National Drug Strategy 2017+

Submission

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Submission to National Drug Strategy 2017+

Dun Laoghaire Rathdown Drug and Alcohol Task Force (DLR-DATF)

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INTRODUCTION

In responding to the government's public invitation to participate in a consultation on the National Drugs Strategy, the DLR-DATF (Task Force) was conscious that it should do so in a manner that encouraged an engagement with these issues locally in the DLR area and that it ensure the process be open to encompass a broad range of issues and concerns, as reflected in the experience of personnel in the field. From the outset however, it was evident that the time available for consultation was limited, with only six weeks available to both organize a consultation and a submission.

The Task Force nonetheless decided to go ahead with a DLR consultation event and in the spirit of making it as open as possible it used a *World Café* approach whereby open-ended questions were used to help participants process their ideas, concerns and reflections on drug and alcohol issues as they impinge on DLR and the wider community, more generally. The *World Café* method is outlined on its website: http://www.theworldcafe.com/

Following this exercise held October 12th, the submission below was drafted, paying particular attention to the issues raised by those who attended the consultation, and including, where appropriate additional material and suggestions to bring clarity to the discussion and to the recommendations arising.

It is important to note that the themes, discussion and recommendations presented here are not exhaustive, but they do nonetheless provide a focus on what is important for now and in addition to including them in this submission the Task Force will continue the process of engagement with these themes irrespective of outcomes from the national process. The headings in this submission:

1. Communities
2. Child, youth and family support and interventions
3. Adult treatment
4. Research
5. Alcohol
6. Clarifying policy
7. Summary of recommendations

1. COMMUNITIES

1.1 When the building blocks for the first National Drug Strategy were first laid during the late 1990s it was accepted at all levels of government that it simply would not work without the engagement and involvement of community organisations. Indeed, twenty years ago, in 1996, the then Taoiseach, John Bruton, alongside the Minister for Local Development, Gay Mitchell TD, convened a meeting in Inchicore of the chairpersons of Local Development Companies (LDPs) in the Dublin area seeking their involvement and assistance in getting local drug task forces off the ground. At the time it was evident that serious heroin use was clustered in the disadvantaged communities that were served by LDPs and that mainstream agencies, including the health board (now HSE), the Gardai, and education and housing authorities lacked the knowledge, personnel and organizational capacities to devise, implement and oversee the interventions that were required. The community sector was called upon to provide vital assistance in establishing services, in developing outreach and in testing out-of-school education and prevention.

1.2 Meanwhile, the Community Development Programme (CDP) – at the time operated by the then Department of Social Welfare (now Social Protection) - was expanded and this helped to ensure that the most affected local communities would have local resource personnel and facilities to build local capacity, to network and to engage collectively, alongside statutory authorities, in developing an appropriate response to drugs and other related social problems.

1.3 Unfortunately the CDP, although it had some weaknesses particularly at a national support level, was wound down almost ten years ago and in DLR, as in other areas, it was subsumed under the work of local partnership companies, which gradually experienced an eroding of their designated community funding base. Under SICAP – the current mainstream programme for local partnerships - the model of community engagement has changed significantly from what it was, and the emphasis on building collective community capacity and networking has suffered greatly from the loss of designated funds thereby creating a strong sense that local connections have been lost, that it appears no longer legitimate for community groups to network, and that developments at local level are being dictated by either external bodies or by internally malign forces.

1.4 In DLR, as in other areas, such developments have weakened the overall position of preventive strategies particularly in relation to community engagement, thereby limiting their ability to mobilise and assist community efforts. There are concerns that in the absence of coherent community structures, local communities experience further fear, and as a result additional criminality thrives and hidden harms arising from addiction to children and young people remain undetected. Of further concern is that with the withdrawal of vital community resources, local people have become disengaged from the problem and lack belief in their own capacities to address it, to take ownership and to formulate responses, as appropriate.

1.5 It is a given that families that need them the most do not attend support services, which is why it is so important that community networking takes place, to reach out to these families, to build relationships and to tap into their own potential and

resources to get them involved in community matters, and ultimately to attend local services, as described in relevant sections below. In the absence of resources to support such basic engagement, community members simply will not sign up to an involvement in community response efforts, and the conditions that contribute to drug use in the first instance will remain and exacerbate the problems further.

1.6 The effective mobilization of people requires that communities be resourced so that members avoid a blaming and stigmatizing approach, that they develop insights into both individual and wider effects of addiction, and that they are able to dispel the many and dangerous myths that are associated with addiction and that easily thrive when there is little effective leadership. Long-term, the absence of leadership and of the resources to support it will have further negative impact on community protection, and on the ability of community groups and personnel both to curtail local drug dealing and anti-social behaviour, and to provide meaningful supports to recovering drug users and their families.

1.7 Taking the above points into account it is be welcomed that the new Minister of State for the National Drug Strategy in the Department of Health, Catherine Byrne, TD, has also been assigned responsibility for *communities* in the Department of Housing, Planning, Community and Local Government. **It is recommended that the Community Development Programme be restored as a mechanism to provide social capital development resources to small disadvantaged communities, particularly those where drug problems are evident. It is further recommended that a revised programme would recruit, at local government level, support personnel relevant to the complex task of promoting and developing community engagement.** While evidently progress is being made in developing structures to support such arrangements, for example LCDC and PPNs, the absence of a direct funding programme, similar to the Community Development Programme, will seriously curtail this work into the future.

CHILD, YOUTH AND FAMILY SUPPORT AND INTERVENTIONS

1.8 There is a lot more known today about education and prevention programmes and their effectiveness than at the outset of this problem two decades ago; two general models have evolved – one inside schools and the other outside, and the DATF obviously is more concerned with the latter, as many young people who come to the attention of local services and projects have left school at leaving age or earlier. The Task Force recognizes there is an ongoing challenge of trying to design an engagement with young people who are not in school, who are not on courses, and who have already become exposed to damaging behavior in relation to alcohol and/or drugs.

1.9 In the DATF's 2014/15 review it decided that the limited resources available should be dedicated more at the upper end of the curve of prevention; thus we have recommended assigning limited resources only to programmes to young people and families where the impact of either personal or familial addiction are

already evident, and where a keyworker response is warranted. In adopting this approach we are conscious there are many calls from community members and others for further investment into broader prevention and early interventions, and we also acknowledge the need to ensure that adult family members of substance misusers often require intensive interventions in their own right. While the Task Force would support these calls, in principle, it believes nonetheless that it needs to act in accordance with considered priorities and that a targeting of those at most risk, and / or whose presenting needs are greatest is justified.

1.10 *Early interventions*

We support the need for early intervention and we hold that the main responsibility in this field is with education and child welfare and in this regard we welcome the work undertaken by Tusla's Prevention Partnership and Family Support Programme in promoting and developing local partnerships to support early intervention. To date in DLR quite a lot has been achieved in relation to structures through this programme and also in relation to training. However, progress in this work risks being jeopardised by the absence of additional resources to support community services development at local level, particularly through projects such as Mounttown Neighbourhood Youth & Family Projects, Barnardos, Springboard and the Family Resource Centres in Balally, Ballyogan, Hillview and Rosemount. **It is recommended that child and family services acquire additional funding, principally through Tusla – Child & Family Agency, in order to operate the basic early intervention, and early years' programmes that are required.**

1.11 *Youth interventions*

In relation to direct interventions with youth it has been this DATF's contention that the ETBs through YPFSF and other funding mechanisms need to support different interventions for young people at different levels of risk and in varying contexts. Taking this approach into account the Task Force assigned a significant YPFSF prevention and education resource directly to Southside Travellers for an initial two years (with a review process). We expect that in due course this arrangement will help illustrate the contextual issues in trying to prevent drug and alcohol problems within the Traveller community. However, this is the only prevention and education resource of this type available to the Task Force and there are other demands for its use. **It is recommended that a new, designated youth prevention resource for Travellers and other minority groups be made available.**

2.5 The Task Force has also re-assigned resources from generalized prevention to develop a targeted Youth Prevention Programme (tier 2/3 in the 4-tier model for adolescent services development), whose focus is on direct engagement of and intervention with under 18s who are at high levels of social risk with respect to substance misuse and associated problems; including of course, young people, whose substance misuse has already caused significant problems in their lives. The problem for the Task Force is simply that there are not enough personnel / resources for this high level activity; a related problem is the need to train-up professional youth work personnel so that they can perform appropriately and with competence within these roles. The Task Force is particularly concerned with reported increases in high level cannabis use among young people, alongside

poly-drug use and that many of those who are already showing harmful effects are not presenting to services, and may not do so for some time. We believe it will require exceptional outreach and youth engagement skills to develop an appropriate response with these groups. **It is recommended that additional funding lines be established to enable DATFs acquire youth intervention personnel at these levels; and it is also recommended that new forms of accredited training be made available to existing youth work personnel to enable them to acquire additional skills for one to one interventions with young people with substance misuse problems.**

1.12 *Prioritising tier 2-3 interventions*

The issue of residential beds for young people is often raised in discussions, especially with community groups and parents. The Task Force however, is aware, through the experience of funded projects that the actual demand for such services is not high; indeed it is suggested that prior to developing residential beds (tier 4 interventions) other tier 2-3 interventions need to be in place. Two years ago the HSE brought together Bray, DLR and East Coast Task Forces with a view to develop a YODA-type tier 3 service for these three catchment areas. However, shortly after the HSE discovered that the resources it thought would be there to support this proposal were no longer there. The DLR DATF has heard nothing from the HSE in relation to this matter since.

1.13 It is our view that there is a sustainable argument to support a YODA-type tier 3 service in every CHO in the Greater Dublin area (i.e. including Dublin county, Kildare and Wicklow), and perhaps others incorporating a wider catchment outside Dublin, i.e. 2-3 CHOs. This option needs to be pursued prior to any further expansion of residential services for young people. Quite apart from the arguments above, residential treatment for people under 18 should only ever be pursued as a last resort, especially when particular account is taken of the history (both distant and recent) of systemic abuse in Ireland's residential settings. And, of course, non-residential treatment is much cheaper. **It is recommended that whatever additional resources become available for providing treatment services for young people be invested in tier 2-3 services, such as community youth intervention personnel at local DATF levels and YODA-type programmes on a CHO level.** There should be no further investment in residential services for young people until an adequate level of tier 2-3 services has been achieved.

1.14 *Family support and interventions*

The DATF's experience of family support has two dimensions: on the one hand issues arise in relation to the adult family members of a person who has presented with a substance misuse problem, while on the other, child welfare issues often arise within the direct context of parental addiction.

1.15 <u>Peer support</u>

The Task Force views the first level of supports as being provided primarily through self-organised networks, such as the National Family Support Network and its regional constituent members; it is also evident however that many individual family members – parents and especially carers, require intensive one-to-one interventions and supports for dealing with presenting issues. In DLR the Community Addiction Service, CAT also provides facilities to the regional parent

support network for hosting meetings, self-help groups etc. It is evident however, that family support groups need additional supports, particularly in relation to self-organised training, and also to put into place intensive, individual supports as required. **It is recommended that a peer-group funding line be established, whereby either the national family support network becomes a conduit for distributing grants to local support groups and networks, or alternatively a ring-fenced funding scheme is assigned to task forces for this purpose, thereby increasing both group and individual supports to parents, carers, and other family members.** In addition the DATF would support extending this approach to developing former drug user peer support groups, particularly where such groups are trying to promote drug-free clubs and social activities.

1.16 Family interventions

The Task Force views the second level of family supports as requiring professional, therapeutic interventions that ideally should be provided within the context of Tusla child welfare and the HSE's addiction services. Currently the Task Force also supports actions in this second arena and these are provided directly by Barnardos and Mounttown Neighbourhood Youth & Family Project; the Task Force indeed has prioritized the need to direct resources to these groups group on the basis of relative needs.

1.17 While ideally the Task Force would like to see both levels of family support operating in an integrated manner, and for the family to be perceived in its totality, such that grandparents, uncles, aunts, and so on can be mobilized to provide care and other supports, in reality support services for children have to give priority to working with the parents, and are often restricted from involving other adult family members unless they have explicit permissions to do so, or if the other family members have been assigned the direct family caring role, in which case they will be involved anyway. Bearing in mind that parental consent and involvement can be contentious, this is a very sensitive area of work and it is the experience of Task Force supported projects that a high level of intensity is required to intervene with complex family issues.

1.18 Given the issues involved, the fact that in some instances family support personnel are responding to inter-generational addictions and traumas, it is clear that more intensive funding is required. It is a matter of concern that Tusla is currently unable to provide reliable data on the extent to which addictions arise as an issue in child welfare, care and protection matters, as obviously this would help in both quantifying the needs and the type of services / personnel required to respond. **It is recommended that Tusla conduct a comprehensive assessment of the impact of addictions nationally, regionally and locally and also that it increase the level and intensity of its funding of these family support services.**

2. ADULT TREATMENT

2.1 National, regional and DLR drug treatment data signify a slow fall-off in the demand for treatment of opiate problems, although in DLR this demand is less than elsewhere. Meanwhile, from the same data it has become clear there is an

increased demand for treatments for alcohol, cannabis, benzodiazepines and other non-opiate drugs, including, some of which are new and previously unknown, especially among younger persons, many of whom are from neighbourhoods and families that previously experienced serious drug problems, and continue to do so. Meanwhile, it is clear that many persons currently on opiate substitution programmes in DLR, require additional intensive housing, employment and medical supports.

2.2 These developments obviously constitute a major challenge in developing a strategic response, especially taking into account that there is only a limited role for established medical treatments for non-opiate drugs, with professional psycho-social programmes widely considered to be most relevant and also that a wider range of professionals would be required to support elderly care.

2.3 Non-specialist personnel

Although treatment of opiate misuse, especially where opiate substitution is involved, takes place primarily within specialist settings, many aspects of alcohol and other non-opiate problems can be managed through the engagement of other personnel, in primary care, emergency departments and in child and family services. Certainly training of relevant personnel in opportunistic brief interventions, and their use in practice is widely considered an effective response to substance misuse, particularly in relation to alcohol-related problems that present in primary care and in emergency settings, and the task force would support efforts to have these developed. Although DATFs can provide some leadership in this issue it more fundamentally requires health care and social care organisations to become involved. **It is recommended that both HSE and Tusla convene a high level engagement with managers and leaders to assess the prospects of mainstream health and social care personnel becoming more aware of addiction issues in their work and in playing a more direct role in its management.** We would argue furthermore, that third level training bodies need to be involved also, particularly in ensuring that health and social care personnel, across all disciplines – doctors, nurses, social workers, psychologists and others – have access to addiction modules during their professional formation. **It is recommended that the training of health and social care personnel incorporate joint training opportunities in the field of addictions.**

2.4 Continuum of care

The DATF supports the Continuum of Care model whereby individuals receive a care plan supported by a range of service providers over time and with a focus on helping the individual to successfully reintegrate into society and overcome their problems arising from substance misuse. In this regard the National Drug Rehabilitation Framework is also supported. This framework is premised on an individually-focused, integrated system of care, whereby service users, depending on their needs, have access to one or more interventions such as opiate substitution, general health services, employment placement or training, legal supports, family support, education and personal development. In addition the Task Force would emphasise that as evidence is emerging of the ageing out of persons receiving methadone treatment, the requirement for elderly care supports, particularly in relation to housing, health and social care, will be required. While the framework is conceptually supported and while many personnel in the field, including in DLR, have been part of a pilot scheme in

support of it, there appears to be a lack of engagement in its implementation, with some confusion as to who in what areas has direct responsibility to make it happen.

2.5 *Inter-agency collaboration*
In supporting the framework, the Task Force believes that a more effective strategy is required to get intervention and treatment agencies working together in a more collaborative manner and in building inter-agency relationships and practices. **It is recommended that rehabilitation coordinators be assigned by the HSE to oversee case management in each relevant catchment area.** Further, while various personnel have had access to training sessions in which the model was outlined, the Task Force has maintained there was a need for more intensive training in collaboration as a practice.

2.6 During 2015-16 the DATF, in conjunction with Southside Partnership, Community Action Network and Maynooth University operated a successful Integrated Collaborative Practice Programme (ICPP) in which 12 front line personnel participated. The programme which led to 20 ECTS at Level 8 was directly focused on developing the knowledge and skills of participants in bringing leadership to inter-agency work. The Task Force is conscious that both the National Rehabilitation Framework and Meitheal (within child and family services) are both premised on developing good inter-agency practices. We would hold that effective inter-agency practices cannot develop in the absence of integrated training, whereby personnel from different services are given the opportunity to train and learn together. We believe that training programmes such as ICPP need to be developed further, certainly within DLR we would like to be able to draw in a wider range of health and social care personnel into developing this programme further. **It is recommended that accredited collaborative practice programmes be implemented to support the National Rehabilitation Framework and other relevant inter-agency developments.**

3. RESEARCH

3.1 There is currently, apart from epidemiological research, a serious dearth of both relevant research and the means to fund same, on contemporary drug and alcohol issues in Ireland. This lack of research was particularly evident during the DATF's recent 2014/15 review and specific issues that warranted significant research investment were indicated.

3.2 It was clear for instance that while there was a need for early interventions for young people, there was a lack of knowledge of their drug-using habits and patterns and of the extent to which these registered as mild, moderate or serious in terms of prospective harms, and alongside there was an absence of research evidence of the more effective programmes and interventions, within the context of human services in Ireland.

3.3 In a similar vein, most persons currently on opiate substitution programmes in DLR are in fact ageing out and some are beginning to exhibit elderly health and social care needs, and there is a particular need for suitable domiciliary

arrangements. Again, there is an absence of robust research on the health and social care pathways of elderly drug users and it is clear that this topic will require significant research investment, perhaps in much the same way that elderly issues such as dementia care have attracted substantial research funding from both state and philanthropic sources.

3.4 Meanwhile, child and family support services in DLR also expressed concern that the harms to children and young people arising from addiction issues lacked comprehensive assessment and there was a need for researchers to address this topic.

3.5 These are just some examples of how the ongoing tackling iof substance misuse is hampered through the absence of adequate research. Given that the NACDA has really not existed, except in nominal terms, there has been no substantial funding in recent years in relation to these and other relevant topics**. It is recommended that a significant tranche of funds, perhaps over 5 years, be assigned through the HRB, to encourage research teams within universities and in other relevant institutes to submit proposals for conducing relevant research.** The HRB should incorporate the programme through a series of calls over its duration and specific research parameters could be set in advance, including for example that research proposals include a partner field agency from statutory, voluntary or community sectors, and that other public and patient involvement (PPI) requirements also be set.

4. ALCOHOL

4.1 The DATF supports the broadening of the remit of Task Forces to include alcohol. The Task Force participated in the National Community Alcohol Project (Pilot) and it currently participates in the Dormant Accounts Substance Misuse Prevention Programme, which has a specific focus on alcohol. The Task Force has incorporated alcohol into all aspects of its current Strategy, 2016-18, and more specifically it has engaged in the following:

- Developing a new substance misuse prevention sub-committee with a particular remit around alcohol
- Developing and rolling out a workshop, "You are what you drink" as a way of engaging local community and other groups in an informed discussion around alcohol related harms
- Developing community events to coincide with Alcohol Awareness Week in November
- Developing a social media programme
- Developing new publicity materials in relation to alcohol-related harms

4.2 The Task Force is unsure of the viability of these actions beyond the period of the Dormant Accounts fund, and in particular if there was to be an additional round the Task Force would like to see it extending over a longer period and it exploring (1) the development and provision of informal, alcohol-free spaces where people of all ages could assemble together to participate in routine social, recreational and similar activities and (2) the development of alcohol policies in employer organisations, commencing with those involved in providing child, youth, family

and addiction services. The Task Force believes that initiatives such as this would provide a sound basis for people to explore and reflect on the underlying reasons as to why and how alcohol harms arise. **It is recommended that a further round of Dormant Account funds be made available to support alcohol initiatives.**

4.3 It is clear there are enormous cultural difficulties in getting people and communities to focus on alcohol in the manner that they might be more willing to do so in relation to illegal drugs. The Task Force nonetheless supports the continued integration of both. It recognizes that there is considerable resistance to the inclusion of alcohol in the National Drug Strategy, and although it is repeatedly stated that alcohol is included, the Task Force believes that this inclusion needs to be specifically stated, as in the National Drug and Alcohol Strategy. The Task Force believes that not naming alcohol contributes to confusion in the field particularly among those with drug and/or alcohol problems who would seek help from funded services and programmes. **It is recommended that alcohol be specified in the title as National Drug and Alcohol Strategy**. However the Task Force believes that long term change can be achieved; it is conscious for instance that significant public health changes have come about in relation workplace smoking and also to people's attitude to alcohol within the context of road safety, and that if alcohol-related road accidents can be reduced through public policy and campaigns then it is possible to reduce other alcohol-related harms also.

5. CLARIFYING POLICY

5.1 There is confusion in relation to current policies on drugs and alcohol. For example, alcohol was added to the remit of Task Forces, who were asked to change their names to reflect this, but alcohol is not named in the title National Drug Strategy 2017+, and although it is continually stated it will be included the thrust of the discussions to date suggest that this inclusion will be nominal only. This reflects reticence and ambiguity in policy-making in relation to the role of alcohol and it remains unclear as to how alcohol policies will be reflected in the new Strategy.

5.2 Similarly, a persistence in conceptualising the use of small amounts of drugs as a criminal matter, even when front line Garda often don't do so, also adds confusion and can potentially weaken public confidence in drug policies. Indeed, the public often believes that the criminal justice system is immediately invoked when even small amounts of drugs are found, whereas this is not the case at all. The debate about decriminalizing drugs is often presented in simplistic terms and with insufficient reference to the ongoing involvement of criminal gangs in the trafficking of alcohol and tobacco, which of course are legal substances.

5.3 The absence of clear policy statements in relation to prescribed drugs within the context of drug policies is also an issue of concern, as is the absence of mental health services in dealing with substance misuse alongside other services. And, furthermore, while there is increasing evidence that generalized education and prevention efforts have limited impact, it is not always apparent that this has

been communicated to government and relevant agencies. The absence of coherent policy can lead to confusion, particularly for the general public, in relation to both policy development and its implementation.

5.4 Taking the above matters into account, **it is recommended that a new alcohol and drugs advisory group be constituted under legislation as an independent state entity with a remit to *advise* government on drug- and alcohol-related issues in Ireland, and on international developments, as they impinge on policy and other matters here.** Its terms of reference should allow it to review, in an ongoing manner, substance misuse, to consult with relevant government departments, state agencies and non-governmental organisations, to commission research, and to issue reports and make recommendations as appropriate in relation to measures such as prevalence, control, prevention, harm reduction, treatment, rehabilitation and other matters of importance.

5.5 The existing advisory group NACDA no longer functions as a distinct entity: it has a website that has not been updated in two years, and there is no evidence of it engaged in ongoing activities relevant to its previously stated role, other than as a vehicle for signing off on outstanding research. A new advisory group however, should be on a statutory footing and have a Board and Staff recruited in accordance with current public service procedures and it should also establish specific, time–limited expert committees to process particularly difficult and sensitive topics, as mentioned above. It would be hoped that by establishing such a body there would be more policy coherence and continuity in the increasingly complex field of drugs, especially now that alcohol has been added to the remit.

6. SUMMARY OF RECOMMENDATIONS

7.1 Communities

- It is recommended that the Community Development Programme be restored as a mechanism to provide social capital development resources to small disadvantaged communities, particularly those where drug problems are evident.
- It is further recommended that a revised programme would recruit, at local government level, support personnel relevant to the complex task of promoting and developing community engagement.

7.2 Child, youth and family support and interventions

- It is recommended that child and family services acquire additional funding, principally through Tusla – Child & Family Agency, in order to operate the basic early intervention, and early years' programmes that are required.
- It is recommended that a new, designated youth prevention resource for Travellers and other minority groups be made available.
- It is recommended that additional funding lines be established to enable DATFs acquire youth intervention personnel at these levels; and it is also recommended that new forms of accredited training be made available to existing youth work personnel to enable them to acquire additional skills for one to one interventions with young people with substance misuse problems.
- It is recommended that whatever additional resources become available for providing treatment services for young people be invested in tier 2-3 services, such as community youth intervention personnel at local DATF levels and YODA-type programmes on a CHO level.
- It is recommended that a peer-group funding line be established, whereby either the national family support network becomes a conduit for distributing grants to local support groups and networks, or alternatively a ring-fenced funding scheme is assigned to task forces for this purpose, thereby increasing both group and individual supports to parents, carers, and other family members.
- It is recommended that Tusla conduct a comprehensive assessment of the impact of addictions nationally, regionally and locally and also that it increase the level and intensity of its funding of these family support services.

7.3 Adult treatment

- It is recommended that both HSE and Tusla convene a high level engagement with managers and leaders to assess the prospects of mainstream health and social care personnel becoming more aware of addiction issues in their work and in playing a more direct role in its management.
- It is recommended that the training of health and social care personnel incorporate joint training opportunities in the field of addictions.
- It is recommended that rehabilitation coordinators be assigned by the HSE to oversee case management in each relevant catchment area.
- It is recommended that accredited collaborative practice programmes be implemented to support the National Rehabilitation Framework and other relevant inter-agency developments.

7.4 Research

- It is recommended that a significant tranche of funds, perhaps over 5 years, be assigned through the HRB, to encourage research teams within universities and in other relevant institutes to submit proposals for conducing relevant research.

7.5 Alcohol

- It is recommended that a further round of Dormant Account funds be made available to support alcohol initiatives.
- It is recommended that alcohol be specified in the title as National Drug and Alcohol Strategy

7.6 Clarifying policy

- It is recommended that a new alcohol and drugs advisory group be constituted under legislation as an independent state entity with a remit to *advise* government on drug- and alcohol-related issues in Ireland, and on international developments, as they impinge on policy and other matters here.