C O R R E C T E D T R A N S C R I P T

STANDING COMMITTEE ON LEGAL AND SOCIAL ISSUES

LEGISLATION COMMITTEE

Inquiry into the role and opportunities for community pharmacy

Melbourne — 28 July 2014

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Witness

Mr I. Newton, OAM, practising community pharmacist.

Necessary corrections to be notified to secretary of committee

The CHAIR — I welcome Mr Irvine Newton, a practising community pharmacist. Thank you very much for your time this morning in appearing before the committee. All evidence taken today is protected by parliamentary privilege, therefore you are protected for what you say here today, but if you go outside and repeat the same things, those comments may not be protected by this privilege. Today's evidence is being recorded. You will be provided with a proof version of the transcript within the next week. Transcripts will ultimately be made public and posted on the committee's website.

I note that you have just provided us with some written information. Thank you very much for doing so. I now invite you to give the committee a brief presentation of 5 to 10 minutes, and then the committee will ask questions of you. Again, thank you very much for appearing before us.

Mr NEWTON — Thank you, Madam Chair and members, for the invitation. My presentation will be brief and the notes I provided are quite brief. I have been asked to speak to a couple of issues, specifically the current level of access of opiate replacement therapy in pharmacies, particularly in rural and regional areas; barriers for pharmacists increasing those services and what we might look at in terms of ways of breaking down some of those barriers; and then some possible incentives that someone might like to provide to make those services more available to people generally.

Before I do that I would like to give a bit of background on myself. I have been providing pharmacotherapies in my pharmacies for more than 20 years, and I have obviously seen a huge change during that period: the perception of the general population of what pharmacotherapies are about, the perception of clients and users of what pharmacotherapies can do for them and the general agreement about success and the successes we have with the program. Further, I have been chair of what we call the Pharmaceutical Society of Australia's Harm Minimisation Committee now for many, many years. That committee provides training, support and mentoring for pharmacist students and trainee pharmacists across the broad spectrum of the state. In fact I will speak soon about the program we have of education, mentoring and training that we have been taking right across the regions all over Victoria and the feedback we have had from that, but as I said, I will focus today on those three issues.

Firstly, I think it is really important to understand that the Victorian community pharmacy general practice methadone program is probably a world leader. We have had comments from people as far away as Glasgow and New York commenting on the way we run the program, the outcomes of our program and the fundamentals of the program, in that it supports people hopefully in their local community with a local pharmacy and a local GP. We see that as a superior model to the clinic model that exists often elsewhere overseas, but even in the state here. It normalises the relationship between pharmacists and clients, and we think that is a huge advantage.

Some of the things we should probably focus on and be fairly proud of are the retention rates. The pharmacotherapy program has by any standards incredible retention rates even compared to other disease states like diabetes, asthma and cardiovascular disease. We have done a couple of guild government agreement inquiries over the last 5 to 10 years, and we have had retention rates over periods of six months tracking people of 90 per cent and more. By any standards we think that is fantastic retention, and of course if you give them subsidies, the retention rates go even higher, so our program is very, very successful in that respect.

An important thing to notice is the demographics of the clients and the people who use the program and in fact drug users generally. There has been an enormous shift and change over probably the last 30 years now. We have about 47 000 clients nationally and over 14 000 here in Victoria. It is important to note that the numbers in recent times have been increasing marginally only, but they are in fact still increasing, so the opiate issue is not going away — opiate dependence is not disappearing. The heroin factor as the initial drug of choice and drug of use and abuse by people is probably diminishing, but it is being replaced by over-the-counter codeine-based compounds and prescription opiates, so the total numbers are staying the same, which raises another question for another day about use of OTC codeine and the massive shift to more liberal prescribing, if you like, of prescription opiates.

In my view it is very important that we recognise the shift and understand the implications, and there are quite a number of those. The cohorts of people who have now come to drug dependence say through OTC codeine use typically have no drug misuse history. They typically start in their thirties. They often start from appropriate use of over-the-counter codeine and prescribed opiates and they are relatively reticent to accept the fact that they are drug-dependent people. They do not see themselves as junkies, they are not heroin users, they are not street drug

users, so their likelihood of approaching or being involved with drug and alcohol agencies is probably diminished because 'I am not one of them'. So it raises lots and lots of questions about how we get these people into appropriate treatment models. Of course they are in serious danger of health issues and death ultimately, and certainly we have seen some deaths in Victoria over the last couple of years because the opiate dependence is driving their use of the drug, and the aspirin, paracetamol, ibuprofen is probably killing them.

We have an ageing population. As we all know, the heroin epidemic started after the Vietnam War in the 1970s and it has grown consequently since then, so any of the older opiate users from those days — any of the people who did survive, and of course not a huge proportion of them survived, but those who did are now in their sixties — may be moving into their seventies, which raises questions about where we go with aged-care facilities, nursing homes, hostels and so on. How will we provide services in those facilities? If your dear old mum is living in a nursing home, do you want the guy in the next room to be a methadone user? I think we have to come to terms with that and all the other health issues that those people would then have as they have aged. After all, generally they have not looked after themselves well over a long period of time, so they have the same and probably worse health issues — cardiovascular disease, diabetes, asthma, respiratory problems — than the general population.

Then the other thing that we ought to be really proud of and acknowledge with the AIDS conference here in Melbourne at the moment is that Australia has a magnificent record in constraining the development and spread of HIV and AIDS in our community, and pharmacy can hold its head up high in that respect, in that as providers of pharmacotherapy programs, needle syringe exchanges and clean injecting equipment right from a very early stage of the development of AIDS as a community issue, the proportion of HIV in our drug-using community is almost non-existent and it always has been. Certainly there are minimal numbers, but we do not have the sort of numbers they had in places in the 1990s, when about 50 per cent of IV drug users in Harlem in New York were HIV positive. I saw some figures the other day that suggest that 40 per cent of IV drug users in Moscow are HIV positive — terrible results. But Victorian pharmacy, or Australian pharmacy generally can really hold its head up and say, 'We made a great contribution to that not happening here'.

On the specific things I was asked to address, the current level of access of opiate replacement therapies in pharmacies, particularly in rural and regional areas, it is fair to say that we have done better in recent times. The pharmaceutical society, through its training program and the support it has had from the Department of Health here in Victoria, has been able to help increase the awareness of pharmacists and the interest of them in providing programs, and they have a consequent increase in not only numbers of pharmacies providing but also pharmacists who are trained and competent and feel comfortable providing programs. However, we have some roaring gaps across the state.

One of the areas we have done really well in in recent times is the western suburbs of Melbourne. You would think that that would be a fair hotpot of places where you might need to provide services, and indeed it is and was. We had a terrible shortage of pharmacists and, more particularly, GPs across that area for quite some time, and we have partially addressed that in recent times. That is partly because of the training and the support we have been able to give, but there are many areas around the state — the north-west, the west, the far east, the north-east — where there are nowhere near enough services, and there are quite a number of reasons for that.

There are two basic reasons, I think. We do not have nearly enough pharmacies. We do not have enough pharmacists trained and competent to do that. Secondly, there is the issue of the lack of uniformity. We might have plenty of pharmacies in some places in the state which will provide pharmacotherapy services, and then we have huge gaps where people just are not able to avail themselves of services because of distance, time or whatever. That presents a real problem. You can do an overall view and say, 'We have X amount of pharmacies providing services', but it may disguise the fact that in many areas we do not have services that are sufficient for people's needs. If people cannot access a service somewhere near where they live or work or operate, then the service is not going to be taken up. People will not have the facility, will not have the desire and will not want to travel long distances to avail themselves of services. When you think that most people actually, at the beginning of the process — everyone who begins the process of the service needs to access it every day of their life. It is a fairly onerous task by any stretch of the imagination, particularly if you are a long way away from where that might happen.

I talked about PSA's development program, and that is certainly taking hold. We are having great results in the regions. People are certainly changing their attitude towards whether they want to provide services and be

involved, and we think that is fairly successful. What are the barriers? The barriers are pretty obvious. The first one is inadequate financial return. If I told you that in 1988 I started providing pharmacotherapy services to Collingwood and was charging $35 a week and that in 2014 I charge $35 a week, I cannot imagine much else in society that has maintained the same figure over that period of time. The reality is that pharmacists understand that most of their clients just do not have the capacity to pay, so, virtually from their own pocket, they are funding the program, but this cannot go on.

We have already seen some large pharmacies in particular but also large chain pharmacies that have just withdrawn from providing services, sometimes with disastrous results. We had one in an inner suburb of Melbourne where the pharmacy had about 70 clients who were attending that pharmacy daily. The pharmacy changed its model, moved down the street, developed a bigger, larger building and said, 'We're not doing pharmacotherapy anymore'. I think, together with the department, we had to try to find other pharmacies that would take up 70 extra clients. That is not a very easy process apart from the sheer angst it provides for those poor clients, who are then suddenly looking for somewhere to go.

The next barrier of course is lack of training and support and mentoring. As I say, we are managing to address that, but we need more help. The isolation within community pharmacies — if you are running a single-pharmacist operation in a small country town somewhere and you are not particularly familiar with providing pharmacotherapies, it is fairly difficult to get started. You are going to be truly dealing with drug-dependent people, and I do not know how to deal with drug-dependent people; I am no more knowledgeable about how they operate than the general population. Finally, pharmacist attitudes — like any member of the population, pharmacists sometimes have attitudes that are not conducive to providing for drug-dependent people. We are working on that, and I think we have seen a massive shift over the last 5 to 10 years in the way pharmacists think about drug-dependent people, but we need more. We need to keep at it, and we need more support to do that.

Finally, the third thing I was to speak about was some possible incentives that might be needed to increase the availability of the services, and obviously the first one is fee payments. Victoria does not support pharmacists in providing pharmacotherapy. It is one of the few states that really does not. We have three funding programs here in Victoria, one of which was an initiative of the pharmaceutical society in fact where the state pays dosing fees — service fees — for clients 18 years and under and for kids in the juvenile justice system 21 years and under. They are great initiatives, but it does not put any money in the pocket of pharmacist providers.

The other one is post-prison release, where the program is paid for for 30 days following release. I could suggest to you that 30 days is very nice, but it would be nice to have 90 days or 180 days to get some real stability. Can you imagine leaving prison, finding a home and some place to live, clothe yourself and feed yourself and trying to find a methadone program — a pharmacotherapy program?

Finally, the other thing we might like to look at would be some training subsidies. It is very expensive for pharmacists, particularly in the country, to give up a day, to get a locum pharmacist to come — to get their business run by someone else — and to then attend training. That is, in a nutshell, what I would like to say, and I would invite any questions.

The CHAIR — Thank you very much for that comprehensive overview of the challenges you see. Can I just have a clarification in relation to the numbers of pharmacies that provide pharmacotherapy? It is my understanding that there are around 100 pharmacies — is that right?

Mr NEWTON — No, we have about, I think, 1400 pharmacies in Australia, and there are about —

The CHAIR — In Victoria specifically?

Mr NEWTON — four hundred and fifty of those, give or take a few extra, providing services here.

The CHAIR — In Victoria — 450?

Mr NEWTON — In Victoria.

The CHAIR — What percentage of overall pharmacies is that?

Mr NEWTON — It is around 40 per cent, I understand, but I think recent figures are showing an increase.

The CHAIR — How many of those are in metropolitan Melbourne as opposed to rural and regional areas?

Mr NEWTON — Sorry, I do not know. I do not have that available.

The CHAIR — That is fine. But the challenge is increasing in the regional areas for lack of ability to — —

Mr NEWTON — The real focus of the challenge is in the regions because of the isolation and the distances between towns. I heard an experience, actually, of a colleague of mine. The daughter was out with another daughter, and they were talking about pharmacotherapy. Something came up. The pharmacist has a pharmacy that is in a small rural community. There is not another pharmacy within an hour in any direction, and he flatly refuses to provide pharmacotherapy. He is not at all interested in doing that. Obviously we need to get to him, to talk to him and to try to change his attitudes towards what it might mean. Can you imagine the isolation of people in that huge area? There are virtually no services available. People have to be pretty committed to start on a pharmacotherapy program anyway. It is a huge decision in a person's life. They think, 'I'm going to change my life and do this instead of that'. They need all the support they can get.

Ms HARTLAND — I have a couple of questions. Maybe I will just ask two, and if there is more time I will ask more. Regarding the actual cost to a pharmacist to dispense this service, you are saying here that $35 is what you receive. What is the actual cost per client?

Mr NEWTON — The only figures we have from any recent times are part of the most recent guild-government agreement study we did, which was carried out over about 15 months. People went and looked at what pharmacy was providing. I get really annoyed because people call it a dosing service. It is not dosing service; it is a comprehensive pharmaceutical care service, and often it is way more comprehensive than you could dream of providing even for an elderly person on cardiovascular drugs or so on. It is about providing a service and providing support. People will provide financial advice, and they will help with housing and all those sorts of things. But even leaving those things aside, if you take the core pharmacy service, which is priced at $9.40 per day, it is something like $70 per week.

Ms HARTLAND — To make sure that I still have the right understanding, someone will come into your pharmacy six days a week and will be allowed to have one take-home dose.

Mr NEWTON — No, there are specific rules in the guidelines. The guidelines in Victoria are the most liberal in Australia in relation to takeaway doses. Some of us who helped to rewrite those are starting to wonder whether we got it right. Can I just explain about takeaways. Takeaways are very necessary for many people. They facilitate the program happening. I have two young men who have been with me now for six or seven years. They never miss a dose. One of them works six days a week full-time. One works five days a week full-time. They have both done really well in their employment. One has just bought a house, and the other one is trying to buy a house. They have both gotten married in recent years. They live off their takeaways. They could not survive, do what they do and have the constructive, invigorated lives that they have without takeaways.

I have some other clients who live in public housing accommodation not 150 metres from my pharmacy. They are on health-care cards. They have virtually nothing to do every day, and they are getting takeaway doses. The reason for having takeaway doses is that it should, in my view, be addressing a need. One of the first things we ought to be talking about is the need, and that means prescribers and pharmacists talking together. Having said that, what was the question?

Ms HARTLAND — You have actually answered the question. It is several years since I have dealt with this issue. This was a problem I encountered with people who were actually working and not being able to get to the pharmacist each day to pick up their dose.

Mr NEWTON — Once again, in the regions you can imagine a situation where people need lots of takeaways just to facilitate them having their doses. The rules are quite specific. You start with no takeaways. Everyone starts with no takeaways. There are various entry points where you get two takeaways maybe and then five after six months and so on. The regulations vary enormously from state to state.

Mrs MILLAR — I am interested in some of the data around the changing demographics and the ageing issue, particularly the comments around those in their 50s and 60s who do not recognise that they have an issue. Clearly pharmacists have a very big role to play here, because these are the kind of people who would not be accessing a GP.

Mr NEWTON — Maybe I have confused you a bit. When I refer to 50s and 60s I am talking about people probably primarily who have been on pharmacotherapies off and on over many years. If someone started using heroin in the 70s and survived all those years, you hope that they are on pharmacotherapy programs. Those people, and there are plenty of examples of them, are now out there. They are ageing really rapidly. Their health state is usually pretty poor, and they are the sort of people we need to start thinking about. We need to consider what we do beyond pharmacotherapy by way of providing health care for those people. They need to live in an aged-care facility like a nursing home and have the nursing home accommodate that and so on.

The other group of people I was talking about were people across a broad spectrum of ages who have now become drug dependent through inappropriate use of over-the-counter codeine compound products or prescription opiates. They could be any age. Typically they start using beyond 30. They are not 19-year-old kids; they are 30 years plus. Typically they are fifty-fifty male and female. They are the people who, I think, are going to have great difficulty embracing and getting involved in pharmacotherapies because they think, 'I'm not a drug user. I'm not drug dependent'. They do not see that they have a problem. The biggest issue at the first stage is actually getting them to address the fact that they do have an issue and that we need to address it.

Mrs MILLAR — It is that second group that I am interested in along with the role that community pharmacists have in being able to work with that group and perhaps get them to access broader health services through the GP or other avenues.

Mr NEWTON — We have a critical role to play. Pharmacists are the most accessible professionals in the community. We are the ones who are dealing those drugs. We see those people regularly. Often they are our long-time customers and clients. We have been trying to develop some training programs. It is really difficult for pharmacists to even cope with a request for codeine over-the-counter products at the moment. That is a really difficult thing. If someone turns up looking poorly dressed and so on, it is not that difficult to ask lots of questions and maybe refuse the sale. But if it is a fine, upstanding member of your local community who lives around the corner and turns up in a suit and with a laptop, that becomes more difficult. It is the same people. Pharmacy has not by any means gotten on top of it yet, but we are getting there, I guess. It is a difficult area. It is probably as difficult as anything we have ever had to cope with. As they progress into drug dependence, how do you then address them and get them to look and see where they are? That is the real issue.

Mr LEANE — I am interested in what actually occurs when a client presents themselves for therapy.

Mr NEWTON — There are two ways. People will be referred from one of the drug and alcohol agencies to a pharmacy or prescribing doctor, and it does not matter which way that happens. The process then is that someone will come to my pharmacy and say, 'I believe you run a pharmacotherapy program. Can I get on your program?'. I will say, 'Yes, of course, but do you have a prescriber — a doctor?'. Sometimes that means they do, but often you will have to direct them to a GP who you know prescribes pharmacotherapy. They will visit the pharmacotherapy-providing prescriber who will sit them down, do the review and make an application to the department for a permit if he sees fit. The department is fantastic these days. They will produce a permit on the same day, which is absolutely critical.

When I first started this thing it used to take two and three days. You had someone who had applied, you had their name and address, but you never saw them. They had made the decision. You only get a small window of opportunity, a few hours, and they have made a decision, have not used for some time and will start on your program. So that is really important. Then the prescriber writes a prescription — a valid script with a valid permit — produces a photo that recognises the client as who they are and endorses that for the pharmacist, and the pharmacist can start that person that very day. So it can all happen within 3 to 6 hours.

Mr LEANE — So after that process, whether it is a daily prescription or dose, what actually occurs then? The client comes in and then what?

Mr NEWTON — Initially the prescription would be for day dosing, face-to-face dosing, or supervised dosing as we call it, and that would be for at least one month perhaps for buprenorphine and two months for methadone. That is presuming all goes well and the client is stable and seen to be doing well. But basically what happens is that the client will attend the pharmacy daily to have that dose and it will be consumed in front of the pharmacist and that will be observed to happen, and the initial prescription will usually be for maybe 7 to 10 days because you would hope that prescribers would review the case after the initial prescription.

Titrating doses is not easy. It requires great skill, and it is one of the things that makes a lot of pharmacists and prescribers a bit nervous. We have seen deaths in recent times. There have been a couple reported by the coroner of people who have been probably — I do not know how to say this — prescribed a couple of doses and died very soon after starting a program. It is an absolute disaster, so people are nervous about that, and rightly they should be. Someone once described methadone as a very boring drug. It is that, but it is also very dangerous, so the titration of the dose to get people to the stable level takes some time and some patience and needs to be done slowly and carefully. That would usually happen over a period and might take up to a month, so the doctor might review that person's case after, say, 7 days, 2 weeks, a month and then so on and they will usually have monthly appointments after that I would think.

Mr O'BRIEN — Thank you, Mr Newton. In relation to the methadone program and the trends you are seeing in relation to over-the-counter opiates and other factors, to what extent are those people ending up on the methadone program?

Mr NEWTON — We do not have any really substantial figures yet. Anecdotally I can tell you that there are people out there who are now on pharmacotherapies. Generally it tends to be buprenorphine rather than methadone. Methadone still comes with a terrible stigma that it had over the years, that it is 'the 'done, 'the street drug' and so on, but methadone is actually a fantastic drug. It is still the gold standard, but we have two gold standards these days — we have one called methadone and one called buprenorphine — but people generally have heard about methadone, they have read newspaper articles and they would not want to be involved in being a methadone client so we are starting to see people certainly on buprenorphine, and there is certainly anecdotal evidence that some of those people are addressing their issue through that, but there is still then the stigma, as they would see it, of having to come to a pharmacy daily to receive a dose — 'Why am I attending a pharmacy seven days a week? Why can't you just give me the stuff to take away?'

Mr O'BRIEN — There is also a bit of an irony in that group too because while the heroin addicts have initially got their habits from illegal activities, in this case they have actually got their habits from materials that may well have come from the pharmacy in the first place.

Mr NEWTON — There is generally acceptance in the population that, 'Yes, it must be okay, it was sold legally, in a pharmacy. It was on a prescription'. Or they say, 'The pharmacist sold it to me so how could that possibly happen?'.

Mr O'BRIEN — So just turning to that core issue, then, of the overuse of opiates and other medication and the role of a pharmacy in looking at what we are determined to consider in extending roles of pharmacies, how can we get a better check on this overuse? What are we doing wrong in the present system, and how will we make sure that that is not exacerbated in any extended role?

Mr NEWTON — I just do not think anyone has put the resources towards doing a substantial study. It is probably a bit fair bit more difficult to study anyway because, believe it or not, opiate-dependant people or people who have been on pharmacotherapy programs or drug-dependent people are actually quite open to being involved in studies. They are unbelievably honest about their behaviour and their drug-use patterns. Again, I do not think you will necessarily find that as easy to happen with those people who are already in denial anyway. So anecdotally we can build up a bit of a case. Certainly there are lots of people like Dr Craig Fry and Malcolm Dobbin at the department, and others, who have now put together lots of figures of cohort studies that they have done about what is really happening, but to extend that to say how many of those people do we now have on pharmacotherapy programs as a result of coming to drug dependence through use of legal drugs — I do not think we know.

Mr O'BRIEN — But if you could perhaps take this on notice, how would a pharmacist's role be best remunerated into the future? You say it is only $35 and that figure has not changed since the 1980s. There is

clearly a conflict in the over-prescription if that is part of the problem in relation to codeine, whether it is over the counter or prescription. Do we need to get it to a situation where pharmacists somehow get rewarded for providing advice to not take any codeine-related substances?

Mr NEWTON — I think those of us who have been involved in an official pharmacy for many years have campaigned for the provision of a payment for not providing a drug.

Mr O'BRIEN — Yes.

Mr NEWTON — The number of times people come to the pharmacy and you talk to them about their symptoms and say, 'I do not think you should take your medication. Do this and this and this' — —

Mr O'BRIEN — That is an ethical thing you are doing, but there is a conflict against that if you are not being remunerated.

Mr NEWTON — Absolutely it is, so it is the conflict that pharmacists live with every day — we are commercial operators trying to make a living but we are also ethical pharmacists just trying to do the best for the health and welfare of the client.

Mr O'BRIEN — I will have to put it on notice because I am at the end of my questioning, but if you could provide us with what work has been done in relation to that issue and how you see that could be extended — —

Mr NEWTON — Do you want me to provide that later?

The CHAIR — If you could take that on notice, that would be most helpful, thank you.

Mr ELSBURY — We have received some evidence that suggests that pharmacists are far too busy to take on any further responsibilities. What is your view of that, considering your experience with this program?

Mr NEWTON — I would probably take a totally different view to that. We are all busy. It depends what you are busy at. My view is that I am a pharmacist first and foremost, and I am more particularly concerned about providing pharmacy professional services than I am about selling dolls and toothpaste and detergents and jelly beans. My view is that if you run a pharmacy and you want to be a really good pharmacist and provide quality pharmacy services, then you resource that well enough to do it. I have found no difficulty doing that over many years in my pharmacy, and many of my colleagues do the same.

The CHAIR — Thank you very much indeed. Unfortunately we are out of time. On behalf of the committee I thank you for your time this morning, your presentation and the written material you have provided to the committee. Your evidence has been most helpful.

Witness withdrew.