



Substance Use

in New Communities: A Way Forward



Western Region
drugs task force
Meitheal Drugaí an Iarthair

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Foreword

It is with great pleasure that I introduce *Substance Use in New Communities: A Way Forward*. This is the third in a series of research reports commissioned by the Western Region Drugs Task Force.

The aim of the National Drugs Strategy is “to significantly reduce the harm caused to individuals and society by the misuse of drugs and alcohol through a concerted focus on supply reduction, prevention, treatment and research” (Shared Solutions, 2005).

Ireland is an established host country for migrant workers, refugees and asylum seekers from around the world with a high proportion migrating to the west of Ireland. Such new communities have brought a diverse range of cultural practices and customs to the western region and require a host community that is culturally sensitive to meet their needs. The Western Region Drugs Taskforce (WRDTF) recognises these new communities and thus their role in assessing needs around the prevention and treatment of substance use.

This document presents an overview of the new communities in the west of Ireland; selects the largest new communities in the west of Ireland and describes substance use in their countries of origin; explores substance use in Ireland in general and among new communities in Ireland, with a focus on the west of Ireland; and reviews the risk factors for substance use in new communities. The final sections outline the barriers to effective service utilisation and possible service level responses, including recommendations for relevant service provision to and with members of new communities in the west.

On behalf of the Western Region Drugs Task Force my thanks to Colette Kelly, Cliona Fitzpatrick and Saoirse Nic Gabhainn of the Health Promotion Research Centre, NUI Galway for the time and effort they put into this report.

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I welcome the opportunity to thank John Curran, T.D., Minister of State with responsibility for the National Drugs Strategy for launching this report and the Department of Community, Rural, and Gaeltacht Affairs for funding this research.

Orla Irwin
Co-ordinator
Western Region Drugs Task Force



*the dawn of the third millennium
could be characterised as the
era of migration.
Sundquist (2001)*



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Mapping New Communities

As Sundquist (2001) stated, “the dawn of the third millennium could be characterised as the era of migration,” and Ireland is a desirable destination country. The rapid immigration of new communities to Ireland from countries in central and eastern Europe, Asia and Africa has cultivated a multi-ethnic, multi-cultural, heterogenous society. Immigrants are often termed ‘new communities’ due to their recent arrival in Ireland.

The latest figures from the 2006 Census show that 414,512 non-nationals are living in the Republic of Ireland; illustrating an exponential increase since 2002. Of these 48,387 non-nationals are living in the west of Ireland with the following distribution; Galway city and county (24,139 non-nationals), Mayo

(10,944 non-nationals) and Roscommon (5,415 non-nationals) (Central Statistics Office, 2006). These counties have a diverse range of new communities, with the most dominant community being from Poland. The unstable employment market in Poland has been the main motivating factor causing people to emigrate to Ireland (Kropiwek, 2006). Other substantial new communities in the western region include Brazilians, Nigerians, Lithuanians and Latvians. These new communities comprise migrant workers, refugees and people seeking asylum. Table 1 presents data from the 2006 Census and shows the number of people from new communities living in the western region, by nationality.

Table 1: New communities in the west of Ireland (adapted from Central Statistics Office, 2006)

Nationality	Connacht	Galway	Mayo	Roscommon
EU countries	35,250	16,030	8,796	4,192
Poland	7,189	4,153	1,191	668
Lithuania	1,955	916	508	234
Germany	1,454	716	273	93
Latvia	1,303	617	316	151
Rest of Europe	1,532	926	283	132
African countries	2,479	1,774	332	159
Nigeria	1,075	804	112	105
South Africa	295	181	66	18
Other	1,109	789	154	36
Asian countries	3,231	1,647	670	303
China	451	275	83	32
Philippines	444	224	58	21
India	504	270	89	56
Pakistan	681	196	221	149
Malaysia	285	215	32	13
Other	866	467	187	32
Americas	4,404	2,919	559	513
USA	2,071	1,130	449	170
Brazil	2,008	1,561	63	329
Canada	222	151	30	12
Australia	361	223	68	28
New Zealand	154	104	23	8
Other nationalities	777	393	173	71
Multi nationality	199	123	40	9
No nationality	174	85	44	24
Not stated	4113	2108	792	462
Total	48,387	24,139	10,944	5,415



Migrant Workers

The United Nations defines a migrant worker as “a person who is engaged or has been engaged in a remunerated activity in a state of which he or she is not a national” (United Nations, 1990). The economic success of Ireland, at least up until recently, has resulted in the immigration of migrant workers to Ireland, with a significant proportion from the EU accession states (which include Poland, Latvia, Lithuania, Slovakia, Slovenia, Cyprus, Czech Republic, Estonia, Hungary and Malta), who have contributed enormously to the economic growth of the country. These new communities primarily comprise people in their twenties and thirties and are predominately male (Central Statistics Office, 2006). A high proportion are married (42%) and reside in rented accommodation with semi-detached houses, flats and apartments being the most popular type of housing (Central Statistics Office, 2006). Nearly 85% of all migrant workers are from the EU (including the UK) as they are free to seek work in Ireland without restrictions. EU nationals (excluding those from Ireland and UK) are generally employed in manufacturing, construction, wholesale/retail trade and hotels and restaurants (Central Statistics Office, 2006). For the more recent accession states the industrial (e.g., manufacturing and construction) and agricultural sectors have been most important. Female migrant workers tend to work in isolated, poorly regulated and lower skilled sectors, such as care services, hotels and catering, restaurants, cleaning and agriculture, leaving them more vulnerable to exploitation (Migrant Rights Centre Ireland, 2008). It is important to recognise that just over 129,000 non-nationals hold a third level qualification with those from Asia having the highest percentage (42%) (Central Statistics Office, 2006). Migrant workers also have the right to vote, as they are ordinarily resident in the state, entitling them to stand for and/or vote in the local elections thereby, theoretically at least, improving their integration into Irish society.

To avail of services all migrant workers need to be habitually resident in Ireland and in order to gain habitual residency a person needs to be living

consistently in Ireland for 2 years. Those with habitual residency are entitled to apply for Jobseeker's Allowance, State Pension (Non Contributory), Blind Pension, Widow(er)'s Non Contributory Pension, One Parent Family Payment, Guardian's Payment, Carer's Allowance, Disability Allowance, Supplementary Welfare Allowance (other than once off exceptional and urgent needs payments) and Child Benefit (Department of Social and Family Affairs, 2004). It has been reported that migrant workers from EU countries are not accessing health services in Ireland due to the high cost of availing of these services, lack of insurance and barriers including not understanding the health system and poor English language skills. (Watt & McGaughey, 2006; Health Service Executive, 2008a; Galway Refugee Support Group, 2009). Thus, when it comes to health services, it appears that a significant proportion return to their countries of origin for treatment (Health Service Executive, 2008a).

The most prevalent non-EU nationality in the west of Ireland are Brazilians who have mainly congregated in Co. Galway, with a population of over 1,500 living in Gort, which is equivalent to approximately one half of the population of Gort. Primarily originating in the state of Goiana, a mostly rural area of central-south Brazil, this new community initially migrated to Gort to work in a meat factory; their main occupations being butchers and meat cutters. Other occupations include builder's labourers and food and drink operatives (Central Statistics Office, 2006). Most of these newcomers had little English or Irish language skills on arrival. It has been argued that as new member states have joined the EU, some Brazilians are struggling to get work permits; many are living in Ireland currently unrecognised and with few rights (Health Service Executive, 2008a). The Gort Embracing Migrants (GEM) programme set out to develop programmes and to problem-solve “*demonstrating unity, transparency and equality for all members of Gort's modern, yet traditional multicultural society*” (Health Service Executive, 2008a). It appears that Brazilians do not access healthcare services for fear that their undocumented status might be exposed.



Asylum Seekers and Refugees

Under the 1951 United Nations Geneva Convention, the Refugee Act 1996, the Immigration Act 1999 and the Illegal Immigrants (Trafficking) Act 2000 were introduced. A refugee is defined as a person *“owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion, is outside the country of their nationality, and is unable to or, owing to such fear, is unwilling to avail him/herself of the protection of that country”*. The number of applications for declaration as a refugee in 2008 has declined dramatically since 2003, down from 7935 to 1735 (www.ria.gov.ie).

Refugees and asylum seekers are primarily of African descent (68% of total) with Nigerians (31% of total) being the largest group. There are more than 1,000 Nigerians in the west of Ireland with Galway city being the most common place of residence. Nigerians have a different age profile to other new communities with one in four under the age of 15 and only 15% in their twenties (Central Statistics Office, 2006). They are predominantly female and over 50% are married. Nigerians typically live in private rented accommodation and mostly in family households where the children are of Irish nationality (Central Statistics Office, 2006). Occupations in which Nigerians are employed include care assistants and attendants, security guards, sales assistants and doctors.

Asylum seekers are those who are waiting for their applications for refugee status to be processed. According to the Reception and Integration Agency (RIA) statistics for August 2008, 8252 people are

seeking asylum in Ireland, 1286 of whom are in the western region. In the west of Ireland, Galway has the majority (795 asylum seekers) followed by Mayo (405 asylum seekers) and Roscommon (86 asylum seekers). Asylum seekers live in direct provision hostels and private rented accommodation. Four direct provision hostels in Galway provide accommodation and board for asylum seekers. These include ‘Lisbrook House’ which has 267 residents comprised of families including children, single men and single women, ‘Eglinton Hotel’ which has 233 residents comprised of families and single females, ‘Great Western House’ which has 161 male residents and ‘Dún Gibbons’ in Clifden, County Galway with approximately 95 residents comprised of families including children. In Mayo, there are two direct provision hostels which include the ‘Old Convent’ in Ballyhaunis which caters for approximately 100 residents and the ‘Railway Hotel’ in Kiltimagh which has less than 100 residents. Roscommon has one direct provision hostel in Ballaghaderreen called ‘Station House’ which has approximately 20 residents.

Refugees have the same rights as Irish citizens to social welfare payments, employment, training and education. They have the right to apply for citizenship after three years of residence. However, a submission from the Galway Refugee Support Group to the National Intercultural Health Strategy (Health Service Executive, 2008a) highlighted the fact that those living in direct provision accommodation are less likely to be accessing services.



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Substance Use in Countries of Origin



Global substance use

Data on global substance use comes from a number of sources, including population surveys, health-service data, policy documents and for illegal drugs, from data on drug seizures, drug-related crime and deaths. The true extent of illegal drug use is unknown, as it is, by definition, hidden in the population (O'Donovan, 2008).

A global overview of tobacco, alcohol and drug use is provided by O'Donovan (2008). More than 1% of the global population aged 15-64 years abuse opiates (including heroin) and the same percentage again abuse cocaine. Use of ecstasy, cannabis and opiates is more prevalent in Asia compared to other continents and regions. Moreover, alcohol consumption rates are increasing, mainly in developing countries and binge drinking in young people is also of concern (O'Donovan, 2008).

The 2008 World Drug Report (United Nations Office on Drugs and Crime, 2008) estimates that approximately 208 million people or 4.9% of the world's population aged 15 to 64 have used drugs at least once in the last 12 months. This figure has remained relatively stable since 2004. The monthly prevalence of drug use is approximately 112 million (2.6%). Rates of problem drug use remains at about 0.6% (26 million people) of the global population aged 15 to 64. Cannabis, consumed by close to 166 million persons, continues to be the most prevalent of all illegal drugs used. Amphetamines are the second most widely used drugs and over the 2006/07 period 25 million people are estimated to have used amphetamines (including methamphetamine) at least once in the previous 12 months, about the same as a year earlier. An estimated 9 million people used ecstasy over the 2006/7 period, up from 8.6 million in 2005/06. Mortality statistics show that illicit drugs claim about 200,000 lives a year versus about 5 million a year for tobacco (United Nations Office on Drugs and Crime, 2008).

The World Health Organisation (WHO) estimates that about 2 billion people worldwide consume alcoholic beverages and 76.3 million people have diagnosable alcohol use disorders. Alcohol causes 1.8 million deaths (3.2% of total) and a loss of 58.3 million (4% of total) of Disability-Adjusted Life Years (WHO, 2002). In Europe alone, alcohol consumption was responsible for over 55,000 deaths among young people aged 15-29 years in 1999 (Rehm & Eschmann, 2002; cited in WHO, 2004).

It is estimated that 1.1 billion adults (29% of the population aged 15 years and over) smoke cigarettes or bidis (a hand-rolled cigarette common in South East Asia and India) daily (Anderson, 2006). The tobacco epidemic kills 5.4 million people a year from lung cancer, heart disease and other illnesses. It is estimated that this number could increase to more than eight million a year by 2030, if further policies and controls are not put in place. Tobacco use is a risk factor for six of the eight leading causes of deaths in the world (<http://www.who.int/topics/tobacco/facts/en/index.html>).

Alcohol, drug and tobacco use and abuse have been substantially linked to the overall burden of disease in Europe with the highest level of drinking alcohol in the world (Rehm et al., 2003; WHO, 2004; Anderson & Baumberg, 2006), around 2 million drug users and an estimate of a third of the population that smokes tobacco (Anderson, 2006). Central and Eastern Europe (CEE) is known for its high alcohol consumption (Popova et al., 2007) however, relatively speaking, there is a dearth of research with regard to substance use found in that region (Andlin-Sobocki & Rehm, 2005). The following section provides a more in-depth overview of substance use in the main countries of origin of the new communities in the west of Ireland; Latvia, Lithuania, Poland, Nigeria and Brazil.

Central and Eastern Europe (CEE)

Alcohol is a leading cause of disease in CEE countries, which is associated with the irregular binge drinking patterns typical in these countries (Varvasovsky et al. 1997; Popova et al., 2007). Popova et al. (2007) compared alcohol consumption across the CEE countries versus southern and western Europe, Russia and the Ukraine. Lithuania and Latvia were found to have the second and third highest level of recorded and unrecorded alcohol consumption in Europe, respectively (Popova et al., 2007). The highest level was in the Republic of Moldova. The highest per capita recorded alcohol consumption in the region was in the Czech Republic (12.9 L of pure alcohol per capita), followed by Slovakia (12.4 L of pure alcohol per capita) and Lithuania (12.3 L of pure alcohol per capita), with beer and spirits the most popular types of alcohol consumed in these countries. Recorded per capita consumption in western European countries (including Ireland) was 11.6 L per capita. Overall, in the CEE, the style of drinking alcohol is characterised by irregular binge drinking patterns (Popova et al., 2007). With regard to alcohol related harm issues, data from eastern European countries (Belarus, Czech Republic, Bulgaria, Hungary, Poland and Russia) suggest a stronger association between homicide rates and alcohol consumption than is the case in western European countries (Bye, 2008).

Poland is known as a 'superpower' in synthetic drug production and is also a transit country for drug smuggling. It has been reported that drug trafficking has become a viable occupation for Poles, with some acting as drug couriers throughout the world (Krajewski, 2003). A study on drug use in Warsaw, Poland in 2002 found that marijuana is the most popular psychoactive drug with 25% of those aged 18-50 years using it in their lifetime. Other substances reported include tranquilisers (8.2%), LSD and amphetamines (6%), while ecstasy and cocaine were used by 3.6% and 2.4% respectively of those surveyed (Sieroslawski et al., 2002). Due to Latvia's geographical location, making it a passage for transfer of drugs from Central Asia to Russia and beyond, there has been a considerable increase in drug access and use in Latvia over the last decade. Data from the European Monitoring Centre for Drugs and Drug Addiction include rates of substance use across the CEE countries. Table 2 below includes data drawn from the 2008 statistical bulletin (<http://www.emcdda.europa.eu/stats08/gps>). For ease of comparison the national rates of substance use for Ireland are also included.

Table 2: Comparison of national level data on substance use across countries

Time frame/substance/age-group	Latvia	Lithuania	Poland	Ireland
Lifetime use of cannabis, (15-64 yrs)	10.6	7.6	9.0	21.9
Lifetime use of cocaine, (15-64 yrs)	1.2	0.4	0.8	5.3
Lifetime use of amphetamines (15-64 yrs)	2.6	1.1	2.7	3.5
Lifetime use of ecstasy (15-64 yrs)	2.4	1.0	1.2	5.4
Lifetime use of LSD (15-64 yrs)	1.1	0.3	0.9	2.9
Lifetime use of cannabis (15-24 yrs)	22.9	15.7	17.3	24.8
Lifetime use of cocaine (15-24 yrs)	1.4	0.7	1.1	7.0
Lifetime use of amphetamines (15-24 yrs)	0.9	2.6	4.8	3.2
Lifetime use of ecstasy (15-24 yrs)	6.2	2.6	2.3	6.5
Lifetime use of LSD (15-24 yrs)	2.8	0.7	1.7	1.0
Last month use of cannabis (15-64 yrs) ¹	1.8	0.7	0.9	2.6
Last month use of cannabis (15-24 yrs)	5.1	2.0	2.5	5.3

¹ Rates of last month use of all other substances were lower than 1% in Latvia, Lithuania, Poland and Ireland.

These data illustrate that adults in Ireland are more likely to have experienced illicit drug use than those in Latvia, Lithuania or Poland. The rates for young people are closer, particularly for cannabis and ecstasy, which are similar in Latvia and Ireland; those from Lithuania and Poland are lower. Comparable data on injecting drug use, problem drug use, treatment demand and drug related mortality are not available across all 4 countries.

Nigeria

Traditional alcoholic beverages have been part of the social and religious life of Sub-Saharan Africa for many years. However it is thought that alcohol use became more problematic with the introduction of western beverages during the slave trade when rum was bartered for slaves (Obot, 1990). Unlike alcohol, which has been available for a long time, other substances are relatively new to Nigeria (e.g., cannabis). Thus, while relatively drug free until the 1980s, the globalisation of capital has been linked with increased drug availability across sub-Saharan Africa, drug trafficking across the continent, and the emergence of criminal gangs to conduct such trade (Affinnih, 2002).

Empirical studies on substance use in Nigeria have predominately focused on alcohol (Gureje et al., 1992; Obot, 1990). A face-to-face interview survey of 'adult heads of households' in the north-central part of Nigeria (n=1562) (the *Middlebelt* study) showed that 54.5% of the sample described themselves as alcohol drinkers with 10.4% describing themselves as 'heavy drinkers' (Obot 1990). Much less work has been reported on tobacco, cannabis, cocaine or other drug use (Gureje et al., 2007; Ibeh & Ele, 2003). Moreover, few studies have been representative of the population, (e.g., studies of cannabis use in Nigeria tend to be retrospective and hospital-based: see Obot, 1990).

More recently, a stratified random sample of households was used to collect self-reports of drug use and dependence from 6752 adults (Gureje et al., 2007). Alcohol was found to be the most commonly used drug both in terms of lifetime history (57.6%) and recent use (19.9%). This was followed by tobacco smoking and non-prescription sedative use (lifetime: 17% and 14% respectively; past year: both 3.4%). Cannabis, cocaine, heroin, opium and LSD were rarely used (combined lifetime use: 0.5%). In contrast, the *Middlebelt* study described above, found that 22.6% of the sample smoked tobacco regularly and 2.6% of respondents described themselves as current users of cannabis (Obot, 1990). Both surveys reported a male predominance among drinkers and smokers (Gureje et al., 2007; Obot, 1990). Differences in substance use by religion were minimal with the exception of alcohol; Muslims were much less likely to use alcohol than persons of other faiths (Gureje et al., 2007).

Specifically in terms of drug abuse the 2008 World Drug Report (UNODC, 2008) presents government sourced figures, showing prevalence of abuse as a percentage of the population for those over the age of 15 years, see table 3.

Table 3: Prevalence of drug abuse in Nigeria (UNODC, 2008)

Drug (year of data source)	Annual prevalence of abuse (15-64 yrs)
Opiates (1999)	0.6 %
Cocaine (1999)	0.5 %
Cannabis (2000)	13.8 %
Amphetamines (1999)	1.1 %

The total number treated for drug problems in Nigeria, excluding alcohol and based on 2004 figures, was 925. The primary drugs of abuse for those treated were: cannabis (89.7%), inhalants (3.7%), depressants (3.9%), amphetamine-type stimulants (2.0%), opiates (1.2%) and cocaine (0.7%) (UNODC, 2008).

Brazil

Traditional alcoholic beverages have been used in Brazil for many years (e.g., the Brazilian Indians used cauim, an alcoholic beverage obtained by fermenting maize). Sugarcane was also readily available and was distilled to produce 'cachaca or pinga' (Galduróz & Carlini, 2007). Another drug used by Brazilians that is local to the region is coca paste, which researchers speculated at that time, was a more serious problem than cocaine use (Inciardi & Surratt, 1997). However, since then there has been an increase in the prevalence of cocaine use, from 0.4% of the population aged 12-65 in 2001 to 0.7% in 2005 (UNODC, 2008).

Research on alcohol use and abuse in Brazil has tended to focus on select communities, such as students, or indeed is confined to certain regions of Brazil. In fact, research indicates that the type and extent of drug use and misuse varies by geographical region in Brazil (Rassool et al., 2004). For example the south-east and the south of Brazil are the areas most heavily affected by cocaine consumption; lifetime prevalence of cocaine use in the south-east of Brazil is 3.7% of the population aged 12-65 and in the south lifetime prevalence is 3.1%. In the north-east and the north lifetime prevalence reaches 1.2% and 1.3% respectively (UNODC, 2008). Availability of cocaine is likely to be greater in south-eastern parts of Brazil due to an increase in the activities of cocaine trafficking groups in those areas (UNODC, 2008).

Overall it appears that alcohol, tobacco and marijuana are the most popular drugs of choice in Brazil (Galduróz et al., 2005). Consumption of illicit drugs appears to be lower than that in the US and approaches figures reported for other South American countries (Galduróz et al., 2005). The increase in cannabis use in Brazil is of concern as the annual prevalence of cannabis use has more than doubled, from 1% in 2001 to 2.6% in 2005 (UNODC, 2008). Details of some of the studies conducted in Brazil, both regional and national, are described below.

In an interview study with 1277 participants from a city in Southern Brazil, aged 15 years and older, the prevalence of alcohol consumption in the last month was 54.2%; 11.9% were considered to have 'at-risk alcohol intake'; and 4.2% were classified as 'alcohol dependent'. Males were more likely to be 'at-risk' and 'alcohol dependent' than females, whereas women (15.1%) were more likely than men (7.9%) to report use of psychotropic drugs, most of which were anxiolytic (de Lima et al., 2003). In a similarly designed study of community members from a city in Southern Brazil, alcohol dependence was twice that reported in the study just described, although a recall period of 6 months was used which may explain some of the difference (Moreira et al., 1996).

More recent work designed to represent the Brazilian population, involved a large household survey of drug use, involving 8589 persons, aged 12 years and older from 107 cities in Brazil (Galduróz et al., 2005). Lifetime use of alcohol, tobacco, marijuana, inhalants, cocaine and stimulants was 68.7%, 41.1%, 6.9%, 5.8%, 2.3%, and 1.5% respectively. Only 4 individuals reported lifetime use of heroin (0.04% of sample). Last year and last month use of the illicit drugs listed above was reported by less than 1% of respondents (except for inhalants; 1%). Half of the respondents (50.5%) reported alcohol use in the last year and 36.1% reported use in the last month. Approximately 11.2% of the sample population was concerned with their own consumption of alcohol (Galduróz and Carlini, 2007). Tobacco use in the last year and last month was reported by 19.5% and 19.2% of the sample respectively (Galduróz et al., 2005).

In terms of drug abuse specifically, the 2008 World Drug Report provides prevalence figures for those over the age of 12 years, unless stated otherwise, see table 4 (UNODC, 2008).

Table 4: Prevalence of drug abuse in Brazil (UNODC, 2008)

Drug (year of data source)	Annual prevalence of abuse (12-65 yrs)
Opiates (2005)	0.5 %
Cocaine (2005)	0.7 %
Cannabis (2005)	2.6 %
Amphetamines (2005)	0.7 %
Ecstasy (2005)	0.2 % (15-64 years)

Adolescents

Illicit substance use among adolescents is also a cause for concern in many countries (ter Bogt et al., 2006). The Health Behaviour in School-Aged Children (HBSC) international report from the 2005/2006 survey explicitly illustrates the prevalence of smoking, alcohol and cannabis use among adolescents aged 11, 13 and 15 years in 41 countries (Currie et al., 2008). Poland, Latvia and Lithuania, some of the main new communities in the west of Ireland, are represented in this international survey. Adolescent substance use in these countries of origin is conveyed in the following table and compared to adolescents in Ireland.


The prevalence of smoking at least once a week among 15-year olds was assessed in all countries and Ireland ranks 16th among 40 countries involved in HBSC 2005/06, with smoking rates higher in many eastern European countries compared to Ireland (Currie et al., 2008). Fifteen year old schoolchildren in Ireland are ranked midway among 40 countries involved in HBSC 2005/06 reporting that they were 'really drunk' twice or more in their lifetime. Table 5 illustrates a higher prevalence of drunkenness among adolescents in their countries

of origin than children living in Ireland. Weekly alcohol drinking is however lowest in Poland, with Ireland ranked 29th among 40 countries reporting alcohol use at least once a week. Overall, Ireland ranks 12th among 39 countries for lifetime cannabis use and has a higher prevalence of use among 15 year olds than the other three countries represented above.

Studies conducted in Nigeria demonstrate that adult users of drugs commonly start in adolescence and young adulthood (Abiodun et al., 1994; Odejide et al., 1987; Gureje et al., 2007). About half of the lifetime users in the latter study had commenced use by the age of 20 years for alcohol, cannabis and tobacco, and 25 years for non-prescription use of sedatives and stimulants (Gureje et al., 2007). Earlier initiation has been reported for overall drug use (14 years or younger; Fatoye & Morakinyo, 2002) and tobacco use (12.6 +/- 3.8 years; Ibeh & Ele, 2003). The impetus to investigate substance use and abuse in young people is evident and is coupled with the growing concern about the negative effects of these substances on youth (Abasiubong et al., 2008).

Table 5: HBSC data on substance use among 15 year old school students (adapted from Currie et al., 2008)

Country	Latvia	Lithuania	Poland	Ireland
% who smoke at least once a week	26.5	22.0	16.5	19.5
% who drink alcohol at least weekly	27.5	22.5	12.0	19.0
% who have been drunk at least twice	44.5	53.5	34.5	33.5
% who report lifetime cannabis use	22.0	15.0	18.5	23.5




In a study of 500 Nigerian students (aged 13-21 years), almost two-thirds of the students reported some experience with alcohol. More males than females smoked cigarettes (37% vs. 10%) and had experimented with cannabis (7.7% vs. 5.8%; Nevadomsky, 1982). In a study of secondary school students (17 yrs +/-1.69) in rural and urban communities in south western Nigeria, drug prevalence rates were reported as follows: analgesics (48.7%), stimulants (20.9%), antibiotics (16.6%), alcohol (13.4%), hypnosedatives (8.9%) and tobacco (3.0%) (Fatoye & Morakinyo, 2002). The prevalence of tobacco was comparatively low, but the majority were daily users, although consumption was confined to 1 or 2 cigarettes ('sticks') a day (Fatoye & Morakinyo, 2002), a feature of use also reported by Nevadomsky (1982). Alcohol and tobacco use was reportedly more common among males than females (Fatoye & Morakinyo, 2002). However, in a school survey of 1200 female students (16.0 +/- 1.36 years) in the south east of Nigeria, smoking prevalence was 7.7% (Ibeh & Ele, 2003).

Thus far psychoactive substances appear to be used in varying proportions among students as further demonstrated by a more recent study of students (16.5-17 years) from 2 local government areas in a south eastern coastal state of Nigeria (Abasiubong et al., 2008). More students from Uyo used kolanuts (31.3%) (the fruit nut of a tree local to Nigeria and the west African region) and sedatives (45.4%), while more students from Eket used alcohol (56.3%), tobacco (34.8%) and cocaine (3.7%). Studies on street children ($n=180$; aged 14.6 +/- 2.6 yrs) indicate that alcohol (23.9% current use), kolanut (13.9% current use) tobacco (10.0% current use) and cannabis (7.8% current use) were the most commonly used psychoactive substances (Morakinyo & Odejide, 2003). Clearly, the prevalence and type of substance use varies between studies examined, and methodological issues play a role in this regard. A study with a representative sample of children and adolescents is warranted to enable a true estimate of the extent of the problem among Nigerian youth.

In Brazil, similar to other countries, concern has been expressed about the health risk behaviours of adolescents (Anteghini et al., 2001), and researchers have stressed the need to draw continuing attention to this issue in South America and particularly in Brazil (Rassool et al., 2004; Pechansky & Barros, 1995). National surveys of drug use in public schools were conducted in 1987 and 1989 and other work since then supports the view that alcohol is by far the most frequently used (and abused) psychoactive substance among adolescents.

A high rate of lifetime alcohol consumption (71%) was reported in a community-based sample of adolescents, aged 10-18 years, ($n=950$), in a city in Southern Brazil (Pechansky & Barros, 1995). A higher prevalence of 'problem drinking' (i.e., with associated physical symptoms such as headaches, dizziness and vomiting) was reported among males (36.8% vs. 28.9%) than females (Pechansky & Barros, 1995). In this study, the mean age for initial experimentation with alcohol was 10.1 years with no gender difference observed. Studies of students from individual cities reflect these figures; lifetime use of alcohol 77% (Silva Ede et al., 2006) and 60.7% (Vieira et al., 2008). In contrast, the large household survey of drug use described earlier, involving 8589 persons who were aged 12 years and older from 107 cities in Brazil, reported lifetime use of alcohol among children (12-17 yrs) at 48.3% (Galduróz et al., 2005) and that 5.2% of teenagers were concerned with their use of alcohol (Galduróz and Carlini, 2007).

Reported use of alcohol and tobacco over the last thirty days was 33% and 4.4% in the study by Vieira et al. (2008). These figures also differ to those from a larger (15,000 students) survey of students from 10 capital cities in Brazil: frequent use of alcohol was reported by 15.0% of students and of tobacco by 6.2%. The findings from the latter study, conducted over 4 time points were not significantly different from the cohorts in 1987, 1989 and 1993 although there were changes in patterns of consumption by gender and age (Galduróz et al., 2004).



These and other studies have included a more comprehensive investigation of both licit and illicit drug use among students. A cohort study of 2059 school students aged 13-17 years from a large beach city in the south of Brazil, found prevalence of smoking tobacco for 13-15 year old boys and girls was 8.3% and 8.8% respectively (Anteghini et al., 2001). In the older age group (16-17 years), the respective figures were 18.7% and 14.1%. The prevalence of drug use for those less than 15 years was 6.0% for boys and 4.2% for girls, whilst respective figures for the older children were 12.6% and 6.5% (Anteghini et al., 2001). In a trend analysis of 4 surveys of school students from 10 capital cities, conducted over the time period 1989 to 1997, lifetime use of any drug consumption was 24.4% in 1997, which was unchanged over the 4 studies (Galduróz et al., 2004). Inhalants were the most popular drugs for lifetime use in all 4 studies with a significant increase in reported lifetime use of amphetamines, marijuana and cocaine in 1997 compared to other years. Although older children were more likely to use drugs, 12.4% of children aged 10-12 years reported lifetime drug use in 1997. For the ten cities taken together, frequent drug use (6 times or more in last 30 days) of marijuana, anxiolytics, amphetamines and cocaine significantly increased in 1997 compared to previous years (Galduróz et al., 2004).

Work in Brazil, similar to that in Nigeria, has also focused on drug use among street children and medical students. In a sample of 1,054 medical students (17 years and older) from 4 universities in Rio de Janeiro, the prevalence of lifetime use of the following drugs was reported: alcohol (96.4%), tobacco (54.3%), tranquilizers (24.2%), cannabis (20.9%), inhalants (18.4%), cocaine (3.4%), LSD (3.3%), amphetamines (1.1%) and ecstasy (0.4%) (Lambert Passos et al., 2006). Of those reporting lifetime use of drugs, the prevalence of use in the last thirty days for alcohol and tobacco was 58.9% and 23.8% respectively. Of those reporting lifetime use of cocaine and inhalants, close to 100% also reported use in the last 30 days (Lambert Passos et al., 2006). A study of street children in 5 Brazilian state capitals found that 74.3% reported using illicit drugs at least once in their lives, with solvents, followed by marijuana, as the most cited drugs; cocaine was most popular in the south-east region (Noto et al., 1997). Another study of Brazilian street children reported in 1998 that 33 per cent of those between the ages of 9 and 11 years and 77% of those between the ages of 15 and 18 years were heavy users of alcohol (see Jernigan, 2001).



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3 Substance Use in Ireland



Alcohol

Ireland is among the highest consumers of alcohol in the European Union with the average rate of consumption of pure alcohol per adult being 13.36 litres per annum (Mongon et al., 2007). This represents an increase of 17% since 1995. Beer is the most popular alcoholic beverage in Ireland representing 51% of total alcohol consumed (Mongon et al., 2007). The rise in wine consumption is also significant with an increase of 170% between 1995 and 2006 (Mongon et al., 2007). In addition, binge drinking patterns are common and drunkenness is a usual occurrence on drinking occasions. Rates in Ireland are considerably higher than the European average for binge drinking with 34% reporting drinking five or more drinks per drinking session compared to the European average of 10% (Mongon, 2007). The 2007 SLAN Survey reports a decrease in the percentage of people consuming six or more standard drinks on one occasion in the week, from 45% in 2002 to 28% in 2007 (Morgan et al., 2008). However, the survey methodology has been changed from postal self-report questionnaires in 2002 to face-to-face interviews in 2007 and therefore confounding factors exist. The HBSC data described previously illustrate that a third (33.5%) of 15 year olds living in Ireland report ever being drunk twice or more frequently.

Mayo, Galway and Roscommon had the lowest rates of treated problem alcohol use among 15-64 year olds in Ireland between 2004 and 2006 contrasting with Sligo which had the highest rates of people seeking treatment (Fanagan et al., 2008). This contrast is significant, with 23 people in Sligo per 100,000 coming forward for treatment compared to 1.3 in Mayo which has the lowest rate in the country (Fanagan et al., 2008). Sligo has the highest number of deaths caused by alcohol abuse in Ireland with 8 per 100,000 deaths related to alcohol (Fanagan et al., 2008). Mayo, Galway and Roscommon are below the national average with approximately 4.9 alcohol related deaths per 100,000 annually (Fanagan et al., 2008).


Tobacco

The 2007 SLAN survey reported that 29% of respondents are current smokers (Morgan et al., 2008). Current smoking was higher among younger respondents and those in the lower social classes. In the western region, 61% reported ever smoking tobacco with 36% reporting having smoked in the previous year and 32% in the previous month. In the 2006 Irish HBSC survey, 15% of participants (aged 10-17 years) reported that they were current smokers (Nic Gabhainn et al., 2007).

Drugs

Drug use in Ireland has become a major topic for discussion in recent years. The most recent SLAN survey, conducted in 2007, reports that 9% of men and 4% of women have taken illicit drugs in the previous 12 months, with marijuana being the most commonly consumed (8% of men and 3% of women) (Morgan et al., 2008). Lifetime cannabis use was reported by 23.5% of 15 year olds in the 2006 Irish HBSC survey (Currie et al., 2008).

The 2006/07 drug prevalence survey of households in Ireland sampled a representative number of people aged between 15 and 64 years and findings have been reported by region (National Advisory Committee on Drugs, 2008a). Almost one quarter (23.3%) of all respondents in the WRDTF area reported having ever taken any illegal drug, which was an increase from the 2002/3 survey when lifetime prevalence was reported at 12.5% (National Advisory Committee on Drugs, 2008a). In 2006/07, cannabis was the most commonly used illegal drug with 21% reporting lifetime use, which was also a significant increase on 2002/03 rates (12.0%). Prevalence rates for lifetime cannabis use among young adults (15-34 yrs) were at least double those of older adults, 29.1% versus 14.5% respectively. Moreover, lifetime and last month prevalence of cannabis use among young adults had significantly increased since 2002/03 (lifetime: 29.1% versus 14.6%, last month: 7.1% versus 1.5%) (National Advisory Committee on Drugs, 2008b). Lifetime use of ecstasy (4%), cocaine (3%), amphetamines



(3%), LSD and solvents (2% each) were also reported for all adult respondents in the WRDTF area. 10% of the respondents reported using sedatives, tranquillisers and anti-depressants with 5% doing so in the previous year and 4% in the previous month (National Advisory Committee on Drugs, 2008a). In the western region, the increase in new cases of drug addiction among under 18s was among the highest in the country (Reynolds et al., 2008a). However, the west has the lowest incidence of treated drug use with 29 cases per 100,000, which may indicate lower problematic drug use rates or lower access to appropriate drug treatment service (Reynolds et al., 2008).

Substance Use in New Communities

When researchers began studying substance use in migrants, attention was focused on how substance use in the minority group differed to the native population, which was considered the 'norm' (Adrian, 2002). Reviews of substance use issues among immigrant communities or among ethnic minority groups tend to draw very similar conclusions despite originating in different countries, focusing on different 'non-native' groups and using very different research methods. For example, Carrasco-Garrido et al. (2007) report lower levels of alcohol and tobacco among immigrants than among the native population with data from the National Health Survey in Spain, and Blake et al. (2001) report lower levels of alcohol and marijuana use among immigrant youth in Massachusetts, particularly so among those living less than 6 years in the United States. Wanigarantne et al. (2003) in their review of evidence from the United Kingdom note that, although the data are patchy, they appear to consistently document higher levels of involvement in substance use among 'white' populations. Similarly, there are a variety of studies that report lower rates of substance use and related disorders among immigrants to the US, particularly for those who are less acculturated to the US (Flores & Brotanack, 2005; Taiéb et al., 2008).

It is important to recognise that there are a range of challenges to interpreting such data. One key issue is that of ethnic identifiers where many challenges remain in relation to the identification of meaningful and appropriate measures (Phinney, 1992; Reid et al., 2001b; Wanigarantne et al., 2003). Another challenge is that due to the low rate of substance use, and particularly misuse, in the general population very large sample sizes are required to identify accurately the rates of substance use and this is multiplied when the desired objectives include the identification of rates in sub-groups of the population (Khan, 1999a; Wanigarantne et al., 2003). A third major challenge is the issue of measurement of substance use; numerous authors report on the reluctance of immigrants from some communities to self-identify as users or problem users because of fears around the confidentiality of data collection mechanisms and the potential linking of the information they may provide to their families or the immigration or police services. Similarly data taken from official sources suffers from the problems associated with the use of ethnic identifiers as well as the lower rates of service utilisation among immigrant groups (Torres-Cantero et al., 2007).

The main Irish national studies on substance use, summarised above, do not generally break down their data by ethnic or cultural group. Thus reliable national figures on substance use among new communities in Ireland are not yet available. However a number of regional projects have begun to investigate this topic, although no general picture can be drawn because of the variety of methodologies adopted.

A study establishing the health needs of immigrants and asylum seekers in Co. Cork and Co. Kerry found that a third of the respondents smoked tobacco; a quarter had ever used marijuana in their life with 1% reporting cannabis use in the past month; 27% had ever drunk alcohol of which 49% reported a weekly intake of less than 2 units (Foley-Nolan et al., 2002). Similar to studies conducted in



other jurisdictions, these data convey a picture of lower prevalence of substance use in new communities from these particular areas compared to the general Irish population.

A small qualitative study by Merchants Quay Ireland (www.mqi.ie), the aim of which was to investigate problematic drug use, reports that cannabis appears to be widely used among members of new communities in Ireland (Corr, 2004). Ecstasy, amphetamines and LSD were more likely to be used by younger members of new communities who were adopting similar drug-using patterns to their Irish peers (Corr, 2004). Of the interviews conducted with 10 participants, 7 reported heroin as their drug of choice and the other 3 reported cocaine use (Corr, 2004). Overall, the Africans in the sample were more likely to smoke cocaine and heroin while eastern Europeans were more likely to inject heroin (Corr, 2004). Half of the interviewees were not involved in problem drug use before moving to Ireland. It was suggested that the stresses associated with migrating may have contributed to the involvement of these participants in substance use.

In the consultation report for the National Intercultural Health Strategy (Health Service Executive, 2008a), concerns about addiction in new communities were raised. The general insufficiency of addiction services and lack of cultural appropriateness of services in existence were highlighted. It was reported that few people could access or attempted to access medical services and linguistic problems were perceived as additional barriers. As part of the process of strategy development, consultation workshops and focus groups were held with ethnic minority groups and community organisations as well as Health Service Executive staff in Dublin, Dundalk, Galway,

Limerick, Sligo and Cork during 2006. The consultation process in Galway identified stress, depression and alcoholism, associated with living in direct provision, as one of the main priorities of new communities and of community and voluntary organisations. Another priority for new communities was to break down the barriers to accessing services and enhance access to information about services and entitlements. This was also of major concern to service professionals who wished to engage with ethnic minority groups, but were faced with difficulties in access and language barriers. These reports are reinforced by recent data collected from asylum seekers in Galway, indicating that 39% of respondents had experienced difficulties in accessing health information and 10% reporting that they had not understood information they had received because of language difficulties (Galway Refugee Support Group, 2009). As has been documented elsewhere, limiting access to healthcare provides an environment in which substance use is more hazardous for new communities than for the majority population (Wanigaratne et al., 2003).

In the second national report from the 2006 Irish HBSC study, immigrant students were assessed with regard to substance use (Molcho et al., 2008). In this study, none of the 28 Nigerian children that took part in the school-based survey reported that they smoked, drank alcohol or took cannabis. Other nationalities involved in the 2006 Irish HBSC study included 24 Lithuanian and 24 Polish adolescents. The Lithuanian adolescents were less likely to report drinking alcohol in the last month and smoking cannabis than the Irish adolescents, while no such pattern was identified for the Poles (Molcho et al., 2008). As far as we can ascertain data on substance use among Brazilian children in Ireland are not currently available.




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Perspectives on Substance Use in New Communities in the West of Ireland



There is an absence of quantitative information on drug and alcohol use in new communities in the west of Ireland, which mirrors the dearth of information at a national level. Such data as do exist, for example those collected as part of the Health Behaviour in School-aged Children (HBSC) study, were not possible to reliably break down both regionally and by population group. Two separate exercises were undertaken in an attempt to further explore substance use among new communities in the west of Ireland. First a number of statutory and voluntary support groups and services were contacted by telephone, and second a review of the regional print media was conducted.

Contact with Support Services

A list of organisations involved in the support of new communities or the provision of substance use services was first drawn up. Telephone contact was made with all those on the list and the sample subsequently snowballed. That is, the representatives of organisations contacted suggested other potentially appropriate groups to contact. A list of organisations and groups contacted can be found in Appendix 1. Contacts were explicitly asked about their perceptions of the substance use issues among new communities in the west of Ireland and whether their group or organisation had any specific policy or strategy on the issue. Almost all of those contacted had no specific or specialist information on the issue at hand, nor did their organisation have a policy or strategy. Some referred to the HSE Intercultural Strategy consultation (Health Service Executive, 2008a), or to the statutory addiction or substance misuse services, but few organisations indicated any direct experience of substance use among members of new communities.


COPE, Galway is a community-based organisation that deals with inequalities and isolation in society brought about by homelessness, domestic violence and being elderly. Evidence indicates that substance use has been found to be associated with homelessness (Glasser & Zywiak, 2003).

COPE recorded the number of non-Irish nationals that availed of their service between mid-August 2008 and November 2008 (personal communication, 2008). There were 23 in total comprising of central and eastern Europeans from Poland, Lithuania, Albania and Czech Republic. They used the services of COPE in Westside House in search of food as there is no provision in the city where people can access food for free or at a low cost. Many of these migrant workers had become unemployed in the previous 12 months due to the downturn in the economy and were living in squats or camping out. It was reported that six homeless eastern European men use COPE's services on a regular basis, of which all have chronic alcoholism and deteriorating mental health. Difficulties in assisting these men were discussed and include challenges due to language barriers and the fact that they have no form of state support as they do not meet the habitual residency requirements (personal communication, 2008).

In Galway, a Refugee and Asylum Seeker Teenagers Support Group is operated by the Youth Work Ireland SPARK project in conjunction with the Gaf Youth Café. In the support group adolescents provide peer support for each other and address issues such as coping skills, assertiveness, dealing with change and accessing help and support. Similar to the data from the HBSC study (Molcho et al., 2008), when asked about substance use, the majority of the group, who were primarily African, did not report substance use involvement. It was reported that the adolescents involved demonstrate a strong respect for their parents and did not want to 'let them down' (personal communication, 2008). The protective effect of family relationships are discussed again later in relation to factors associated with substance use among adolescents.

Media Analysis

Public interest in and concern about issues of substance use among new communities is both driven by and informed by the media. During 2008



a range of stories emerged in the national press that highlighted the involvement of new communities in excessive drinking or drug-taking. Examples include the case of a Uzbeki drug-dealer given an 18-month prison sentence for possession for sale or supply of cocaine and ecstasy (Irish Times, April 12th), that of two Indonesians remanded in custody following the seizure of cannabis (Irish Independent, July 5th), and of two Polish men charged with cultivating cannabis and opium (Irish Times, June 18th).

Other stories in the national press emphasised the link between substance use and violent crime, such as a story appearing in a number of papers concerning a Polish criminal, suspected of being a member of a 'drugs gang' who was charged with a knife attack on a journalist while being drunk and high from cannabis use (Irish Independent, April 18th; 19th). Two substantial controversies emerged during 2008; the first on whether the rates of road traffic accidents were higher among new communities due to their consumption of alcohol before and during driving (Irish Independent, February 17th), an assertion for which the Automobile Association were reported as saying there was no evidence. The second concerned speculation on the link between alcohol misuse and knife crime, where it was claimed that over a quarter of fatal stabbings claimed the lives of foreign nationals and that almost half of such stabbings were carried out by other non-Irish nationals (Sunday Tribune, June 22nd). Such data indicate that foreign nationals are more likely to be victims of fatal attacks than Irish nationals and there remains a gap in our understanding of the underlying explanations for this.

On the other hand a range of stories also brought attention to the non-use or lower levels of substance use among immigrants (Irish Times, May 14th; Irish Independent, August 21st; Irish Times, October 7th; Irish Times, October 8th), or the risks of substance use associated with living in Ireland. These include first-hand account of members of new communities finding it hard to integrate with the drinking and

drug-taking cultures of Irish youth. One story related the killing of two Polish men who refused to buy alcohol for teenagers (Irish Times, March 17th), while another highlighted the risk for homeless foreign nationals becoming involved in drug misuse (Irish Times, December 30th, 2008).

Given the role of the press in reflecting and informing the public interest, and in effecting our understanding of the extent and nuance of particular issues, a review of regional newspapers was undertaken as part of the research for this report. The aim was to collect and document perspectives on substance use in the west of Ireland, and specifically among new communities.

Methodology

All newspapers published in counties Galway, Mayo and Roscommon between December 8th and December 14th, 2008 were read by two researchers, and all articles related to tobacco, alcohol or drugs were highlighted. Newspapers collected included: The Roscommon Champion, The Roscommon Herald, The Western People, The Mayo News, The Sligo Champion, The Connaught Tribune, The Galway City Tribune, the Connacht Sentinel, The Tuam Herald, The Galway Advertiser, The Galway Independent and Galway First. Excluded from the subsequent analyses were boxed and classified advertisements and advertorials. Also not included were references to bars, clubs, hotels, restaurants or social events where alcohol or other substances were not explicitly mentioned. Photographs of alcohol, such as in the social pages, were not considered. Each of the 91 articles identified was subsequently classified in relation to the type of substance(s) mentioned, the context and when individuals were mentioned, the nationality of the individual. In many cases the nationality had to be inferred from the name of the person given – invariably one that appeared to be Irish. In the small number of articles where the nationality was explicit the individuals were always described as being from outside of Ireland.



Results

Only one article explicitly mentioned tobacco alone and referred to the popular country music singer Big Tom and his giving up smoking because of illness (Tuam Herald, 11th December). A second article referred to smoking in the context of promoting a teenage disco where smoking, alcohol and drugs were not to be allowed.

Of the 90 articles identified that referred to alcohol or drugs, the vast majority (69; 76.6%) concerned alcohol and only a minority (27; 30.0%) referred to any illegal drugs². There were no identified articles that mention prescription drugs, or the use of medications. The range of contexts in which alcohol was mentioned was substantial, from court reporting of drunk-driving and public drunkenness, to reports of free alcohol available in licensed premises. In contrast, other drugs were only referred to in the negative, and usually in the context of a court case following a drug seizure. In addition, the majority of articles concerning alcohol were general in nature and did not refer to any specific individuals. In the case of other drugs, almost all articles referred to named drug users or drug dealers.


Of the 69 articles that mentioned alcohol, 29 (42.0%) reported on the negative effects of alcohol for named individuals. Most commonly these included reports of drunk driving (9), public drunkenness (5), committing a crime when intoxicated (8), or a defendant being given bail on condition of abstaining from alcohol (3). However, as noted above most articles that mentioned alcohol did not refer to specific individuals. Rather they reflected a range of perspectives on alcohol, from warnings about the dangers of drinking at office parties and drink-driving, to notices informing readers where free or cheap alcohol could be obtained, items highlighting alcohol awareness for youth and columns advising readers on how to choose wines. Community notices included items

on the Pioneer Association and Alcoholics Anonymous, as well as bars and public houses where particular alcohol promotions were to be held. News items referred to publicans wholesale purchase of alcohol and the Lord Mayor buying (or in this case not buying) drinks for council members; arts reviews referred to alcohol, pubs and drunkenness as portrayed in film and theatre; and an obituary mentioned how the deceased loved to have 'a few pints' after a football match.

In total 31 of the articles that included reference to alcohol also included references to specific individuals, almost all of them Irish. One referred to an Englishman, and members of new communities in the west of Ireland were referred to three times. In only one case was this negatively, in that a Latvian man was reportedly arrested for public intoxication in a Mayo town. In one article, also reported in the Mayo News of December 9th, an Irish man was fined for public drunkenness and possession of illegal substances and the fine was awarded to a homeless Latvian man in order to assist him to purchase a flight home to Latvia. Reference to this episode appeared in two further papers (a separate article in the Mayo News, 9th December and the Western People, 9th December), although there was no mention of the public drunkenness in the latter articles. The third reference to members of the new community was in a column where the author recounted experiences of a group of young Polish immigrants dancing in a public house and reminding the reader of how much the Polish have contributed to Irish society (Roscommon Champion, 9th December).

There were fewer references to other drugs and of the 27 articles identified, 6 (22.2%) were general in nature and did not refer to any specific individuals. Three concerned drug awareness and education, one to addiction service development (Connacht Tribune, 12th December) and the remaining two to drugs being prohibited at a local teenage disco (Roscommon Champion, 9th December) and

²Some articles referred to both alcohol and other drugs.



concerns about herbal cannabis being sold in a local shop (Western People, 9th December). The remaining 21 references to drugs concerned reports of arrests or convictions for drug possession (14), reports that defendants were drug free (2), or ordered not to take drugs while on bail (1), crime committed due to drug use (1), and one case of obstructing a drugs search (1). Three of the articles referred to members of Ireland's new community; there was a report of two Asian men caught in possession of €200 worth of ecstasy (Galway City Tribune, 12th December), a Polish man accused of growing cannabis (Tuam Herald, 11th December) and the seizure of cannabis plants at the home of a Chinese woman (Western People, 9th December).

These analyses suggest that there is more interest in alcohol related issues than in other drugs and that there is more ambivalence about alcohol (which is presented as both potentially dangerous and positive and worthy of promotion) than other

drugs (which are presented entirely negatively). In relation to the issue at hand, only 5 articles in total were identified where members of new communities and alcohol or other drugs were explicitly linked and in just 3 of those cases these concerned drug possession or public drunkenness.

Even if there were available quantitative data for substance use among new communities, data collection in the region would suffer the same challenges as outlined above for national level data; thus they are unlikely to become available in the short to medium term. Lack of reliable regional information is a challenge to service development. Nevertheless we can draw on the perceptions on the issue outlined in this section to assist with developing suitable responses. These perceptions should be considered alongside what can be drawn from the international literature on risk factors and the possible role of service development in addressing these issues.



*Few life experiences are as
life-changing and complex as
migration.*



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5 Risk Factors for Substance Use in New Communities



Few life experiences are as life-changing and complex as migration (Carta et al., 2005). Almost all aspects of life are different and the processes involved, physical, social, emotional and environmental are challenging, time-consuming and fraught with difficulty. Such changes and challenges are stressful and place the immigrant at risk for a range of disadvantages relative to the host community, many of which also increase the risk for substance use and misuse. The risk factors for substance use among new communities are generally the same as those for others; they include mental health difficulties and social and economic disadvantages including isolation, poor education and unemployment (Khan, 1999a).

The potential for involvement in risk behaviour and substance use is high among new communities given the stresses inherent in leaving their country of origin. Factors contributing to this distress include discrimination, social exclusion, and unemployment, resulting in increased depression and anxiety levels (Pernice & Brook, 1996; Begley, 1999; Sherlock, 2002; Corr, 2004; Wanigaratne et al., 2003). Substance use has a strong association with mental health problems (Boys et al., 2003; Merikangas et al., 1998) and it is possible that the distress experienced and environment in which new communities live could become contributing factors for use of substances such as drugs and alcohol (Carballo et al., 2001; Wanigaratne et al., 2003).

A number of models have been proposed that try to help explain the relationship between immigrant status and substance use. The most frequently cited is the acculturation model (e.g., Flores & Brotanek, 2001; Taiëb et al., 2008). This posits that immigrants arrive in a new country steeped in the culture of their country of origin (typically including low rates of substance use and negative attitudes towards substance use); but as they become more immersed or involved in the culture of the host or new country they become progressively acculturated

– adopting the norms, attitudes and behaviours of the new country (including tolerance of and exposure to substance use). Thus acculturation (Berry et al., 1987) defines the cultural changes that are experienced by new communities in their host countries. Others have pointed out that the process of acculturation is confused and complicated by socio-economic disadvantage (Sundquist, 2001); and that attributing substance use to the cultural or racial aspects of minority status is to ignore the myriad of social, economic and environmental disadvantages minority groups experience (Taiëb et al., 2008). Indeed it has been argued that not only do such experienced disadvantages complicate the picture; they fully explain variations in substance use previously attributed to 'race' or 'culture' (Reid et al., 2001a).

Johnson (1996) outlines two alternative models; the acculturative stress model and the striving stress model. The acculturative stress model proposes that experienced cultural conflict in the host community interacts with poor coping resources, both economic and social for dealing with the stresses inherent in the life changes involved and means that immigrants can find it difficult to cope well with such changes. Thus substance use is conceptualised as a maladaptive coping response (Berry et al., 1987). The striving stress model focuses on frustrated aspirations in the host country; it argues that substance use is a response to unfulfilled goals (Kuo, 1976; Vega et al., 1987). While full empirical testing of these models, particularly comparative testing, is incomplete they suggest some key common risk factors including; social relationships and in particular social integration, stress especially that related to migration, and economic resources including employment and associated educational opportunities. Risk factors can interact and reinforce one another and thus are not entirely independent factors.

Social exclusion and social networks

Substance use has long been associated with difficult social integration (Carta et al., 2005). Loss of social networks and support structures among individuals from new communities can increase the likelihood of substance use. Even when family and friends are in Ireland, asylum seekers living in different counties may not be able to visit friends and family for long periods of time (Stewart, 2006). Migrant women in Roscommon and Cavan were interviewed and reported that they would like more social activities that did not involve a public house (Migrant Rights Centre Ireland, 2008). They also reported a lack of constructive or leisure opportunities *“There’s nothing to do here really, when you have a day off you can just sit home and that’s it, that’s all”* (Migrant Rights Centre Ireland, 2008). It also appears that migrant people are not confident about contacting organisations and community groups that could facilitate their involvement in activities in their local communities (Migrant Rights Centre Ireland, 2008). The subsequent sense of boredom and feeling low can lead to engaging in substance use similar to reasons cited by Irish drug users. As cited in Corr’s (2004) qualitative study, one Nigerian drug user said: *“I started using drugs because I had nothing to do at the time. I got involved with friends that I shouldn’t have got involved with”*.

Social exclusion is widely reported by individuals from new communities. Results from a qualitative study of the direct provision hostels in Galway reported feelings of *“being forgotten, dumped, marginalised, and excluded from the host society”* (Stewart, 2006). Social exclusion also refers to living in socially deprived areas where unemployment, crime, poor skills, low income, bad health and family breakdown are likely to be high. Media reports have referred to the risk factors for new communities associated with substance use, (e.g., overcrowding and poor housing) (Waine & McLoughlin, 2005). For some, accommodation has been organised by employers therefore job loss can also result in homelessness and increased risk

of psychiatric illness and drug dependency (Waine & McLoughlin, 2005). There have also been examples in the media of the exploitation experienced by migrant workers in Ireland by employers and landlords, such as providing below-minimum wage, long hours and few holiday entitlements. Issues associated with the indigenous population such as racism, discrimination and lack of acceptance have also been proposed as possible triggers for individuals from new communities to use substances (Corr, 2004). Migrant support groups in the west of Ireland endeavor to counteract social exclusion among new communities; however this is a complex issue requiring action at multiple levels.

Traumatic experiences and stressors

Refugees and asylum seekers in the west of Ireland are often forced migrants and may suffer serious mental ill-health due to the trauma of wars, conflict and violence in their native country. Thus Post Traumatic Stress Disorder (PTSD) is common among forced migrants; indeed it is the most common mental health problem reported by refugees and asylum seekers (Carta et al., 2005); psychological effects that can occur include depression, anxiety, frustration, aggression and social withdrawal (Stewart, 2006). These psychological disturbances are risk factors for the onset of problematic substance use in individuals.

A qualitative study on the mental health of asylum seekers and refugees in Galway city showed that experiences of past traumas and fears for the future, length of time living under the direct provision accommodation system and language barriers had a negative impact on mental health (Stewart, 2006). Refugees’ perceptions of health were more positive as a result of their independent lifestyle, although language barriers and unemployment were still significant barriers to integration for this group. Asylum seekers and refugees did not feel socially integrated and included in Irish society (Stewart, 2006).



Other stressors experienced by new communities in the west of Ireland are the strain associated with being undocumented, having illegal status and the associated strain of worrying about being discovered. Having no access to medical services except in the case of an emergency is an additional strain. In interviews with migrant women living in rural Ireland, one woman described her experience of being undocumented by stating: *“I think when you move here you are lost. I think myself, I was illegal for a while, you carry on, you put your head down”* (Migrant Rights Centre Ireland, 2008).

Unemployment

Due to the recent economic crisis in Ireland, unemployment among new communities is rising considerably and is likely to continue to do so. The struggle to enter suitable employment is compounded for many by poor English language skills and unfamiliarity with local structures and systems (Reid et al., 2001a). High unemployment rates and the high concentration of migrant workers in low-paid, low status jobs with little job satisfaction is a major risk factor for low self-esteem and confidence, which ultimately may increase the risk of initiating or increasing rates of substance use (Alcorso, 1990). Many individuals from ethnic minorities find they struggle to find suitable employment. A further associated risk, reported in some countries, is when migrants are drawn into the profitable illicit drugs market, which is generally unskilled and requires no formal training (Reid et al., 2001a).

Khan (1999a; 1999b) argues that drug users from new communities face consequences that are over and above those experienced by others. These are related to discriminatory stereotyping and include: more likely to be demonised as drug dealers and traffickers; less likely to be found within the care systems and are more likely to be diverted to the criminal justice or psychiatric services rather than the health system; and more likely to be ostracised by their families and thus have greater need to draw on health and social care services. These risks


compound the problems they experience and require that service responses must be fully cognisant of such challenges.

Risk and protective factors for substance use in adolescents from new communities

Migration is a stressful time for adolescents; and studies have found it may increase risk for mental health and substance use (Gill et al., 2000). Migrants are often forced to alter their cultural values and behaviours to adapt to the lifestyle of the indigenous population. Carbello et al., (1998) report that the explanations posited for substance use among children of immigrants have ranged from an expression of frustration at the difficulties of integration to a manifestation of social marginalisation.

Along with acculturation, the isolation, rejection and loss of a social network adds to the stress of migration. There is some evidence from Ireland to suggest that immigrant children report lower levels of supportive peer relationships than others. The 2006 HBSC study reported that adolescents from new communities in Ireland were less likely to report positive peer relationships than Irish adolescents (Molcho et al., 2008). They were also likely to report that their school class accepts them as they are, or that they spend 3 or more evenings with friends. Polish adolescents in this study were more likely to report having been in a fight and less likely to report having a good relationship with their classmates. Adolescents from Lithuania also reported having less positive relationships with their classmates and although they were less likely to have been in a fight, they were more likely to report being bullied than Irish adolescents (Molcho et al., 2008).

It is important to recognise that having fewer social relationships with peers from the host society has also been found to impede substance use among adolescents from new communities due to lack of interaction with substance-using peers and lack of



knowledge of where drugs can be sourced in their locality (Marsiglia et al., 2008). Therefore mixing with Irish peers may present a risk factor for substance use among these adolescents from new communities. The extent to which having Irish friends is a risk or protective factor (Carballo et al., 1998) has yet to be determined, and most likely will involve elements of both.

It has been argued that a protective factor amongst immigrant adolescents are the strong family ties that are evident among Brazilian and Nigerian cultures. Families from most new communities migrate to Ireland with a sense of hope and optimism for a better life. This sense of optimism is a possible deterrent for engaging in risky behaviour. Substance use may be avoided for at least the first few years, as adolescents perceive the consequences will extend beyond themselves to the family (Marsiglia et al., 2008). This protective factor may help partly explain why Nigerian adolescents, who participated in the 2006 Irish HBSC study, did not report any substance use.

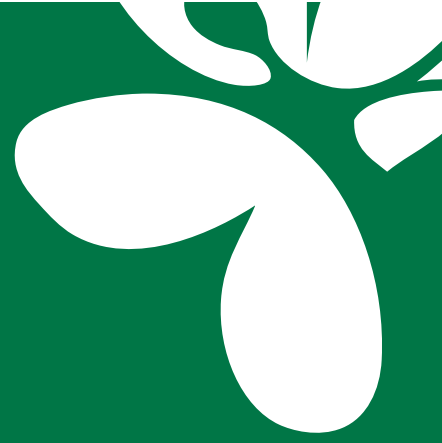
A unique risk factor for young people from new communities has been noted by a number of authors (e.g., Reid et al., 2001a). This is the issue of a mismatch between youth and their parents or wider family in the extent of acculturation. The education system generally offers a structured environment through which immigrant youth can

mix with youth from host communities, the language of the host country becomes ingrained and the cultural practices and expectations of the host country become more familiar. For some this can lead to conflict with the family, who may see the young person as 'deserting' or being disloyal to their own community. Such conflict can lead to isolation from the community and can expedite the acculturation process, also leaving the young person with fewer family supports and protection. The documentation of such a process highlights the importance of working in partnership with new communities across services.

Education may be a protective factor against substance use with individuals that drop out of school being more likely to use drugs than those who complete school (Obot et al., 1999). Educational attainment is inversely related to the risk of substance use and misuse. Youth from ethnic minority and migrant groups can be at risk of school drop-out and low attainment because of a range of issues associated with their families, including poverty, language and family expectations (Reid et al., 2001a). Prevention of early school leaving among youth from new communities is vital as it increases their chances of becoming fully employed with an associated decrease in the likelihood of initiating substance use or developing problematic patterns of use.



The potential for involvement in risk behaviour and substance use is high among new communities given the stresses inherent in leaving their country of origin.



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Barriers to Effective Service Utilisation



Support Groups and Services

Many reviews highlight the lower levels of minority ethnic groups, immigrants or new community members accessing health services (e.g., Rissel & Rowling, 1991; Reid et al., 2001a; Carta et al., 2005; Reid et al., 2001c). It has been argued that the lower rates of accessing drug and alcohol treatment should not necessarily be interpreted as reflecting lower need (D'Avanzo, 1997). Rather, a series of issues effectively prevent and dissuade drug users from accessing treatment and need to be fully recognised and addressed in order to render services equitable. The key barriers to service utilisation can be divided into objective factors related to information and service provision and subjective factors related to the views and perceptions of potential service users and service professionals (Carta et al., 2005). Barriers include views in new communities regarding drug use, deficits in knowledge and understanding of services available, perceptions of services available, issues around payment and physical access to services, communication difficulties and the role of service professionals.

Substance use, and particularly illicit substance use, has been associated with a range of negative connotations in all communities; but data from some ethnic groups, particularly those from parts of Asia, suggest that intense shame and stigma are present. Motivation to 'protect' the self, the family and the community from being negatively labeled is high and conceptions of 'izzat', honour or respectability are important (Wanigaratne et al., 2003). Traditional self-reliance is a preferred route to dealing with problems than is approaching statutory services (Reid et al., 2001c). Fear of social censure and the risk of being ostracised mean that those experiencing substance use problems are less likely to seek help.

There is also evidence to suggest that there is a lack of understanding in relation to how services are structured and how to access help (Corr, 2004; Carta et al., 2005). This is particularly the case for new

immigrants, but it appears among all groups. Information on service provision is rarely multi-lingual and structures may be quite different from those in countries of origin. While primary care services do form the first line of defence for most immigrants and can be an appropriate route into other services, there remain concerns about confidentiality and about whether an admission of substance use will effect other treatments received (Alcorso, 1990). Indeed there are documented concerns about the confidentiality of substance misuse services and the extent to which information provided may be shared with other statutory services such as the police or immigration services (Reid et al., 2001c; Wanigaratne et al., 2003; Corr, 2004; Carta et al., 2005).

Services are perceived as being targeted at white opiate users and as adopting Eurocentric or Anglo-Saxon approaches to treatment (Corr, 2004; Wanigaratne et al., 2003). Scepticism has been reported regarding the over-emphasis on the medical model of treatment (de Leon et al., 1993; Reid et al., 2001c), and the focus on the individual as opposed to the family. Such models tend to deny the salience of kinship ties and require the 'patient' to attend and respond to treatment in isolation from their family members. It has been argued that this is a substantial barrier to treatment for a range of ethnic groups (de Jong et al., 1998; Jakka et al., 1999). In addition there is some evidence of unrealistic expectations of services, for example expecting a rapid resolution to problems that have been developing over long periods of time (Reid et al., 2001c).

Physical access to services can also manifest as a significant barrier, and this is particularly the case when services are centralised, but members of new communities are geographically dispersed. Fears around the potential costs of services are also important; these range from concerns about professional fees as well as the potential impact on employment and income generation of engaging with treatment.



A primary barrier to effective service provision is language, particularly for immigrants with poor English language skills (Reid et al., 2001a; Carta et al., 2005). In most European countries mental health services are generally only available in the majority language (Watters, 2002). As Carta et al. (2005) point out, communication in the form of language is the primary tool of the mental health or addiction worker and they are highly dependent on communication skills to do their work. Poor language skills, particularly comprehension, also militate against treatment adherence (Reid et al., 2001a). One alternative is the provision of interpreters. Poor access to interpreters dissuades potential service users from contacting or requesting services or from continuing with a course of treatment (Amodeo et al., 1997). However, even where translations services exist, the cost associated with them for service providers means that they are frequently under-utilised (Beyer & Reid, 2000).

A further barrier is the attitudes and behaviour of service professionals. There have been many examples of discriminatory behaviour and stereotyping, alongside a general absence of cultural competency (e.g., Reid et al., 2001c). In Ireland, Corr (2004) reported that stigma, discrimination and racism among drug treatment staff, and among Irish clients, prevent substance users accessing services. Littlewood & Cross (2008) illustrate the stereotyped attitudes of mental health professionals that need to be challenged and addressed. Wanigaratne et al. (2003) outline the varying impact of direct racism and institutional racism both of which result in prejudice and power imbalances and dissuade service users from new communities and minority ethnic groups. Further, treatment provision can be complicated by the lack

of cross-cultural applicability of diagnosis and treatment approaches (Taiëb et al., 2008). These findings should not be too surprising as the levels of education that service professionals receive in relation to migrant issues, either during basic or advanced training or during continuous professional development are minimal and this needs to be addressed as a matter of urgency (Carta et al., 2005).

The recent National Intercultural Health Strategy 2007-2012 has identified the key barriers in terms of access to healthcare services for new communities. The issues raised are broadly similar to those summarised above and include: lack of accessible information, lack of understanding of entitlements and how the health system works, unavailability of interpreters and experienced or anticipated racism. Also raised were concerns about costs for services and transport to and from service providers (Health Service Executive, 2008b). For those living in rural areas this is compounded by the location of services relative to their homes, poor transport connections and sometimes long working hours (Health Service Executive, 2008b; Migrant Rights Centre Ireland, 2008; Galway Refugee Support Group, 2009).

Specifically in relation to alcohol and drug treatment service the National Intercultural Health Strategy 2007-2012 highlights that a perceived or experienced general lack of understanding about cultural practices is a deterrent for accessing drug and alcohol treatment services. Also salient were fears concerning being exposed and the perceived stigma and shame associated with substance use among certain ethnic groups (Health Service Executive, 2008a).



Substance use, and particularly illicit substance use, has been associated with a range of negative connotations in all communities.



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7 Appropriate Service Responses




The term services in this context refers to all services designed to minimise the occurrence of inappropriate substance use and tackle the negative consequences of such use. Thus it covers health information, health education, health promotion, early identification, treatment and secondary support services. This section draws on the literature in relation to effective service responses and recommendations from previous studies and consultation exercises, and is designed to help address the barriers identified in section 6 of this report. However, it is important to acknowledge that there is a dearth of evidence underpinning many of the suggestions made. Although some evaluation studies are extant, evaluation in this field is a challenging, time-consuming and expensive process; and what works in one setting may not be as useful in another. In a sense these are pragmatic and in some cases 'best guesstimates' of what could work. Given that all changes to service delivery are negotiated within services and are implemented in line with available resources both financial and human, it will be important to use these suggestions as a starting point in consultation with service professionals, service users and representatives of migrant workers, asylum seekers and refugees in the west of Ireland.

A number of authors point out the importance of introducing change in a planned, collaborative multi-sectoral fashion (Reid et al., 2001c; Wanigaratne et al., 2003). Carballo et al. (1998) argue that, in order to ensure that migration is both healthy and socially productive, it will be necessary to balance resources with a commitment to equity. High quality planning and surveillance are both prerequisites to best practice service provision; education is required both for immigrants and for service providers. First, the drive to ensure best practice for all means that initiatives should not be bolted on to existing models of service provision; rather they should form an integral component of services, planned for at the outset and mainstreamed into all organisational activity (Khan, 1999b). Many authors have argued that cultural

appropriateness should be central to policy and planning initiatives to provide drug services to new communities (Sangster et al., 2002; Singh & Passi, 1997).

Khan (1999b) argues that ensuring 'race equality' within services is simply good practice in organisational management and service delivery. However it does require improved consciousness and learning for all those involved. Action is required at multiple levels and Wanigaratne et al. (2003) suggest that change needs to be implemented at policy, management and staff levels; all three levels of change must be co-ordinated in order that they support and reinforce each other. As early as 1990, Rissel & Rowling outlined a process for the development of a locally appropriate model of service delivery to minority groups that takes into account the population size, financial resources available, language, geographical location, age structure of target population, period of residency, culture, drug problems, community readiness and use of services. The overall aim of such a process would be to develop cross-service and inter-sectoral approaches to help provide seamless and connected services to families (Reid et al., 2001c; Wanigaratne et al., 2003).

Such a comprehensive approach needs to include the provision of information and education to a range of stakeholders, including service professionals, service users, families and communities (Reid et al., 2001c). For professionals the key issues are learning about how to plan and provide effective services to immigrant groups, why such changes to normal practice might be necessary and improving consultation and participative skills. Rather than race and ethnicity being added on to training as a specific topic (the vertical approach), each issue in substance use training should include appropriate reference to racial and cultural issues (the horizontal approach), just as gender and social class issues might be addressed (Wanigaratne et al., 2003).



The issue of language, specifically English language proficiency, has emerged as a key factor that needs to be addressed. In order to maximise the support that can be given to members of new communities in relation to substance use language training is required. Elder (2003) reported that such training in English can be both efficient and effective; it is an advantage for a range of purposes not just engaging in treatment, but also for availing of training and employment opportunities and improving social integration. Other education needs for families, communities and service users include: knowledge of substances including the risk and protective factors for use; identifying substance use problems and basic first aid, service structure; how to access services; and increasing awareness around service processes such as issues around confidentiality and how treatment works.

Appropriate approaches do not merely comprise information provision, but also require skills development, as would be the case in multi-cultural health education, described by MacDonald et al. (1988) as *“learning opportunities designed with sensitivities to cultural values, beliefs and practices; carried out in relevant languages; developed in and implemented with the active participation of members that are truly reflective of the ‘target’ group; and taking into account the participating group’s definition of health and its cultural diversity”*. Particular opportunities are present in relation to primary prevention, given the likely low rates of substance use among immigrant youth (Blake et al., 2001).

One possible strategy to improve awareness and educate new communities about substance use is to identify key individuals within new communities and train them to deliver awareness raising activities (Singh & Passi, 1997). Previous literature has found adolescents from new communities to be more knowledgeable about substance use than older generations, and it would be important to consider this when developing delivering drug awareness activities (Sangster et al., 2002). Increasing the capacity of user groups has the added advantage of further facilitating their

participation in both the education of professionals and community members, and, in the development of service delivery and evaluation as advocated by Reid et al. (2001c) and Wanigaratne et al. (2003). Such involvement could be as advisors, user group members, bi-cultural workers, translators, community mediators and trainers or more generally as community council members or members of the informal social support network.

Appropriate developments in the delivery of services need to be informed by the educational approaches outlined above. Increased training and education leading to increased levels of consultation and participative planning will generate locally appropriate recommendations for change. Nevertheless, the literature does point to a number of key areas for action which are discussed below. These include increasing awareness of services, the process of service delivery, addressing language difficulties and introducing new methods of working such as outreach work in the context of a community development approach. In relation to increasing awareness of services and how they work, all publicity and public relations needs to be multi-lingual and properly targeted (Reid et al., 2001c); communications that are mediated by community health advisors have been shown to be effective (Elder, 2003).

Health professionals require training to be more culturally competent in order to provide individuals of new communities with the best possible service (Rassool, 2006). Cultural mediation in drug and alcohol treatment services can enhance cultural sensitivity providing a communication link between service providers and users and can also be a resource for new communities (Calvo, 2007). In relation to the delivery of treatment services it is important that those in clinical support and management sectors of services should be culturally competent (Wanigaratne et al., 2003); thus recognising that responsibility does not lie solely within the frontline staff in a given service. One of the barriers to service utilisation that is frequently raised concerns fear about the



confidentiality of service provision. In order to address such fears, Wanigaratne et al. (2003) recommend shortening assessment procedures and explaining the rationale for the various pieces of information collected, being clear about the nature of confidentiality, and explicitly stating who would have access to the stored information in the future. A further suggestion involves having first contact by telephone, which would guarantee anonymity (Reid et al., 2001c), and would also allow the procedures and processes to be explained.

In terms of the therapeutic process itself, there is a need for increased understanding of the lifestyle and values of cultural groups. It has been recommended that therapists consider adopting the interactive styles of the specific groups during the treatment process (Reid et al., 2001c). This would likely involve the development of specific therapeutic protocols for each cultural group (Reid et al., 2001c). Most important and drawing from the international literature would be finding appropriate mechanisms for including families throughout the process (Rissel & Rowling, 1990; Reid et al., 2001c; Wanigaratne et al., 2003).


Apart from increased access to language education and training for immigrants, two approaches to dealing with the issue of language difficulties have been suggested. The first is increased recruitment of ethno-specific workers (Reid et al., 2001c), that is professional staff with a similar ethnic background to service users. The second is the use of bilingual workers, sometimes referred to as bi-cultural workers or intercultural mediators. The deployment of bilingual workers is not without controversy, as they tend not to be trained in drug and alcohol issues and could compromise, or be perceived to compromise, confidentiality as well as the therapeutic process from diagnosis to discharge. On the other hand it is important to recognise that bilingual workers could also have a role in providing a more holistic service, especially in making links with other support services in the community and voluntary sector (Reid et al., 2001c; Wanigaratne et al., 2003). On an

allied issue, and as Alcorso (1990) points out, it is not sufficient to provide language and interpretation services in the public sector when most immigrants obtain health information from primary care providers.

In relation to the development of more holistic models of service delivery, it is appropriate to consider the use of peer outreach workers (Reid et al., 2001c) as part of a community development based outreach approach (Patel et al., 2002; Rissel & Rowling, 1990; Wanigaratne et al., 2003). This could include goals such as supporting the community to discover and build on their own strengths and develop their own resources to tackle existing risk factors for substance use (Wanigaratne et al., 2003; Reid et al., 2001c). A community development approach can help build an alliance between new communities and service providers encouraging community members to access mainstream services (Wanigaratne et al., 2003). However it is important that personnel are not 'over-academic' (Johnson & Carroll, 1995). For example, Corr (2004) suggested recruiting drug users from new communities and empower them to circulate information in their social networks.

Geographical dispersal has been adopted as a key aspect of resettlement policy with the hope that it would aid the integration of new communities into host societies. However, there is little evidence that this is effective and it does lead to increased levels of isolation and mental health difficulties (Carta et al., 2005), both of which are risk factors for substance use (Carballo et al., 1998). The separation of spouses and families as a result of policy can also lead to similar problems.

It is clear there are limitations to our current knowledge base that require attention. Thus further work on monitoring of substance use in new communities is warranted. The inclusion of ethnic identifiers in all statutory and commissioned data collection has been controversial and, at times, counter productive (Khan, 1999a; Reid et al., 2001b). Much debate remains about the



appropriateness of collecting such information at all, what should be collected and how data should be subsequently interpreted. A variety of different measures have been employed in the past (race/racial appearance, place of origin/country of birth, primary language/language spoken at home, ethnic identification), all of which, it is has been argued, fail to accurately capture the full complexity and sophistication of the underlying concept (Reid et al., 2001b). Nevertheless, useful comparisons and conclusions can be drawn and the difficulty in getting it 'right' should not deter attempts to improve the quality of the data that is drawn on to plan and improve services.

As with all services, it will be important to comprehensively evaluate service provisions that are designed to be culturally sensitive (Johnson, 1996). All changes require evaluation and should include feedback from users groups as well as staff (Wanigaratne et al., 2003); this is particularly important when targeted service users are not well represented by service professionals (in terms of gender, age, social class, educational status or nationality) and in an environment where resources are scarce or competitive.



One possible strategy to improve awareness and educate new communities about substance use is to identify key individuals within new communities and train them to deliver awareness raising activities.




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Conclusion and
Recommendations



Migration is a “politically and historically highly loaded issue” and there are inherent risks associated with emphasising migrant health as a problem; new communities can be pigeon-holed, stereotyped and discriminated against (Junghans, 1998). It is important that we use the best information available to make judgements on the basis of maximising health equity for all and particularly that opportunities for protecting health and well-being are grasped when available.

New communities come from countries where existing rates of substance use among adults are generally lower than they are in Ireland and because most have not been living in Ireland for long periods and are unlikely to be fully acculturated the rates of use are likely to be low in comparison to the rest of the population. During the course of this research little evidence was uncovered of a real and substantial problem that requires immediate fire-fighting action. Relative to the rest of Ireland, the western Region has few new community members, and they are not concentrated in particular socio-economically disadvantaged communities, although that may change. Some of the real challenges facing service providers in other areas and other countries are not as urgent here. While real and effective treatment services are required immediately for some in the short term, more general service development can develop in an appropriate consultative manner, in partnership with new communities members, and it could be facilitated across service providers in a co-ordinated and strategic manner.

In the west we face a situation where the risk factors for substance use that have been identified elsewhere exist or are emerging among new communities and thus the opportunity now exists for co-ordinated preventive action. Such actions must operate side-by-side with other preventive activity designed to promote health in the widest sense. Evidence based health promotion must include action to improve life chances for all, and should include opportunities for appropriate

education, employment and housing, as well as health literacy, health education and access to health and social services. Barriers to effective service utilisation must be tackled and minimised; requiring supports for new communities, service providers and especially communication between the two. Thus action is required across multiple sectors and at multiple levels.

Recommendations for Service Providers

1. Service providers should develop a multi-disciplinary, cross-sectoral forum, under the auspices of the WRDTF, which can engage in the planning process to render all services equitable. Such a forum requires adequate resourcing and needs to set clear goals and principles by which it will operate. All levels of service should be represented, including those involved in strategic development, management and service delivery.
2. Members of new communities need to be involved in all aspects of the service planning and delivery, thus appropriate representatives need to be identified and trained. Liaison with existing programmes such as the intercultural mediators training provided by Access Ireland and the Galway Refugee Support Group would be particularly appropriate.
3. As part of the advocacy agenda, the WRDTF and service providers should support the provision of skilled English language education for all new communities. Other educational programmes for new communities, that focus on drug issues and increasing service awareness, should be delivered multi-lingually and need to be developed in conjunction with new community members, bearing in mind potential differences between population sub-groups. Advocacy is also required to support the reunification of families where possible and to promote social integration.

4. Training for service providers in best practice protocols for working with new communities need to be developed. This will require enhanced cultural competency and the direct involvement of new community members.
5. The potential role of ethno-specific workers and intercultural mediators within services deserves further exploration and research, particularly in relation to the perceived acceptability of such staff to target service users in a treatment setting.
6. The adoption of a community development framework for service enhancement needs to be subject to a needs analysis and fully costed; the support and advice of existing and experienced organisations such as Cáirde should be invited.
7. The adoption of an ethnic identifier in all forms of data collection is required to monitor evolving trends and progress towards goals. This should be an integral part of all official and commissioned data collection.
8. All changes to policy process, consultation, training opportunities, service planning and service delivery deserve to be comprehensively evaluated. This will be essential in order to develop an evidence-based and locally appropriate response that promotes equity and health across the population.

While drawn from the research undertaken for this report, it is relevant to point out that many of the recommendations here are consistent with those in the 2008 Intercultural Health Strategy (Health Service Executive, 2008b). Although consistent, this should not be misinterpreted as being dependent; the recommendations below may inform local implementation of national strategy, but should also be considered as appropriate in their own right. There are a range of existing structures, fora, NGOs and community groups that are experienced in the implementation of recommendations such as these and may be willing to support the planning and execution processes. These include, but are not limited to the Galway Refugee Support Group, Access Ireland, Cáirde, the Irish College of General Practitioners, the Asylum Seeker and Refugee Support Service, the Migrant Rights Centre, and the Asylum Seeker/Refugee Committee of the Primary Care Department and the Health Service Executive, West.



Migration is a “politically and historically highly loaded issue” and there are inherent risks associated with emphasising migrant health as a problem; new communities can be pigeon-holed, stereotyped and discriminated against.



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Appendix 1



Appendix 1: List of community organisations contacted during the course of this research

1. Galway One World Centre
2. Galway People's Resource Centre
3. Galway Refugee Support Group
4. Galway Migrant Service
5. Galway City Partnership
6. St Vincent de Paul, Western Region
7. Cope, Galway
8. Galway Healthy Cities
9. Refugee Legal Service, Galway
10. Youth Work Ireland SPARK project
11. Health Service Executive Western Area Drug Services
12. Mayo Intercultural Action Group
13. Health Services Executive Addiction Counselling Services
14. Simon Community, Galway
15. Roscommon Partnership
16. Bridgestock Ltd. (Asylum seeker and refugee accommodation services)
17. School of Political Science and Sociology, NUI, Galway
18. Department of Public Health, Health Service Executive West







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