LAW REFORM, DRUGS AND CRIME PREVENTION COMMITTEE

Inquiry into the supply and use of methamphetamines, particularly ice, in Victoria

Melbourne — 3 February 2014

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Mr S. Goma, Manager, Professional Services, Strategic Harm minimisation in Pharmacy (SHarP) Advisory Group, Pharmacy Guild of Australia – Victoria.

The CHAIR — I welcome our two witnesses: Angelo Pricolo, chair, Strategic Harm minimisation in Pharmacy (SHarP) Advisory Group, and Stan Goma, manager, professional services. They are also both from the Pharmacy Guild of Australia. This is a joint parliamentary committee of the Parliament, the Law Reform, Drugs and Crime Prevention Committee, and we are currently investigating the supply and use of methamphetamines, particularly ice, here in Victoria. We have already had a number of public hearings in Melbourne and a number in regional Victoria as well. We thank you for your time this afternoon, and we also thank you for your written submission. I read it a couple of days ago, and it has some interesting recommendations which we would like to flesh out this afternoon.

We have allotted until 2 o'clock for this session. Before I ask you to provide a verbal submission I will read you the conditions under which you are presenting this afternoon. Welcome to the public hearing of the Law Reform and Drugs and Crime Prevention Committee. All evidence taken at this hearing is protected by parliamentary privilege as provided by the Constitution Act 1975 and further subject to the provisions of the Parliamentary Committees Act 2003, the Defamation Act 2005 and, where applicable, the provisions of reciprocal legislation in other Australian states and territories. It is important that you note that any comments you make outside the hearing, including effective repetition of what you have said in evidence, may not be afforded such privilege. Have you received and read the guide for witnesses presenting at parliamentary committees?

Mr GOMA — Yes.

Mr PRICOLO — Yes.

The CHAIR — It is also important to note that any action which seeks to impede or hinder a witness or threaten a witness in the evidence they give or have given may constitute and be punishable as contempt of Parliament. We are recording the evidence and will provide a proof version of the Hansard transcript at the earliest opportunity so you can correct it as appropriate. Welcome. We are in your hands.

Mr PRICOLO — Thank you. I have not done this before so you will have to accept some of my inconsistencies. Thank you for the opportunity to come down and have a chat to you. The first thing I want to say is that sometimes a pharmacy gets overlooked in a lot of public health forums. I think that is an oversight — and I will run through a couple of little things in the presentation — because we have such an amazing network right across the country and it is underutilised. Certainly this is one area where maybe we can change that situation.

I have a little bit of background information about the guild itself and community pharmacies, so I will just run through those, and I will do that quite quickly because hopefully you will have some questions which will be more focused, and we can talk about it that way.

Overheads shown.

Mr PRICOLO — The guild itself was founded in 1928. That is even before the Carlton Football Club, which is as far back as my history goes. We are the leading industry body for community pharmacy such that about 80 per cent of pharmacies are part of the guild. I tried really hard to get a similar statistic for the AMA, just to provide a bit of a comparison, and my best information is that it is a fair bit lower, but as hard as I tried, with all my contacts, I could not achieve a number, which I thought was interesting in itself — you just cannot get that number. It is a bit odd. Maybe someone can enlighten me on that.

The fact that we represent that many pharmacies is very important. It is probably about 5300 pharmacies Australia-wide, and it is about 1300 just in Victoria. Obviously dispensing prescriptions is part of what we do, but there is a lot more to it, and there are a range of counselling and community services that we provide, which varies. Often you will find that in some more remote settings the pharmacy is called upon to do a lot more than it is in a lot of metro settings.

I think the standout line on that slide is the number of visits each person in Australia makes to a pharmacy. It is 14 times per year. That is every person, which is a huge statistic, and as we get into talking about ice, I think it is relevant to understand that even if somebody is not coming to the

pharmacy to purchase their drug of choice, somehow everybody ends up in a pharmacy, whether it is to buy a toiletry need or whether it is to buy a drug that is used in conjunction with the drug that is their drug of choice, whether it is their recreational drug or whatever.

The fact that we have such a network and that people are visiting on such a regular basis means that we are an excellent point of contact, and that works both ways. It is a point of contact for people to get to us but also for us to get to them. The basis of what we try to implement is not different to a lot of other community groups. It is around the three-pronged attack to harm minimisation, and I am sure you are well aware of that. In terms of supply reduction, real-time monitoring is something that has eluded the country in terms of prescription real-time monitoring. We are in a terrible state at the moment where the government has, in a nutshell, purchased a model from the Tasmanian government, and now it is in this holding formation because the states and territories cannot get together to have a unified model so that we can all access prescribing and dispensing information.

We keep talking about it, and every time we say there is a drug problem we say, 'Well, real-time dispensing is going to help that', but we just say it and I do not feel we are getting any closer. We are in this holding pattern and we were there a year ago as well. So with that background, it is interesting to note that the Pharmacy Guild, which is pharmacy owners, put about a million dollars a year of membership from our pharmacy owners into a system called Project STOP, which is used to track and monitor the sale of over-the-counter pseudoephedrine products.

I cannot think of too many other fields where you actively fund a system that will reduce your own sales, but that is effectively what we do because by monitoring we slow down the supply, monitor and reduce the number of sales, which is a valuable asset in the distribution of OTC pseudoephedrine, and it has markedly changed the landscape. It is also interesting to note that in Victoria Project STOP is not mandatory whereas in most other states it is, so I think that is something we need to look at. We also need to ask ourselves why we can have this real-time OTC system up and running and yet we cannot seem to manage it for the prescription drugs. If we look at the number of prescription opiate deaths, it is scary and yet we have been running this system for three or four years and its biggest downfall in Victoria is just the fact that it is not mandatory, and again we cannot seem to get heads together so that it becomes mandatory. Pharmacy wants it to be mandatory, and it is in other states, and yet again we are in this holding pattern where we do not seem to be going anywhere.

The CHAIR — You say other states. Do you mean every state bar Victoria?

Mr PRICOLO — No. I can check that for you and I will not guess, but I know in Queensland it is mandatory and I am pretty sure it is in WA but — —

Mr GOMA — WA and South Australia.

The CHAIR — But not New South Wales?

Mr GOMA — Not New South Wales.

Mr PRICOLO — Nothing is mandatory in New South Wales — I forgot this is on the public record. Sorry — joking. Nationally consistent regulation, adequate regulation of internet pharmacies, education campaigns — these are all measures that are very important, and pharmacy in some way is trying to achieve — one of the areas where we let ourselves down, and again I think it is where we need some help from the regulators, is that the wrong drugs are being price promoted by some pharmacy outlets. This is something we do not want but we are powerless to stop it. The guild is not an organisation that can change that, but certainly it is something we are not happy with, and as far as a public outcome is concerned it is something we would love to see changed.

Do you understand what I mean when I say price promotion? It is including drugs of abuse or potential abuse on a list of price-cutting items. It is outrageous. It is just crazy. The form work for the legislation is there to be able to stop price promotion but it is not enacted. There is a schedule of drugs which is empty because we have not put any drugs in it, and specifically that schedule is

drugs that are not supposed to be price promoted, so we have the framework but are not doing anything. It is just another revving-in-neutral example.

Probably a third of the syringes that are used to inject by intravenous drug users in Australia are supplied from pharmacy. A third. So that is millions a year. I think that is an important statistic to understand also in light of the push at the moment for vending machines for syringes.

Mr SCHEFFER — How are the other two-thirds accessed?

Mr PRICOLO — There are different community centres that supply syringes. The fact that not all pharmacies provide syringes means that it is only one-third; otherwise it probably would be far more. I do not know the number of pharmacies that supply syringes, but when you consider that probably 40 per cent of pharmacies are involved in opiate substitution therapy, it may be somewhere around there.

The CHAIR — What is the point of that? Are you suggesting greater control over it, dispensing syringes? There are diabetic users and the like who access that. What was the point you were making on the statistics in relation to syringes?

Mr PRICOLO — The fact that a third of them go out of pharmacy?

The CHAIR — Yes.

Mr PRICOLO — It is similar to what I was saying at the start, which is just what an important contact point pharmacy is. A contact point is just another interface where you get to confront your challenges. The reason why an injecting room in Sydney has done so well is because there are people who visit a pharmacy, who visit a doctor, who are intravenous drug users. Then you have a different set who will go to an injecting room. Now all of a sudden you have gained access to a group of people to whom you may not have had access before. It is much easier to deal with the problem, to try to deal adequately and treat and improve outcomes if you have access. If you do not have access, then you are throwing punches in the dark. The idea of an injecting room where all you are doing is providing electricity and a safe environment means that the syringes are not ending up in a laneway. There are a lot of positive reasons. You only have to look at the outcome from the Yarra community group. I think the councillors there voted 9 to 1 to have an injecting room and yet we still cannot seem to get that past state level. I am sorry to bring that back onto the agenda, but it is something that needs to be — —

The CHAIR — That is all right. We asked about that this morning, and in fact another group of witnesses were strongly in favour of having safe injecting rooms and some control over the environment.

Mr PRICOLO — I think if you talk to people in the sector, there are not too many people who are opposed. Because the evidence for the benefit is so overwhelming, to the drug user and to the community, it is hard to understand, other than that it is a change and change is always difficult to impose or begin. Other than that, I have not heard a good, strong argument against.

Ice is a particularly interesting drug because it is so incredibly potent. Methamphetamine in that form, as we know, is such a huge problem. The reason again that pharmacy becomes very much involved — even though obviously we are not selling the ice and a lot of the starting material is not coming from us but is being shipped in — is that the nature of the drug and the high that it creates so intensely means that you have to come down. So the benzos are coming from pharmacy, which again alludes to what I was saying earlier, that even if we do not have that direct contact we subsequently are getting contact. Again, even if it is not directly with the person who is taking the benzos, then it is someone else who is an intermediary and the drugs are moving on.

There is a role there for education and for understanding how the drug works and what the problem is, whether it is the use of the drug or the syringes. Again, with a drug like ice, it is smoked; it is used by a different route of administration generally. The older drug users are used to using speed, which was a less potent version, in a powder variety. That was more often than not injected. You still have a population that will inject that drug because that is what they are used to. And then of

course there is a huge group who are just addicted to the needle and they will inject water. I have had eye drops stolen from the pharmacy and when I have talked to the guys and said, 'What are you doing?', they have said, 'You don't understand. It's the needle. I'll inject water, if I have to. It's the needle'. So we are dealing with a group of people who have very particular needs.

Just getting back to pharmacy and the guild and I suppose our position before I open it up to questions, I will make another point to illustrate the network of pharmacy that we have and the challenges that we have in trying to sometimes even justify our existence in the health system. When the bird flu epidemic hit in 2009 I remember getting a phone call on a Sunday morning from the guild saying, 'We have to distribute this Tamiflu; the virus has gone crazy and pharmacy has been chosen as a network'. I got that call on Sunday morning and on Sunday night I had 500 packets of Tamiflu on my shelves that had arrived via a courier and I was dispensing it on Sunday night. It was a not even 24-hour turnaround, so there is an incredible network there.

It is also, I suppose, part of the frustration when you see the AMA's reaction to pharmacy wanting to do vaccines, which, for the record, in 50 states of the USA have been done out of pharmacy for the past five years. That is not to mention the UK and various other places. We get this incredible kickback from the AMA that we do not know which end of the needle to hold or something. I do not know. It is that crazy stuff. To be left out of this loop as well would be an unfortunate outcome for the community.

That is kind of what I wanted to say. If anyone has any questions for myself or Stan — I do not know if Stan has a comment to make, but otherwise, thank you very much for the opportunity to come down and have a chat. It is good to see Dave again.

The CHAIR — Can I just home in on this real-time monitoring, which I guess for all of us has raised a number of questions. I have read your submission. Given that it is basically nationally supported by the guild anyway and by some states — and in fact the Drugs and Crime Prevention Committee recommended such seven years ago — I am trying to work out what is the resistance.

Mr PRICOLO — Are we talking about Project STOP or are we talking about real-time prescription monitoring?

The CHAIR — The real time. It is an evolution, is it not?

Mr PRICOLO — No, they are two completely separate things.

The CHAIR — We are talking about data collection on prescribed drugs that are bought over the counter that are documented in relation to possibly being used for — —

Mr PRICOLO — That is Project STOP, and that is only to monitor pseudoephedrine, although the platform can be used to monitor — —

Mr SCHEFFER — Can you just go back and explain how that works? You are in the pharmacy, someone walks in — —

Mr PRICOLO — I am in the pharmacy. I get a photo ID. Usually it will be a drivers licence. I plug in the number and what comes up on my screen is the purchase history of that person over the last — I do not know; I am not even sure whether it is 6 or 12 months. In a snapshot what I see straightaway is that I can identify people who have bought 3, 6 or 10 packets on the same day or in the same week in other pharmacies. So I know straightaway that it is not a valid purchase; it is not someone who has a head cold. There must be another explanation.

At the moment that is being used for only pseudoephedrine. There is no reason why it cannot be used for other OTC products, and the obvious one of course is codeine. Codeine and combination OTC products are a big problem too, but we will talk about that another day.

Mr SCHEFFER — What is the distinction between Stop and — —

Mr SOUTHWICK — mandatory reporting?

Mr PRICOLO — Stop is OTC — over the counter. When we are talking about real-time monitoring of prescriptions, then we are talking about what goes on the doctor's computer. We are generally then talking about the benzos and not what is in my safe, the opioids, so we are not talking about MS Contin, Endone and morphine. That is a different system and that would mean that when a doctor writes that prescription, potentially other doctors and other pharmacies will have access to know at that point. If I am a doctor shopper I will go to more than one doctor. Then I go to see this doctor and when he tries to write an MS Contin script he knows that the guy down the road wrote one. That can have varying forms as well, because there is also the facility for the dispensing to come up as well. Just because the doctor wrote it does not mean that it has been picked up. Then you run into other problems with the AMA and the RACGP, but again that is another — —

The CHAIR — I am sorry to go back to this point, but reading your notes, they say:

> A real-time monitoring system is already used to address the pseudoephedrine issue through a national program called 'Project STOP' —

which is —

> a real-time, web-based program designed to track … sales and assist law enforcement in identifying … 'runners'.

So Project STOP is at the counter, whereas the national monitoring system is at the doctors/prescription level.

Mr PRICOLO — Correct.

The CHAIR — It was not made clear to me that there was a distinction between the two.

Mr PRICOLO — Apologies. The doctors do not have access to Project STOP and OTC sales.

The CHAIR — So how many people are participating in the real-time monitoring at the doctors/prescription level? Is that a nationally supported program?

Mr PRICOLO — My understanding is that when the federal government purchased it from the Tasmanian government early last year it was supposed to be up and running across the country by 30 June or something, and we are nowhere near that. The main problems with that are, first, getting the states and territories to agree on how it will look and how it will work and what will be monitored and how much history there is and who has access to it. The other huge problem of course is opt in/opt out, and the other issue around that is privacy.

They are the stumbling blocks that are stopping that from coming into place, but, again, I brought that up and highlighted Project STOP because we have been running it for five years across the country. It is very similar in a lot of respects. It single-handedly has made an enormous difference. It gives pharmacy borrowed protection. It means that we can have something solid — objective — to base a decision on rather than judging somebody who walks in as to whether the sale is legitimate or not. Of course for everybody who walks in who wants to purchase, whether they are sick or they are making up a story, the symptoms are the same; they have a runny nose, and they have a cold. It is pretty hard from our side of the fence. As much as I respect our friends at Victoria Police, I did not train to be a policeman. That is not what I want to do. That is a tough gig.

The CHAIR — Are they the same reasons that there would be a reluctance by the Victorian government to introduce or support Project STOP?

Mr PRICOLO — Project STOP as a mandatory — I do not know. I really do not understand why it is not mandatory.

The CHAIR — You have not gotten any feedback from the governments today — —

Mr PRICOLO — Look, probably at a higher level in the guild they have. They know that the previous Vic president had discussions with Victoria Police, and I know he presented it to them

and was very encouraging of that legislation being adopted. Again, I do not know why it did not go anywhere.

Mr CARROLL — The fact, Angelo, that the majority of pharmacies have registered for Project STOP — —

Mr PRICOLO — Correct.

Mr CARROLL — So making it mandatory — how big a difference does it make when they have already signed up for it?

Mr PRICOLO — The fact that you are signed up does not mean that you are using it. Again, I think we really successfully encouraged our members to sign up and made it as easy as we could and put the platform in place, so it was just a matter of clicking on and doing a couple things.

Making it mandatory is one thing; the other thing that I think is very important is that it should be supported, and it should be funded. It needs to be improved. The reason I do not use it all the time — and I do not, although I use it the majority of the time — is because it is cumbersome and a little bit slow. It could be better, and in a community pharmacy setting there can be a lot of pressure on you depending on your workload. Unfortunately sometimes you take the easy road out. Making it mandatory will force us, firstly, not to do that, but hopefully what it will also do is encourage this area to get a bit of funding rather than the guild and our members' subscriptions going towards — everybody wants the data. Vic Police get the data, and everybody wants the data. That is really handy, but I do not see that really as our place to have to fund that system. We have already for the last four or five years; I think that is enough.

Mr GOMA — Can I just add to that? We also know that in the states where it is mandatory the quality of the data is a lot better because it is done consistently. Every time somebody presents to pharmacy with a request for pseudoephedrine, it is recorded, so you can rely on that information, whereas here in Victoria, unfortunately, it is patchy. We believe that having it mandatory will certainly ensure that every single transaction is recorded. That is one thing.

The other thing is that it helps identify people who have a problem. Going back to what Angelo said earlier, one of the things we are very keen to emphasise is the unique position that community pharmacies exist in. If somebody comes to you with frequent requests for pseudoephedrine, it allows you to start a conversation about what other issues they may have. Pseudoephedrine in some ways is somewhat unique because the person who may be purchasing it is not an ice user per se, but in relation to other drugs, such as Nurofen Plus, what we believe is that community pharmacies can, having identified that somebody has a problem, refer them to treatment, for example. The fact of recording it — making it mandatory — is going to make a significant difference if it were to happen.

Mr SOUTHWICK — I just wonder, Angelo, in terms of those not signed up to the program, how aware do you think the users are in terms of a pharmacy that may be more lenient when it is offering up Nurofen Plus or other types of product?

Mr PRICOLO — Very.

Mr SOUTHWICK — Very. And that sort of information would be fairly easy to track, I gather, in terms of — —

Mr PRICOLO — I think it is so. There is word of mouth and then there is just your own experience. It is pretty easy to decide where you are going to go shopping with that information.

Mr SOUTHWICK — So by us having some form of legislation, that would be one way of fixing that particular — —

Mr PRICOLO — Yes, for sure, because, as Stan said, we will then get consistency. We do not just get good data but we get a consistent approach and focus.

Mr SOUTHWICK — Okay. At the other end we were talking about the community pharmacies being, if you like, the place where it has that interaction. One of those areas is, obviously, morphine-dispensing programs. Obviously morphine is not used as part of ice treatment, but it is for many addicts who are coming in. Is there any additional counselling that is involved or anything other than handing the morphine over to the user currently? Is there any sort of, if you like, good practice that could be learnt from some pharmacies and implemented as a broader form of harm minimisation treatment?

Mr PRICOLO — Yes. I suppose my first comment is that there are good bricklayers and bad bricklayers, there are good doctors and bad doctors, and there are good pharmacy practice models and ones that are not as good. Certainly the best practice ones would offer, as I said, a ranges of services. There are close to 14 000 people on ORT — opiate replacement treatment — here in Victoria, and there are about 43 000 in Australia, so we have a fair slice of them. New South Wales has about 17 000 or 18 000. For every person on ORT, there is probably another one who should be, which means that nationally we are talking about maybe 100 000, and in Victoria we are talking about 25 000. They are big numbers.

Out of those, whereas when you read about the landscape in the 70s or maybe early 80s when heroin was the drug of choice and a lot of people used one drug as their drug of choice, what we are seeing a lot more of now is multiple drugs being used. Similar to that example of people using ice during the day and then two days later using something to come down, often the drug of choice to come down is heroin — although that has diminished as well — and the other drugs that are being accessed as the opioid are the prescription opioids. I suppose what I am getting to is that a lot of the people on ORT in the pharmacy are also ice users, so there is a big crossover.

Pharmacy has an incredibly unique model of distributing and supplying ORT. I remember speaking about the way methadone is dispensed at an addiction conference in the US probably four years ago. They almost fell over when I told them that almost 40 per cent of community pharmacies in Australia dispense methadone as a substitute for opiates. I can remember having a bit of fun with them and saying that I could not understand why they were surprised that we dispense methadone at a pharmacy when if I wanted to buy beer in the US, I could go to a pharmacy. They do not think it is funny to sell beer at a pharmacy, but they do think it is funny to dispense methadone.

It is a unique model. It is also in Europe; Europeans do not have methadone dispensed from community pharmacy. The huge advantage of community pharmacy is that it begins to normalise the treatment. If you have a stand-alone clinic, it labels the individual who goes there; it is not conducive to helping them get back into the mainstream. The community pharmacy model is amazing. It gives a lot of these kids a focus for the day. The supervision is very important, especially at the start. There are a lot of things to be said for the way methadone and buprenorphine are dispensed from pharmacies.

To get back to your question, that is obviously a fantastic opportunity. In many of the pharmacies, certainly at mine, it is an access point and an opportunity to discuss what is going on. When one of the guys who has been stable on your program comes in, it is pretty easy to see once they have started to dive into ice, because the change is radical. The thing about ice is just how quickly it takes effect, how many neural pathways it smashes and how many neurotransmitters it releases all at once. It is like a fuse blowing; it is a short, quick effect and hence, because you see such a change, it is picked up pretty quickly.

Mr McCURDY — Can you just give us some clarity, in terms of the ingredients of ice, we hear about battery acid and paint stripper and all these other things that go into it, by restricting over-the-counter pharmaceutical drugs, does that mean they will go elsewhere or find that they need to put more paint stripper or battery acid in, or is it that the over-the-counter drugs are more for the downers, when they are trying to come down in two days time?

Mr PRICOLO — Firstly, when you are buying speed, ecstasy or crystal meth — we do not even know. People think they know what they are using but they do not even know what they are

using. For us to sit here and say, 'This much of that's been used' — we do not have good statistics, we do not really have a good snapshot other than what we claim to think.

In terms of where the raw material is coming from, we know that it is not a huge percentage from community pharmacy. I can remember years ago where there would be drug busts and they would be talking about a house they found with a thousand packets of — —

Mr GOMA — Sudafed.

Mr PRICOLO — Sudafed. We are not seeing that very much anymore. A huge part of that is because of Project STOP and the vigilance of pharmacy and what it has been able to do. I think that was probably one of the reasons — and I am sure there are others — why other markets have been accessed to get raw materials. The internet and all other sorts of networks are raiding that. I think that what is coming out of pharmacy now is probably a small percentage of what ends up on the street, but nevertheless it is probably still a significant minority of the raw materials.

It would be silly for us to say, 'Therefore we don't really have to worry about it'. I think if we were to let our guard down, it would incrementally begin to increase again. It is just human nature.

The CHAIR — The issue as I see it, if we use the New Zealand model, where there is a requirement to have a prescription for pharmaceuticals that are likely to be used as precursors — I am assuming you have had this argument, and I suspect we are having it as a government too — is where do you find the right balance between trying to stop the illegal use of precursors through the pharmacies as against protecting the rise of legitimate users of those drugs? Is that a fair comment? The New Zealand model is a big stick where you have to have prescribed drugs for indicated precursor materials.

Mr PRICOLO — Let us be frank, the fact that you need a prescription to get opiates does not mean that they are not dying by the dozen in EDs from prescription opiates, so pushing it onto the doctors does not necessarily fix the problem; it just shifts it, and it restricts access for you if you get a head cold as well as increases the Medicare bill, because when you want a cold and flu tablet you have to see a doctor first. So there are some real issues with adopting the New Zealand model. Ultimately, does it fix the problem? I do not think it does. I think it shifts it, so let us tackle it in a different way.

Mr GOMA — The other thing about that of course is that if you make it a prescription-only item, what somebody can successfully do is to see multiple doctors and get multiple prescriptions, whereas what Project STOP attempts to do is to prevent the supply so that if the pharmacist is in a position to see when the last supply occurred, they can actually say, 'No, I'm sorry, we won't supply at this point'. Unfortunately it is not mandatory, so it is not happening. I think the idea that making it prescription only is going to solve the problem is misguided because it does not really reduce people going doctor shopping or pharmacy shopping.

The CHAIR — You become judge and jury a bit, though, do you not, with repeat prescription requests?

Mr PRICOLO — Yes, as I said earlier, unfortunately the policing role that more often we are having to play is not something that we are necessarily trained in other than we experience it, and it is certainly not something we enjoy.

Mr SOUTHWICK — Would it be fair to assume that a lot of the stuff they have got from the pharmacies is for home cooking purposes, so it is for smaller usage? In that regard, does that in turn become a problem in terms of quality for those people who are trying it and experimenting with it and doing it for themselves? Tim alluded to battery acid and so on.

Mr PRICOLO — Yes, quality is one issue and the other is safety.

Mr SOUTHWICK — Quality in turn leading to — —

Mr PRICOLO — I also mean safety —

Mr SOUTHWICK — Of the cook.

Mr PRICOLO — of the cook as well.

Mr SOUTHWICK — Yes, sure.

Mr PRICOLO — Have you seen *Breaking Bad*?

Mr SOUTHWICK — Yes.

Mr PRICOLO — It is a hazardous occupation, but there is no shortage of people who want to get involved because the upside is obviously seen as big enough to try your hand at it. Minimising that is very important.

Mr SOUTHWICK — So even amongst the smaller amount that is coming through, there is potentially more harm for that group because they are more at that desperate end —

Mr PRICOLO — Correct.

Mr SOUTHWICK — and they do not necessarily have the expertise?

Mr PRICOLO — Correct, yes. I suppose in a way you could probably of think that as a harm minimisation strategy in itself. Another little thing, I know that crack pipes have been withdrawn from sale. Is that really a great harm minimisation strategy? It is a policing strategy, but it just pushes people towards the syringe. I would much rather somebody smoke crack than use a syringe. There are fewer evils and problems associated with smoking compared to breaking the integrity of your skin.

Mr CARROLL — Stan and Angelo, I am very keen to get your views on how successful a pharmacological product like methadone would be for crystal meth. There seems to be a demand for such product. Why has it not been developed? Could you could fill in the committee on the process of how something like that could come to fruition? We have heard evidence from some people who recommend a pharmacological-type solution to provide assistance with people needing treatment. What are your views as pharmacists?

Mr PRICOLO — I do not think that the fact that we do not have substitutes is not from lack of trying; I just think that unlike with methadone and buprenorphine — and a couple of other drugs that are used as substitutes for opiates around the world — nothing has been found. It is probably a more difficult drug to substitute in the way that it works. I have not really read anything about any drug being used as a substitute that has had a good success rate. Having said that, I have seen some being used, but just not with a success rate that you would then consider rolling them out as — —

Mr CARROLL — To be effective, a substitute would have to be developed that would almost have the equivalent effects on the brain in terms of serotonin and dopamine levels, things like that — —

Mr PRICOLO — It would be something that would mimic in the same way methadone mimics what heroin does, and in so doing be long acting — so it is single use, orally active, safe and affordable. Methadone just ticks so many boxes in terms of being a useful and efficient substitute. Why has it not been developed? It is a really tough question, but the short answer is it has not been developed so in the interim we have to look at different things and models. Obviously cognitive and behavioural counselling is where we are at.

Mr GOMA — I think it is true that the pharmacology of it is a lot more complex and so it will no doubt take time before we get to that point because, as Angelo mentioned, what you need as an alternative or substitute is something that is safe and predictable in the way it takes effect. Unfortunately at present there is no one drug that can replace what is out there. In the absence of that, I think we are forced to look at prevention, which is where we feel community pharmacies can play a significant role. Certainly early identification is also very important because clearly if somebody is identified early, the chance of successful treatment is a lot higher as well.

Mr CARROLL — So it is difficult to develop and very difficult to mimic. Does that mean there are no research trials being undertaken at the moment that you are aware of?

Mr PRICOLO — For instance, I know dexamphetamine has been used, and I am pretty sure it has been trialled in Australia as well. But dexamphetamine needs to be dosed multiple times in a day — they are really quite high doses — and that requires a certain level of compliance. It has had its issues; it certainly has not been successfully used. I know that other drugs have also been used in the States. As you can imagine, whatever we think our problem is here, add a multiplication factor and you can start to understand what is happening in the States. It is certainly not the case that it has not been looked at, but nothing has developed as a viable alternative.

Mr CARROLL — Thank you.

Mr PRICOLO — Obviously it is the immediate thing that you think of. The reason is that methadone is such a gold standard in substitution and it works so well. Methadone changes lives within 24 hours; it is ridiculously effective. It returns people to normality; they can become completely functional. To think that we are just going to stumble across a bullet like that is probably a little bit naive at the moment.

Mr CARROLL — Is that the sort of thing the committee should be looking at? We are looking at making best practice recommendations. In order to get the resources, does government need to partner with the private sector to fund that sort of investigative work and research? Or is it the view that what ice does to the brain is just so out of this world it is going to be very difficult to find a safe substitute to do that?

Mr PRICOLO — Both of those things are important. You cannot neglect the people who are in the eye of the storm at the moment. The reality is that we are not going to have the treatment developed through research in the short term so I think it would be negligent of us not to do both. Again it just comes down to what our funding level is and how big a problem it is at the moment as to how much we would devote to treating the guys who are already in that predicament.

The CHAIR — Angelo, we might have to leave it there; we have come to the end of our time. I have a final question. I suspect the committee will be looking in some detail at Project STOP and perhaps real-time monitoring nationally now that we understand the difference. From an internet point of view, how does that impact on not compromising the Project STOP documentation for over the counter? How much business have you lost through the internet and how much of that business will not be able to be included in Project STOP?

Mr PRICOLO — Stan might have a better number. It is hard to gauge the level that pharmacy has lost through the internet and then it is hard to break that down and say how much of that is going to this illicit area or turning a licit drug into an illicit drug. I do not have accurate numbers, but if I was going to guess, I would say that it is maybe encroaching on 5 per cent — or not even 10 per cent. How much of that is people accessing these drugs that would bypass Project STOP? I believe there is some sort of system in place that ticks the box for buying pharmacy-only medicines, but I do not think it is terribly difficult to bypass.

Having said that, I think that internet sales in this area should just be wiped out totally; they just should not exist. There should not even be an opportunity to be able to buy without fronting up. If it continues, then it makes a mockery of everything that I do and everything that I try to achieve. If you can avoid that level of scrutiny and hide behind an internet browser, it makes me feel as though the level of professionalism that I try to adopt is wasted and it is going to make it more difficult for me to convince my members and say, 'This is what we have to do', because of course they will say, 'Why can you buy it over the internet and bypass all that?'. That is a really serious problem.

I will just re-emphasise that issue of price promotion of drugs and use. Price promotion of paracetamol is bad enough. We know how many paracetamol admissions there are to casualty. That is mainly because the drug is so accessible and cheap yet it is ridiculously potent and causes more overdoses then people could ever imagine. Paracetamol overdose is a terrible way to die.

The CHAIR — On that rather gloomy note, thank you for your time, Angelo and Stan.

Mr PRICOLO — Thank you.

Mr GOMA — Thank you.

Witnesses withdrew.