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Commentary

Nurse prescribing of opioid agonist treatment in Ireland: Evidence, governance, and the politics of drug policy decision-making

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ABSTRACT

Globally, opioid agonist treatment (OAT) is recognised as a cornerstone of evidence-based responses to opioid dependence. Many countries have expanded access by enabling nurses to prescribe methadone and buprenorphine, with consistent evidence of safety, effectiveness, and improved equity of access. Despite this precedent, Ireland has not introduced nurse prescribing of OAT. Drawing on policy reviews, communications, national strategy documents, legislation, parliamentary debates, international literature and media reports, this commentary positions this issue as an important initiative which has been excluded from Irish drug-policy.

This commentary highlights a clinical and regulatory paradox: Irish nurses may prescribe controlled opioids for pain and palliative care for a person who is dependent on opioids, but are legally prohibited from prescribing the same medications for OAT. Independent reviews and government policy have recommended exploring nurse prescribing to address persistent workforce shortages. This commentary identifies how governance structures have marginalised nursing perspectives and mobilised evidence selectively, contributing to inaction. The authors propose that this case illustrates how existing approaches, varying accountability, and political framing shape policy decisions. With a new national drugs strategy in development, Ireland faces a choice: continue with non-inclusive, traditional governance or adopt inclusive, evidence-informed reform that aligns with international best practice.

Introduction

Like many countries, Ireland is struggling to provide the staff needed to meet the demand of a growing population with increasing health complications. The Economic and Social Research Institute (ESRI) recently reported that the number of General Practitioners operating in Ireland will need to increase by up to 31 % to meet the growing demand, and this requirement could be higher depending on changes in work practices and new community-oriented health policies (Connolly et al., 2025). Consequently, Ireland needs to adapt its services and staffing to meet these demands. Key to this is developing adaptive and resilient structures so health systems can respond appropriately to emerging crises using data, research, and evidence to guide decisions (Correia et al., 2025). This includes adapting the scope of practice of healthcare workers and "promoting role substitution or delegation as appropriate" Correia et al. (2025, p. 227).

One adaptation that has become popular is the extension of prescribing rights to staff other than doctors, typically nurses and pharmacists. A recent review of prescribing in Australia by Fong et al. (2020) identified three broad models of prescribing- not delivered directly by medical practitioners: *structured arrangements,* where prescribing is permitted only in limited scenarios; *supervised prescribing,* where prescribing occurs fully but in consultation with a doctor; and *autonomous prescribing,* where prescribers independently prescribe without medical oversight. While it is a recent development in many jurisdictions, nurse prescribing in the US can be traced back to the 1960s (Kroezen et al., 2011). Many countries have approved schemes to allow nurses to prescribe; the exact remit and scope of practice vary between jurisdictions, and they largely fall within the three approaches outlined above. The expansions to nurses' roles have been studied extensively in many settings, with the general conclusion that nurse prescribing is as safe, effective, and efficient as care provided by a medical doctor, and service users are as satisfied with the care (Creedon et al., 2015; Gielen et al., 2014; Kroezen et al., 2011; Weeks et al., 2016).

This commentary employs a governance lens, guided by two key questions: (i) How have Irish oversight structures engaged with clinical and policy evidence around nurse prescribing of OAT? (ii) What does the process of decision-making reveal about professional hierarchies and

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decision-making in Irish drug policy? We examine the Irish governance structures to examine why Ireland has not adapted to the growing international evidence for nurse prescribing OAT. We also examine why, based on experience, this may be a significant error. As a commentary, this paper does not involve primary data collection; we privilege independent evaluations, communications, peer-reviewed research, legislation, media reports, and parliamentary records as the backbone of our synthesis. We recognise that the governance landscape is in transition: the 2017–2025 strategy has concluded, and a new national drugs strategy is in development; findings reflect the situation up to late 2025. While the focus of the discussion is on Ireland the points debated have an international remit in terms of nurse prescribing of OAT globally.

Opioid treatment demand and delivery of services in Ireland

Ireland's opioid landscape has shifted from the 1990s epidemic to a steady decline in new presentations. New opioid cases fell from an annual average of 1251 (2006–2010) to 519 (2020–2024) (Health Research Board (HRB) (2025, 2023). Despite this specific decline, the wider system is under pressure, with total drug treatment demand reaching a record 13,295 new cases in 2024. With approximately 20,000 opioid users, only half of whom are in treatment, Ireland retains one of Europe's highest opioid-related mortality rates (EMCDDA, 2019, 2021; Comiskey et al. 2009). OAT treatment in Ireland is primarily delivered through privately practising General Practitioners [GPs], usually seeing patients weekly, with payment structured on a piece-rate basis for maintaining patients on OAT. Some specialist clinics led by addiction psychiatrists exist, traditionally supported by multidisciplinary teams (Healy et al., 2022). The addiction services have been affected by the shortage of GPs to prescribe OAT, which has resulted in measures such as telemedicine (Crowley & Delargy, 2020) or pre-writing prescriptions in advance of taking leave. These practices indicate that the system is at capacity and would unlikely be able to adapt rapidly to the demands a new opioid epidemic would place on services.

Risk and legislative responses

Medical practitioners in Ireland have recently warned of the nitazene threat, advocating for legislation for preemptive strategies such as over-the-counter naloxone (McNicholas et al., 2025). These risks highlight a critical need for rapid OAT access and adaptable regulatory frameworks to handle potential synthetic opioid surges. However, Ireland has a history of struggling to implement legal frameworks in relation to drug misuse. While work began on drafting legislation for a Medically Supervised Injecting Facility (MSIF) in 2015, it was signed into law in 2017 (Atkin-Brenninkmeyer et al., 2017) due to legal and planning challenges, it only opened in December 2024, almost a decade later. By this time, drug use in Ireland had changed considerably, and subsequently, there is a need for more drug consumption rooms to cater for those who consume drugs by other means than injecting.

Disparities in service delivery: waiting times and geographic inequalities

Despite a 28-day target for commencing opioid agonist treatment (HSE, 2024), waiting times remain inconsistent across Ireland. Historical press reports in *The Irish Medical Times* highlighted those national improvements often masked deep regional inequities, with some clinics recording delays of nearly six months even as overall lists declined (Gantly, 2012; Lynch, 2012). More recently, *The Irish Times* reported that while national averages often appear compliant, rural applicants can wait up to three months (Holland, 2023). Health service data revealed a stark range, from just 4 days in Dublin to 83 days in the Midwest, illustrating that temporary pandemic-era improvements were not sustained (Medical Independent, 2020).

Analysis of Health Research Board (HRB, 2025) data of 9 Irish health regions (2009–2024) substantiates these disparities. As of 2024, patients in Region 1 accessed treatment in just one day, whereas those in Region 2 waited approximately 58 days, more than double the national target. The data also reveals volatility; Region 2 had reduced waits to 25 days in 2012 but has since regressed. Conversely, Region 3 demonstrates that improvement is possible, dropping from 244 days in 2009 to 28 days in 2024. Together, these sources confirm that access to evidence-based care in Ireland remains structurally constrained and heavily determined by geographic location. These deficits are likely to be related to a lack of prescribing capacity within the current system (Van Hout et al. 2018).

Nurse prescribing of OAT; Irish, international context and evidence

The effectiveness of OAT itself is uncontested (UNDOC, 2024; Sordo et al., 2017; World Health Organisation, 2015, 2009). The protective benefit increases by up to 70 % where synthetic opioids are circulating (Pearce et al., 2020), cementing OAT as a critical and cost-effective public health strategy (National Institute for Health & Clinical Excellence, 2007). The key policy challenge is how to ensure timely, equitable access. To overcome prescriber shortages and improve equity of access, many jurisdictions have integrated nurse prescribing of medications for opioid use disorder. In the United States, nurses campaigned to have prescriptive authority for OAT to adequately confront the opioid crisis there (O'Connor, 2011). The Comprehensive Addiction and Recovery Act (2016) authorised nurse practitioners and physician assistants to prescribe buprenorphine; subsequent evaluations showed rapid increases in treatment capacity, particularly in underserved rural and Medicaid-serving areas (Andrilla et al., 2019; Barnett et al., 2019). It is worth noting that state-specific laws in almost half of US states limit nurses' prescriptive authority for OAT, greatly inhibiting a federally allowable treatment solution (Germack, 2021). In Canada, nurse practitioners prescribe buprenorphine in most provinces and are especially active in rural and northern regions, with evidence of improved access in underserved communities (CCSA, 2018). In Australia, where state-based frameworks allow nurse practitioners to prescribe OAT; studies highlight increased accessibility and reduced burden on doctors, particularly in remote settings (DoHAC, 2014).

In Europe, the United Kingdom and the Netherlands provide mature examples of nurse prescribing in OAT. Nurse independent prescribers have long been authorised to prescribe controlled drugs, including methadone and buprenorphine, within competency frameworks and audit systems; evaluations link nurse prescribing to increased capacity without compromising quality or safety (Clancy et al., 2019; Public Health England, 2017). In Ireland, prescriptive authority is not automatic for advanced nursing grades but requires a specific qualification and registration with the Nursing and Midwifery Board of Ireland (NMBI, 2019). Practitioners operate autonomously within their scope, adhering to local policies, procedures, protocols, and guidelines (PPPGs), rather than collaborative agreements with medical practitioners (NMBI, 2019). *The Misuse of Drugs (Amendment) Regulations 2017* (Government of Ireland, 2017a) authorise Registered Nurse Prescribers (RNPs) to prescribe Schedule 2 and 3 opioids (e.g., morphine), provided the drugs are listed in Schedule 8 and fall within the nurse's specific clinical scope (NMBI, 2019). However, nurse prescribing of OAT is not permitted. A current legal paradox means that nurses may prescribe controlled opioids for pain and palliative indications, even for a person who is dependent on opioids, but not methadone or buprenorphine for dependence itself (Government of Ireland, 2017a, 2017b).

Evidence for nurse prescribing of OAT

The benefits of nurse prescribing are well established with outcomes comparable to those of physicians (Gielen et al., 2014). Evidence from the United States following the implementation of the Comprehensive Addiction and Recovery Act (2016) demonstrates that enabling nurse

prescribing of OAT delivers immediate, measurable improvements in capacity, equity, and access. The legislative change unlocked a dormant workforce, resulting in a 182.3 % expansion in treatment capacity by nurse prescribers within a single year, compared to just 2.1 % growth for physicians (MACPAC, 2019). A recent qualitative study involving nurses and midwives from Ireland, Europe, Australasia, and the United States highlighted that nurse prescribing was embedded in holistic, person-centred care and could reduce waiting times in underserved areas (Annunziata et al., 2025). A global scoping review synthesised peer-reviewed studies and concluded that nurse prescribing of OAT is feasible, safe, and effective, particularly where access barriers are pronounced (Banka-Cullen et al., 2023). Modelling suggests that, without nurse prescribers, large segments of rural America would have little or no access to evidence-based treatment (Andrilla et al., 2019).

Three lessons emerge: (1) governance matters; nurse prescribing can be safely implemented when supported by competency-based training, guidelines, and audit; (2) legislation is decisive; reform can rapidly expand workforce capacity; and (3) equity is central; nurse prescribing is particularly impactful in addressing geographic inequities and serving marginalised populations. Furthermore, Annunziata et al. (2025) demonstrate that across diverse contexts, when nurses are enabled to prescribe, they deliver innovative, equitable, and holistic care, but face systemic barriers including restrictive legislation, stigma, and inconsistent training opportunities.

Irish policy context

Governance

Ireland's drug policy governance was intended to embed inclusivity and accountability, yet evaluations and stakeholder accounts highlight persistent weaknesses. Oversight of the national drugs strategy was assigned to the National Oversight Committee (NOC) ,[1] supported by six Strategic Implementation Groups (SIGs). However, unclear roles, weak accountability, and limited communication between NOC and SIGs undermined effective oversight (Grant Thornton Ireland, 2025). Stakeholders called for stronger national leadership and more inclusive decision-making.

The contested role of nursing in governance illustrates these limitations. In 2022, nurses were excluded from the reconfigured NOC. Following public and parliamentary criticism, the Minister reinstated their representation (Baker, 2022; Ryan, 2022). Meanwhile, medical professionals were overrepresented, while psychotherapists, pharmacists, psychologists, or social workers had no formal role in this forum (Joint Committee on Health, 2022). This episode highlights that, not unlike international experience, representation is politically mediated rather than systematically safeguarded, echoing the exclusion of nurses from OAT prescribing (Stewart et al., 2025). In this context, governance shortcomings reflected in deficits with care planning and failure to implement expert recommendations have been highlighted and acknowledged in parliamentary fora (Joint Committee on Health, 2022). The experience of nursing underscores the contested nature of representation and the marginalisation of multi-disciplinary perspectives within governance structures.

Reviews of the current system

The Opioid Treatment Protocol (Farrell & Barry, 2010), commissioned by the Department of Health and Health Service Executive (HSE), remains the most comprehensive independent review of Ireland's OAT system. It identified long waiting lists, geographic inequities, and workforce constraints, and recommended exploring nurse prescribing "in line with international best practice" (p. 31). The outgoing national strategy, Reducing Harm, Supporting Recovery 2017–2025 (2017), committed to a health-led, evidence-informed approach and, under Action 2.1.14, tasked the HSE with examining mechanisms to expand OAT access, explicitly including nurse prescribing (Department of Health, 2017; Health Service Executive, 2022). A recent independent government-commissioned evaluation of the strategy reinforced concerns about equity gaps, limited GP participation, and workforce shortages and recommended strengthening governance and inclusivity (Grant Thornton Ireland, 2025). Peer-reviewed studies have identified significant challenges with service users' experiences of OAT treatment in Ireland and indicate dissatisfaction with the current system. This has manifested in terms of service users feeling an increased sense of marginalisation and disrespect, with limited opportunities to progress their recovery (Healy et al., 2022; Mayock & Butler, 2021).

The politics of evidence and expertise

The problematic framing of evidence to maintain existing policy positions is evident in the state's handling of Action 2.1.14 of the National Drugs Strategy. The HSE (2022) recommended against nurse prescribing, relying on its absence from a Delphi consensus study (Durand et al., 2022) to claim it was not a required solution. The Minister subsequently cited these findings to affirm that "no objective need" had been identified (Feighan, 2022). However, this framing was challenged on methodological grounds (Kelly, 2022, p1). As clarified in a rebuttal, the Delphi exercise specifically evaluated retaining pandemic-era adaptations; since nurse prescribing was not a pandemic measure, its absence was a methodological boundary rather than a negative finding regarding its efficacy or need.

The governance structures surrounding the National Drugs Strategy prevented the framing of evidence in this way from being effectively reviewed. Despite the rebuttal being submitted to the Minister (Kelly, 2022), a decision not to consider further evidence was maintained. Contrary to the NOC's commitment to accountability,[2] no mechanism existed for stakeholders to dispute the HSE's interpretation or enter a dissenting letter into the official record. This illustrates how evidence may be applied selectively to reinforce decisions, while governance structures limit the scope for alternative clinical perspectives. This response aligns with the international experience, where it has been observed that asymmetric power influences what evidence is used in drug policy (Stevens A., 2020)

The refusal to develop nurse prescribing has drawn parliamentary criticism. At the Joint Committee on Health (2022), Deputy Róisín Shortall challenged the restriction of prescribing authority to doctors, stating: "Nurses are centrally involved in the provision of services… Why is that (prescribing of OAT) restricted to doctors?" The HSE responded by citing "legal impediments" and claiming the role's necessity had yet "to be determined", despite the concurrent strain on service provision.

Later, experts highlighted the inconsistency of permitting nurse prescribing for pain but prohibiting it for dependence (Joint Committee on Drugs, 2024). They argued that governance failures and stigma were blocking safe, cost-effective models. It was further noted that excluding addiction services from the Health Information and Quality Authority (HIQA) inspection regime, unlike other health services, weakens accountability and perpetuates the marginalisation of people who use drugs through policy decisions.

[1] For information relating to The National Oversight Committee see: https://www.gov.ie/en/department-of-health/publications/national-oversight-committee/.

[2] https://www.gov.ie/en/department-of-health/publications/national-oversight-committee/#terms-of-reference-for-the-noc-2021-2025.

Bureaucratic reframing

The Department of Health's formal reply to the clinical nursing representatives' request for an objective evidence review underscored a systemic resistance within the NOC regarding engagement with critique. When specific concerns were raised by nurses regarding the suppression of evidence on nurse prescribing, the Department's correspondence reframed this clinical advocacy as a conflict of interest. In a formal response, the Department stated that it was "inappropriate for a member to use the NOC to advance the position of a particular organisation or interest group" (Department of Health, 2024). This statement reveals an application of governance rules which failed to distinguish between professional lobbying for self-interest and clinical advocacy aligned with international evidence. By framing the proposal to introduce nurse prescribing as the "position of an interest group", akin to a trade union demand rather than a public health intervention supported by international evidence, the State effectively insulates itself from expert critique. This dismissal reflects a broader trend in drug policy governance where clinical advocacy is reframed as 'interest group activity' to insulate policy communities from challenge (Duke & Thom, 2014).

Furthermore, when pressed on the substantive governance failures, the Department relied on bureaucratic deferral, pointing to an "upcoming independent evaluation" as the appropriate forum for these issues. This reliance on future reviews serves as a mechanism of inertia, allowing immediate, evidence-based interventions to be stalled indefinitely while deferring accountability. This episode illustrates a refusal to recognise nursing as a partner in clinical leadership equal to medicine, reducing legitimate professional expertise to the status of a "sectional interest" to be managed rather than engaged (Kuhlmann et al. 2025; Xu et al. 2025). Ultimately, this deferral proved paradoxical: the independent evaluation by Grant Thornton Ireland (2025) explicitly identified this governance gap, while witnesses before The Joint Committee on Drugs (2024) reiterated that the lack of independent inspection contributes directly to inertia on reforms.

The impact of current governance structures on service delivery

Governance structures dating back to the 1998 Methadone Protocol continue to centre prescribing authority within the medical profession, creating a structural imbalance that limits multidisciplinary influence (Joint Committee on Health, 2022). This dynamic was illustrated during a July 2024 parliamentary debate, where the Minister rejected an amendment to enable nurse prescribing by citing, on advice, the "complexity" of OAT patients (Seanad Debates, 2024). This stance particularly disregards the established competencies of ANPs, trained in advanced assessment, diagnosis, and pharmacology for patients with multimorbidity (NMBI, 2019, 2017; Public Health England, 2017). These skills are routinely applied across acute and community settings, often with populations more clinically complex than those receiving OAT. Expert witnesses have since testified that despite the ability of nurses to prescribe potent opioids like fentanyl in palliative care, the regulatory exclusion of OAT or the use of methadone for pain relief necessitates physician reassessment for addiction patients, creating duplication and inefficiency (Joint Committee on Drugs, 2024; Hanna & Senderovich, 2021). With recent reviews identifying significant capacity deficits (Grant Thornton, 2025), maintaining these historical restrictions hinders a flexible workforce response to service demands and geographic inequities (Annunziata et al., 2025).

Policy implications

Legislative and governance reform

Ireland's current framework permits nurse prescribing of controlled opioids but prohibits OAT prescribing by nurses. Aligning OAT prescribing with existing nurse prescriber governance should be prioritised (Government of Ireland, 2017a, 2017b). Integrating nurse prescribing into national workforce planning, especially via ANP's in addiction and mental health, would address bottlenecks and align with WHO task-shifting guidance (WHO, 2008). This aligns with international qualitative findings, where nurses called for postgraduate curricula, mentorship, and interprofessional support to underpin safe prescribing (Annunziata et al., 2025). The new strategy should establish transparent criteria for representation on oversight committees, formalise agenda-setting processes, and embed mechanisms for independent evidence review to prevent selective mobilisation of studies that exclude key options (Joint Committee on Health, 2022; Joint Committee on Drugs 2024).

Addiction services should be brought within an independent inspection regime (e.g. HIQA), increasing transparency and aligning with broader health system accountability norms and human rights (Healy et al., 2022). It is imperative that we establish a transparent framework for evidence use that systematically considers independent evaluations, peer-reviewed research, and parliamentary reports; guard against the exclusion of nursing and other healthcare professionals and service-user expertise. Such reforms are essential for credible evidence-informed policymaking. The Irish case further exemplifies that evidence alone is insufficient; governance structures, professional hierarchies, and political will determine whether evidence-based models like nurse prescribing are adopted.

Conclusion

The lack of progress in Ireland on nurse prescribing of OAT illustrates the interplay of evidence, governance, and professional politics in drug policy. As has been demonstrated in this commentary, there is strong evidence supporting nurse prescribing of OAT in other jurisdictions, and there have been numerous indications in policy and parliament to progress it. Consequently, one is left to conclude that if it is not a policy or evidence issue, it must be due to governance and professional politics. The progression and oversight of this issue to date illustrate deficits in the structures that oversee the implementation of Irish drug policy. International evidence shows that nurse prescribing is safe, effective, and critical for expanding access. Independent reviews in Ireland have repeatedly identified the need for workforce solutions, yet governance structures, power imbalances and legislative barriers have sustained inaction. Nurses remain authorised to prescribe potent opioids for pain but are prohibited from prescribing them for dependence, a regulatory paradox with no clinical justification. As Ireland develops a new national drugs strategy, there is an opportunity to realign policy with evidence and equity: legislate for nurse prescribing of OAT; integrate nurse prescribers into workforce planning; strengthen governance, inclusivity, and independent oversight; and mobilise evidence systematically. Without these reforms, Ireland risks perpetuating inequities in OAT access and undermining its commitment to a health-led approach. More broadly, the Irish case underscores a key lesson for international drug policy: evidence must be embedded within transparent and inclusive governance structures if it is to drive meaningful reform.

CRediT authorship contribution statement

Peter Kelly: Writing – review & editing, Writing – original draft, Project administration, Formal analysis, Conceptualization. **Catherine Comiskey:** Writing – review & editing, Formal analysis. **Barry Mc Brien:** Writing – review & editing, Data curation. **Adam R. Winstock:** Writing – review & editing, Formal analysis. **Philip James:** Writing – review & editing, Writing – original draft, Formal analysis.

Declaration of competing interest

Professor Catherine Comiskey, Professor Adam Winstock, and Mr. Barry McBrien declare that they have no known competing financial

interests or personal relationships that could have appeared to influence the work reported in this paper. Philip James and Dr. Peter Kelly declare that they have no competing financial interests or personal relationships related to this work. Philip James serves as the President of the Ireland Chapter of the International Nurses Society on Addictions (IntNSA), and Dr. Peter Kelly is a board member of the same organisation. These professional roles are disclosed in the interest of transparency; however, the authors declare that these affiliations did not influence the analysis or interpretation of the data presented in the commentary.

References

Andrilla, C. H. A., Moore, T. E., Patterson, D. G., & Larson, E. H. (2019). Geographic distribution of providers with a DEA waiver to prescribe buprenorphine for the treatment of opioid use disorder: A 5-year update. *The Journal of Rural Health, 35*(1), 108–112.

Annunziata, N., James, P., Comiskey, C., Lavelle-Cafferkey, S., Banka-Cullen, S., Zini, M. B., Menon, U., & Kelly, P. (2025). "When we are allowed to do good things, we do great things": An exploration of nurse and midwife prescribing in substance use treatment. *Journal of Addictions Nursing* [In Press].

Atkin-Brenninkmeyer, E., Larkan, F., & Comiskey, C. (2017). Factors concerning access to a potential drug consumption room in Dublin, Ireland. *Cogent Social Sciences, 3*(1), Article 1398207. https://doi.org/10.1080/23311886.2017.1398207

Baker, N. (2022). *Expert nursing group removed from National Drugs Strategy*. The Examiner. https://www.irishexaminer.com/news/arid-40784433.html.

Banka-Cullen, S. P., Comiskey, C., Kelly, P., Zeni, M. B., Gutierrez, A., & Menon, U. (2023). Nurse prescribing practices across the globe for medication-assisted treatment of the opioid use disorder (MOUD): A scoping review. *Harm Reduction Journal, 20*(1), 78. https://doi.org/10.1186/s12954-023-00812

Barnett, M. L., Lee, D., & Frank, R. G. (2019). In rural areas, buprenorphine waiver adoption since 2017 driven by nurse practitioners and physician assistants. *Health Affairs, 38*(12), 2048–2056.

CCSA, Canadian Centre on Substance Use and Addiction. (2018). *Best practices across the continuum of care for treatment of opioid use disorder*. https://www.ccsa.ca/sites/default/files/2019-04/CCSA-Best-Practices-Treatment-Opioid-Use-Disorder-2018-en.pdf.

Clancy, C., Kelly, P., & Loth, C. (2019). State of the art in European addictions nursing: Perspectives from the United Kingdom, Ireland, and the Netherlands. *Journal of Addictions Nursing, 30*(3), 139–148.

Comiskey, C., Kelly, P., Leckey, Y., McCulloch, L., O'Duill, B., Stapleton, R., & White, E. (2009). *The ROSIE study: Drug treatment outcomes in Ireland*. The Stationery Office.

Comprehensive Addiction and Recovery Act of 2016, Pub. L. No. 114-198, 130 Stat. 695 (2016). https://www.govinfo.gov/app/details/PLAW-114publ198.

Connolly, S., Kakoulidou, T., & McHugh, E. (2025). *Projections of national demand and workforce requirements for general practice in Ireland, 2023–2040: Based on the Hippocrates model* (p. 75). ESRI. https://doi.org/10.26504/rs215

Correia, T., Kuhlmann, E., Lotta, G., Beja, A., Morais, R., Zapata, T., & Campbell, J. (2025). Turning the global health and care workforce crisis into action: The pathway to effective evidence-based policy and implementation. *The International Journal of Health Planning and Management, 40*(1), 224–233. https://doi.org/10.1002/hpm.3860

Creedon, R., Byrne, S., Kennedy, J., & McCarthy, S. (2015). The impact of nurse prescribing on the clinical setting. *British Journal of Nursing, 24*(17), 878–885. https://doi.org/10.12968/bjon.2015.24.17.878

Crowley, D., & Delargy, I. (2020). A national model of remote care for assessing and providing opioid agonist treatment during the COVID-19 pandemic: A report. *Harm Reduction Journal, 17*(1), Article 49. https://doi.org/10.1186/s12954-020-00394-z

Department of Health. (2024). *Correspondence to Dr Peter Kelly regarding governance of the National Oversight Committee*. Drugs Policy Unit [Unpublished correspondence].

Department of Health. (2017). *Reducing harm, supporting recovery: A health-led response to drug and alcohol use in Ireland 2017–2025*. Department of Health. https://health.gov.ie/blog/publications/reducing-harm-supporting-recovery-2017-2025/.

DoHAC, Australian Government Department of Health. (2014). *National guidelines for medication-assisted treatment of opioid dependence*. Commonwealth of Australia. https://www.health.gov.au/sites/default/files/national-guidelines-for-medication-assisted-treatment-of-opioid-dependence_0.pdf.

Durand, L., Keenan, E., Boland, F., Harnedy, N., Delargy, Í., Scully, M., Mayock, P., Ebbitt, W., Vázquez, M. O., & Corrigan, N. (2022). Consensus recommendations for opioid agonist treatment following the introduction of emergency clinical guidelines in Ireland during the COVID-19 pandemic: A national Delphi study. *International Journal of Drug Policy, 106*, Article 103768.

Duke, K., & Thom, B. (2014). The role of evidence and the expert in contemporary illicit drug policy. *International Journal of Drug Policy, 25*(5), 964–971. https://doi.org/10.1016/j.drugpo.2014.01.015

EMCDDA, European Monitoring Centre for Drugs and Drug Addiction. (2021). *Opioid-related deaths: Health and social responses*. https://www.emcdda.europa.eu/publications/mini-guides/opioid-related-deaths-health-and-social-responses_en.

EMCDDA, European Monitoring Centre for Drugs and Drug Addiction. (2019). *Drug-related deaths and mortality in Europe*. http://www.emcdda.europa.eu/publications/rapid-communications/drug-related-deaths-in-europe-2018.

Farrell, M., & Barry, J. (2010). *The introduction of the Opioid Treatment Protocol*. www.drugsandalcohol.ie/14458.

Feighan, F. (2022). *Correspondence to Dr. Peter Kelly regarding the HSE response to Action 2.1.14 of the National Drugs Strategy*. Department of Health, Ireland [Letter]17th November.

Fong, J., Cashin, A., & Buckley, T. (2020). Models of prescribing, scope of practice, and medicines prescribed: A survey of nurse practitioners. *Journal of Advanced Nursing, 76*(9), 2311–2322. https://doi.org/10.1111/jan.14444

Gantly, D. (2012). *Fall in the waiting list numbers for opioid substitution therapy*. Irish Medical Times. https://www.imt.ie/news/fall-in-the-waiting-list-numbers-for-opioid-substitution-therapy-08-08-2012/.

Germack, H. D. (2021). States should remove barriers to advanced practice registered nurse prescriptive authority to increase access to treatment for opioid use disorder. *Policy, Politics, & Nursing Practice, 22*(2), 85–92. https://doi.org/10.1177/1527154420978720

Gielen, S. C., Dekker, J., Francke, A. L., Mistiaen, P., & Kroezen, M. (2014). The effects of nurse prescribing: A systematic review. *International Journal of Nursing Studies, 51*(7), 1048–1061. https://doi.org/10.1016/j.ijnurstu.2013.12.003

Government of Ireland. (2017a). *Misuse of drugs (Supervision of prescription and supply of methadone and medicinal products containing buprenorphine authorised for opioid substitution treatment) regulations 2017 (S.I. No. 522/2017)*. The Stationery Office.

Government of Ireland. (2017b). *Misuse of drugs regulations 2017 (S.I. No. 173/2017)*. The Stationery Office.

Grant Thornton Ireland. (2025). *Evaluation of the National Drugs Strategy 2017–2025: Reducing harm, supporting recovery*. Commissioned by the Department of Health. https://www.drugsandalcohol.ie/43790/1/Evaluation_of_the_National_Drug_Strategy_Reducing_Harm_Supporting_Recovery_2017-2025.pdf.

Hanna, V., & Senderovich, H. (2021). Methadone in pain management: A systematic review. *The Journal of Pain, 22*(3), 233–245. https://doi.org/10.1016/j.jpain.2020.04.004

Healy, R., Goodwin, J., & Kelly, P. (2022). 'As for dignity and respect… me bollix': A human rights-based exploration of service user narratives in Irish methadone maintenance treatment. *International Journal of Drug Policy, 110*, Article 103901.

HRB, Health Research Board. (2025). *National Drug Treatment Reporting System (NDTRS) data: Referral to treatment, 2009–2024*.

HRB, Health Research Board. (2023). *Opioids: The Irish situation*. https://www.drugsandalcohol.ie/17313/1/HRB-NDL_Opioids_factsheet.pdf.

Health Service Executive. (2022). *Response in relation to Action 2.1.14 (Mechanisms to expand OST access)*. National Social Inclusion Office. Unpublished report submitted to the Department of Health, November.

HSE, Health Service Executive. (2024). *Social inclusion services NSP metadata 2024 Health Service Executive*. https://www.drugsandalcohol.ie/40597/.

Holland, K. (2023). *Methadone should be prescribed by nurses to cut long wait times, says addiction expert*. The Irish Times. https://www.irishtimes.com/ireland/social-affairs/2023/01/08/methadone-should-be-prescribed-by-nurses-to-cut-long-wait-times-says-addiction-expert/.

Kelly, P. (2022). *Re: Response to HSE update on National Drugs Strategy Action 2.1.14*. School of Nursing and Midwifery [Letter to Minister Frank Feighan]1st December.

Kroezen, M., Van Dijk, L., Groenewegen, P. P., & Francke, A. L. (2011). Nurse prescribing of medicines in Western European and Anglo-Saxon countries: A systematic review of the literature. *BMC Health Services Research, 11*(1), 127. https://doi.org/10.1186/1472-6963-11-127

Kuhlmann, E., Bueter, A., & Jukola, S. (2025). Multi-professional healthcare teams, medical dominance, and institutional epistemic injustice. *Medicine, Health Care and Philosophy, 28*(2), 219–232. https://doi.org/10.1007/s11019-025-10252-z

Lynch, P. (2012). *GP rejects relevance of methadone waiting list drop*. Irish Medical Times. https://www.imt.ie/news/gp-rejects-relevance-of-methadone-waiting-list-drop-22-08-2012/.

Mayock, P., & Butler, S. (2021). Pathways to 'recovery' and social reintegration: The experiences of long-term clients of methadone maintenance treatment in an Irish drug treatment setting. *International Journal of Drug Policy, 90*, Article 103092.

Medical Independent. (2020). *Opioid addiction service waiting times fell dramatically*. Medical Independent https://www.medicalindependent.ie/in-the-news/breaking-news/opioid-addiction-service-waiting-times-fell-dramatically/.

McNicholas, R., Sweeney, N., Fenton, F., & Keenan, E. (2025). Enhancing naloxone provision in patients with comorbid mental illness and opioid use disorder amidst the rise of nitazenes in Ireland. *Irish Journal of Psychological Medicine*, 1–2. https://doi.org/10.1017/ipm.2025.10102

National Institute for Health and Clinical Excellence. (2007). *Understanding NICE guidance—Information for people who use NHS services: Methadone and buprenorphine for managing opioid dependence*. NICE.

NMBI, Nursing and Midwifery Board of Ireland. (2019). *Practice standards and guidelines for nurses and midwives with prescriptive authority* (4th ed.) https://www.nmbi.ie/NMBI/media/NMBI/NMBI-Practice-Standards-Guidelines-02-03-2020_2.pdf?ext=.pdf.

NMBI, Nursing and Midwifery Board of Ireland. (2017). *Advanced practice (Nursing) standards and requirements*. Dublin: NMBI. https://www.nmbi.ie/NMBI/media/NMBI/Advanced-Practice-Nursing-Standards-and-Requirements-2017.pdf?ext=.pdf.

O'Connor, A. B. (2011). Nurse practitioners' inability to prescribe buprenorphine: Limitations of the Drug Addiction Treatment Act of 2000. *Journal of the American Academy of Nurse Practitioners, 23*(10), 542–545. https://doi.org/10.1111/j.1745-7599.2011.00656.x

Joint Committee on Health. (2022). *Debate: Joint committee on health*. Houses of the Oireachtas. https://www.oireachtas.ie/en/debates/debate/joint_committee_on_health/2022-01-19/3/.

Joint Committee on Drugs. (2024). *Debate: Joint committee on drugs use*. Houses of the Oireachtas. https://www.oireachtas.ie/en/debates/debate/joint_committee_on_drugs_use/2024-10-17/2/.

MACPAC. (2019). *Buprenorphine prescribing by nurse practitioners, physician assistants, and physicians after CARA 2016*. Medicaid and CHIP Payment and Access Commission [Accessed 18 December 2025] at: https://www.macpac.gov/wp-content/uploads/2019/11/Buprenorphine-Prescribing-by-Nurse-Practitioners-Physician-Assistants-and-Physicians-after-CARA-2016.pdf.

Pearce, L. A., Min, J. E., Piske, M., Zhou, H., Homayra, F., Slaunwhite, A., Irvine, M., McGowan, G., & Nosyk, B. (2020). Opioid agonist treatment and risk of mortality during opioid overdose public health emergency: Population-based retrospective cohort study. *BMJ*, 368.

Public Health England. (2017). *The role of nurses in alcohol and drug treatment services: A resource for commissioners, providers and clinicians*. Public Health England.

Ryan, O. (2022). Nurse to be appointed to National Oversight Committee on Drugs after row over membership. *The Journal*. https://www.thejournal.ie/national-oversight-committee-on-drugs-frank-feighan-5686524-Feb2022/.

Seanad Debates: Amendment on nurse prescribing of OST. (2024) https://www.kildarestreet.com/sendebates/?id=2024-07-09a.265.

Sordo, L., Barrio, G., Bravo, M. J., Indave, B. I., Degenhardt, L., Wiessing, L., Ferri, M., & Pastor-Barriuso, R. (2017). Mortality risk during and after opioid substitution treatment: Systematic review and meta-analysis of cohort studies. *BMJ*, 357.

Stevens, A. (2020). Critical realism and the 'ontological politics' of drug policy. *International Journal of Drug Policy, 84*, Article 102723. https://doi.org/10.1016/j.drugpo.2020.102723

Stewart, D., Baird, K., White, J., & Buchan, J. (2025). Nursing and midwifery's impact on health policy development: A literature review. *International Nursing Review, 72*(3), Article e70061. https://doi.org/10.1111/inr.70061

UNDOC, United Nations Office on Drugs and Crime. (2024). *World drug report 2024*. Stylus Publishing, LLC.

Van Hout, M. C., Crowley, D., McBride, A., & Delargy, I. (2018). Optimising treatment in opioid dependency in primary care: Results from a national key stakeholder and expert focus group in Ireland. *BMC Family Practice, 19*(1), 103.

Weeks, G., George, J., Maclure, K., & Stewart, D. (2016). Non-medical prescribing versus medical prescribing for acute and chronic disease management in primary and secondary care. *Cochrane Database of Systematic Reviews*, 11. https://doi.org/10.1002/14651858.CD011227.pub2

WHO, World Health Organization. (2008). *Task shifting: Rational redistribution of tasks among health workforce teams: Global recommendations and guidelines*. https://iris.who.int/bitstream/handle/10665/43821/9789241596312_eng.pdf.

World Health Organization. (2009). *Guidelines for the psychosocially assisted pharmacological treatment of opioid dependence*. http://www.who.int/substance_abuse/publications/Opioid_dependence_guidelines.pdf.

World Health Organization. (2015). *Management of substance misuse—The global burden*. Retrieved August 31, 2015, from http://www.who.int/substance_abuse/facts/global_burden/en/.

Xu, J., Qi, L., & Mao, A. (2025). The barriers to nurses with prescriptive authority in exercising their prescriptive role: A systematic review and thematic synthesis of qualitative studies. *Global Qualitative Nursing Research, 12*. https://doi.org/10.1177/23333936251356349