

Consultation Questions

National Pharmaceutical Drug Misuse Strategy

Read these questions in conjunction with the Discussion Paper from which they are derived.
Select and address only the items of relevance.
Retain numbering as shown below.

Question 1

Are there any other key stakeholders of relevance to the development of the NPDMS?
Australian College of Nurse Practitioners;
Aboriginal Peak bodies; and community groups
Consumer Advocacy groups such as Australian Pain Management Association; Mental Health groups such as MIND - Chronic and Pain Australia;
Prescribers of pharmaceuticals;
Educational bodies such as Heads of Schools in Universities in disciplines such as Nursing, Medicine, Psychology, Dentists, surgical podiatrists, physiotherapy, social work, allied health;
Family and carers associations;
Services for the ageing;
Department of Child Safety
Medical Rehabilitation services;
Palliative care providers;
Work cover;
Refugee and migrant health;
Aboriginal and Torres Strait Islander health .

Question 2

Are there any other significant gaps in our knowledge?
Lack of data collection and dissemination across regions, service jurisdictions and state borders impedes decision making and sensible distribution and use of resources and expertise. A move to improving data collection on a national basis and the implementation of "real time monitoring" at the point of pharmaceutical sales is necessary improve this situation and allow for a more prompt response.

However such a move needs to be tempered by the prevailing community view about what is acceptable or not. Similarly there needs to be greater understanding about the information needs of various organisations e.g. Aboriginal health services, sobering up services, detox services, ambulance services, police, GPs, Housing and community services etc.

An emerging source of supply is the Internet. Appropriate resources need to be allocated to monitor, regulate, police and understand the dynamics and mechanics of this and quantify associated trends and problems;

Lack of knowledge of the impact and use of over the counter analgesics, other medicines and drugs in refugee settings;

Data from hospitals and community based health care services.

Question 3

How do factors impacting on the social determinants of health impact on the misuse of pharmaceuticals?

Outer suburban and rural areas: Significant resourcing issues for people living and working in rural and remote areas - they are often unable to access quality information,

safe medication support and regular health care providers, as well as afford the expense of treatment and allied assistance

Poor literacy and numeracy; distance and poor access to reliable transport and timely health care services; poverty and low/no employment and unsafe housing - i.e. Lower socio economic groups: Often this group does not have adequate education or have access to education, or access to adequate health care.

Private health care: Even with private health cover, some people in this group can find the gap payments unaffordable

Prescribers working in rural and remote areas experience difficulties in accessing professional education, or being able to leave their posts as they cannot backfill their positions. Therefore, keeping them up to date on appropriate prescribing of these OTC preparations, as well education on as how to manage patients who are doctor shopping and/or bullying doctors for scripts can be difficult.

Gaols are filled with people who have alcohol and other drug issues yet there is either none (or very little) A&D treatment provided. Therefore, incarcerated people either continue with drug use inside, and/or resume their use and illegal drug related activities as soon as they are released. Incarcerated people provided a "captured audience" if they can be provided with mandatory treatment including individual counselling and group work. Research suggests that we have the same outcomes with people who are mandated into treatment and those that voluntarily attend treatment, so why not mandate all people in the gaol system with A&D related offences into treatment/counselling whilst they are incarcerated? Nurses and other allied health practitioners are the perfect disciplines to provide this treatment.

Nurse practitioners (NPs) may be able to provide services to under serviced areas. (see "other" at the end of this document for more information)

Lack of support, hope and resilience diminishes a person's capacity to cope with stress and therefore those affected are less likely to be able to use non-pharmacological interventions as alternatives to 'self managed' alcohol, medication and drug use. alcohol and other drug related brain injury affecting people's cognitive and behavioural capacity is a major barrier to their own risk prevention associated with drug use, general decision making and ability to respond well to cognitive behavioural therapy and other thinking based therapies.

Increased access and use of pharmaceuticals amongst school children "in case" of pain or inability to cope i.e. practice of analgesia in school lunch boxes. The recent National Secondary School Childrens Drug Survey has reported up to 52% x 16 yrs old female students are using OTC analgesics weekly and this has risen over the last 12 years.

Extensive discountng by 'pharmacy warehouses' of pharmaceuticals with the potential to casue dependence (possibly need to consider minimum pricing and reducing max quantities that can be purchased, for these substances).

Question 4

How do these agendas and strategies impact on Australia's responses to pharmaceutical drug misuse?

At this stage most of these agendas and reforms work independently of each other. they assume high levels of lieteracy and numeracy amongst those needing and taking OTC and prescribed medicines.

Greater controls including improved packaging and lower quantities allowed to be sold; need to be introduced regarding the availability of OTC pharmaceutical (analgesics) at the point of sale and across state borders e.g. those that have the potential to cause dangerous complications or overdose such as paracetamol and non steroidal anti-inflammatories, combinations of these containing other medicines such as aspirin or codeine; tolerance to codeine can occur from over use of (inadvertant due to pain or other reasons) can occur; and other substances that can be used in the manufacturing process of other drugs (e.g. ecstasy or amphetamines) need increased control.

Consumers of these products also require effective education and clear understandable information and directions about the safe selection and use of over-the-counter (OTC) medications (oral and topical); and prescribed medications. This should include what constitutes unsafe use and the implications and complications of such. Similarly effective support and education on alternative ways to manage life's problems and acute and chronic pain (e.g. adequate hydration can help relieve headaches, work life balance to relieve stress, accessing psychologists to deal with problems rather than take tablets as a quick fix).

In terms of people who have been misusing OTC codeine products, we need Nurse practitioners and more GPs to prescribe Suboxone in a minimally restricted setting for uncomplicated or stable clients, freeing up spaces for clinical management of complicated cases in the OTP programs; even more GPs and services/practices with Nurse Practitioners may agree to manage clients with opiate dependency who have not been injecting or using illicit opiates.

Question 5

How do the current operations of the PBS contribute to, or reduce, the misuse of pharmaceutical drugs?

PBS: Many pharmaceuticals with the potential to cause complications including tolerance and dependence are available through the PBS for a minimal cost and provide a quick and apparently easy solution to suffering. This option is often more attractive than the time, cost and energy required to find healthier problem solving options e.g. psychological intervention and social support. (It should be added that the cost of seeing a psychologist is prohibitive for many people. This barrier encourages greater reliance on the PBS for affordable medications).

Also many prescribers would seem to be unaware of their obligations when prescribing medications with the potential to cause dependence.

Concerns that some GP's do not comply with QUM principles and best practice

It would seem that some prescribers give little thought to the quantities of medication prescribed and often no monitoring;

Increase in the culture of using opioids in the first instance e.g. discharge medications from acute hospitals;

Minimal education provided to the community;

Feedback from pharmacies demonstrate their frustration and fears about unsafe and inappropriate prescribing and lack of satisfactory practices and mechanisms to alleviate risks.

Question 6

What role do police agencies and other law enforcement agencies have in responding to problems of pharmaceutical drug misuse?

Police: need access to information when responding to problems such as identity fraud

(e.g. multiple medicare cards and multiple IDs to obtain prescriptions), fraud due to stolen prescription pads, forged prescriptions to obtain the drugs and so on. This is compounded by legal problems arising from offences related to misuse of substances e.g. stealing, driving offences, (police need to be able to feed this information back to the prescribers of the substances, as well as regulatory bodies, so that the appropriate interventions can be adopted and to prevent the same problems happening repeatedly).

Chemical supply: Increased regulations on pharmaceutical and other industries to prevent access to large raw chemicals/products used in the manufacture of illicit substances

Dealing and on-selling prescription drugs: Police and law enforcement need sufficient resources to deal with issues as they arise

Funding for more drug court programs. Operating more drug courts will relieve some of the pressure on the prison system and force people with drug related issues to go through treatment for this addiction. In order for this to work, we would also need adequate funding to operate more places within residential rehabilitation treatment facilities.

Inappropriate prescribing: Education programs and penalties for doctors who continue to prescribe inappropriately are required

Question 7

To what extent are pharmaceutical drug misuse problems impacting on policing agencies in different jurisdictions

Drug dependence and intoxication can lead to a range of mental and physical health complications, and social and behavioural problems, including anti-social behaviours and crime; Relevant early intervention and targeted treatment options need to be provided and where needed, mandated for people whose problem drug use has led to serious conflict with law enforcement agencies;

Inconsistent approaches across the country and lack of timely and consistent intelligence gathering;

Lack of compulsory recruitment of pharmacists for Project Stop;

Lack of protection of pharmacies trying to comply with Project Stop;

Little incentives for police to follow up crimes associated with forgery, alterations, thefts etc.

Perception of no consequences for offenders.

Question 8

What can we learn from other countries' experiences with problems with, and responses to, pharmaceutical drug misuse?

Australia needs to learn about what works and what does not work and decide how best to adapt/apply regulatory frameworks that have been successful in other countries such as in the UK

Question 9

What, if any, unintended consequences might be expected in Australia if levels of access to medications such as opioid analgesics were to be reduced? What strategies could be put in place to avoid these unintended consequences?

A wide spread health education strategy to inform the public about the reasons for increased restrictions around the supply of opiates and options available to them is required. To support this, more resourcing and education for agencies tasked with prescribing e.g. GPs, Nurse Practitioners, and others treating dependence, is required as a way of ensuring that services deliver best practice and are accessible and culturally safe so that seeking treatment is preferable to continued use.

In terms of people who have been using OTC codeine products at harmful levels, enable GPs and A&D Nurse Practitioners to prescribe Suboxone for detoxification, in a minimally restricted setting on the provision that they are appropriately assessed and followed up.

Systems, specialist resources and funding need to be in place for patients with exceptional circumstances so that their needs can be adequately met e.g. carers of children or other dependents, disabled, elderly and/or otherwise incapacitated (sometimes it is impossible for these patients to have daily pickups or even manage with Webster packs).

Question 10

To what extent is there a current evidence/practice gap in Australia concerning the use of opioids for CNMP?

This group of people, many of whom have chronic disease such as the elderly and Aboriginal groups, have complex needs which require more treatment options than those currently available. While medications including opioids have an important place in treatment, their use needs to be carefully managed after appropriate assessment (and ongoing assessment). Non-surgical interventions with the goal of improving function, are preferable to surgical intervention. However at this time Medicare reimbursement favours the use of surgical interventions. Again resourcing and education are required to address the needs of this group of people.

More appropriate assessment for acute hospital admissions and realistic LOS;

There is minimal training for QUM or the appropriate management of persistent pain for interns, nurses, Aboriginal health workers etc

Unrealistic expectations regarding acute and chronic pain management which is fostered by media and product advertising, work and life pressures and increasing numbers of older people with acute and chronic health conditions and pain.

Question 11

To what extent is there a current evidence/practice gap in Australia concerning the use of benzodiazepines for conditions such as anxiety and insomnia?

Benzodiazepines are no longer the first line treatment for anxiety and insomnia, yet they are still widely prescribed. Alprazolam usage in particular seems to be increasing alarmingly. Education of prescribers in 'best practice' is required.

Unrealistic expectations of the population for pharmaceutical solutions to life's problems and anger towards GP's when this is not supplied;

Lack of resources for non-pharmaceutical approaches;

Lack of adequately trained A&D nurses to monitor Benzodiazepine reductions;

Lack of GP's willing to prescribe for Benzodiazepine reduction;

Lack of funded positions for A&D Nurse Practitioners to assist GPs and doctors to assess, monitor and prescribe for uncomplicated detoxification regimens

Lack of research for use of withdrawal medication such as flumazenil.

Question 12

Is there other evidence of harms stemming from pharmaceutical misuse?

As the discussion paper outlines there is ample evidence of health and social harm as a result of pharmaceutical misuse regardless of whether the source of the pharmaceuticals is prescription or other means. OTC analgesic use of NSAIDs, paracetamol and aspirin, and combinations of these with each other as well as codeine is 'the elephant in the room'. Transfusions due to Gastrointestinal bleeding; accidental and intentional OD from paracetamol; many trade names for the same product leading to unintentional over use and resulting in complications etc etc. the price wars between chemists and supermarkets for NSAID products and paracetamol is affecting how much is used - its not just the consumer who needs to be protected, but also their families and particularly children and young people.

Interestingly there is a paucity of research into some of the long term effects of medications used to treat dependence.

Increase in presentations to ED in patients seeking pharmaceuticals and increase in "code greys" in response to refusals;

Anecdotal evidence of threats of suicide if patients are not given pharmaceuticals;

Evidence of drug dealing and diversion outside of GP practices, pharmacies and EDs;

Increase in threats to staff in wards trying to contain excessive use of pharmaceuticals;

Patients needing IV antibiotic therapy due to infections secondary to IV pharmaceutical misuse and then longer hospital stays due to lack of appropriately trained nurses in the community to manage their treatment;

Increase in deaths from naïve opioid users especially in context of work injuries and other rehabilitation;

Danger of reinforcing patient as having a disability to get work cover or insurance benefits thus minimising opportunities for recovery.

Question 13

Certain groups in the community (such as those living in rural areas and those experiencing social disadvantage) appear to be disproportionately affected by levels of harm associated with pharmaceutical drug-related problems. What could be done to address this in a targeted way?

A wide spread health education strategy to inform those at high risk about the drug-related problems. To support this, more resourcing and education is required for agencies tasked with prescribing e.g. GPs, or treating people suffering the effects of drug related problems such as rural nurses, Indigenous health workers and mental health workers.

Also ensuring that services can be delivered in a way that makes seeking treatment more affordable.

Incentives to attract workers to regional, rural and remote areas of need should be considered. School teachers have traditionally been required to work in regional/rural/remote areas. Perhaps a similar system, where medical, nursing and allied health staff are 'incentivised' to practice in regional, rural and remote communities for a certain period of time would address work force needs (providing this was not a disincentive to adopt these professions).

Greater use of Nurse Practitioners (see "other" at the end of this document for more information)

Use of efficient technology to access health care and education in these areas, e.g. telehealth and video conferencing need to be expanded.

Development of AOD Nurse Practitioners to provide a model of care that incorporates community development and health education as well as appropriate treatment options;

Adequate remuneration of Addiction Medicine specialists to provide mentoring for GP's as well as specialist clinics for reviews;

Question 14

To what extent is Australia's Prescription Shopping Program able to impact on the misuse of pharmaceuticals?

This vital initiative is under-developed, very limited and slow to respond (due to several factors: the number of prescriptions that must be filled, and the time it takes for the information to reach the appropriate data base before action can be taken, how up to date the data entry system is, very limited accessibility to system for health workers such as ATODS staff and so on). It has a limited impact in it's present form and does not detect those people visiting multiple pharmacies for OTC preparations, including sedating anti-histamines.

Question 15

How effective is Australia's current approach to the regulation and monitoring of these medications and how could the current approach be improved?

Further limitation on supply of OTC medications likely to cause dependence or that can be used to manufacture other substances.

Consistent supply regulations across all states and territories.

If advertising of OTC products is permitted then options other than the medication to be outlined (in a similar way to the technique used in the current Nurofen television advertisement with a well known swimmer offering several alternative suggestions about the treatment of headache)

Monitor usage through "Real Time" monitoring that links retail outlets at point of sale to a National (or State) database that can be accessed by GPs, ATODS, Pharmacists, Hospitals etc to inform when and how much medication is prescribed and dispensed;

Inconsistencies across the country result in confusion and extra work by practitioners when trying to track a patient's prescribing history;

Pharmaceuticals are still freely available on streets;

Inconsistent response to GP's who continually do not comply with regulations and monitoring and work outside of the principles of QUM;

A CMMS would save PBS money and also reduce adverse events particularly in complex patients and the elderly;

Lack of understanding by magistrates if GP's are brought before the courts;

Reluctance of many health practitioners to report a colleague's inappropriate practices.

Question 16

What are the key issues that arise concerning the balance between measures which are intended to enhance the quality use of medicines (such as a CMMS) and the needs to protect the privacy of patient information?

Lack of understanding in regard to “duty of care” and “confidentiality”;
Fear of prosecution;
Regulations around governance - who would manage this data and what happens with the info - how is it accessed which protects the privacy of information for individuals.
What data is collected? Which medications? What are the boundaries of what we record, and then how we act on this information, and what we do with the information.

Question 17

Are there any measures that could be introduced in the short term that would enhance our ability to monitor the prescription and dispensing of these medications?

Trial of real time monitoring;

A consumer targeted advertising campaign about medications with the potential for dependence.

Clarification of duty of care and confidentiality;

Education of all health workers of the need for adequate assessments and follow-up strategies when risks identified;

Education of interns in hospital regarding discharge medications and discharge information provided to GPs;

Minimal amounts of S8 medications provided in hospital discharge medications;

A&D Nurse Practitioners with PBS available to follow up patients in the community.

Question 18

How are the current prescriber remuneration patterns impacting on patterns of pharmaceutical drug misuse?

GP payments through Medicare encourage the use of pharmaceutical 'solutions' over other more time consuming interventions;

Different health models across the states resulting in varying access to Addiction Medicine Specialists impacts on the availability of specialist care;

Addiction Medicine Specialists are not remunerated at the rates similar to other specialists. This results in only small number of trainees across the nation and the dwindling of specialists in some states.

Question 19

To what extent is OST accessibility and dispensing fees impacting on patterns of pharmaceutical drug misuse?

OST is a sound option for dependent patients but if it is harder or more expensive to access then it is unlikely to provide a long term solution.

Inconsistent access across the country with a greater concentration of prescribers in metro regions;

Disabled and elderly clients have difficulty in accessing OST and more likely to misuse pharmaceuticals;

Patients unable to afford or pharmacists reluctant to provide daily pickups or Webster packs

Question 20

To what extent are the current patterns of availability of adjuvant drugs impacting on patterns of pharmaceutical drug misuse?

Adjuvant drugs have a proven role in the stepped pharmaceutical management of chronic non malignant pain (CNMP). To be effective they need to be affordable for long term use.

Consequently the inability to afford adjuvant drugs encourages the prescribing of a range

of opioids (with little acknowledgement of the principles of QUM);
Danger of misuse of adjuvant drugs;
Lack of evidence of the efficacy of some adjuvant drugs and off-label use.

Question 21

To what extent are these difficulties impacting on patterns of pharmaceutical drug misuse?

CNMP, which has been largely overlooked, is responsible for a significant amount of pharmaceutical drug misuse. A National coordinated approach to this present and growing problem is required if the issue of appropriate management including the appropriate prescribing of, and affordable access to, opioids and adjuvant medications is to be effectively addressed

Many Pain Services exclude patients perceived as drug seeking;

Long waiting times for pain services promote continuation of Pharmaceutical Drug Misuse and re-inforcement of "helplessness and hopelessness" of these patients;

Inability of mainstream A&D services to help manage these patients;

Patients with persistent pain who are misusing pharmaceuticals do not consider themselves as drug users and are reluctant to access A&D treatment services. Different approaches are needed; These patients fall between the cracks.

Question 22

To what extent are problems with hospital to community transitions impacting on patterns of pharmaceutical drug misuse?

Effective follow up is well recognised as an important part of the treatment strategy for people who have substance dependence. Patients who are not provided with this are more likely to relapse within a month of discharge. This is compounded by pressure to discharge early. Yet, patients are frequently discharged early, with little post-discharge follow-up arranged, with too much medication or without arrangements to acquire appropriate medication. Communication between services providing treatment remains patchy at best.

More funded positions for A&D Nurse Practitioners to help with this transition and to ensure better arrangements for follow up and prescribing can help address this problem (see "other" at the end of this document for more information).

Hospital pharmacies reporting large increase in discharge medications including short and long acting opioids with minimal instructions to GPs;

Shorter stay in hospitals resulting in patients still requiring analgesia on discharge;

Lack of training for interns in the potential for abuse of pharmaceuticals;

Lack of suitably A&D trained/qualified nurses to manage patients in the community;

Inadequate funding for A&D Consultation Liaison nurses within the hospital and health system

Question 23

To what extent would a CMMS enhance the QUM in Australia?

Raise the profile of the principles of QUM;

DATA collecting and research;

Monitoring of QUM

Question 24

How could Australia's data collection and sharing processes in this area be enhanced?

Question 25

Are there any other gaps in the research?

Compare the cost of over prescribing on PBS to an adequately resourced ORT national free program

Question 26

What other clinical responses are required?

Adequately resourced Addiction medicine physicians and A&D Nurse Practitioners; Multidisciplinary Teams for the ability to resource and mentor rural areas;

(see "other" at the end of this document for more information about the role of Nurse Practitioners)

Question 27

What other workforce development responses are required?

Increase undergraduate education (nursing, medical, allied health) in relation to all aspects of dependence.

Educate and employ more A&D Nurse Practitioners with specialist skills in addiction (see "other" at the end of this document for more information).

Extension of the Mental Health Nurse Incentive Program

<http://www.medicareaustralia.gov.au/provider/incentives/mental-health.jsp>

Question 28

What other consumer-oriented responses are required?

Increased regulation around the advertising of pharmaceuticals (which need to include non-pharmaceutical options) to consumers;

Decreased access to OTC medications;

Generic prescribing can result in consumer confusion, especially with elderly patients who are presented with medication with different brand names each time they have a prescription filled and which can lead to the inadvertent use of medications.

Question 29

Are there any other potential contributions that technology could make?

Point of sale real time reporting;

Electronic prescriptions that can be sent to a nominated pharmacy and held there until the patient presents.

At the point of the prescriptions generation (the Doctors Rooms, Hospital etc) a random, unique identifier could be electronically generated and assigned to that patient, for that specific prescription (or group of, on a particular date) and pharmacy, which the patient/guardian would then need to produce at the point of service/collection (pharmacy). That way only the patient/guardian could collect the medication – a new random identifier would be generated each time the patient went to the doctor and was "given a script".

As an added level of security the practitioner's unique identifier could also be randomly reallocated on a regular basis – e.g.: quarterly. It could simply be that they need to log on a Medicare site and be reissued. This of course would be a barrier for those that have limited internet access or limited knowledge on how to use the internet.

Removing or at least minimising the use and availability of hard copy prescriptions could have an enormous impact.

Question 30

To what extent is Australia's current self-regulatory approach to the marketing of pharmaceuticals effective?

How well existing self regulation arrangements between the medical profession and pharmaceutical industry working requires review.

Other issues:

If you wish to address issues not covered in the above questions, please do so at the end of your submission.

Nurse Practitioners (NPs)

The role of Nurse Practitioner (NP) is a recent development in the career choices available to nurses. The role can potentially contribute to the prevention of substance dependence, the education of health professionals about substance dependence as well as the care of people who have developed dependence and as a consequence of OTC pharmaceutical misuse is of considerable importance to the National Pharmaceutical Drug Misuse Strategy.

A Nurse Practitioner is a registered nurse whose depth of clinical experience within their specialty, their education to at least Masters level, and authorisation through endorsement by the Nursing and Midwifery Board of Australia of AHPRA, allows them to function autonomously and collaboratively in an advanced and extended clinical role.

To be eligible for endorsement NPs need:

- general registration with no restrictions on practice;
- advanced nursing practice complemented by research, education and management;
- to meet the competency standards for nurse practitioners approved by the Nursing and Midwifery Board of Australia of AHPRA; and
- to complete the requisite qualification.

They work in a range of specialties including but not limited to:

- Cardiology
- Mental health
- Wound management
- Emergency medicine

There are also a few NPs whose expertise is specifically related to drug and alcohol (D&A) dependence.

The majority of NPs are employed by state and territory governments, although the number of positions available at this time is very limited e.g. Queensland has only recently employed its first and only NP in the D&A sector.

The private sector, either as an employee or in independent practice also offers opportunities especially as NPs now have access to the Medicare Benefits Schedule (MBS), the Pharmaceutical Benefits Scheme (PBS) and can order relevant diagnostic tests. It is likely that over time more nurses will follow this career path.

Within the D&A sector NPs have a special role to play. For instance GPs are generally reluctant to prescribe Opiate Substitution Therapy (OST). The South Australian (SA) example of 2008 illustrates this. Of the 2000 GPs in SA only 55 prescribed OST. Consequently very little OST is provided to this needy group except through public clinics or prisons. Qualitative research undertaken in SA suggests that GP reluctance stems from:

- their lack confidence, knowledge, time and remuneration;
- concern about exposing other patients or practice staff to OST patients;
- too much pressure to take on more OST patients;

- concern that this group of patients can be very dysfunctional and take up a lot of time;
- increased attention from the medical board to their practice.

NPs can potentially fill this void, in a clinically sound and cost effective manner, by taking on the management of this group of patients.

NPs can also have a role:

- linking the patients of GPs to specialist drug and alcohol clinics;
- in collaborative private practice with GPs;
- providing guidance to GPs around the management of withdrawal and maintenance;
- as an educational resource e.g. reviewing with GPs the problems that inappropriate prescribing creates e.g. alprazolam;
- providing access for underserved opiate management in rural and remote areas;
- as a resource for mental health workers who working with dual diagnosis patients.

However at this time there are several barriers to this emerging NP role:

- There are very few D&A NPs; more are required.
- There are very few champions to help establish the role.
- Each NP needs to develop a Health Management Protocol outlining their scope of practice and formulary that meets the requirements of their employing authority e.g. various state health authorities. This is by necessity a slow and thorough process.
- Additional positions need to be funded (there are already several nurses who have completed the requisite studies and experience who do not have positions).
- Study at Masters level is very costly. Financial assistance to undertake the necessary study is required (\$14,000/year course fees).
- Candidature positions are required for nurses undertaking NP studies.
- Uncertainties about medico-legal implications in collaborative private practice with GPs are yet to be worked through.
- The impact on GP practices' liability insurance with NPs practicing collaboratively is yet to be determined.