalisation, poverty, discrimination and compromised health (Fountain, 2006). Research indicates there is a distinct lack of structural understanding of Traveller negotiation of conflict within dominant sedentarist societal norms and values (Cemlyn, 2008). Gender based focus groups (*n=12*) of Travellers (*n=57*) were conducted as part of a large scale regional needs analysis for Travellers and substance use in Ireland (Van Hout, 2009a), and analysed thematically using the social capital framework, in terms of Traveller experiences within '*settled*' communities, exposure to drugs and drug using contexts. Discriminatory experiences, low levels of institutional trust and influx of drug activity in Traveller communities is contributing to the neutralisation of drug taking risk, and the development of normative and reciprocal relationships in drug activities. A holistic, inter governmental approach is needed to address social exclusion factors by reducing marginalisation, preserving the Traveller ethnic identity, minimising racist and discriminatory instances, understanding the Traveller risk environment, and fostering inclusive relationships with '*settled*' communities.

Key Words

Travellers, Social Capital, Assimilation, Social exclusion, Risk, Drug Use

Background to Research

Introduction to the Irish Traveller Community

'The Irish Traveller Community' are identified as a 'people with a shared history, culture and traditions including, historically, a nomadic way of life on the island of Ireland' (Joyce, 2002 see Irish Traveller Movement, www.itm.ie). Travellers have been part of Irish society for over 200 years (Binchy, 1994; Ni Shuinear, 1994; Clarke, 1998) and currently occupy 0.6% of the population (Central Statistics Office [CSO], 2006). The Traveller community maintain their ethnic identity, by way of reinforcement of 'separateness' and distance from the 'settled' community (Pavee Point, 2005) and centralize their ethnicity in the structure and maintenance of their 'closed' community (Liegeois, 1987; Liégeois and Gheorghe, 1995). The presence of these inner and outer boundaries for the Traveller community positions wide family networks within a greater social system (Saunders *et al.*, 2000; Griffin, 2002a). A history of exclusion and mistrust has contributed to the development of reciprocal suspicion and hostility between sedentarist society and the Travellers (Helleiner, 2000; Joyce, 2002; Cemlyn, 2008). A variety of negative stereotypes of Travellers and the '*itinerant way of life*' exist (Ni Shuinear, 1994) with such prejudices often deemed more acceptable than that of other racial groups (Stonewall, 2003; Cemlyn, 2008). Irish Travellers in the UK and Ireland are denied the designation of ethnic minority group and are neglected by the majority of ethnic monitoring systems (Morris, 1999; Niner, 2003; Commission for Racial Equality [CRE], 2004). The denial of rights and lack of visibility of Traveller culture in mainstream policy results in socio political exclusion (McVeigh, 1997; Stonewall, 2003; Cemlyn, 2008).

Traveller housing is the central focus of societal discrimination, is often inadequate, unsafe and lacking in basic utilities, and contributes to poor health, compromised education, employment and health service access (Hyman, 1989; Hughes, 1998; Kenrick and Clark, 1999; Morris and Clements, 2001; Morris and Clements, 2002; CRE, 2004). Instances of racial harassment, bullying and evictions are common, and undermine fundamental Traveller rights (Cemlyn, 2008). About half of the Traveller population is in some form of housing (Clark and Greenfields, 2006). Research shows that identified '*push*' factors (i.e. lack of Traveller housing and suitable transient sites) are present in causing Traveller families to seek local authority housing (Niner, 2003; Clark and Greenfields, 2006). Therefore, for many Traveller families the move into

'settled' housing is a reluctant choice (Cemlyn, 2000; Morris and Clements, 2001; Parry *et al.*, 2004b; Cemlyn, 2008), with the '*aversion to conventional housing*' finally recognized as legitimized reasoning for homeless Travellers to refuse 'settled' accommodation (Johnson and Willers, 2004:188).

The Irish Traveller Community and Drug Use

Traveller life circumstances are characterised by identified risk factors for problematic substance use such as poverty, marginalisation, ethnic discrimination, poor mental health, unemployment and lack of education (McCarthy, 2005; Pavee Point, 2005; Fountain, 2006). The risk of early onset of drug use and pathways to problematic drug use are exacerbated by the location of Traveller housing close to marginalised areas experiencing drug activity and contributing to increased Traveller contact with drug users and dealers (Pavee Point, 2005; Van Hout, 2009a). The closeness of Traveller family bonds within halting sites or sheltered housing whilst traditionally offering resilience to drug use, has the potential to escalate drug use within the close proximity of parental, sibling or wider family network influences (Pavee Point, 2005; Fountain, 2006; Van Hout, 2009a; Van Hout, 2010). Equally, the presence of strong family networks with traditional anti drug norms and values can act as a protective mechanism. Traveller youth are perhaps most at risk due to their experiences of discrimination and difficulties engaging within the formal education system (Jordan, 2001a; Jordan, 2001b; Pavee Point, 2005). Traveller children and youth remain the most underserved population within the formal educational system, typified by poor teacher attention, lower expectations, bullying and discrimination (Plowden, 1967; Swann, 1985; Jordan, 2001a; Jordan, 2001b; Lloyd and Stead, 2001; Department of Health and Children [DoHC], 2002). Peer socialisation within drug using groups and high levels of leisure boredom remain a significant risk factor for Traveller youth drug use (Van Hout and Connor, 2008a; Van Hout, 2009a; Van Hout, 2010).

Research suggests that recreational drug use is becoming increasingly socially accommodated in Irish society (National Advisory Committee on Drugs [NACD], 2008a; Alcohol and Drugs Research Unit [ADRU], 2009). The availability and accessibility of illicit drugs in Ireland is increasingly apparent, with a wider range of substances used by varied social groups, ethnic minorities and ages (NACD, 2008a). The lack of ethnic identification in health reporting systems has made anecdotal evidence of emerging

drug use among Irish Travellers, particularly hard to quantify (Fountain, 2006). Traveller drug use is anecdotally lower than the general Irish population with male Travellers presenting with higher levels of drug use than females (McCarthy, 2005; Fountain, 2006; Van Hout, 2009a; Van Hout, 2010). Cannabis remains the most commonly used illegal substance for both Travellers and for the population of Ireland (Hurley, 1999; Fountain, 2006, NACD, 2008a, Van Hout, 2009a). Some anecdotal reports of opiate use among Travellers indicate an increase in both inhalation and intravenous use in recent times (Fountain, 2006; Van Hout, 2009a).

The Social Capital Framework in understanding Risk and Drug Use

Social capital is regarded as an important conceptualization in the understanding of social control, social solidarity, community and individual behaviour and health disparities (Baum, 2000; Carpiano, 2006; Muntaner and Lynch, 2002; Poortinga, 2006; Ziersch *et al.*, 2005). Structural components of social capital describe social networks, associational life and relationships, with cognitive elements contained within these social networks based on trust, cohesiveness, support, reciprocity and perceived civic engagement (Theall *et al.*, 2009). Subramanian and Kawachi (2006) describe bonding social capital as generated out of relationships and social networks between similar persons (i.e. neighbours and friends). Bridging social capital in contrast, operates between dissimilar persons at the same level of social hierarchy (i.e. participation in clubs or organisations) (Rojas and Carlson, 2006). The level of individual and community investment in these social networks and associational relationships generates social capital in the form of resources that individuals can utilize to promote self growth and opportunity. Low levels of social capital can occur in the process of exclusion of certain groups (i.e. ethnic minorities) from societal structures (Youngblade *et al.*, 2006). Social capital is 'of' the people and 'for' the people and is fundamental to community networks based on reciprocal relations, where individual responsibility shifts toward that of collective responsibility (Putnam, 2001). This is of particular interest for this paper, in terms of Travellers existence as socially excluded group in Ireland, and yet characterized by a strong sense of ethnic identity and potent family networks within the dominant 'settled' society. Drug use within this ethnic group represents potential for dual exclusion in the form of stigmatization, further social exclusion, health disparity and ethnic dispersion.

Cheung and Chueng (2003) presented new insights into the inter relatedness between social capital and drug use, by referring to certain networks and groups as positive or negative social capital. This model however appears excessively dualist and fixed, in terms of the network either represented as positive or negative, and neglects the dynamic aspect of social networks and relationships. In particular, emerging social accommodation of drug use (i.e. cannabis) in contemporary Ireland has shifted away from the 'good' versus 'bad' ideology of drug use. The key premis of interest here is how the social capital environment 'enables' the emergence of socially situated drug risk and drug activity in the Traveller community. The social epidemiology of drug risk is central to linear and non linear relationships and networks between individuals and their social environments, and offers greater understanding of the reciprocal nature of drug interactions through day to day experiences within 'localised' settings (Rhodes, 2002; Galea *et al.*, 2009). The evaluation of risk is rational when understood, reinforced and internalized within the 'localised' world of the user or his/her cultural context, and presents distinct differences in drug behaviours relating to class, gender, and ethnicity (Bourdieu, 1986; Lash, 2000, Rhodes, 2002). The neutralisation of these drug risk boundaries within 'localised' settings (France, 2000; Lovell, 2002) can be applied to the assimilatory experience of Irish Travellers and their contact with the 'local' sedentarist world of drug use. Drug risk environments therefore create, mediate and support 'cultures' of risk and resilience whereby drug using sub cultures are grounded in social networks and relationships. Thereby, drug use becomes a medium for group membership, support and solidarity, but also a method of achieving social space, status and sense of social agency (Lupton and Tulloch, 2002; Linsdstrom, 2008). The aim of this paper is to conceptualize recent exploratory research on the Traveller community and drug use in Ireland (Van Hout, 2009a; Van Hout, 2009b; Van Hout, 2010) within the social capital framework of associational life, trust, reciprocity, normative groups, risk neutralisation and mutual extraction of resources within the 'localised' Traveller risk environment

Methodology

Research Design

The research was undertaken as part of a large scale funded service needs analysis on the Traveller community and drug use in Ireland (Van Hout, 2009a). Prior to fieldwork, a predevelopment phase of several weeks was conducted in order to engage

with the Traveller communities. This was done in order to enable the participants to develop a relationship with the researcher, garner trust, retrieve optimum research material and create potential relationships with service agencies in each area. This phase was facilitated by the Traveller organisations who acted as '*gatekeepers*' for the initial introduction and explanation of the research aims. The researcher worked closely with the '*gatekeepers*' in the identification and recruitment of a Traveller research assistant (TRA) in each area, who assisted in the recruitment of the research participants and also facilitated each focus group with the researcher. The researcher conducted 12 focus groups of 3-5 Traveller men, women and youth ($n=57$). Focus groups were selected in order to allow for discussion and retrieve optimum illustrative material relating to the Traveller narratives.

	Total	Traveller Men	Traveller Women	Under 20 years
Area 1	36	14	14	8
Area 2	4	4	0	0
Area 3	17	1	8	8
Total	57	19	22	16

Research Considerations

The researcher discussed the aims and objectives of the study with each group of Travellers both in the pre development phase and also prior to the focus group. An information sheet outlining the aims and methods of the research was given to all participants before asking for informed consent to partake in the research. This information was repeated verbally to the Travellers at the beginning of each focus group session. Confidentiality and anonymity were emphasised throughout the course of the research, and participants were facilitated to withdraw at any stage. Participants were encouraged to ask for clarification during all stages of the focus groups. In addition to the original needs analysis focus of the research in terms of Traveller drug use and service experiences, this research aimed to explore three key themes relating to social capital and drug use, namely; Traveller culture and life experiences, exposure to drug activity and drug taking patterns. The Travellers were encouraged to explore these themes and discuss any thoughts, opinions and ideas they had in relation to the recent advent of drugs within their communities.

Data Analysis

All focus groups were coded, audio taped and transcribed. A thematic analysis (Nvivo) identified, compared and contrasted the information garnered. The narratives were then mapped within a conceptual discourse of social capital and risk in relation to ethnicity and trust, neutralisation of risk, normative and reciprocal frameworks for drug use, and resource acquisition.

Results

Some Travellers remarked on the dangers of generalizing the idea of drug use within Traveller communities in Ireland and stressed that their information was in confidence and personal, and not necessarily similar to their peers. There appeared to be certain reluctance in some Travellers to admit to any contact or experience with drug activity in their areas.

Traveller Culture and Life Experiences

Most Travellers commented on the inherent changes in Traveller '**way of life**' and how levels of transience have been restrained and tempered by local authority efforts to house Travellers in group and local authority housing. These efforts have contributed to the dispersion of Traveller families and increased social anxiety, isolation and experiences of anti social behaviour in marginalised housing areas. The majority of Travellers described feeling socially excluded and highlighted the common practice of attempting to disguise their identities in order to avoid discrimination. Some Travellers commented that their identity contributed to an overall sense of hopelessness and inability to participate within their communities, and described their feelings of frustration relating to their attempts to both reject and accept '**settled**' culture. This is evident within the following quotes describing day to day life experiences for some Travellers;

"People judge Travellers on maybe 5 or 6 bad ones, and then the whole lot of them are getting judged, its like if one young fella goes down and he smashes all the windows, well people that were talking to him the next day, they might be blackened, and then it slowly goes out that they have a bad name, whether they've done it or not."

"You're living in the same community but you're not in it";

"The minute they hear Traveller..you are out the door".

The overall lack of opportunities in securing employment and completing education were deemed to contribute to depression, anxiety, boredom and low self esteem, and were seen as contributing to drug use in the Traveller community. A Traveller male commented on his efforts to secure employment;

“Once they heard me name..they told me the job was gone.I got me support worker to ring for me and the job was still there”.

A Traveller woman remarked on the levels of dual discrimination and said,

“We find it difficult as women to get education, training and employment, but it’s much harder when you are a Traveller.”

Some Travellers reported leaving school early because they felt discriminated against and ridiculed, with many given a ‘**colouring book**’ in classes, instead of participating with the ‘**settled**’ children. This contributed to poor literacy, difficulties in completing forms and poor employment prospects. Some Travellers commented on the relationship between poor educational attainment and drug use in Traveller youth and a Traveller male observed the need for community intervention;

“The person with no goal in life...you need to give him something..bring him down a different road”.

Exposure to Drug Activity

The majority of Travellers emphasised that drug use was not part of the “**Traveller way of life**”, but that it was an emerging issue in their communities. A Traveller man remarked;

“You would never hear of drugs among Travellers, going back I’d say even ten years, but now its a big thing’ .

The Travellers noted an increase in drug use in Ireland with greatest visibility of drugs in urban areas. Others commented on the increase in drug availability within their local housing areas and their halting sites. A young Traveller male observed that young Travellers were in increasing contact with drugs at school and said;

“There’s drugs in every place...wherever you look..it’s everywhere...at school..at home ...if you’re not up to much at night..you might as well take a few yokes or whatever..there’s no difference between us and the lads [settled]”.

The following remark was made by a Traveller man describing his experience of recent drug use within his halting site;

“They try and settle in with the “settled” community and then if the “settled” ones are going to do it then the Travellers are going to do it, not saying that Travellers wouldn’t do it amongst themselves, they would.”

The majority of Travellers whilst acknowledging the presence of drug activity in close proximity, observed that this was rarely discussed between Traveller families. Older Travellers were fearful of drugs and considered all drugs equally dangerous. Attempts to hide addiction and deal with addiction within families were common. A Traveller female commented on the stigma of addiction within the family and said;

“Sure we had to lock the uncle in the caravan...it was awful..he went mental...we didn’t know what to do..the GP would make a house visit...we had to deal with it ourselves..we went to the priest and we prayed”.

An older Traveller woman remarked on how Traveller culture has changed in recent years in terms of social control of those who are unmarried;

“If you were single it would be harder for you to use drugs cos you would have to keep it quiet, or they mightn’t be able to get married”

““If you’re single no-one is supposed to know what you’re doing, and if you have done something really wrong, your parents might say, you’re not good enough or whatever, whereas if you’re married anything goes, what you do in your own home is your business”.

Other Travellers commented on the presence of informal networks of Traveller women supervising the young people (mostly Traveller girls). Young Traveller men were not easily chaperoned as they assumed adult like roles at an early age, and ***“hung around with the older Traveller men”.***

Some Travellers commented that drug use was coming from within their own communities, in terms of exposure, availability, opportunities to purchase and consume drugs. Drug dealing was reportedly based on entrepreneurship of some Travellers to a market opportunity, and as control method to ***‘keep drugs within themselves’***. Some Travellers commented that the Traveller way of life in terms of its transiency and unaccountability was ideal for ***‘drug trafficking’***, whilst others rejected the idea of drug dealing within their communities. The following quotes illustrate how Travellers perceive these local drug economies to affect them;

“People give out about it but the drugs are too easily available to them, and it’s only going to get easier to get them”;

“There are some people making big money out of drugs. They’re going to be around for ever, you are never going to get away from them people”.

Drug taking patterns and practices

The Traveller groups reported that ‘**ecstasy, speed, hash**’ and ‘**cocaine**’ are currently the most commonly used drugs within the Traveller community. Illicit drug taking was reportedly most prevalent among young Traveller men, and relatively uncommon among Traveller women. The lower anecdotal reports of illicit drug use among Traveller women were attributed to lower levels of opportunity, freedom and income. A young Traveller commented on solvents and cannabis smoking common among younger Travellers. It appeared to be predominantly single Traveller men, both young and older who were reportedly engaging in drug use and drug dealing. In terms of licit drug use, the prevalent use of night sedation, tranquillisers and anti depressants among both men and women, was deemed to be a consequence of high levels of disability, co morbidity and depression, coupled with over prescription from local general practitioners, diversionary use among each other and poor literacy leading abuse.

The majority of Traveller narratives in this research presented a fear of addictive use, whether in terms of appearing like a ‘**junkie**’, ‘**bringing shame on the family**’ or stigma related to accessing mental health and addiction services [usually situated together in Ireland]. The primary reasons for illicit drug use and to a lesser degree, the diversionary use of prescription medication were related to boredom, curiosity and depression. A Traveller man remarked on the levels of drug experimentation among Traveller youth;

“Some Traveller young fellas are taking them and more Traveller young fellas don’t take them. You can’t tar them all with the one brush”.

Younger Travellers appeared to recognise moderated drug use and presented with somewhat modern day adolescent perspectives relating to the hierarchy of drug risk. A young Traveller male commented; ‘

“No 15, 16, 17 year old I know has a serious drug problem. Serious is like ecstasy, Hash is just a buzz, weed is just a buzz, to relax you like, It’s more like older men that take serious drugs”

Discussion

The social capital approach to understanding and drug behaviours are embedded in 'socially constructed discourses of risk and morality' (Rhodes, 2002:86). The Traveller drugs risk environment within Irish society can be viewed as a '**social space**' whereby a multiplicity of social, ethnic and cultural factors interact to discourage, facilitate and mediate forms of drug activity. The research supports previous literature in emphasising that the Irish Traveller community, as ethnic minority and existing within the mainstream '*settled*' society experience increasing fragmentation of cultural values, discrimination, social exclusion and marginalisation (Binchy, 1994; Ni Shuinear, 1994; Clarke, 1998, Cemlyn, 2008). Subramanian and Kawachi (2006:118) indicate that one's '*cultural consonance in lifestyle*' which is defined as '*the degree to which people succeed in achieving the normative lifestyle as defined by their culture*', is associated with greater perceived social capital and in turn the prediction of positive and improved health outcomes. The dominant and underlying conflict occurs between the Traveller community and the '*settled*' society (Griffin, 2002b). In the wider sense of social capital, this separation between the Travellers and '*settled*' communities contributes to lower social capital, by compromising levels of institutional trust, wider community trust and reciprocity within '*settled*' associational life. Kim *et al.*, (2006) in their research on community bonding and bridging social capital found that measures of trust and relationships between members of ones ethnic group are related to positive social capital, reduced risk taking behaviours and self perceived positive health status. Youngblade *et al.*, (2006) indicate that higher levels of risk behaviour are associated with communities with lower rates of social capital, and decreased likelihood of risk behaviours (such as drug use) among communities with greater ethnicity. However, one must note that ethnic minorities such as the Travellers experience great social exclusion, which lowers levels of social capital, thereby posing a risk for drug use, however strong their inner perceptions of social capital are in terms of Traveller ethnicity, older generations of strong anti drug philosophy and close knit Traveller community boundaries.

Ethnic identity encompasses specific norms, distinct values and typical behaviours which are transmitted within generations, and has been found to be negatively related to drug use and pro drug using attitudes (Kulis *et al.*, 2002). The protection of ethnic identity, and thereby perception of social capital has much to offer in terms of offering

resilience to drug experimentation (Brook *et al.*, 1998a; Brook *et al.*, 1998b; Belgrave *et al.*, 2000; Townsend and Belgrave, 2000). Those with high evaluations of ethnic pride report higher levels of self esteem, with personal self esteem acting as negative correlate to drug use (Hughes and Demo, 1989; Crocker *et al.*, 1994). However as in this research, many Travellers attempt to hide their identity to avoid racism and potential hostility, with Travellers in '*settled*' housing often seen to be denying their own culture (Cemlyn, 2000; Morran, 2002; Garrett, 2004b; Cemlyn, 2008). The failure to acknowledge Traveller ethnic culture and race equity lies in '*aggressively assimilationist attitudes*' (Garrett, 2004a; Cemlyn, 2008). For these Travellers existing within dominant Irish discourse, the assimilatory experience was deemed stressful, and contributes to a loss of ethnic identity and fragmentation of the traditional culture and protective norms. Research indicates that problematic substance use and indeed emerging drug use among ethnic minorities are often a manifestation of psychosocial distress relating to the assimilation process (Brook *et al.*, 1998a; Brook *et al.*, 1998b; Kulis *et al.*, 2002; Waller *et al.*, 2003; Brook and Pahl, 2005; Walsh and Krieg, 2007).

Social capital is commonly grounded within social interaction, engagement and civic levels of interpersonal and institutional trust (Putnam, 2004). Putnam (2001) describes '*thin trust*' as a general form of trust with individuals one is not directly acquainted with (i.e. the glue linking different groups to each other). Such '*thin trust*' stimulates individual willingness to trust those outside of the immediate circle, within a reciprocal circle of trust and solidarity, enhancing social cohesion, collective action and inclusion (Putnam, 2001). The inherent lack of trust and avoidance of contact between Travellers and the '*settled*' public discourse is historically grounded (McVeigh, 1997; Helleiner, 2000; Cemlyn, 2008). Traveller and '*settled*' communities operate on a reciprocal stasis of mistrust, suspicion and hostility with '*settled*' Irish society (Ni Shuinear, 1994; Stonewall, 2003; Helleiner, 2000; Pavee Point, 2007). The overall lack of Traveller representation in public and community discourse remains an issue (Cemlyn, 2008). Social exclusion is a result of mistrust within greater social structures (Berkman and Glass, 2000; Stockdale *et al.*, 2007). This lack of trust restricts the formation of social networks, development of inter related groups, and contributes to heightened stress, tension, crime and drug use (Ross *et al.*, 2000, Boardman *et al.*, 2001; Latkin and Curry, 2003). However, within a community focus, Stockdale *et al.*, (2007) describes the presence of '*nested support systems*' which consist of layers of social networks

providing social support, to attain community stability within the greater social structure, and within an individual level to provide trust and inter personal relationships. Community research on social capital illustrates that greater levels of resources and activities for residents can lower levels of negative social capital and thereby reduce levels of criminality and other risk taking behaviours such as substance use (Youngblade *et al.*, 2006). However, Youngblade *et al.*, (2006) also indicated that after a certain level of risk behaviour such as drug use is engaged in by a proportion of a community, this behaviour accelerates and incidence rates increase. Therefore in this context, greater social resource acquisition in the form of Traveller community integration and development of associational relationships can also pose a threat in the form of drug exposure, drug use and drug dealing networks.

Research indicates that individuals with high levels of personal social capital are in the position to garner greater levels of social support from peers or family members in times of crisis, when compared to individuals experiencing poor levels of social capital (Cohen and Wills, 1985; Tsutsumi *et al.*, 1998). Factors such as potent family networks, school, work and community bonding offer resilience to drug use (see Hawe and Shill, 2000 who mention the “*spray-on*” effect of social capital). The Traveller world is essentially patriarchal and characterised by early marriages within Traveller families and high levels of social control of women prior to marriage (Cemlyn, 2000; Morris and Clements, 2001; Parry *et al.*, 2004b; Parry *et al.*, 2004c; Helleiner, 2000, Griffin, 2002a; Cemlyn, 2008). In contrast, Traveller boys assume adult like roles at an early age and experience less parental monitoring (Smith, 1997a; Smith, 1997a; Helliener, 2000). Social capital research shows that women have a greater propensity to creating social relationships, are more active in the community, and have a more sensitive and caring role in the community (Warr, 2006; Healy *et al.*, 2007). However, like women from other minority ethnic groups, Traveller women experience an intersection of a number of racism and sexism (Helleiner, 2000; Griffin, 2002a; Griffin, 2002b). In this way, even in the advent of problematic drug use within Traveller families, Traveller family cohesiveness may bolster their perceptions of social capital relating to support, trust and solidarity. One might assume that therefore the Travellers possess great levels of social capital within their own communities and families, and not within dominant social discourse in ‘*settled*’ Ireland. However, this type of bonding capital can foster exclusivity within insular groups, thereby reinforcing the inner

perspective of homogenous groups and their '*thick trust*' within individual relationships, and reducing opportunities for the development of '*thick trust*' within the greater social structure (Putnam, 2001).

Popular discourses on drug use and relative harmfulness of certain drugs (see Parker 2003) stimulate and facilitate the neutralisation of risk. Social groups can disseminate norms for collective and individual behaviours, with costly sanctions for those who deviate (Bolin *et al.*, 2003; Bailey, 2005). Norms for drug use are reinforced within the social network, whereby socially isolated individuals have a greater likelihood to smoke, drink and use drugs (Lovell, 2002). Traditional Traveller culture offers resilience to drug use whereby social networks of older Travellers advocate abstinence and strive to regulate levels of deviant behaviour in Traveller youth within the context of strong family ties and support (Pavee Point, 2005; Fountain, 2006; Van Hout, 2009a). Drug use may be seen as an act to conform within certain groups, or in the creation of new space or new cultural capital (Bourgios, 2003; Scott, 2002). This may indeed be the case for Traveller youth in their conflicting attempts to retain their both their ethnicity, achieve youth status and assimilate within the school setting. Positive social capital is linked to level of educational attainment and strength of bonding with the school (Weitzman and Karawachi, 2000; Lundborg, 2002). Traveller's educational status is considerably lower than that of their settled peers (Jordan, 2001a; Jordan, 2001b; DoHC, 2002) and there is a lack of cultural acceptance of Traveller culture within the formal education setting (Pavee Point, 2007). The '*settled*' culture of schools may be experienced by Traveller parents as a threat to the preservation of their culture, through their resistance to assimilation within the dominant discourse, fear of their child being harassed and as a result of parental negative schooling experiences (Clark, 1997; Okely, 1994; Okely, 1997; Kiddle, 1999; Derrington and Kendall, 2004; O'Hanlon and Holmes, 2004; Power, 2004). For those young Travellers identified as '*early school leavers*', community life experiences can be very negative when their families are housed in areas, where they experience isolation from wider Traveller networks and frequent harassment. The educational setting may therefore pose a risk for drug socialisation as Traveller youth engage within youth sub cultures which may present with a context for drug use.

Fitzgerald (2009) in his qualitative work on drug dealing with the localised risk environment observed that drug dealing and drug use can be a central feature in the development of local economies and normative group settings, with a subsequent merging of roles between drug users and dealers. In this way, drug dealing contributes to the accumulation of social capital as resources, roles and networks within social connectivity (see the concept of “*mutual extraction*” pertaining to Russian drug hustling, Pilkington and Sharifullina, 2009). A rise in perceived social capital connected to such activities within groups and communities can correspond with a parallel increase in criminal activity, particularly among excluded or marginalized communities (McNeal, 1999; Katz, 2002; McCarthy *et al.*, 2002; Adaman and Çarkoğlu, 2003; Salmi and Kivivuori, 2006; Wright and Fitzpatrick, 2006). Drug dealing as entrepreneurial activity for Traveller communities may therefore represent greater perceived social capital for those engaging in this activity in terms of bonding, reciprocity and trust, and inversely poorer social capital for those Traveller communities experiencing consequent neighbourhood disorganisation and instability.

Conclusion

Social capital is presented in this article as a resource relating to networks and associational relationships between Irish Travellers and the dominant Irish ‘*settled society*’, and how individual and collective actions relating to risk and drug use can be better understood within the sanctioning of the “*local social world*” of Travellers. The restricted ‘*sense of Traveller belonging*’ in dominant Irish discourse is the crux of the problem for Travellers in Ireland. Ethnicity appears to have an adverse affect on social capital and particularly in the case of Travellers where trust is impaired within sedentarist Irish discourse. The process of assimilation therefore contributes to a relinquishing of Traveller social capital. One must endeavour to understand these inter related networks of inner and outer boundaries of Traveller existence, with an acceptance of Traveller cultural embeddedness and a culturally informed analysis of risk and resilience to drug use. These interplays of inner and outer discourse are the key to understanding drug use shifts and changing patterns of drug use among Travellers within modern Irish society.

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Paper 13. Van Hout, M C (2010). Traveller drug use and the school setting: Friend or Foe? Letter to the Editor. *Journal of Alcohol and Drug Education*. Volume 54, Number 2, August, 7-16.

Dear Editor,

I am writing to discuss recent research findings on Travellers and drug use in Ireland, in relation to an emerging key theme of the potential assimilatory threat which the formal educational setting poses for Traveller youth amidst rising drug activity within the Traveller communities. The Travellers are an indigenous nomadic minority documented as being part of Irish society for over two centuries (NiShuinear, 1994). The Traveller community centralize their ethnic identity as a closed nomadic group with distinct perceptions of inner and outer social boundaries, by operating as 'separate' from sedentarist communities (Griffin, 2002). Traditional Traveller culture places great value on normative behaviours and belief systems (i.e. anti drug philosophies), clearly defined gender roles and expectations regarding early adult markers pertaining to marriages, autonomy, role definition and financial independence, and the prioritisation of family based learning and traditional entrepreneurship (Fountain, 2006). This traditional Traveller value stelsel clashes with the Gauje [sedentarist] formal education setting, with academic attainment seen as irrelevant to the Traveller world and contributing to poor literacy and early school leaving during childhood years (Kiddle, 2000; Reynolds *et al.*, 2003; O'Hanlon and Holmes, 2004; Bhopal, 2004). It is seldom that Traveller family or home learning values of interdependence and independence are reflected within the dominant learned dependence sedentarist schooling approaches. This contributes to further institutional and social exclusion, overt negative stereotyping, disrupted learning, and compromised self esteem, early school leaving and high absenteeism (Jordan, 2001a; Jordan, 2001b). For nomadic families, formal schooling attempts are further compromised, contributing to parental condoned absences, discontinuance, high absenteeism and poor retention, thereby forming the basis of entrenched patterns of non transfer of Traveller children from primary to secondary level (Bhopal, 2004; Derrington, 2007).

The prime concern for Traveller parents is based on an inherent fear of the sedentarist world, potential dissipation of Traveller culture and fragmentation of Traveller families, and stems from personal prejudicial experience of schooling, or attempt to protect their

culture, where family and home education within the context of cohesive family networks serve a central role in the protection of their children from antisocial environments (Derrington, 2007). According to Kiddle (2000:266), the most frequently voiced Traveller attitude was **'I'll let them go to school to learn to read and write, but then they have to learn our way of life'**. The act of sending their children to school and the potential exposure to psychosocial harm is often perceived by the Traveller community as *'a dereliction of parental duty'* and as manifestation of group disloyalty (O'Hanlon and Holmes, 2004:29). The threat of the assimilatory process, however selective remains grounded in a fear of the acculturation of Traveller youth into mainstream youth culture, often perceived by Travellers as deviant and clashing with Traveller moral, sexual and behavioural codes (Levinson and Sparkes, 2006).

The research was undertaken as part of a large scale funded regional needs analysis of Travellers and drug use on behalf of the Western Region Drugs Task Force [WRDTF] in Ireland (Van Hout, 2009a). Triangulation of data from Travellers and key stakeholders was used to illustrate the perceptions of both *'sides of the coin'* in terms of Travellers living in *'settled'* [sedentarist] Irish society and Traveller experiences of drug use as emerging trend within their closed communities. A pre development phase of several months was conducted in order to engage with the Travellers groups prior to fieldwork, in order to garner trust, improve access pathways, enhance familiarity with the researcher and thereby retrieve an optimum level of information. A Traveller research accomplice (TRA) in each area acted as a *'gatekeeper'* to assist in the recruitment of participants. It was deemed important to include the Travellers themselves in the organisation and facilitation of the research, in order to lend a sense of ownership of the research process and to stimulate the development of relationships with key drug service organisations in the region.

Gender specific focus groups (3-5 participants) were conducted in 12 locations in counties Roscommon, Mayo and Galway, in the western region of Ireland (**n=57**). The focus groups were semi structured and guided by key themes relating to the Traveller community associational life, Traveller culture and drug use, exposure to drugs, levels of drug related knowledge, gender, generational and type differences in drug use, drug use reasoning, drug taking contexts and patterns, perceptions of drug related risk, levels of problematic drug use in the Traveller community, and experiences of school

and community based education. The research participants were encouraged to explore these themes, share any thoughts and opinions, and discuss any issues relevant to the recent influx of drugs within their communities. Secondly, the research was complimented by a series of semi structured individual interviews with key stakeholders (*n=45*), identified as having contact with Travellers in the course of their work and deemed well positioned to detect recent developments in the lives of Travellers. The researcher accessed a comprehensive listing of addiction, health, social, law enforcement, probation, community, educational, housing and Traveller organisations in the west of Ireland. All potential contacts were contacted in order to explain the purpose of the research and with permission an interview was conducted. In addition, snowballing of contacts occurred with inter agency referral which achieved a certain level of data saturation for the research area. These interviews explored issues relating to Traveller culture, associational life and drug exposures, levels of drug activity in the region, Traveller knowledge and attitude to drug use, levels of Traveller drug use, methods of dealing with problematic drug use, and Traveller awareness, experiences and utilisation of drug services available.

The research was guided by recommendations from Traveller Ethics, Research and Information Working Group, which was established by the Department of Health and Children in 2002. The researcher explained the purpose of the research verbally to all research participants, [as illiteracy is common among Travellers], and participants were allowed to leave the focus groups and terminate interviews if they so wished. Confidentiality was assured to all participants and stakeholders are not identifiable as per location or job type. Both focus groups and interviews were tape recorded with permission, coded and fully transcribed. The narratives were content and thematically analysed using Nvivo, in order to present areas of comparable and contrasting thoughts, opinions and ideas. Thereby, a certain level of synchronic reliability was achieved, whereby two or more perspectives between the narratives of Travellers and stakeholders were in relative agreement according to the themes pertinent to the research aims.

The research supported earlier Irish findings that the Irish Traveller community, and particularly Traveller youth are at increasing risk of problematic drug and alcohol use, not only due to their ethnic minority status, prejudicial experiences and health disparity,

but also their experiences of compromised educational and employment prospects (McCarthy, 2005; Fountain, 2006; Van Hout and Connor, 2008a). The older generations of Travellers strive to maintain a strong sense of ethnic identity, attachment and affiliation to their culture typified by adherence to traditional anti drug norms and practices. The protection of Traveller identity thereby has much to offer in terms of offering resilience to drug exposure, amidst increasing contact with pro drug using sedentarist sub-cultural norms. Older Travellers in particular are proud to be Travellers and this Traveller orientation is typified by strong sense of pride in their culture, cultural values, potent family bonds and group solidarity. A Traveller woman said ***“The more Travellers that want to help Travellers maybe we can deal with the problem”***. However, cultural separation between Traveller groups and the sedentarist world exacerbates poor living circumstances, antisocial behaviour, criminal activity and problematic drug use. Levels of problematic substance use among Travellers are additionally deemed a manifestation of psychosocial distress relating to inherent assimilatory struggles.

There was a growing recognition by both the Travellers themselves and the key stakeholders that both licit and illicit drugs are readily accessible throughout Ireland and clearly no longer confined to marginalised sedentarist areas. A Traveller man said; ***“It’s not just a Dublin problem or a Galway problem, it’s a national problem and now it’s a Traveller problem...the issue of heroin is a dreadful problem for our community...it’s getting’ bigger and bigger every day...”*** In addition, the key stakeholders reported that Travellers accessing addiction services were increasing steadily in the last five years, with alcohol reported as primary problematic drug, followed by secondary use of cannabis, cocaine and heroin. Alcohol abuse within the Traveller community remains a fundamental problem and represents a potential ‘gateway’ toward to drug experimentation and problematic drug use. A young Traveller commented on how alcohol abuse can introduce young people to drugs, and lead to poor decision making; ***“The drink can be abused....if you are offered a drug [hash] then....you don’t have the awareness... I was asked twice at school....in the end I tried it...”*** An agency worker said; ***“The last couple of years cocaine has become the problem in the Traveller community....you can recognise the ‘smack head’ heroin users in the Traveller groups....pathetic looking individuals.....but you can’t recognise the cocaine users so well...cocaine seems more acceptable***

somehow for settled people and now for the Travellers also.” Prescription medication abuse remains prevalent across all Traveller age groups, and most particularly amongst the Traveller women, with a Traveller woman commenting; ***“me friends get them from the doctor...or you get one from your friends when you aren’t sleeping or feelin’ great...you don’t know whether you are coming or goin’ or whether you are in the day or in the night.....you’re like a zombie....you’re takin’ em’ to keep calm and relaxed....life is tough you know.”***

The Traveller community is traditionally bound by fear of drugs and potent anti drug values, and until recent times have been somewhat protected from exposure to drugs by limited contact with ‘settled’ communities. However, this closed nature, particularly in the event of problematic drug use leads to inherent difficulties in accessing treatment, and frequent attempts to deal with the problem within a closed family setting. A Traveller mother said; ***“Traveller families try to hide one of their own is using drugs ...you’d never think one of your own would be taking drugs”***. A Traveller man said ***“The Travellers need to open up and talk...-break the silence....Travellers are too proud....they are carrying the shame of it but not talkin’ about it....they are embarrassed and ashamed..”***. A Traveller women said ***“I got married very young at 17...got caught up in alcohol addiction....the drink brought me to places I didn’t want to go..brought shame to my family..and let down..I nearly died..I didn’t know there was any rehab centres..didn’t know how to get help..tried the pledge [religious oath] but it never worked..my sister told me I had fell by the wayside..my mother didn’t want to know me..”*** However, whilst the Travellers currently present with lower levels of drug use than the general population, according to both research cohorts, Traveller youth drug use is rising in terms of drugs chosen and diverse patterns of use [poly substance use, intranasal cocaine use, inhalation and intravenous heroin use, with groin injecting increasingly common]. An older Traveller mother described her experience of drug addiction in her family and said; ***“I lost me son 4 year ago....I had him in clinics but he didn’t want the help...I didn’t want to believe it meself....It started when he went to the local youth training centre...he got mixed up with the wrong crowd....then he went inside....he came back to me 4 days before he died....the prison wouldn’t take him back in....he wasn’t lookin’ right..he said ‘Mammy, I’ll see ya after....I never saw him again....the Gardai [Irish police] came the next day...night and day his***

face is in front of me..where did I go wrong..it's very hard". The recent influx of drug activity within Traveller families is evident, with an agency worker commenting ***"I can see strangers coming into the Traveller halting site....Traveller children are being exposed to an awful element of society within their own homes, never mind at school...it's very difficult for Traveller parents to protect their children from it.."***

Some older Travellers commented on how traditional Traveller culture is changing with greater numbers of Traveller boys, and in more recent time's Traveller girls attending local schools. Some stakeholders described how the lengthened retention rates of young Travellers within the educational setting appears to expose them to peer drug experimentation and use, and repercussive drug use filtering into the older Traveller communities. Some older Travellers reported intense concerns about Traveller peer socialization within antisocial youth crowds, the inner struggles of Traveller youth to ***'deny their identity and fit in'***, and attempts of Traveller parents to curb this form of assimilation by increased parental monitoring, ***" I won't let my young fella take the school bus..I walk him meself...you don't know what they do be doing on that bus"***. Another Traveller parent said ***"I won't let my daughter take the school tour..I don't want her mixing with those girls...they're smoking and drinkin..and messin' with the boys"***. It appeared to be common that Traveller youth would verbally disseminate drug educational material obtained at school to older Travellers [often illiterate], with many Traveller parents voicing concerns at the apparent advocacy of harm reduction or informed choice relating to drug taking decisions. The stakeholders described similar inherent difficulties in Traveller drug education, in terms of inability to comprehend harm reduction advocacy, great inner shame in admitting drug use and resistance to accessing local services. A Traveller father said ***"sure how can we say its wrong to do it, when they're coming home from school with leaflets about this drug and that drug in their school bags...and the kids themselves say all the lads are doing it...smoking the hash that is..I think it's wrong...but you can't tell em'....they won't listen"***.

It appears that Traveller cultural traditions and practices can simultaneously facilitate drug use and promote abstinence. This was deemed by the majority of each research cohort to occur in the context of a supportive Traveller peer group encouraging drug

experimentation, the presence of a family member using drugs in close proximity in a caravan or halting site, and conversely as deterrent within strong Traveller family networks and close parent –child relationships, advocating anti drug attitudes and complete abstinence from all forms of drug use. A Traveller man said ***“sure what can you expect..there’s nothing to do around here...we just drink, smoke the hash amongst ourselves and have a laugh..where’s the harm in that”***. However, the pathways toward drug experimentation and indeed problematic drug use for Travellers are compounded by poverty, poor mental health, almost total unemployment [within the sedentarist world at least] and continued prejudices from local residents. A Traveller youth described his experience of heroin addiction; ***“When I was on the gear [heroin]....smokin’ was no good to me...It started with the lads after school....then I was on me own most of the time...I started injectin’.....I wasn’t eating, I wasn’t sleepin’..was puttin bad stuff into my body....I couldn’t take it no more..I needed the help...I didn’t want my daughter not knowin’ who her father was.. ‘settled’ folk were ignorin’ me on the street...and that goes for me own family as well.”***

Many Travellers observed difficulties in attending ‘settled’ services, and additionally recognized the contradictions posed by their ***‘itinerant way of life’***, certain levels of mobility and engaging in residential treatment groups. Both Travellers and stakeholders recognized the need for peer led and gender specific educational modalities, both within older Traveller generations, and as adjunct to school based drug education received by Traveller youth engaging in formal education. An agency worker said; ***“Fathers and mothers need to talk among themselves....break the silence....addiction knows no boundaries...sisters; brothers....move beyond the shame....take a stand against drugs...know what drugs are and recognise the possible signs of drug use...”***. Other Travellers highlighted the need to increased outreach of community drugs workers within their halting sites, culturally acceptable drug educational materials using pictures and media [dvd’s] to take into consideration prevalent Traveller illiteracy; and the implementation of culturally sensitive treatment modalities where Travellers can attend Traveller led groups and on an outpatient basis, so as to accommodate the Traveller way of life.

In conclusion, it is clear that Travellers and particularly young Travellers are experiencing contradictory norms and values in their assimilatory experiences of cultural and social change with the sedentarist Irish society, acting normative exposure to drug use. The experiences of biculturalism along the continuum of assimilation perhaps pose the greatest risk for younger generations of Travellers who experience cultural confusion and cultural shame as they strive to integrate within schools and form friendships. Traditional Traveller culture is diminishing in potency and over time one would question if drug use among Travellers will replicate or even exceed that of the sedentarist population, given the marginalisation, discrimination and health disparity characteristic of this community. The level of Traveller attachment to both Traveller and '*settled*' values overtime will predict the risk for future drug prevalence and potential levels of problematic drug use. Thereby, the formal educational setting as first port of call, has much to offer in providing positive and culturally acceptable forms of peer led drug education for Traveller youth, given the youthful demographic of both the Travellers as ethnic group, and indeed Traveller drug users in general.

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Paper 14. Van Hout, M C (2007). A Community Perspective of Cocaine Use in Ireland.- A Brief Exploratory Study. *Contemporary Drug Problems*. Spring, Volume 34, No 1, 103-111.

Abstract

The emphasis of this exploratory research was on documenting perceptions of the extent of cocaine use in an inner city community (of 4000 households) in Ireland. The study was undertaken due to rising community concern of apparent increasing pervasion of cocaine availability, increased cocaine use as social activity and the destructive impact on both individual and community context. Interviews were conducted with a range of informants including drug-service providers, An Garda Síochána (Irish police), youth workers, drug counsellors, family support workers, general medical practitioners, hospital personnel, night-club owners, publicans, parents and carers, taxi drivers, doormen, community workers, money advice and lending services, outreach workers, prison liaison officers, politicians and a small number of key informants considered to have experience of and insight into common and preferred drug-taking practices in the community. The research pointed to the increased visibility of cocaine in the community at many levels, and an increased likelihood of intranasal cocaine use among social poly-drug users, in addition to the problematic patterns (injecting and smoking cocaine) presented by those attending the methadone clinic. The level of poly drug use noted in both the methadone treatment population and those using cocaine recreationally represents a significant challenge for drug education, prevention, and treatment services in this Irish community. The perception of social and indeed problematic drug users that cocaine is a 'safe' drug needs to be addressed, given the levels of risk behaviour associated with injecting cocaine, with sharing of snorting and smoking instruments, and poly drug use of cocaine in combination with alcohol and other drugs.

Key Words

Cocaine, Service Provision, Treatment, Opiate, Poly drug Dependency

Background to Research

Increases in cocaine use and seizures across Europe have been statistically visible in the last two decades (EMCDDA, 2006). Irish drug treatment statistics indicate that while heroin remains the primary drug of misuse among drug users who seek treatment, available national and regional treatment figures suggest that cocaine is currently observed as a secondary drug of misuse (HSE, 2006). Reports of an increased level of cocaine use in the Irish pub/dance and club scenes are linked to greater cocaine availability, decreasing price and increased social acceptance of cocaine use (Mayock, 2001b). As cocaine users can often continue to function normally in the face of increasing dependency and coupled with the lack of dedicated cocaine treatment services in Ireland, it is thought that mainstream treatment services may only be servicing the '*tip of the iceberg*'. Against a background of increasing affluence in Irish society, the emergence of cocaine use among all social strata and location, increased cocaine seizures and heightened gang/drug related violence, this trend of cocaine use in Ireland is cause for concern from a public health and order perspective.

Research Aim

This research aimed to investigate an inner city community's perception of cocaine use in Ireland. The study was undertaken due to rising community concern of apparent increased cocaine availability, increased social and problematic use among opiate addicts and recreational users, hostile gang behaviour on the streets, and the destructive financial impact on heavy cocaine users and their families.

Methodology

Interviews were conducted with a range of informants including drug-service providers, An Garda Síochána (Irish police), youth workers, drug counsellors, family support workers, general medical practitioners, hospital personnel, night-club owners, publicans, parents and carers, taxi drivers, doormen, community workers, money advice and lending services, outreach workers, prison liaison officers, politicians, priests, teachers and a small number of key informants considered to have experience of and insight into common and preferred drug-taking practices in the North Dublin suburb ($n=88$). The interviews lasted between 30 and 45 minutes depending on what the interviewee had to say, and all material was tape recorded and coded in order to ensure anonymity and confidentiality. The interview schedule contained a range of themes including perceived cocaine availability, modes of use, settings of use,

perceptions of risk, impact on family and community, fears regarding cocaine use and issues regarding service provision.

Research Findings

Those working in the community sector and resident in the area indicated that cocaine seizures had increased in the last three years, that more individuals were presenting at the methadone clinic with a cocaine related difficulty, and that more clients were presenting with financial difficulties caused by cocaine debts. Other respondents also remarked that cocaine was currently more visible on the club/dance/drug scene and indicated an increased social acceptance of cocaine as a drug of choice among the age groups of eighteen to forty five years. Others commented on the perception that cocaine was perceived as a “safe” drug particularly in light of the community’s history of severe heroin abuse and related problems.

“sure even someone’s parents are using coke at the weekend and they are in their forties...everyone’s at it, its no big deal , just a treat at the weekend. People have so much more money now, with the Celtic Tiger and all, it’s often cheaper to club together and get some gear [drug supplies] for the weekend.” (Youth Worker)

Local taxi drivers commented on the prevalence of cocaine use among young people at night and that; ***“You know where to get drugs, any drugs when you see a shoe hanging on a telegraph pole, that’s where you’ll see them dealing. The shoe tells you where to go....” (Taxi Driver 1)***

“There’s loads of cocaine in **, the dealers are outside of the area and the coke is being brought in, by the girlfriends in their cars, and the kids at school. I even know of one of the biggest drug dealers using a disabled lad to sell the coke from under his wheelchair.... How bad is that?” (Taxi Driver 2)***

A notable feature of informants' reports was that despite the general belief concerning increased cocaine availability in the area, many also felt that they had no concrete evidence of cocaine's emergence as a major social and public health issue, certainly compared to heroin and cannabis use. Respondents felt that cocaine use was extremely secretive and consequently, unlikely to come to their attention, apart from in the toilets of local pubs and clubs or within the course of their jobs in the community. ***“Cocaine users are often able to disguise their cocaine use and function normally, and only some will present with severe dependency and associated***

difficulties. There are so many normal people taking cocaine at the weekend, it only becomes a problem when they can't get to work on a Monday and things start to slide from there.” (Drug Counsellor 1). However, a number of professionals working at community-level did report direct experience and evidence of cocaine use and considered this development to be recent. It appears that cocaine users are classified as belonging to two distinct groups;

1) the individual on methadone maintenance using cocaine in a variety of ways (snorting, smoking and injecting) and;

2) the recreational drug user displaying regular use at weekends and occasionally through the week and only snorting the cocaine.

“Those using cocaine recreationally have never used heroin and do not classify themselves as drug users.” (Drug Counsellor). It is usual practice for these individuals to “club” together to buy a larger quantity for the weekend. Several key informants commented, **“you just know who's using coke ... you can see them going to the loo [toilet] in pairs, you can hear them sniffing and snorting in the loos and coming out stoked [high].” (Parent).** Others remarked; **“sure the pub owners don't care:... these lads will drink more on cocaine, so why not turn a blind eye?” (Drugs Worker).** Others commented that some pubs were putting special cisterns in place and special lights in the toilets in order to combat cocaine use on their premises. Other key informants observed that **“the smoking ban has led to increased drug use on the streets.... They're openly using and dealing outside of the pubs.... It is intimidating and has stopped me going out for a pint;... I am now careful where I go at night. You're liable to get picked on for nothing.... You can feel the aggression in the air,... and you see them coming back from the loos sniffing their red noses.” (Youth Worker)**

Many of those interviewed commented on the negative impact which cocaine use will have after a period of use: **“We've seen an increase in suicidal tendencies, and psychotic behaviours presenting in the area. People feel they can manage coke if they're snorting and these people are not accessing the treatment services.... The perception is, if they are not injecting it's ok, as long as they're not seen as the local junkie..” (Drug Treatment Services).** With regard to the use of cocaine by those on methadone, a doctor commented that **“these people don't care as long as they can get their hands on something, they will inject, snort and smoke, and are**

very clued in to the preparation of the coke.” (General Practitioner). Another informant noted that “they will use the cocaine in varying degrees from regular[ly] to irregularly and always within the home setting.” (Drug Counsellor)

In general those interviewed commented on the lack of awareness regarding the potential health-related harm caused by cocaine, and particularly when it was used in combination with alcohol and other drugs. The general perception amongst the recreational user is that it is **“the rich man’s drug, and if all the celebrities use it, why not me?”** From a law enforcement perspective, **“there’s some fear of getting caught with coke,... but they have it snorted in a second ... and this results in a complacency, particularly in the pubs.... It is very difficult to monitor the personal user;... we focus on the house raids.” (Drugs Squad).** Several service providers mentioned the occurrence of cocaine-related debts for some individuals, whereby **“the coke is given on tick [credit], the debt builds up, sometimes up to €4000, and then the individual has to pay it back. There is some degree of fear and intimidation involved,... and sometimes the parents have to take out credit union loans.... This places an incredible burden and strain on family relationships.” (Family Support Worker 1).** Another key service provider observed that **“the young person comes to us afraid of the drug dealer;... sometimes all their social benefits are handed over the dealer every month.... They often have an eviction order, no gas or electricity.... The impact on the children is terrible:... poor diet, lack of heat and lack of socialization with other kids.... They don’t get to school often or to play with other kids, as their parent can’t function.” (Family Support Worker 3)**

Interviewees engaged in the provision of services to drug users were asked whether the needs of cocaine users can be adequately met within the context of existing treatment interventions. Considerable variation emerged on the appropriate way to address cocaine use in the context of existing services. While some respondents felt that specific tailor-made interventions were required to deal with the needs of cocaine users, others believed that current services needed to develop the knowledge and expertise required to deliver appropriate intervention and counselling. One informant raised several questions around this: **“Do we need have a segregated service for each drug? Do we need separate cocaine centres? Will this avoid the labelling of**

the drug treatment centre?” (Drugs Worker) Another added, “Or do we need to look at what’s behind the cocaine addiction? Are we better off promoting prevention and education?” (Youth Worker) A third informant emphasised the effects on others: “The effect of increased levels of aggression in those using cocaine coupled with mounting debts in some cases, would lead to concern regarding community safety on the whole. The general culture prohibits any search for help of those intimidated.... No one dares to rat on the dealers:... life wouldn’t be safe. There is a perception that these recreational users are looking for the risk, the sensation, and wish to appear fearless and unpredictable...” (Prison Liaison)

Conclusion

This research indicates an increased prevalence of poly drug cocaine use among groups of recreational drug and alcohol users, as well as poly drug use among those attending the methadone clinic. It is however exceptionally difficult to accurately measure the levels of cocaine use, due its hidden nature within this community. It is important to state that *‘the nature of cocaine use is likely to be diverse and that the role and function of cocaine within the drug repertoires of social/recreational cocaine users is likely to differ substantially from that of ‘seasoned’, heavy and problematic opiate drug users’* (Hammersley and Ditton, 1994; Mayock, 2001b:49).

The perception that cocaine is a safe or clean drug with minimal health complications needs to be addressed from a health promotional perspective, given the levels of risk behaviour associated with cocaine use and also with injecting, and the sharing of snorting or smoking instruments (Mayock, 2001b). Evidence suggests that social cocaine users do not see themselves as needing to access treatment for their cocaine use, and also that they view the existing treatment services as being *‘for the real junkies’*. The poly drug use reported within the opiate treatment population and among the social cocaine users represents another significant challenge for health promotion, drug education, prevention, treatment, and family support services in the community.

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Research Support Materials

The Research Areas



The rural youth research was conducted in the **South Eastern** Region of Ireland.

The Traveller research was conducted in the **Western** Region of Ireland.

The Cocaine research was conducted in inner city north side **Dublin**, Ireland.

1. *Rural Youth Research Materials*

a) *Youth Interview Template (adapted from Mayock, 2002).*

First Time Drug Use

- Can you tell me about the **first time** you used a drug?
(Circumstances/Individuals present)
- How **old** were you on this occasion?
- Had you **planned** to take the drug/s on that occasion?
- What had you heard about this drug/s prior to first use?
- Did you purchase the drug/s were you supplied by a **friend or acquaintance**?
- Did you look forward to your first experience with the drug/s?
- What did you expect on that occasion?
- Can you describe your **first experience with the drug**?
- Was it enjoyable/ a disappointment?
- How did it compare to drinking alcohol?
- Which mode of ingestion did you use on that occasion?
- What would you say were your primary motives for trying the drug at this stage?
- Did you have any worries about the consequences on that occasion?

Subsequent Drug Use

- What was the **time lapse between first and second use of drugs**?
- Were you *definitely* interested in trying the drug/s again following first use?
- Was your second (and /or subsequent use) of the drug similar to your first experience?
- What, would you say, were your **main reasons for wanting to try the drug/s again**?
- Would you say that you planned subsequent use or simply waited for the opportunity to arise?

Current Drug Use

- How would you describe your **current drug use**?
- **What drug/s** would you say you now use most regularly at present?
- How **frequently** do you use the drug/s?
- In what **circumstances (time, location, and setting)** do you typically use the drug/s?
- How would you describe the buzz or hit from the drug/s used?
- Have you ever used drugs alone?
- Do you use **several drugs together**? If so, what drugs?
- Does this practice enhance your drug experience or buzz?
- How much (approximately) do you **spend on drugs per session/bout of use**?
- Are there **times or places where you would definitely not use drugs**?

Social Context of Drug Use

- Do you usually use the drug/s in the company of **friends**?
- What is your preferred setting for use? Why?
- Do you use drug/s in the company of non-users? If so, have you ever felt apprehensive about doing so?
- Are some/most/all of your friends aware that you use drug/s?
- If no, do you think some or all would disapprove of your activities?
- How many of your friends (do you think) have used drugs?

- Which would you say is the most popular or most frequently used drug within your network of friends/acquaintances?

The Drug Experience

- How would you describe what you feel or experience when you use a drug/s?
- How does each drug compare to the other?
- What would you say are the **most appealing aspects of the drug/s**?
- Does the experience live up to the drug's reputation?
- Are there **negative sides to drug use**? If yes, can you describe them?
- Have you ever experienced undesirable negative side effects?
- What would you say are your **main reasons for using drug/s**?
- Which drug/s do you think you will use at sometime in the future?

Availability, Quality and Cost

- Is it easy to **access a** supply of drug/s? If yes, which type of drug/s?
- How do people generally go about securing a personal supply (in your opinion)?
- Are the "right" contacts necessary to secure a supply?
- What are your primary access routes to the drug/s (e.g. friends, dealer, acquaintances)?
- Do you depend on other (i.e. friends) as a means of securing a supply?
- Does the **quality** of the drug/s vary?
- Do you ever worry or question the quality of your supply?
- What is the **street value of the following drugs at present?**

An ecstasy tablet

A gram of amphetamine/speed

A gram of cocaine

An ounce of hash

- Are certain drugs more or less expensive than before?
- How would you rate the cost of a drug/s against the payoff (positive drug experience)?
- Would you say that certain drugs are more economical than others?
- How much do you **spend on drug/s per week or per month**?
- If you had more money, do you think you would spend more money on drugs?

Method of Drug Use

- How do you usually use your drug/s of choice (mode of ingestion)?
- Have you ever used any other method of ingestion (e.g. injecting, snorting, free basing, smoking etc)?
- Would you say there are advantages and disadvantages to certain methods of ingestion?
- Have you ever combined certain drugs together?
If yes, what are the advantages of this practice?
If no, are there certain reasons why you haven't?
- Is there any advice you would give to a novice drug user?

Risk Perceptions

- Do you consider **certain drug/s as "safe" drug/s**?
- How do **certain drugs compare in terms of potential health risks**?
- Do you think that some drug/s can be dangerous or potentially addictive?
- Have you ever experienced **adverse or negative side effects** following the use of certain drug/s?
- Which negative effects would you say are most common for young drug users?

- Have you ever worried or considered the **potential health risks** associated with drug use?
- How would you say the risks associated with legal drugs (alcohol and tobacco) compare with illegal drugs?
- What about the **legal consequences of getting caught**? Do you believe you would be charged?
- Have you ever worried about the possibility of this happening?
- Do you have ways of trying to ensure that your activities are not detected by law enforcement?

Personal Drug Use

- Have you ever experienced definite negative or undesirable repercussions which you would attribute to your use of drug/s?
- Have you ever felt a sense of having lost **control as a result of your drug use**?

If yes, how did you respond to this feeling?

If no, what would be your response if this happened to you?

- Have you ever felt a sense of craving for a certain drug/s?
- Did you ever go through a period of regular drug use?
- Would you say that **drug use ever had negative repercussions for your school work or personal relationships**?

Thank you for your cooperation. Is there anything else you would like to discuss?

b) Consent Forms for Youth

15-17 year old alcohol, cigarette and drug use in the South East of Ireland

This brochure describes the research, so that parents and students can decide if the student will take part. We encourage parents to talk about the research with their child and whether the student wants to take part.

PLEASE SHARE THIS BROCHURE WITH YOUR PARENTS/STUDENT

Many agencies in Ireland, including schools, work to help teenagers grow up in healthy environments. To do this better, we need to find out more about the strengths and weaknesses in our communities and programmes for youth.

To help do this, this research will take place in October 2005 and consist of a survey and interviews.

Who will be asked to take the research?

Students in 4th -6th classes across the South Eastern Region of Ireland.

Why is the research taking place?

The survey looks for patterns in prevalence, knowledge, attitudes and behaviours relating to substance use. We will use the information from this survey to plan the interview phase of this research, which will ultimately provide public health recommendations to help support and educate teenagers in the community.

This survey and interviews are completely voluntary. If a student takes part, she/he may skip any question, and may stop filling out the survey at any time. Any student who decides not to take the research will participate in an alternative activity provided by the school, such as reading or working in the library. A student's marks will not change whether or not she/he takes part. There is no penalty for not taking part in the research.

How is student identity protected?

Students will not write their names anywhere on the survey or on the answer sheet. There are no codes or other information to match a survey with a particular student. Students put completed surveys into an envelope that is sealed before it leaves the classroom. No one from the school will look at the survey. Survey reports will not identify any student. Local health departments may ask to use survey answers to examine health behaviours and to develop local programs targeting youth. Other researchers may also ask for the survey data. If survey information is given to health departments or researchers, they will be required to keep survey information anonymous.

Questions about the research can be sent by e-mail to ***. This survey is compiled adhering to European Monitoring Centre for Drugs and Drug Abuse Protocol and National Advisory Committee on Drugs Ethical Guidelines (2005).**

c) Interview Questions Service Providers (adapted from Mayock, 2001b)

Drug Service Staff Numbers presenting with drug related difficulties (stable, increase, decrease/ Evidence of certain drugs / Primary v Poly Drug use / Treatment need for Adolescents / Implication for Treatment and Service Provision.

Key Informants Who is using drugs (age group/background/Socio Economic status/Availability, cost and purity? / Are certain drugs more accessible than previously? / In what kind of settings is use taking place? / Patterns of Use (regular/recreational/occasional etc).

Gardai Drug Seizures and arrests: have the figures for adolescent arrests changed dramatically in recent years? / Any indicators of increased availability of drugs at street level? / If yes, how have the Gardai responded to this new development?

Youth Workers Is there any evidence of increased use of drugs among young people? / Any evidence to suggest that drugs are easier to access and /or more affordable than previously? / What are the dominant perceptions of the risks associated with drug use? / Are youth workers adequately equipped to respond to current drug use trends?

General Practitioners Numbers presenting with drug related difficulties (stable, increase, decrease)/Evidence of certain drugs as primary drug of misuse/ Treatment needs of Adolescents/ Implication for treatment and service provision.

Hospital Personnel Any evidence of certain drugs emerging as drug of choice? / Accident and Emergency Admissions.

d) Interview Questions Parents

1. How satisfied are you with the facilities available to young people in your community?
2. What drugs available in your community?
3. Who do you feel introduces young people to their first drug?
4. What are the common places where young people take drugs in the community?
5. What is the main reason for young people taking drugs?
6. What concerns would you have about young people taking drugs?
7. Which service would you contact if a young person was using drugs?
8. Do you think adults understand why young people take drugs?
9. Do young people grow out of using drugs as they get older?

2. The Traveller Community

a) Traveller Interview Template

1. What is the extent and nature of substance misuse in the Traveller community in the Western Region of Ireland?

- * What are the common patterns and trends of misuse for these Travellers?
- * Is there gender and age-related differences present in the selection of substances used and progression pathways towards problematic substance use?
- * What are the primary and secondary substances of choice?

- * Is there preference for poly-substance taking and is this substance use recreational, occasional, or regular?
- * What is their lifetime and last month prevalence or experience of drug and alcohol use? Are these trends similar to national trends?
- * Who introduced them to the substance – is the “*mainstream*” community providing the context for introduction to certain substances?

2. In relation to your substance use:

Current Drug Use

- * How would you describe your **current drug use**?
- * **What drug/s** would you say you now use most regularly at present?
- * How **frequently** do you use the drug/s?
- * In what **circumstances (time, location, setting)** do you typically use the drug/s?
- * How would you describe the buzz or hit from the drug/s used?
- * Have you ever used drugs while alone?
- * Do you use **several drugs together**? If so, what drugs?
- * Does this practice enhance your drug experience or buzz?

Social Context of Drug Use

- * Do you usually use the drug/s in the company of **friends**?
- * Are some/most/all of your friends aware that you use drug/s?
- * If no, do you think some or all would disapprove of your activities?
- * How many of your friends (do you think) have used drugs?
- * Which would you say is the most popular or most frequently used drug within your network of friends/acquaintances?

The Drug Experience

- * How would you describe what you feel or experience when you use a drug/s?
- * What would you say are the **most appealing aspects of the drug/s**?
- * Are there **negative sides to drug use**? If yes, can you describe them?
- * What would you say are your **main reasons for using drug/s**?

Availability, Quality and Cost

- * Is it easy to **access a** supply of drug/s? If yes, which type of drug/s?
- * How do people generally go about securing a personal supply (in your opinion)?
- * Are the “**right**” contacts necessary to secure a supply?

- * What are your primary access routes to the drug/s (e.g. friends, dealer, and acquaintances)?
- * Do you depend on other (i.e. friends) as a means of securing a supply?
- * Does the **quality** of the drug/s vary?
- * If you had more money, do you think you would spend more money on drugs?

Risk Perceptions

- * Do you consider **certain drug/s as “safe” drug/s?**
- * How do **certain drugs compare in terms of potential health risks?**
- * Do you think that some drug/s can be dangerous or potentially addictive?
- * Have you ever experienced **adverse or negative side-effects** following the use of certain drug/s?
- * Have you ever worried or considered the **potential health risks** associated with drug use?
- * How would you say the risks associated with legal drugs (alcohol and tobacco) compare with illegal drugs?
- * What about the **legal consequences of getting caught?** Do you believe you would be charged?
- * Have you ever worried about the possibility of this happening?
- * Do you have ways of trying to ensure that your activities are not detected by law enforcement?

Personal Drug Use

- * Have you ever experienced definite negative or undesirable repercussions which you would attribute to your use of drug/s?
- * Have you ever felt a sense of having lost **control as a result of your drug use?**
- * Have you ever felt a sense of craving for a certain drug/s?
- * Did you ever go through a period of regular drug use?
- * Would you say that drug use ever had negative repercussions for your school work or personal relationships?

3. Is there direct experience of substance misuse within the Traveller family and community?

- * What attempts are made to support a Traveller with problematic substance use?

* Have there been instances of home detoxification attempts and how do Traveller parents discourage their children from substance experimentation?

4. Are there certain levels of abuse (e.g. alcohol, prescribed medicines) which are tolerated by the Traveller community?

* Is there normalisation of certain substances used? Is there an element of self-medication?

* What is the impact of problematic substance use on the Traveller family (financial/emotional)?

* Is substance use a coping mechanism for the problems experienced by Travellers?

* Has violence within the home increased in correlation with the development of problematic substance use?

* What are the common perceptions of risk relating to drug and alcohol use (health/legal/financial/emotional)?

5. Are there certain prompts within the Traveller community that help prevent substance misuse (e.g. Lent) or alternatively promote misuse (e.g. celebrations)?

* From whom do Travellers receive drug and alcohol related information?

* What are the levels of drug and alcohol health and harm-related knowledge?

* Are young Travellers in education disseminating drug educational knowledge received from the Social Personal Health Education programme to older members of the Traveller community?

* In relation to prescription and over-the-counter medication, are low literacy levels causing potential harm?

* Is there any evidence of more serious drug use such as heroin, cocaine and crack cocaine?

6. What are the specific service needs around substance misuse? How can Travellers receive integrated and targeted drug prevention and treatment services?

b) Interview Template Traveller Service Stakeholders and Key Informants

1. What is the extent and nature of substance misuse in the Traveller community in the Western Region of Ireland?

* What are the common patterns and trends of misuse for these Travellers?

* Is there gender and age-related differences present in the selection of substances used and progression pathways towards problematic substance use?

* What are the primary and secondary substances of choice?

* Is there preference for poly substance taking and is this substance use recreational, occasional, or regular?

* What is their lifetime and last month prevalence or experience of drug and alcohol use? Are these trends similar to national trends?

* Who introduced them to the substance - is the "*mainstream*" community providing the context for introduction to certain substances?

2. Is there direct experience of substance misuse within the Traveller family and community?

* What attempts are made to support a Traveller with problematic substance use?

* Have there been instances of home detoxification attempts and how do Traveller parents discourage their children from substance experimentation?

3. Are there certain levels of abuse (e.g. alcohol, prescribed medicines) which are tolerated by the Traveller community?

* Is there normalisation of certain substances used? Is there an element of self-medication?

* What is the impact of problematic substance use on the Traveller family (financial/emotional)?

* Is substance use a coping mechanism for the problems experienced by Travellers?

* Has violence within the home increased in correlation with the development of problematic substance use?

* What are the common perceptions of risk, relating to drug and alcohol use (health/legal/financial/emotional)?

4. What are the routes and progression pathways towards drug misuse within the Traveller community?

* What are the ages of initiation to substance use and is the Gateway Hypothesis applicable?

* Is there a presence of a drug taking sub culture as in "*mainstream*" drug taking groups with its own drug practices, drug language and support network?

* Are young Travellers presenting with similar substance use patterns as “*mainstream*” adolescents? Is this trend similar with the older generation?

5. Are there certain prompts within the Traveller community that help prevent substance misuse (e.g. Lent) or alternatively promote misuse (e.g. celebrations)?

* From whom do Travellers receive drug and alcohol related information?

* What are the levels of drug and alcohol health and harm related knowledge?

* Are young Travellers in education disseminating drug educational knowledge received from the Social Personal Health Education programme to older members of the Traveller community?

* In relation to prescription and over-the-counter medication, are low literacy levels causing potential harm?

* Is there any evidence of more serious drug use such as heroin, cocaine and crack cocaine?

* From a legal perspective is there a presence of a divergence of Traveller economic activity into drug dealing? Where do Travellers purchase illicit drugs?

6. What are the specific service needs around substance misuse? How can Travellers receive integrated and targeted drug prevention and treatment services?

* What can mainstream services do to help prevent or treat substance misuse within the Traveller community?

* In relation to literacy problems and feelings of discrimination, what are the best ways to disseminate drug educational material? Do the risk factors relating to poverty, lack of literacy skills and education and feelings of discrimination exacerbate potential risk of substance abuse in Travellers?

7. What recommendations can be made towards other agencies and strategies to help prevent or treat substance misuse amongst the Traveller community?

* How many Travellers have accessed services and what was their experience?

Paper 10- Primary Care.

The focus group involved an open discussion in relation to Primary Care service provision for Travellers, namely; recognition of Traveller culture and ethnic identity; Traveller participation/engagement in the consultation process and establishment of Primary Care clinics; emerging issues in Traveller Health; role of the Primary Health

Care worker for Travellers (PCHT) and recommendations for a positive Traveller Primary Health Care System.

3. Cocaine

a) Interview Template Service Stakeholders and Key Informants

- Is there any evidence to suggest that Cocaine is easier to access and/or more affordable than previously in the ***** area ?
- Are the numbers of *****residents using Cocaine increasing, decreasing or stable?
- What age group in***** is using Cocaine as recreational drug ?
- Is there evidence of increased use of Cocaine among young people in *****?
- Is Cocaine being used as a primary substance of mis-use ?
- If No, please state what *the primary substance of misuse (includes alcohol)* is.....
- How would you describe the patterns of Cocaine use amongst *****residents ?
- What is the primary mode of ingestion of Cocaine amongst ***** residents ?
- Is there any evidence of Crack Cocaine being used amongst ***** residents ?
- In what kinds of settings is Cocaine use taking place in *****?
- What are the dominant perceptions of the 'risks' associated with Cocaine use amongst ***** residents ?
- What age group is using Cocaine as secondary presenting problem to heroin /methadone dependency amongst ***** residents ?
- Are you (if resident of *****) or your clientele (resident of *****) intimidated due to increased drug dealing activity on the streets of ***** ?
- Are Community Services in the *****area adequately equipped to respond to these current Cocaine use trends?
- Given the current trend of Cocaine use in the ***** area, in your opinion what are the implications for treatment and service provision?

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