

2nd February 2026

Medicines and Poisons Regulation Branch
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**AODCCC response to prescribing by registered nurses and pharmacists:
amendment of the Medicines and Poisons Regulations.**

The following content is an extract from an online survey; we have included responses that are pertinent to our members.

About you:

How would you like your submission to be treated?

Publish my submission with my name and/or organisation

**Are you responding as an individual or providing the views of an organisation
(choose ONE option)?**

Providing the views of an organisation

**If you are responding as an organisation, please provide the name of the
organisation:**

Organisation name: Alcohol and other Drug Consumer & Community Coalition

What is your email address?

Add your email address: info@aodccc.org

1. Designated registered nurse prescribers (DRNP): regulatory options and Schedule 8 prescribing

1.1 Which regulatory option do you support for prescribing by designated registered nurse prescribers (DRNP)?

Option 4 - authorise DRNP prescribing and include requirements in a mandatory 'prescribing instrument'

1.2 If you supported Regulatory Option 3 or Regulatory Option 4, please comment on whether any of the suggested requirements described in the Consultation discussion paper should be modified or removed, and what modification should be made:

AODCCC believe Designated Registered Nurse Prescribers (DRNPs) should be authorised in a manner consistent with other health practitioner classes who hold an endorsement for scheduled medicines. Specifically, allowing DRNPs to prescribe in line with the requirements of the Nursing and Midwifery Board of Australia Guidelines (option 2), with inclusion of additional safeguarding measures as mandatory prescribing instrument (option 4) is the preferable option providing these are available to the public on the WA Health website.

An advantage of authorising DRNPs is the potential to enable families and carers of people who use drugs to have access to more timely health care for themselves and their families.

AODCCC recognise that essential medicines play a critical role in saving lives, reducing suffering, and improving health outcomes. However, for these benefits to be realised, medicines must be accessible, affordable, safe, and used appropriately.

AODCCC emphasises that equitable access to essential medicines is not only a matter of public health but also of social justice.

Additionally, AODCCC members with rural and regional perspectives alongside lived and living experience saw these regulatory options to hold potential for faster access to medications bringing hope for better health outcomes.

1.3 If you supported Regulatory Option 3 or Regulatory Option 4, are there additional specific requirements that should be included in the Regulations or in a 'prescribing instrument'?

AODCCC are aware through our membership that the family and carer of people who use drugs have repeatedly expressed concern, supported by a body of evidence that some practitioners, including medical practitioners, nurse practitioners, and pharmacists have at times placed profit motives above patient safety.

This question raised and highlighted concerns, particularly in relation to Schedule 8 medications, such as opioids, which carry well-known risks of misuse, dependence, and harm.

AODCCC is of the opinions that any future prescribing instruments (as outlined in the previous consultation discussion papers) must be further developed and informed inclusive of expertise of 'real people' with lived and living experiences across the spectrum of substance use.

From a broader view, our members identified that the language used in the consultation discussion papers, particularly around 'prescribing instruments' was neither consumer-friendly, nor inviting or inclusive of fostering diverse viewpoints. The language throughout was overly bureaucratic, at times inaccessible, thus creating barriers to understanding and meaningful participation for consumers, families, and carers.

1.4 If you selected Regulatory Option 1 (Do not authorise prescribing by DRNP), please explain why you chose that option and, if applicable, provide information about other mechanisms that could be used to authorise prescribing by DRNP:

Not applicable

1.5 Which autonomous prescribers should be able to enter into a prescribing agreement with a DRNP?

Medical practitioner, Nurse practitioner, Dentist, Endorsed midwife, Endorsed podiatrist, Endorsed optometrist

1.6 If you did not select all the autonomous prescribers in Question 1.5, please explain why you excluded certain classes of autonomous prescriber

AODCCC did not exclude any of the suggested classes of autonomous prescriber. AODCCC members consistently draw upon their lived and living experience, reference group members are initially supportive that expanding prescribing to Drug and Alcohol Registered Nurse Practitioners (DRNPs) and pharmacists could reduce treatment delays, improve access to essential medicines, and create more logical and accessible care pathways, particularly where nurses and pharmacists with high levels of AOD literacy and knowledge are closely involved in ongoing care.

Some respondents noted that pharmacists frequently correct prescription errors and play a key role in maintaining continuity of care for consumers, family and carers. Several participants shared that in their own health journey nurses often have a deeper understanding of a person's circumstances than General Practitioners (GPs).

Overall members voiced strong concerns about the serious inconsistencies in how medicines in WA are supplied, stored, and distributed. Further shared LLE illustrating where drug-related harms had occurred associated with prescribing patterns. Several spoke passionately, from harm-reduction perspectives grounded in increasing dignity and social justice. Overall emphasising that current inconsistencies directly endanger the health and wellbeing of individuals, families, carers, and health professionals alike.

These voices are calling for urgent action: the establishment of better-informed safeguarding, more transparent accountability, and clearer, more equitable governance to ensure that any expansion of autonomous prescribing frameworks genuinely increases safety, trust, and community wellbeing and are not just another top down policy approach.

1.7 How supportive are you of DRNP issuing prescriptions for Schedule 8 (S8) medicines?

Somewhat supportive

1.8 Please explain why you chose this option:

Whilst members were generally supportive and expressed positive reflections toward nurses as a professional group, unanimously agreeing that the Registered Nurses have the option to become DRNPs is essential and long overdue. Members strongly advocated (DRNPs) undertake further AOD-specific education to strengthen their expertise and ensure their practice is informed by non-stigmatising, harm-reduction-focused perspectives and AOD literacy.

Members also raised serious concerns about the use of stigmatising language within the healthcare sectors, the bureaucratic barriers that can block access to care, and the harmful narratives that continue to be perpetuated in clinical environments.

Drawing on both personal and shared experiences, participants highlighted the complex realities surrounding prescribing Schedule 8 medications, additionally current issues related to illegal distribution, challenges in accessing affordable medications safely, overprescribing, and the impacts of forced withdrawal for people who require schedule 8 medications, particularly those accused or convicted of offences or otherwise deprived of liberty in custodial settings.

These issues demand a much broader and ongoing consultation process, one that amplifies the voices of people with lived and living experience and enables a deeper, more nuanced analysis beyond what can be captured within the scope of this brief consultation exercise.

1.9 Please select any of the following factors that would increase your level of support for Schedule 8 (S8) prescribing by DRNP:

Limit S8 prescribing to oral opioids for acute pain., Only allow DRNP to prescribe up to 14 days treatment., Not allow repeats to be prescribed., Only allow S8 prescribing when DRNP have access to ScriptCheckWA, with the exception of prescribing for hospital inpatients and people in residential care or custodial settings., Only allow DRNP to prescribe S8 medicines for adult patients.

1.10 If there are any other factors which would increase your support for Schedule 8 (S8) prescribing by DRNP, please provide details:

Other factors that would increase support for Schedule 8 prescribing by DRNP:

Prioritise lived-experience leadership, sustainable changes must be co-designed with people who have lived and living experience of alcohol and other drug (AOD) use, along with their families, carers, and communities. These insights are essential for creating prescribing policies that are safe, practical, and grounded in real-world experience.

Strengthen safeguards and accountability in current systems such as ScriptCheckWA while valuable are not sufficient on their own. Strengthening accountability also requires genuine collaboration, by communicating effectively with marginalised groups such as people who use AOD and their families as stakeholders. Every aspect of prescribing practice must also protect and promote human rights, AODCCC amplifies personal and collective LLE to advocate for positive, systemic change which prioritises safety, dignity, and equity for everyone.

AODCCC calls for investment in education and empathy: Pharmacists, nurses, and prescribers need advanced training in harm reduction, trauma-informed care, and non-stigmatising communication to better understand and respond to the complexities of AOD use. And for the Department of Health to further commit to continuous consultation with AODCCC which will ensure more diverse voices of people who use drugs, their families and carers remain central to the development, review, and evaluation of all new and evolving prescribing practices.

3.1 Should DRNP be authorised to supply medicines in Schedule 2 (S2, pharmacy medicines) and Schedule 3 (S3, pharmacist only medicines)?

Through the voices of our membership, people with a lived or living experience of alcohol and other drugs (AOD) in Western Australia we are consistently informed by personal stories that reveal deeply entrenched and multifaceted systemic barriers hindering access to locally available health care. Geographic isolation contributes significantly to these disparities, with limited access to non-stigmatising, non-

discriminatory, and affordable supply of essential medications. This is just one example where Drug and Alcohol Registered Nurse Practitioners (DRNPs) could play a vital role in increasing access to more equitable health care services.

4. Pharmacists: regulatory options for prescribing

4.1 Which regulatory option do you support for prescribing by pharmacists?

None of the options are suitable

None of these options were suitable for the following reasons: The language used in the consultation discussion papers was identified as confusing, neither consumer-friendly, nor inclusive of a broader range of perspectives. Participants noted that the papers were written using highly technical, clinical, and regulatory terminology that may be familiar to professionals but inaccessible to many consumers, families, and carers, particularly those who have expertise through living or lived experience of alcohol and other drug (AOD) use.

This type of language risks creating barriers to meaningful engagement by reinforcing existing power imbalances between public sector professionals and community members. It risks inadvertently conveying judgment or authority, which not only discourages the sharing of experiences openly but also impacts confidence that LLE perspectives are valued equally.

To enable authentic participation and richer insights, consultation materials should adopt clear, accessible, and empathetic language, grounded in harm-reduction, respect, and collaboration to create a sense of safety, inclusion, and empowerment for all contributors

5. Prescribing of Schedule 8 medicines by pharmacists

5.1 How supportive are you of pharmacists issuing prescriptions for Schedule 8 (S8) medicines, even if this is at a future time?

Neither supportive nor unsupportive

5.4 If there are any other factors which would increase your support for Schedule 8 (S8) prescribing by pharmacists, please provide details:

Other S8 factors: In principle, AODCCC members who participated in the reference group consultation indicated that they would personally seek, support, and encourage the people they care for to access health care through pharmacies, particularly if the prescribing of Schedule 8 (S8) medications becomes an available option. Several members highlighted that the cost and limited availability of consultations with medical professionals authorised to prescribe S8 medications, such as General Practitioners

and Psychiatrists, are prohibitive. Others noted there are very few bulk-billing doctors in Perth, and even fewer specialists.

Concerns about how pharmacists would conduct consultations, the level of autonomy individuals would retain in their health care decisions, the extent of pharmacists' access to personal health records, and broader issues around privacy, informed consent, and the management of electronic medical records were key themes emerging from these discussions. These themes emphasise that the distinct nature of alcohol and other drug (AOD) issues requires careful consideration, particularly in regard to stigma reduction and privacy protections.

Further consultation and the genuine participation of people with a lived or living experience of drug use, as well as their families and carers are clearly required. Embedding their LLE insight is essential to defining what information is relevant and appropriate for pharmacists to access, and to ensuring that any future pharmacist prescribing models occur within a harm reduction approach, with commitment to non-stigmatising service and healthcare delivery.

AODCCC members consistently raise concerns about current prescribing practices, sharing experiences of over-prescribing, misinformation, service refusal, and perceived misuse of professional authority, both by individual practitioners and within the broader system. At worst, members have described encounters that felt paternalistic; however, others have shared positive experiences of being treated respectfully by trusted, knowledgeable pharmacists who provided person-centred care.

Across all discussions, members strongly advocated for increased education and training for pharmacists who work with AOD consumers, their families and carers. Which emphasises that expectations of improved outcomes without appropriate investment in workforce support through training and education are unrealistic, tokenism and potentially dangerous.

6. Prescribing instrument content applicable to collaborative prescribing by pharmacists

6.1 Which of the following topics should be included in a prescribing instrument for pharmacists to support collaborative prescribing?

Processes for competency assessment of pharmacist prescribers., Governance framework for agreements with autonomous prescribers.

Prerequisites, such as years of clinical experience and recency of practice, required competencies for a pharmacist to participate in collaborative prescribing agreements. Required formal training, Continuing professional development (CPD) requirements, Reassessment/refresher requirements

Type of practice site. For example: public hospital, general practice, residential aged care facility.,

Type of prescription. For example: inpatient medication chart, outpatient prescriptions, discharge prescription.,

Details of medicines that can be prescribed. For example: a list of medicines (formulary), a clinical protocol or reference to a guideline (such as the Australian Therapeutic Guidelines), medicines included in each patient's clinical management plan, restrictions to certain schedules.,

Details of the health conditions for which pharmacists can prescribe treatment.,

Prescribing limits. For example: whether a pharmacist can initiate a new medicine, substitute a medicine with another in the same class, change formulation, duration of prescribing, when to refer to an autonomous prescriber.,

Record keeping requirements. For example: clinical record of consultation with patient.

6.2 Please provide details of any other information you think should be included in a Prescribing Instrument for Pharmacists to support collaborative prescribing:

Expanding collaborative pharmacist prescribing represents a critical opportunity to improve access to timely, safe, and person-centred care for people who use alcohol and other drugs (AOD).

By embedding harm-reduction principles and drawing on the expertise of pharmacists (and nurses) this approach can reduce treatment delays, enhance medication safety, and create more seamless care pathways.

Central to this development is co-design with people who have lived and living experience, ensuring prescribing models promote dignity, equity, and non-stigmatising practice across all health settings.

In conclusion, the implementation of collaborative pharmacist prescribing must be underpinned by robust clinical governance, transparent accountability, and clear regulatory oversight. Equally, success depends on embedding lived and living experience expertise at every stage of policy design, implementation, and evaluation to ensure prescribing practices are informed by real-world perspectives.

Future prescribing instruments must be grounded in harm reduction and human rights which will promote equitable access to care.

7. Collaborative prescribing agreements between pharmacist prescribers and autonomous prescribers

7.1 Which autonomous prescribers should be able to enter into a prescribing agreement with a pharmacist?

Medical practitioner, Nurse practitioner, Dentist, Endorsed midwife, Endorsed podiatrist, Endorsed optometrist

7.3 In the hospital setting, should each prescribing agreement be approved by a Drug and Therapeutics Committee or equivalent?

Yes

7.4 If you answered Yes to question 7.3, please explain why you chose this answer:

AODCCC believes there should be safeguards and accountability, with adequate opportunity for patients to self-advocate and be provided transparency, and self-advocacy around decisions.

7.6 Within a health organisation, should a prescribing agreement apply to all pharmacists with demonstrated competency, or should each agreement only apply to a named pharmacist?

A named pharmacist only

7.7 When should the prescribing agreement be reviewed?

At a fixed time period, such as annually or every 2 years., If requested by the pharmacist prescriber., If requested by the autonomous prescriber., If requested by the Drug and Therapeutics Committee or equivalent., If requested by the Department of Health.

AODCCC supports strengthening safeguards and increasing accountability by promoting fair, transparent processes that uphold high standards of practice and care. We call on sector leaders and decision-makers to advance AOD literacy (comprehensive alcohol and other drugs knowledge and awareness) among pharmacists through meaningful professional development, including AOD training codesigned, or co-facilitated by lived experience perspectives of AOD.

8. Prescribing instrument content applicable to the Enhanced Access Community Pharmacy Pilot (EACPP)

8.1 Which of the following topics should be included in a prescribing instrument for pharmacists to support the Enhanced Access Community Pharmacy Pilot?

Separation of prescribing and dispensing - policy and procedure requirements.,

Requirements for advice to the patient's usual primary care prescriber.

Prerequisites, such as years of clinical experience and recency of practice., Required formal training or, in the future, required endorsement by the Pharmacy Board.,

Continuing professional development (CPD) requirements., Reassessment/refresher requirements.

Service to be conducted at registered pharmacy premises., Dedicated consulting room that ensures patient's privacy and confidentiality., Sufficient space within consulting room for patient, carer/support person, pharmacist, consumables, equipment and

documentation., Secure system for record keeping., Requirement to keep a consultation record, including a documented treatment plan.

8.2 Please provide details of any other information you think should be included in a prescribing instrument for pharmacists to support the EACPP:

AODCCC also emphasises the need for safeguards and accountability measures that ensure transparency in decision-making and provide adequate opportunities for individuals to self-advocate. These principles must be incorporated into any future prescribing instruments for pharmacist to support the EACPP to promote safe, equitable, and consumer-centred practice.

Furthermore, trauma-informed care (TIC), trauma-informed practice (TIP), and psychologically-informed or trauma-informed environments (PIE/TIE) must be embedded within future prescribing instruments to support pharmacists better meet the needs of people who use drugs and their families seeking care in community pharmacies.

Increasing AOD literacy (comprehensive alcohol and other drugs knowledge and awareness) levels that exceed current practice standards within pharmacy operations strengthens community trust, reduces barriers to care, and supports safer, respectful, consistent, and accountable service delivery.

9. Withdrawal of prescribing agreements (applicable to designated registered nurse prescribers and pharmacist prescribers)

9.1 How supportive are you of a regulation that allows the Department to direct the withdrawal of a prescribing agreement, where there is significant risk to the health, safety and welfare of a person or the public?

Somewhat supportive

9.2 How supportive are you of using the current provisions of the Act, to restrict a health practitioner's professional authority, instead of there being a specific regulation about withdrawal of prescribing agreements?

Somewhat supportive

10. Other comments 10.1 If you wish to provide further information in response to the consultation, please type in the box below:

The Alcohol and Other Drug Consumer & Community Coalition (AODCCC) is the state peak body for alcohol and other drug (AOD) consumer driven systemic advocacy in Western Australia. Representing just under 1000 members as of January 2026, the AODCCC serves as a conduit for individuals and families with lived and living

experience (LLE) of AOD to have their voices heard, their expertise recognised, and their perspectives inform public policy.

Our aim is to empower consumers, their families, and supporters to influence systems that shape health and wellbeing across Western Australia. The knowledge, insights, and expertise of people with lived and living experience are integral not only to the work of the AODCCC but also to reduce stigma, build stronger, healthier, and more inclusive communities throughout the state.

To assist the Department of Health in obtaining stakeholder feedback on the preferred options for regulating prescribing by Designated Registered Nurse Prescribers (DRNPs) and pharmacists under the Medicines and Poisons Regulations 2016, the AODCCC convened a dedicated reference group meeting with seven paid community members, including families, carers, and significant others of people who use drugs, to share their lived and living experience (LLE) and expertise. The AODCCC acknowledges and deeply respects the emotional labour, openness, and vulnerability demonstrated by participants throughout the stakeholder feedback consultation process.

The stakeholder feedback within this consultation draws directly from the lived expertise of AOD consumers, families, and carers. Every person seeking care whether for a medical prescription or broader treatment brings a unique history, complex experiences, and inherent dignity. Safe, respectful, and informed prescribing practices must therefore align with individual needs, circumstances, and wellbeing.

A recurring theme was the urgent need for greater commitment and resourcing to ensure that prescribing decisions genuinely reflect person centred, safe, and culturally informed practice. Members emphasised that this work cannot succeed without the leadership and meaningful involvement of people with lived and living experience of alcohol and other drugs. Their insights reveal how prescribing practices often intersect with trauma, criminalisation, family stress, and long-standing experiences of stigma within health systems.

The consultation highlighted that current systems and safeguards are not consistently effective in preventing harmful prescribing. Despite mechanisms such as ScriptCheckWA, which provides real-time data on monitored medicines and is designed to support safer clinical decision-making, our members have shared multiple examples in which vulnerable individuals have encountered stigma, discrimination and been placed at risk of harm.

Families and carers reported that, in many cases, existing prescribing practices fail to meaningfully acknowledge or incorporate their perspectives, leaving them feeling silenced and excluded from the care process. Emphasising that recognising and involving families, whenever appropriate, fosters greater trust, improves communication, and creates safer, more supportive environments for people who use drugs.

In closing, the AODCCC strongly advocates for a collaborative, harm reduction focused approach that embeds lived-experience leadership in the design, implementation, and evaluation of prescribing instruments frameworks. Such an approach will help prevent unintended harm, reduce stigma, and foster systems of care that are humane, responsive, and equitable. Furthermore, AODCCC urges the Department to embed lived-experience leadership throughout the design and implementation of any expanded prescribing frameworks, to safeguards and strengthen governance, and to invest in comprehensive education for prescribers. By doing so, Western Australia can lead the nation in establishing safe, equitable, and compassionate prescribing practices that uphold human rights and deliver improved outcomes for individuals, families, and communities affected by alcohol and other drugs.

Thank you for your consideration and commitment to inclusive policy development.

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