**Feedback Prescribing rights under the Misuse of Drugs Act 1975 and Medicines (Standing Order) Regulations 2002**

This submission is made of behalf of the New Zealand Rural General Practice Network.

Prescribing restrictions in the Misuse of Drugs Act

A response is given to requested information in the form of questions from the document “Feedback Sought Prescribing rights under the Misuse of Drugs Act 1975 and Medicines (Standing Order) Regulations 2002 March 2012”

* 1. Designated nurse prescribers

1. Do you support retaining the current controlled drug prescribing restrictions on nurse prescribers which are:
2. Nurse Practitioners
3. Diabetes nurse specialists
4. Any other nurses who gain designated prescriber status in the future.

No, Controlled drug restrictions should be consistent across all prescribing groups of health professionals who are responsible for the provision of health services and within their scope of practice.

b) If you consider the existing controlled drug prescribing restrictions for nurse prescribers need to be amended please specify.

Designated nurse prescribers can currently prescribe controlled drugs under regulation 21 (4B) of the Misuse of Drugs Regulations for

1. for the treatment of a patient under their care;
2. in an emergency;
3. in a quantity reasonably required for the treatment of a patient for up to 3 days.

It is proposed that categories a and b are suitable, however category c is restrictive in the care of patients who have palliative care requirements, long term pain conditions and suffer from formally diagnosed attention deficit disorders.

Restricting prescribing to 3 days places unnecessary burden on the patient to access their medication. It also places unnecessary barriers for nurse practitioners in their service provision for their patients.

Exemplar

A real life example of this is a youth who has a formal diagnosis of ADHD and has been prescribed methylphenidate by his psychiatrist. He has previously been a troubled youth and has been in trouble with the police. While on methylphenidate he is able to cope well, organize his life and has a reasonable relationship with his child. When not on methylphenidate he drinks too much alcohol and smokes marijuana, he says to calm his jumbled thinking. This youth relates well to the nurse practitioner who he sees for most of his usual care and wants to be able to access his medication from her rather than having to make a separate and more expensive appointment with the doctor. Please note that care is offered within a practice where the doctor and the nurse practitioner work in collaboration, however the patient chooses who he sees based on cost, convenience and his ability to relate to the provider.

It is also relatively common to have patients who require a higher level of pain medicine other than paracetamol alone, and who are unable to tolerate NSAIDs. Paracode is currently unable to be prescribed for more than three days for patients seeing a nurse practitioner, and yet tramadol is able to be prescribed.

The restriction appears to be based around the addiction potential of the drug rather than the actual need and management of the patient. Prescribing decisions should be based around current best practice thinking and guidelines and how it fits the diagnosis and circumstances of the patient. Prescribing decisions should be made by health professionals, who are qualified to make them, as determined by the qualification standards of the registering body. Access to the most appropriate medication should not depend on the professional group that the prescriber belongs to.

Please also note that in the rural environment prescriptions for controlled drugs may be issued from a doctor who is based away from the patient and it is often a nurse who provides every day support and assessment, this is highly significant in palliative situations.

* 1. Midwives

The NZRGPN would consider that midwives be able to prescribe appropriate medication for the women under their care in relation to the best practice guidelines of the day. Formularies have the disadvantage of becoming outdated as new drugs and new guidelines are developed.

It is noted that it would be considered appropriate for midwives to be able to prescribe controlled drugs during labour.

* 1. Dentists

The NZRGPN is unable to comment on the appropriateness of the current restrictions given the lack of information pertaining to their practice by the NZRGPN.

* 1. Doctors

The NZRGPN supports retaining the current restrictions for doctors prescribing controlled drugs.

* 1. Optometrists

The NZRGPN is unable to comment on the appropriateness of the current restrictions given the lack of information pertaining to their practice by the NZRGPN.

2. Ability to Issue Standing Orders.

a) Should any other groups of health practitioners be enabled to issue standing orders? If yes, please indicate:

i) Which authorized prescribers you believe should be permitted to issue standing orders. Please supply supporting reasons.

All authorized prescribers should be allowed to issue standing orders. In the last decade there has been a growth of service provision outside of the traditional doctor/patient service model. The necessity for service provision from other than medical providers has been born from patient need, and the gap in current service provision. This is more obvious in the rural sector, and it is here that we see the emergence of true collaboration between health care providers from practice right through to governance on national organizations such as the NZRGPN.

It is noted that Nurse Practitioners with Prescribing are working to become authorized prescribers in legislation before parliament at this time.

In the future, and as it is beginning to be now, it may be that registered nurse practitioners with prescribing rights may work with and along side registered nurses who would provide medication under standing orders.

An example of this is Nurse Practitioners who work along side registered nurses in Youth Clinics, or Maori Health Providers. It is noted that these providers often cater to the poor and disadvantaged and non responders in our communities. Currently the only person who can issue a standing order in these situations are doctors or dentists, in the rural sector the doctor may not necessarily work within an organization therefore may not be as readily available to support a standing order.

ii) Whether, in your view, such authorized prescribers have the systems and resources to issue standing orders in practice. If not, what would they need? Please give supporting reasons for your answers.

At this point there has been a considerable body of work done on standing orders by various interested parties in rural New Zealand. Although guidelines exist, it is not clear what checks and balances exist to ensure compliance with the law.

National guidelines including standing orders would be a considerable help here.

It is also of upmost importance that clear and easy access of information between health providers, including pharmacists, nominated by patients is essential to prevent conflicting and inappropriate prescribing and to prevent abuse of the system.

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