



**All Ireland
Traveller Health Study**
Our Geels

Travellers in Institutions



All Ireland Traveller Health Study

Travellers in Institutions Part C of Technical Report 2

September 2010

Drafting Team:

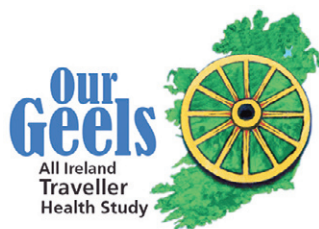
Dr Anne Drummond

Ms Brigid Quirke

Executive Editor:

Professor Cecily Kelleher

For the All Ireland Traveller Health Study team



All Ireland Traveller Health Study Team

School of Public Health, Physiotherapy and Population Science, University College Dublin

Summary

Due to low numbers and lack of an ethnic identifier it was not possible to extend the AITHS into most types of institutions. However, because recent Republic of Ireland (ROI) national census data shows that over 140 Irish Travellers were resident in prisons, and because Travellers sometimes self-identify in prisons for accommodation purposes, the study was extended into prisons in ROI.

The health of prisoners is a cause for concern globally, with high prevalence of mental health disorders, addiction and substance abuse, communicable diseases and chronic diseases. Despite the challenges to providing health services in a custodial environment, health service provision in prisons is a global public health priority and there have been significant developments in the Irish Prison Service (IPS) in this regard in recent years.

For the census all prison Governors in ROI were asked to provide the number of Travellers that they estimated to be resident in their prison during the AITHS census. The number of Traveller men estimated by the IPS to be in prison (299) was nearly double that reported through the census by Travellers themselves (150), however, the IPS-estimated number of Traveller women prisoners (21) was much closer to that reported by their families (18). Notwithstanding these differences, this study confirms that Travellers are over-represented in prison compared to the non-Traveller population, and according to Traveller families' responses to the AITHS census, Travellers comprised 4.6% of the prison population during the census as compared to 0.9% of the ROI population. The risk of a Traveller man being imprisoned was at least 5 times that of a non-Traveller man, and the risk for a Traveller woman was 18 times that of a non-Traveller woman.

For the health status study, despite cooperation of all parties, because of low recruitment rates and data limitations the study could not be completed. However, valuable lessons that will benefit planning future research in this area were learned.

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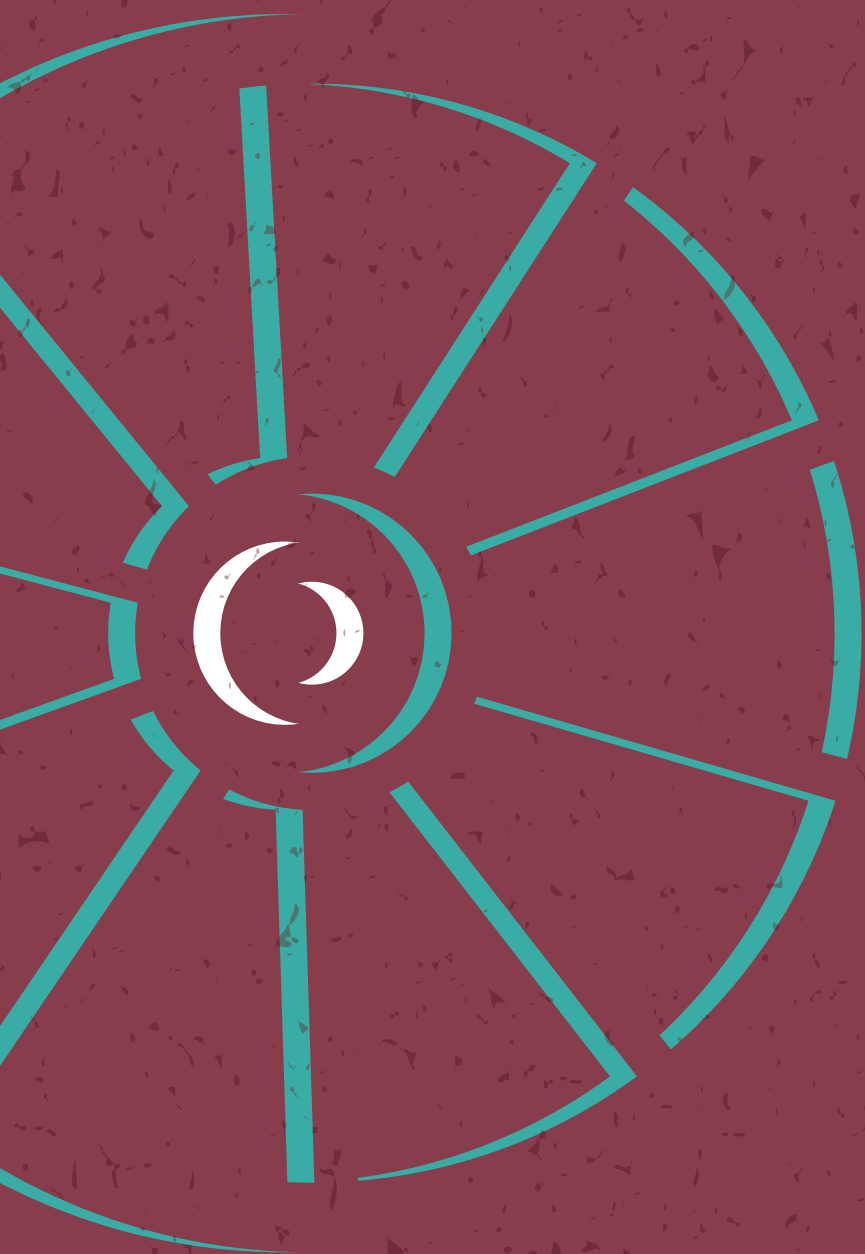
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Travellers in Institutions



1. Introduction

This part of the report describes the AITHS follow-up on Travellers resident in institutions or communal establishments at the time of the census.

The Republic of Ireland (ROI) national census results of 2002 and 2006 suggest that very small numbers of Travellers are resident in institutions; the types of institutions with the highest numbers of Traveller residents were hospitals, hostels, shelters, refuges and prisons (Central Statistics Office, 2004 and 2007c) (Table 1).

Table 1: Travellers enumerated in communal establishments in ROI censuses 2002 and 2006

Type of establishment	No of Institutions ¹		Total enumerated ¹		Travellers enumerated ¹		Travellers as % of total in Institution	
	2002	2006	2002	2006	2002	2006	2002	2006
Prison	20	15	3,237	3,133	194	145	5.9%	4.6%
Hospital	229	244	23,219	22,689	160	110	0.7%	0.5%
Shelter/Refuge/ Hostel	384	189	7,472	5,681	113	81	1.5%	1.4%

¹Source of data: Irish censuses 2002 and 2006 (CSO, 2003b, 2004, 2007b, 2007c)

Extending the study to Travellers resident in institutions posed a challenge due to the low numbers of Travellers and the large numbers of institutions.

Inpatient stays in hospitals are temporary and normally relatively short, and in the absence of an ethnic identifier within hospital data systems, identification of Travellers in hospital and consequent follow-up was not possible or feasible. The need for an ethnic identifier for this purpose has previously been highlighted (Traveller Health Unit Eastern Region, 2000).

It is recognised that there is a difference between homelessness and inadequate accommodation for Travellers, that Travellers present to homeless services and that homelessness is a growing issue for Travellers; however, the extent of the problem is not fully known (Pavee Point, 2006). Due to lack of an ethnic identifier or ethnic monitoring within homeless services, and the likelihood that Travellers who are homeless are cut off from their families, Travellers in hostels are difficult to identify, even by the homeless service providers themselves (Kennedy, 2007).

Travellers are over-represented in young people leaving state care in ROI, accounting for 9% of those leaving the care of Health Boards and 12% of those leaving the care of the Special Schools system (Kelleher *et al.*, 2000). Travellers constituted approximately 12% of the total male Detention School population between 1991 and 2007 (Carr, 2009). Despite this over-representation, identification of Travellers in this population at any given time is not feasible.

Irish Traveller is not a category within the Irish Prison Service IPS data management system; however, it is known that Travellers are over-represented in the prison population. In the 2002 and 2006 Censuses, while Travellers represented approximately half of one percent of the total ROI population, Traveller prisoners (Table 1) comprised 5.9% and 4.6% respectively of the prisoner population (Central Statistics Office, 2003b, 2004 and 2007b, 2007c). Routine prison statistics do not identify Travellers in prison, thus Irish Travellers are likely to be counted as having Irish or UK nationality. This comprises 92.2% of ROI prisoners (Irish Prison Service, 2009a). However, the Forensic Mental Health Service (FMHS) routinely establish ethnicity, and in a study of 352 committals to Cloverhill prison over a 4-week period in 2000, Travellers accounted for 6% of male and 4% of female committals, and male and female Travellers had a relative risk of imprisonment compared to the settled community of 17.4 (95% CI 2.3-131.4) and 12.9 (95% CI 1.7-96.7) respectively (Linehan *et al.*, 2002). In 2002, 4.2% of remand prisoners self-identified as Travellers (Linehan *et al.*, 2005). In a 2003 study, Travellers were over-represented among both male sentenced and remand committals accounting for 5.4% of the sample, and among female committals accounting for 10.6% of the sample; both proportions compared to 0.6% in the community (Kennedy *et al.*, 2005).

The majority of the AITHS census survey of Irish Traveller families in ROI was carried out during a 6-week period commencing 14th October, 2008. A census question asked participating Travellers whether any of their family members was resident in an institution during the time period of the census. The range of possible institutions included: hospitals, long-term care (nursing homes), children's homes/in care, psychiatric care, hostels, Bed and Breakfast (B&B) accommodation, refuges, respite care, prisons, corrective institutions and homeless institutions. Results for ROI are shown in Table 2.

Table 2: Travellers in institutions in ROI as reported by Travellers in AITHS ROI census 2008

	Numbers in Institution	% of total Traveller Population ¹
Hospital	57	0.16
Long term care	65	0.18
Children's Home	41	0.11
Psychiatric care (Mental Hospital)	27	0.07
Hostel	13	0.04
Bed & Breakfast	3	< 0.01
Prison	168	0.46
Homeless	13	0.04
Corrective institution for young people	3	< 0.01

¹ Source: AITHS Census report: Traveller population 36,224

The AITHS census results are consistent with national censuses in ROI for 2002 and 2006, which enumerated very small numbers of Travellers in hospitals (160 and 110 respectively) and nursing/children's

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homes (63 and 67 respectively) relative to the number of such institutions in the country. The numbers of Travellers in hotels, B&Bs and educational establishments were in single digits. Even if the numbers were greater, or the number of institutions smaller, in the absence of an ethnic identifier it was not feasible to ask persons in charge of most institutions to undertake a census of the number of Travellers in their institution. This was identified as an area which would prove challenging in the demographic advice provided for the AITHS project (Kobayashi, 2006).

Census reports in Northern Ireland (NI) provide information on the population that are resident in communal establishments (1.4%) and the proportion of the full population that are Irish Travellers (0.1%); however, the proportion of institutional residents that are Irish Travellers is not reported (Northern Ireland Statistics and Research Agency, 2002). The average number of prisoners in custody in NI in 2008 was 1,493, comprising 1,442 men and 51 women (Northern Ireland Prison Service, 2009). The number of institutional residents likely to be Irish Travellers was too low to permit follow up in institutions in NI (Northern Ireland Statistics and Research Agency, 2002).

The 2006 ROI census identified that the largest number of Travellers were located in shelters/refuges (81) and prisons (144). The lack of ethnic identifier in homeless accommodation (Pavee Point, 2006) precluded any follow-up in that domain. Despite a recommendation to the Irish Prison Service in 2002 that the ethnic origin of all inmates, including Travellers, be recorded on reception (Fitzpatrick and Associates, 2002), the sub-category of Irish Traveller has not been included in the IPS database.

Use of an ethnic identifier to facilitate data collection and planning for Irish Travellers in a variety of institutional contexts from hospitals to homeless shelters and within the prison and forensic mental health systems, has been called for by stakeholder and research groups (Fitzpatrick and Associates, 2002; Linehan *et al.*, 2002; Kennedy *et al.*, 2005; Fountain, 2006; Pavee Point, 2006) and its absence limited the opportunities to extend the study to all institutions. However, because of the available information about the ROI Irish Traveller prison population (Central Statistics Office, 2004, 2007c and Kennedy *et al.*, 2005), and because prisoners often self-identify by asking to be accommodated near to other members of the community, this part of the study focused on a census, and the health status, of Travellers resident in adult prisons in ROI.

2. Prisoner Health

Health in prisons is a priority of global public and population health (Møller *et al.*, 2007). In this section, the literature relating to general prisoner health is reviewed, with reference to the situation in Ireland and among Travellers where information exists. Ethnic minorities are over-represented in prisons globally, and information on recognized minorities, such as Australian Aboriginals and New Zealand Maori is provided where relevant. An overview of the prison health services, which is delivered in a different manner to the health service for the general community, is also provided.

2.1 Health Problems of Prisoners

In the UK, Watson *et al.* (2004) identified the main prison health themes in the international literature as mental health, substance abuse and communicable diseases, recognising that these 3 themes are inextricably linked. They reported that prisoners bring a wide spectrum of health problems to prison, such as mental health problems, substance abuse, smoking, and communicable diseases, including hepatitis and HIV, and that the prevalence is often greater than in the general population. In addition, prisoners were also at risk of a number of health problems while in prison. Harris *et al.* (2006), in a wide-ranging literature review on the health needs of prisoners in England and Wales, found that prisoners were more likely to have suffered from some form of social exclusion than the general population and from significantly greater degrees of mental health problems, substance abuse and worse physical health. It was also noted that most of the literature on the health needs of prisoners addresses the health needs of all prisoners, thus focusing on the needs of the majority prison population of young white males; the needs of discrete groups, such as women, older prisoners and ethnic minorities may thus be limited when planning healthcare in prisons.

The first general healthcare study of the Irish (ROI) prison population (Centre for Health Promotion Studies NUI Galway, 2000), which had a high response rate of 88%, found differences in health status between prisoners and the general population, including lower self-reported levels of excellent or very good health. Other relevant differences highlighted were higher rates of current cigarette smoking, lifetime drug use and alcohol consumption among prisoners. While diet was comparable to the general population, exercise patterns were better. However, a considerable burden of chronic illness was noted despite the prison population being relatively young (mean age 27 years, and 70% aged less than 35 years). The study found high intake of prescription medication and high consultation rates with prison health services. It confirmed mental health, addiction, and infectious diseases as priority issues, and primary health care, including health promotion, as priority health needs for prisoners. Almost a third of prisoners had schooling to primary level only and half of males had been unemployed prior to detention. A separate literacy survey shows that a significant number of prisoners in ROI are illiterate (Morgan and Kett, 2003). In the Irish general population education status (Kelleher *et al.*, 2003) and social disadvantage (O'Shea and Kelleher, 2001; Kelleher *et al.*, 2002; Fitz-Simon *et al.*, 2007) are known to be predictive of poor self-rated health status and this has previously been confirmed for the Irish prisoner population also (Hannon *et al.*, 2007). More recently, a study of nursing in the IPS confirmed mental health, infectious diseases, chronic diseases, health promotion, primary care, education and prevention as ongoing predominant health needs themes (Health Service Executive, 2009).

2.1.1 Mental Health in Prisons

Mental health problems among prisoners are a global issue. There is a disproportionately high rate of mental disorders in prisons, often because disorders are present prior to imprisonment, but also because mental health disorders may develop during imprisonment due to many factors, such as overcrowding, solitude or lack of privacy (World Health Organisation, 2005). Research in this area tends to focus on the prevalence of mental health disorders among prisoners compared to the general community. Fazel and Danesh (2002) carried out a systematic review of 62 surveys involving 23,000 prisoners from 12 different countries, which confirmed that the mental health of prisoners is an international problem of increasing proportions; while rates varied, prisoners were 2 to 4 times more likely to have psychosis and major depression and 10 times more likely to have anti-social personality disorder than the general population. A systematic review (Sirdifield *et al.*, 2009), based mostly on UK research, but which also included international studies, found that the literature reported a wide range of prevalence rates for the major mental health disorders in prisons, and that this possibly resulted from the use of different diagnostic screening tools, including self-reports. However, a common pattern was that the incidence of mental health disorders was often found to be higher in women and in ethnic minority groups.

A survey of prisoners in England and Wales (Singleton *et al.*, 1998) found that while prisoners represented only 0.1% of society, most prisoners had mental health problems, with only 10% of prisoners showing no evidence of any of 5 disorders considered in the survey (personality disorder, psychosis, neurosis, alcohol misuse and drug dependence) and 70% with more than one of the listed disorders, with higher prevalence for each disorder than in a similar survey of the general population. The rate of diagnosed mental health problems among black and ethnic minority prisoners was lower than among white prisoners. In Australia prevalence of any psychiatric disorder among prisoners is 80% compared to 30% in the community (White and Whiteford, 2006).

In New Zealand, despite over-representation within prison, no significant differences were found in lifetime rates of mental disorder between Māori and other ethnic groups (Tapsell and Mellsop, 2007). In a qualitative study of mental health in prisons in the English Midlands, Durcan (2008) identified a wide variety of issues impacting on mental health for prisoners including (a) pre-prison: chaotic lives prior to being in prison, often including abuse and homelessness, and a history of mental ill-health; (b) prisoner experiences: being in prison, separation, bullying, lack of someone to trust, self-harm, worries about children, having nothing to do; and (c) gaps in service provision including poor mental health screening and limited support for prisoners' mental health. On a positive note, inreach services were found to be making a difference.

In ROI, mental health issues among prisoners were noted in the General Healthcare Study of Prisoners (Centre for Health Promotion Studies NUI Galway, 2000), with nearly half of men and 75% of women prisoners considered 'cases' (using General Health Questionnaire-12), i.e. may be significantly in need of psychiatric treatment, and 37% of men and 64% of women prisoners describing themselves as moderately or extremely anxious or depressed. Issues for Irish prisoners' mental health were most recently highlighted in the Report of the Expert Group on Mental Health Policy – A Vision for Change

(Department of Health and Children, 2006), which described the role of the Forensic Mental Health Services (FMHS), which is primarily concerned with the mental health of persons who come into contact with law enforcement agencies, the Garda Síochána, the Courts and the Prison Service. The FMHS operates an inreach service to prisons, with psychiatrists and forensic nurses visiting prisons on a routine basis, and arranging transfers to the Central Mental Hospital or other psychiatric hospitals as necessary.

Prisons also provide services in the areas of psychology service and social work (probation and welfare) which are relevant to mental health. Research carried out by the FMHS demonstrates the extent of mental health problems among prisoners: 19% of remand prisoners suffered from a mental illness, adjustment disorder or personality disorder during the screening process; 22% had been mentally ill in the 6 months prior to screening, and 31% had a lifetime psychiatric diagnosis (Linehan *et al.*, 2005). In another study rates for all mental illnesses combined ranged from 16% (committals) to 27% (sentenced) for men, and 41% (committals) to 60% (sentenced) in women; rates of psychosis were 3.9% for male committals to prison, 7.6% among those on remand and 2% among sentenced men; the rate of psychosis for women was 5.4% (Kennedy *et al.*, 2005). Linehan *et al.* (2005) found that 28% of remand prisoners had a lifetime history of deliberate self-harm. Prisoners were also found to have greater mental health co-morbidity and it was noted in FMHS studies that there is over-representation of Traveller and homeless populations within prisons.

Cemlyn *et al.* (2009) reported that, despite no supporting official statistics, in the UK staff that work with prisoners consider that Travellers and Gypsies are over-represented in prison suicides. In ROI prisons, 29 of the 43 deaths in custody between 1988 and 1996 were suicides, giving an average of 3 per year; this showed an increase on the average of 1 per year for the period 1980 to 1987 (Dooley, 1997). Of the 75 deaths in prisons between 2000 and 2008, 18 were confirmed suicides, and some inquest results are pending (Irish Prison Service, 2009a). There is no mention of any Traveller deaths in prison, possibly due to lack of an ethnic identifier, however Traveller groups have noted that Travellers in prison are a high-risk group for suicide (Pavee Point, 2005).

Traveller prisoners' mental health has been specifically highlighted in a number of the studies carried out by the FMHS (Linehan *et al.*, 2002; Kennedy *et al.*, 2005; Linehan *et al.*, 2005; Duffy *et al.*, 2006). In reviewing the case register of admissions for the three years 1997 to 1999, Travellers accounted for 3.4% of forensic psychiatric admissions compared to 0.38% of the general population at that time; it was noted that the over-representation in psychiatric admissions reflected an over-representation of Travellers among prison committals. Travellers were found to have more learning disability and less severe mental illness than other groups studied (Linehan *et al.*, 2002).

2.1.2 Substance Abuse in Prisons

Sirdifield's systematic review found that alcohol misuse is a major issue in prisons worldwide in addition to drug misuse, with studies reporting up to 67% of prisoners with a substance abuse disorder; furthermore, many offenders have used drugs during their current sentence (Sirdifield *et al.*, 2009). In Ireland, Dooley (1997) estimated the proportion of the prison population with a recent background of

major drug abuse at over 40%. The General Healthcare Study of Prisoners (Centre for Health Promotion Studies NUI Galway, 2000) identified that 72% of male and 83% of female prisoners had taken drugs at some stage in their lives, while 63% of males and 83% of female prisoners had taken drugs other than cannabis and marijuana within the previous 12 months. The report also noted that prisoners tended to be heavier and more frequent drinkers than the general population. Nearly half of Irish prisoners with a history of injecting drugs continued to do so while in prison, and 21% of prisoners who used drugs reported that they had started to inject while in prison (Allwright *et al.*, 2000). Linehan *et al.* (2005) and Kennedy *et al.* (2005) reported between 61% and 79% of prisoners to be addicted to alcohol or other drugs.

Among Traveller prisoners the relative risk of self-reported drugs and alcohol problems combined for remand Traveller prisoners in contrast to remand white European prisoners was 1.46 (95% CI 1.11-1.9) (Linehan *et al.*, 2002). In a study of remand prisoners, all Travellers interviewed had a history of alcohol dependence and abuse and 98% had a lifetime history of substance abuse disorders (Kennedy *et al.*, 2005).

The National Drugs Strategy (interim 2009-2016) identifies both prisoners and Travellers as at-risk groups and target groups for intervention, treatment and rehabilitation (Department of Community, Rural and Gaeltacht Affairs, 2009). The strategy acknowledges the limited data available on the number of Travellers who present for drug treatment. Fountain (2006) acknowledged the difficulty in ascertaining prevalence due to lack of an ethnic identifier but reported that while usage appeared to be lower, the geographic prevalence pattern among Travellers broadly mirrors national prevalence patterns of the general population. In focus group and one-to-one interviews with Traveller prisoners, Fountain reported that the perception among participants was that access to drugs is easier in prisons and that many Travellers take drugs for the first time in prison or increase their use of drugs while inside. The report also noted that the issues related to drugs and Travellers are closely associated with marginalisation and inequality, therefore Travellers are more likely to be exposed to the risk factors that lead to drug use.

2.1.3 Communicable Diseases in Prisons

The problem of HIV/AIDS in prisons is an international problem and Watson *et al.* (2004) present evidence of this from studies carried out in Africa, Australia, Ireland, Pakistan, Spain, UK and USA, with high prevalence rates reported. Other communicable diseases noted internationally include syphilis, hepatitis and tuberculosis (TB). In ROI, 9% of Irish prisoners were infected with hepatitis B, 37% with hepatitis C and 2% with HIV (Allwright *et al.*, 2000).

2.1.4 Chronic Disease in Prisons

While the prisoner population tends to be relatively young, being in prison can in itself be a health hazard, and prisoners tend to lead lifestyles that are more likely to put them at risk of ill health. Chronic diseases such as lung disease, heart disease, diabetes, epilepsy, diseases of the reproductive system and cancer are common problems in prisons worldwide (Møller *et al.*, 2007).

In Ireland, the NUI Galway study on prisoner health reported that the rate of self-reported general health as being excellent or very good was 29% for male prisoners and 16% for females; while the majority of prisoners were mobile (85%) and self-caring (97%), 42% of men and 59% of women prisoners reported moderate or extreme pain or discomfort (Centre for Health Promotion Studies, 2000). 22% of males and 29% of females reported a long-standing illness, and in male prisoners this was associated with older age groups, poor self-reported health and shorter sentences. Intake of prescription medications among Irish prisoners was high (30% male and 74% female). In all cases prisoners had poorer health status than the general population. The vast majority of prisoners were current cigarette smokers (91% men and 100% women) (Centre for Health Promotion Studies, 2000). A number of factors were identified, which were independently predictive of poor self-rated health: level of education, General Health Questionnaire (GHQ) Psychiatric caseness, prescribed medication, chronic self-limiting illness and reported verbal abuse by prison officers (Hannon *et al.*, 2007).

In New South Wales, despite Aboriginals being over-represented in the prison population, few significant differences were found between Aboriginal and non-Aboriginal prisoner health status across a range of self-reported physical and mental health measures, despite significant differences in socio-demographic factors; both male and female Aboriginals rated their health more positively than non-Aboriginals, although not significantly so (Kariminia *et al.*, 2007).

2.2 Healthcare Provision in Prisons

The WHO (Møller *et al.*, 2007) advocates that that people who are in prison have the same right to healthcare as everyone else, and there are numerous international standards to support this. Close links between prison-administered health services and public health are recommended and some countries have begun to move prison health towards being part of the general health services of the country rather than under the responsibility of the prisons (Møller *et al.*, 2007) thus totally separating custodial/disciplinary and healthcare functions. Health-promoting prisons and primary health care are high priorities for prison health services globally. In the UK, the drive for improvement of prison health services has led to primary care trusts (National Health Service [NHS]) taking over responsibility for commissioning or providing healthcare for prisoners in their area (Harris *et al.*, 2006).

In Ireland, the Irish Prison Service (IPS) has a statutory responsibility for provision of primary healthcare services in each prison under part 10 of the Prison Rules (Department of Justice, Equality and Law Reform, 2007). There have been major developments and improvements in IPS healthcare services in recent years.

2.2.1 Irish Prison Healthcare Services

An expert group was set up in 1999 to review structures and organisation of prison health care services in Ireland following recognition in a series of reports over the previous decade that healthcare provision in Irish prisons was failing to keep up with international standards, evidenced by factors such as an absence of nurses and the limited number of hours during which doctors were present (Health Service Executive, 2009).

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The 'Report of the Group to Review the Structure and Organisation of Prison Healthcare Services' (Irish Prison Service, 2001), referred to as the Olden Report, recommended that there should be equivalence of care between the prison population and the general population, development of healthcare standards, and a multidisciplinary approach. This report noted the disproportionate representation of Travellers in prison, and that prisons facilitate accommodating Traveller prisoners in shared cells in recognition that Travellers cope poorly with the stresses associated with close confinement in prison. The report recommended that special prisoner groups should receive special attention from health care staff, and in the context of this recommendation, suggested, because of the nomadic nature of Travellers, that a primary aim of prison health care should be to seek to remedy existing health deficits while Travellers were in prison and to establish the links for Travellers with healthcare structures in the general community.

The recommendations of the Olden report are noted in the national health strategy 'Quality and Fairness, a Health System for You' and advancement of the report's recommendations is one of the sub-objectives under the strategy's target to reduce health inequalities (Department of Health and Children, 2001). A Prison Health Working Group was established in 2002 and comprised representation from the Irish Prison Service, Department of Justice, Equality and Law Reform, Department of Health and Children and Health Boards. Under the auspices of this group a Needs Assessment was established to assess the primary healthcare needs of the prison population and the 'Irish Prison Health Care Needs Assessment' was published in 2003 (Irish Prison Service, 2003). It recommended that the Irish prison health care service should reflect the Irish Primary Care Strategy model and recommended improvement in many areas such as governance, human resources, services, and others. The need to address the special needs of minority groups, such as women, juveniles and ethnic minorities is noted; no specific reference is made to Travellers. With the exception of the 2001 Olden report, Traveller prisoners are neither noted as a separate group, nor singled out for comment in most Irish Prison Service health-related documentation.

Following implementation of many of the recommendations of the 2003 'Needs Assessment' report, there has been an increase in both the range of services and the human resources available to the healthcare directorate, and this is evidenced in individual prisons with services such as: the implementation of a nursing management structure, professional pharmacy services, addiction counselling services, addiction nursing and other specialised nursing posts, and the provision of a variety of inreach services, in the domains of dental, mental and addiction services. Visiting committee reports for 2008 (Department of Justice, Equality and Law Reform, 2008 a-n) make reference to overall health services, mainly commenting on resources provided, including new resources, and improvements required, and to recent improvements in the services. In particular, note is made in a number of reports about increase in healthcare staff resources (nurses, nurse managers, psychologists, addiction counsellors), and generally to improvements to drug addiction and counselling services in individual prisons. A number of reports make note of improvements to psychiatric services, including inreach services and the links with the Central Mental Hospital (CMH); only one visiting committee (Cork) noted an urgent need for improvement in mental health services. The HSE made provision for 10 additional beds in the CMH in December 2008 and 21 consultant-led inreach sessions per week are provided in Irish prisons (Irish Prison Service, 2009a). No issues associated with ethnic minorities, or Travellers, were raised in any of the 2008 visitors' reports.

The Healthcare Directorate developed a broad set of healthcare standards in 2004, and these were most recently updated in 2009; although no specific reference is made to Travellers, the standards include providing culturally appropriate healthcare (Irish Prison Service, 2009b).

In 2008, the IPS employed 20 doctors on a full or part-time basis; other specialist services are arranged by a private contract or service level agreement with the Health Service Executive. There were nurse managers in all the closed prisons and complex nurse managers in three main prisons: (Mountjoy/Dochas, Port Laoise/Midlands and Cloverhill/Wheatfield).

The IPS 2008 annual report (Irish Prison Service, 2009a) documented the significant developments for 2008 as:

- Completion of implementation of the new nursing management structure;
- Introduction of professional pharmacy services to all prisons (except Cork);
- Additional beds in Central Mental Hospital (mentioned above); 21 consultant-led inreach forensic mental health sessions available weekly in all Dublin prisons, Port Laoise and Midlands prisons;
- Addiction counseling services rolled out to 13 prisons/places of detention, delivering approximately 1,000 hours per week of prisoner access to addiction counselling; addiction nursing posts were assigned to Mountjoy prison; and methadone treatment is available in 8 prisons, accessing 80% of the prison population; a consultant-led inreach addiction service is available in Cloverhill, Wheatfield and Mountjoy;
- Contract awarded for the provision of Drug Treatment Pharmacy Services in Mountjoy/Dochas;
- Publication of a Drug Treatment Clinical Policy;
- Other inreach services include dental services to the Dublin prisons;
- A focus on the introduction of the computerised Prison Medical Record System (PMRS), permitting access to prisoner medical records through a central secure electronic database, from any computer terminal within the service system, facilitating better clinical decision making.

2.2.2 Irish Prison Nursing Services

Nurses were first recruited to the IPS in a full-time capacity in 1999, and in 2008 there were 117 nurses employed nationally (Health Service Executive, 2009). The key services currently provided are primary care and chronic disease management, addiction and mental health services (Irish Prison Service, 2009a). In the UK, healthcare services in prisons became part of the National Health Service (NHS) in 2006, with a requirement to provide health services of the same range and quality as the general public receives in the community (Department of Health and the Home Office, 2007). In Ireland, the role of the Health Service Executive (HSE) remains peripheral to prison healthcare delivery, however, on foot of

a recommendation of the 2001 Olden report, and because nurses deliver the majority of professional healthcare to prisoners nationally, a review of nursing in the prison service was recently published by the HSE Nursing and Midwifery Planning and Development Unit (2009), based on research carried out in partnership with the IPS. While the focus was on the role of the nurse, this report confirmed the five major health needs for prisoners as addiction, chronic illness, infectious diseases, mental health and health promotion.

2.3 Traveller Health in Irish Prisons

With the exception of the publications associated with the FMHS, there is little documented about the health status of Travellers in prison in ROI, although some work carried out in the UK reflects on issues associated with Irish Traveller prisoners that may impact health. On a positive note, in a qualitative study in the UK, Power (2004) found fitness and exercise to be a recurring theme among Irish Traveller men in prison in the UK. However, he also found evidence of negative stereotyping and racism towards Irish Travellers in British prisons and a lack of recognition of Irish Traveller ethnicity and culture. He reported highly negative attitudes and behaviours from some prison staff towards Irish Travellers in prison in the UK. Irish Traveller men in prison were often isolated from family, especially if families were nomadic, as literacy problems mitigated against communication and facilitation of visits. He also noted the lack of understanding of Traveller culture and ethnicity in British prisons with very little knowledge of Irish Travellers included in Prison Service training.

In Ireland, all new recruits that joined the Irish Prison Service since 2005 are eligible to undertake a Higher Certificate in Custodial Care, offered in Port Laoise, by Sligo Institute of Technology. Modules include social and health topics such as: Sociology and Criminology, Health and Society, Ethics, Introduction to Social Psychology, Human Rights and Prison Law, and Equality and Diversity. This training is likely to improve Irish prison officers' understanding of, and possibly reflection on, the issues that affect minority groups and the health issues associated with all prisoners.

3. Study Methodology

In 2008, the Irish Prison Service (IPS) administered 14 prisons in ROI, including 2 prisons that accommodate women. The prison population varies considerably on a daily basis; in 2008 the number of committals was 13,557 and the average daily population was 3,544, comprising 3,420 males and 124 females (Irish Prison Service, 2009a). National censuses of 2002 and 2006 show that while 0.08% of the total population of ROI were in prison on census nights, the proportion of the Irish Traveller community that was in prison was between 0.6 and 0.8%.

3.1 Irish Prison Service: Traveller Prisoner Census

In February 2009, the IPS Research Ethics Committee (REC) approved data collection for a Traveller prisoner census. Governors in the 14 ROI prisons were asked to provide the number of Traveller prisoners in their prison on 3 specific dates during the time of the AITHS community Census (14th October, 2008, 28th October, 2008 and 11th November, 2008), based on Irish Travellers who self-identified, such as by requesting to be accommodated adjacent to other members of the Traveller community. Governors were invited to provide any comment that they considered would be of interest to the aims of the study. No Traveller names were required in the data collected. The IPS subsequently provided data on the total number of prisoners in custody on the same 3 dates.

3.2 Irish Prison Service: Traveller Health Status Study

Following consultation, UCD and the IPS Healthcare Directorate agreed a protocol for extending the health status study into prisons, taking into account the constraints associated with identifying Traveller prisoners, the logistics of external researchers accessing prisoners and the availability of prison staff to accompany researchers during data collection. Methods of data collection used in previous studies were not considered feasible for logistical reasons - for example, collecting data at time of committal (Linehan *et al.*, 2002) or administering self-completion health questionnaires to prisoners (Centre for Health Promotion Studies NUI Galway, 2000). For this study the IPS disseminated promotional information targeting Traveller prisoners (information flyers and posters), and facilitated access to Traveller prisoners to 2 UCD researchers who were trained health professionals, in order to to gain Traveller prisoners' consent to collect specified data from their prison medical record. The protocol was approved by the IPS REC and an application for exemption from ethical approval was approved by the UCD Human Research Ethics Committee by July 2009. Security clearance for researchers to enter relevant prisons was received in October 2009.

For security reasons and because of lack of audiovisual facilities the dedicated Our Geels DVD could not be used in prisons. Information flyers and posters, containing images and text that would be attractive and of interest to Traveller prisoners, and of a size that was feasible for display in the prisons, were prepared in association and consultation with Pavee Point (Figures 1 and 2). Choice of prisons took into account the census estimate of Traveller prisoners in each prison and the advice of IPS staff that were familiar with local security conditions. Due to the low number of female prisoners only male prisons were included. A pilot process was carried out in a single prison between November 2009 and January 2010. An additional 3 prisons with large populations were targeted, between January and April 2010, with the aim of recruiting a sample of 100 Traveller prisoners, to allow comparative analysis.

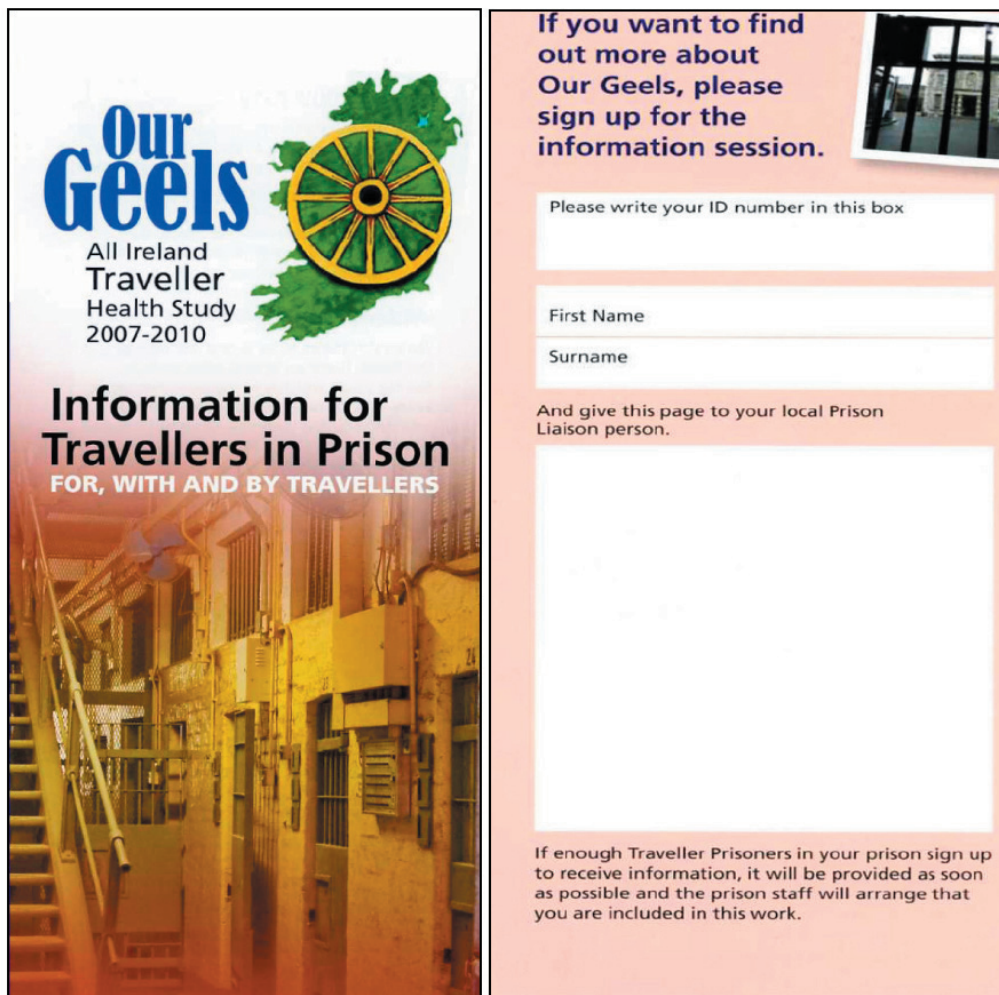
Figure 1: Information poster (A3) displayed in participating prisons



In each prison, a liaison person was appointed (in all cases a member of the IPS nursing staff), who met and was briefed by the UCD researchers, and who subsequently briefed staff and prisoners and disseminated the information documentation. Posters were displayed in common areas of the prison: food collection areas in each division, the school, library, gym, surgery and chaplaincy. The posters invited Traveller prisoners to participate in the study and to express interest by contacting the nursing staff and asking for a brochure.

Nursing staff also actively disseminated brochures. Brochures contained a page permitting interested Traveller prisoners to 'sign-up' for the information session (Figure 2). Staff were aware of and willing to accommodate prisoners with literacy difficulties. It was noted during the pilot process that Traveller prisoners had good relationships with the prison chaplains, and chaplains were subsequently included in the staff asked to communicate information about the study to relevant prisoners.

Figure 2: Cover (L) and 'sign-up' sheet (R) from the brochure disseminated in prisons



On 'Consent Day' in each prison, Traveller prisoners who had expressed interest in participating were brought either singly or in groups of 2 or 3 to a dedicated room, where researchers informed them about the project and provided a copy of the data collection form, explaining the nature and purpose of the data being sought. Questions on the form comprised a subset of the health status questions asked in the community during the AITHS. Interested participants consented in writing; consent was witnessed by 2 researchers.

UCD researchers were provided with access to relevant individual medical records to collect the data.

3.3 Qualitative and Health Service Provider Studies

The aim of the qualitative semi-structured interviews was to explore Traveller health status, uptake of health and social services, health needs and health determinants as perceived by key individuals who work with, and have knowledge of, Traveller prisoners. Three personnel relevant to the Traveller prisoner community participated: a senior member of the IPS Healthcare Directorate, a nominee of the Forensic Mental Health Services and a representative of Traveller Family Support Services in Exchange House. Interviews were held in April 2010 in accordance with the health service provider semi-structured interview protocol. Two focus groups (one male, one female) were arranged, in consultation with the Family Support Service in Exchange House, with Travellers who were ex-prisoners. Setting up the groups took some time because of the sensitivity involved in recruitment and because many Travellers that engage with Exchange House do so because they are in crisis. On the day, for a variety of reasons, none of the clients who had agreed to attend were able to do so, and it was deemed unlikely that rearranging the event would be successful.

Three key stakeholders associated with prisoner health were interviewed as part of the qualitative study, and 6 prison nurses were invited to participate in a health service provider Computer-Assisted Telephone Interview (CATI). Outcomes from prisoner-associated qualitative and health service provider input are integrated into Technical Report 3.

4. Findings

4.1 Census

14 prisons (100%) responded to the IPS census request, however, not all prisons were able to provide the requested data. Three all-male prisons, with large prisoner populations, responded that the prison information system ethnic identifier did not contain a field for Irish Travellers, and that they could not identify Traveller prisoners. Both prisons accommodating females responded, giving an average estimate of 21 female Traveller prisoners. Based on the average number of male prisoners in custody on the 3 dates, the number of male Traveller prisoners was estimated by scaling up the number of male Traveller prisoners from the 11 responding prisons, giving an estimate of 299 male Traveller prisoners (Appendix 1).

Table 3: Prisoners in custody, including estimated Traveller prisoners, by gender

	IPS Prisoners in custody (average) during census Oct/Nov 2008 ¹ n (%)	IPS estimated Traveller Prisoners in custody (average) during census Oct/Nov 2008 ² n (%)	Traveller reporting of Travellers in Prison Oct/Nov 2008 ³ n (%)
Male	3,537 (96.5%)	299 (93.4%)	150 (89.3%)
Female	129 (3.5%)	21 (6.6%)	18 (10.7%)
Total	3,666 (100%)	320 (100%)	168 (100%)

Sources: ¹Irish Prison Service; ²AITHS Prison Census Oct/Nov 2008; ³AITHS Census Oct/Nov 2008

The IPS estimate of female Traveller prisoners was very similar to that reported by Traveller families during the AITHS census; however, the IPS estimate of male Traveller prisoners was almost double that reported by Traveller families (Table 3). Based on the number of Traveller prisoners estimated by the IPS, Travellers accounted for 8.7% of the prison population; according to Traveller families' responses to the AITHS census, Travellers accounted for 4.6% of the prison population (Table 4). It is not possible to verify which source provides the true number of Travellers in prison, and subsequent analysis was carried out using both figures.

Table 4: Traveller prisoners as a proportion of all prisoners in custody

	Average number of Prisoners in custody during census Oct/Nov 2008 ¹	IPS estimates of Travellers in custody Oct/Nov 2008 ²	Traveller estimates of Travellers in custody Oct/Nov 2008 ³
		Travellers as % of prisoners in custody Oct/Nov 2008	Travellers as % of prisoners in custody Oct/Nov 2008
	n	n (%)	n (%)
Male	3,537	299 (8.5)	150 (4.2)
Female	129	21 (16.3)	18 (14.0)
Total	3,666	320 (8.7)	168 (4.6)

Sources: ¹Irish Prison Service; ²AITHS prison census Oct/Nov 2008; ³AITHS census Oct/Nov 2008

Table 5: National Census records of Traveller prisoners in custody by gender

	Total prisoners enumerated in census ¹		Traveller prisoners enumerated in census ¹		Travellers as % of total in custody ¹	
	2002	2006	2002	2006	2002	2006
Male	3,122	3,018	183	132	5.9%	4.4%
Female	115	115	11	13	9.6%	11.3%
Total	3,237	3,133	194	145	5.9%	4.6%

¹Source: National Irish censuses 2002 and 2006 (Central Statistics Office, 2003b, 2004, 2007b, 2007c)

Table 6: Risk of imprisonment

	IPS estimates of Travellers in custody			Traveller estimates of Travellers in custody		
	Risk per 10,000	Relative Risk	(95% CI)	Risk per 10,000	Relative Risk	(95% CI)
All		11.0	(9.8-12.3)		5.5	(4.7-6.4)
Travellers	89.1			46.6		
Non-Travellers	8.1			8.5		
Male		10.8	(9.6-12.2)		5.2	(4.4-6.1)
Travellers	169.9			84.5		
Non-Travellers	15.7			16.4		
Female		22.0	(13.8-35.1)		18.3	(11.1-30.1)
Travellers	11.5			9.8		
Non-Travellers	0.5			0.5		

Based on the IPS estimate of Traveller prisoners, the risk of a Traveller being imprisoned was 11 times that of a non-Traveller (RR 11.0, 95% CI 9.8-12.3), and for Traveller women the risk was 22 times that of non-Traveller women (RR 22.0, 95% CI 13.8 - 35.1).

When calculated using the Traveller-reported prisoner population, the risk of a Traveller being imprisoned was more than 5 times that of a non-Traveller (RR 5.5, 95% CI 4.7–6.4), and for Traveller women the risk was 18 times that of non-Traveller women (RR 18.3, 95% CI 11.1-30.1).

The relative risk of imprisonment was higher for female Travellers than for males in both analyses. In the general population men are 27 times more likely to be imprisoned than women (RR 27.5, 95% CI 23.06-32.76) (based on 2006 census), whereas Traveller men were 8 times more likely to be imprisoned than Traveller women (RR 8.6, 95% CI 5.27-14.01) (based on Traveller estimates of Travellers in prison). Sources of data for relative risk calculations are provided in Appendix 1.

4.2 Health Status Study

The recruitment process for the health status survey yielded 26 Traveller prisoners, (36% of all Travellers estimated by the IPS to be in custody in participating prisons on consent day). Most prisoners who attended the session had not previously heard of the study through their families. While every Traveller that attended the information session consented, it became evident as the process progressed that many Traveller prisoners were either unable or reluctant to attend. The reasons for this were varied. Some Travellers that had expressed interest in advance were otherwise engaged when the researchers were present (for example in court or with visitors). To circumvent this, researchers visited the prisons at the weekend (no visitors or official business on Sundays); however, many simply declined to attend on the day. On the other hand, some Travellers who had not expressed interest in attending did so when a friend or cellmate returned from the information session and encouraged them to participate. During the information session, a number of Travellers expressed concerns, such as whether participation (or not) would affect a pending temporary release, whether the Governor might see their medical history, or whether this study was linked to random drug testing. Some prisoners expressed a preference to telling the researchers their medical history over it being taken from their record. One prisoner expressed willingness to participate because he '...had nothing to hide'. All of these concerns were allayed and these prisoners did consent, however a potential for self-selection bias emerged. In addition, on completion of the consenting and data collection process in three prisons, and with knowledge that recruitment in the fourth prison was affected by logistical issues in the prison, it became clear that in order to achieve the target sample of 100 it would be necessary to extend the process into many more prisons, which was not feasible.

Data collection was carried out on an iterative basis, and access to the electronic medical records was provided, where possible, at the end of consent day. During data collection it was not possible to collect reliable and consistent data on all of the desired variables, in some cases because of the way the electronic system recorded medical history and in others because some data fields (e.g. smoking and drinking habits) were not completed in all records. In some cases it was possible to check consistency of data by reviewing narrative data in the records.

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Taking into account the poor response rate and incompleteness of the data for some important variables, the data collection process was discontinued.

Because the achieved sample was small ($n=26$) and not representative, the limited findings cannot be reliably compared with those from any other study, such as the NUI Galway Prisoner Health study (Centre for Health Promotion Studies, 2000), or the AITHS.

The mean and median age of the participating group was 28 years (SD 7.6), with 65% aged less than 30 years. In the total male prisoner population 53% are aged less than 30 (Irish Prison Service, 2009a). Among the 20 sentenced prisoners 65% had sentences of less than 12 months; this suggests that among those that were willing to participate, offences were relatively minor. Among all male sentenced prisoners in 2008, only 15% were serving sentences of less than 12 months (Irish Prison Service, 2009a). Based on these preliminary analyses, it was considered possible that a self-selection bias might exist among participants.

Notwithstanding that the sample was not representative of the total population of Traveller prisoners, it was noted that more than quarter of the group (27%) was documented as having been treated for a chronic disease in the previous 12 months. More than half (58%) had addiction problems and 39% had mental health problems for which they were being treated and 81% were currently taking prescription medication. Because all prisoners are routinely seen by a nurse and a doctor on committal, 100% had engaged with the medical service in the previous 12 months; the median number of interactions including committal was 8 with a nurse, and 10 with a doctor. Among the 62% who had interacted with the psychiatric services, the median number of interactions in the past 12 months was 4.5.

Table 7: Summary of Traveller prisoner health status recruitment process

Prison	A	B	C	D	Total
IPS estimates of Travellers in custody Oct / Nov 2008	Not known	30	58	30	118+
Traveller prisoners who expressed interest in advance of consent day	13	29	9	-	51
IPS estimates of Travellers in custody on consent day	16	31	25	-	72
Total number of prisoners in custody on consent day	420	552	530	-	1,502
Estimated no. of Travellers in custody as % of all prisoners in custody on consent day	3.8%	5.6%	4.7%	-	4.8%
No. of Traveller prisoners that attended the information session (no. consented)	9(9)	15 (15)	2(2)	-	26 (26)
Consent rate %: Travellers in custody who consented as % of information session attendees	100%	100%	100%	-	-
Response rate %: Travellers who consented as % of IPS estimate of Travellers in custody on consent day	56%	48%	8%	-	36%

5. Discussion

Absence of an ethnic identifier was a major barrier both to accessing and recruiting Traveller prisoners and to collecting data in institutions. Follow-up in in prisons relied on prison personnel's knowledge of Travellers' identity for the census and on active self-identification by Travellers (health status study). Three prisons specifically noted that it was difficult to identify Travellers, making comments such as '*...no separate record is maintained ...in respect of Travellers; ...we could not be sure that it would be 100% accurate (as to who is a traveler [sic])*'. However, 11 prisons did provide estimated numbers, with one commenting that '*...they are not asked nor do they disclose whether or not they are from the traveller [sic] community*', and that their numbers were based on prisoners being identified as from '*... this [Traveller] community by experience, familiarity, name, address, disposition, characteristics and so on*'. It is possible that this method of providing numbers was used by most prisons that provided numbers and may be part of the explanation for the difference in IPS and Traveller-reported male prisoner numbers. When trying to recruit Travellers to the health status study, it was necessary to rely on Traveller self-identification in response to promotional documentation and information disseminated by prison staff. Issues of trust and a history of suboptimal engagement with structured services are likely to have played a role for those that did not respond. For those that did attend the information session, a number expressed concerns around what would be done with the information and who would have access to it – mostly within the prison system.

The IPS census estimates of Traveller prisoner numbers were very close to the number reported by Traveller families for female prisoners, but not for males, where the IPS estimated number was double that reported by families. The reasons for the difference between the IPS and Traveller families' estimates of male numbers are likely to reflect the fact that the IPS had to estimate the numbers, the sensitivity around any family volunteering information that a family member is in prison or that some Traveller prisoners had become dissociated from their family. However, whether using IPS (320) or Traveller estimates (168) of Travellers in custody, Travellers were over-represented in prisons in ROI at between 4.6% and 8.7% of all prisoners in custody, a multiple of the proportion of Irish Travellers in ROI population (0.5% in 2006 Census; 0.9% in AITHS census 2008) and this is reflected in the high relative risk of imprisonment. Traveller men are at least 5 times more likely to be imprisoned than non-Travellers; Traveller women are at least 18 times more likely to be imprisoned than women in the general population.

In particular Traveller women were over-represented. The gender distribution among the Irish population and among Irish Travellers is almost half and half (plus or minus 2%) according to censuses of 2002, 2006, and the AITHS census (2008). According to the IPS Traveller Prisoner census and Traveller family reports, male Traveller prisoners accounted respectively for 8.5% and 4.2% of all male prisoners, while female Traveller prisoners respectively accounted for 16.3% and 14.0% of all female prisoners. Using either method of estimating the numbers, the risk of imprisonment for Traveller men is lower than that for Traveller women. This contrasts with the findings of the 2000 Forensic Mental Health Service (FMHS) study where male and female Travellers accounted for 6% and 4% of all male and female

prisoners respectively (Linehan *et al.*, 2002), and there are consequent differences in the relative risk of imprisonment in the 2 studies, where Linehan's relative risk for Traveller men (17.4) exceeded that for Traveller women (12.9). The difference in findings of the 2 studies may be explained by a number of differences in methodology. The FMHS study focused on committals in two Dublin-based prisons - Cloverhill, the largest remand prison, and Dochas, the larger of the 2 female facilities; Department of Environment figures were used for Traveller population statistics as the census did not collect this data at that time. However, in a later FMHS study, using different methodologies and including both sentenced and remand committals from all prisons, Irish Travellers were found to be more prevalent in remand centres outside Dublin (11.4%) compared to Cloverhill (1.6%), and the rate of female Traveller committals within all female committals (10.6%) exceeded the male committal rate (5.4%) (Kennedy *et al.*, 2005).

Minority groups are often over-represented in prison. In Australia and New Zealand, where ethnic identification is based on prisoners' preferred ethnic choice, Indigenous (Aboriginal) and Maori populations are a routine sub-group for analysis in official statistics. In Australia in 2009, 25% of all adult prisoners, (25% of male and 28% of female prisoners) were indigenous, and indigenous adults were 14 times more likely to be imprisoned relative to other Australians (Australian Bureau of Statistics, 2009). Female Aboriginal prisoners comprised 8% of all Aboriginal prisoners (Krieg, 2006). The rate of imprisonment for Maori was 5-8 times higher than for other ethnicities in New Zealand (Department of Corrections, 2008), and Maori women are particularly over-represented in comparison to other ethnicities; they comprise 60% of female offenders. Reasons proposed for over-representation include socio-economic factors, alcohol and other drug misuse and mental health problems (National Indigenous Drug and Alcohol Committee, 2009; Department of Corrections, 2008). It should be borne in mind that in this study more than 99% of Irish Travellers were not in prison.

Traveller prisoners receiving medical care prior to detention have access while in prison to medical, nursing, psychiatric pharmacy and dental services, and psychological and social supports. While supportive of health promotion in prisons, healthcare staff of the IPS pointed out that singling out any minority group for health promotion activities does not always work in a custodial setting and can risk breaching individual medical confidentiality; however, for any prisoner with a chaotic lifestyle, such as homeless prisoners or prisoners with addiction or serious mental health issues, detention in prison can provide an opportunity for compliance with treatment regimes that require, often multiple, follow-up that may not be feasible for them in the community (such as vaccination against communicable diseases or access to dental and mental health services).

Travellers and prisoners are 2 minority groups whose health is a cause for concern. Traveller prisoners have double disadvantage and are a cohort worthy of further investigation. Currently, research on Traveller prisoner health can only be easily carried out if data collection is based on all prisoners, if ethnicity is established, and Traveller health is analysed as a sub-group, or if some means of Traveller

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self-identification is used; the latter might be too much to expect within a custodial setting. Our attempt to get Traveller prisoners to single themselves out for identification failed to yield a reliable sample, though those that were assessed seemed typical of disadvantaged prisoners. Previous studies (Linehan *et al.*, 2002; Kennedy, 2005) had the benefit of the ethnic identifier used routinely on all Central Mental Hospital admissions. Including 'Irish Traveller' as a value in the existing ethnic identifier field in the prisons' IT system was recommended as part of a prisons' cultural awareness study in 2002 (Fitzpatrick and Associates, 2002), and such a move would facilitate Traveller health to be reported as part of routine high-level health status monitoring, and would also facilitate targeted recruitment of Travellers for future health research in this area.

6. Appendix 1

Estimation of Male Traveller Prisoner Population

- a) 3,537 male prisoners recorded by IPS in 14 prisons during the AITHS census (100%).
- b) 2,564 male prisoners recorded by IPS in 11 prisons during the AITHS census (72.5% of a).
- c) If 217 male Traveller prisoners estimated by IPS in 11 prisons during AITHS census comprise 72.5%, then 100% is 299.

Note: the distribution of male Traveller prisoners across all male prisons is not known, however there is no reason to expect the male Traveller distribution in the three large male prisons that did not return estimates for the census period to differ from the male Traveller distribution in prisons that did return estimates.

Relative Risk

Sources of data for calculating Relative Risk of imprisonment for Travellers as compared to non-Travellers:

- a) Total, male and female non-Traveller populations from National census 2006 minus b);
- b) Total, male and female Traveller populations from AITHS census 2008;
- c) Total, male and female prisoner populations from IPS records of average prisoners in custody during AITHS census 2008 minus d);
- d) Total, male and female Traveller prisoner populations from i) IPS estimates of Traveller prisoners during AITHS census, and ii) Traveller reports of family members in prison from AITHS census 2008.

Sources of data for calculating Relative Risk of imprisonment for Traveller males/females as compared to non-Traveller males/females:

- a) Male/female non-prisoner population from National census 2006 minus b);
- b) Male/female prisoner population from IPS records of prisoners in custody during AITHS census 2008;
- c) Male/female Traveller population from AITHS census 2008 minus d)
- d) Male/female Traveller prisoner population from Traveller reports of family members in prison, AITHS census 2008.



