

# WEST HEIDELBERG COMMUNITY LEGAL SERVICE

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## BACKGROUND PAPER

### **PREVENTING DISCRIMINATION AGAINST PARTICIPANTS IN PHARMACOTHERAPY PROGRAMS**

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## **Methodology**

This discussion paper is the result of a literature review coupled with information obtained from discussions of the with the author whilst on clinical placement at the West Heidelberg Community Legal Service which is co-located with the Banyule Community Health Service.

## **Introduction**

This discussion paper has been prepared in response to the prevalence of discrimination experienced by participants on pharmacotherapy programs in the community. It also examines the general issue of the human rights of drug users on pharmacotherapy programs and the role of both service providers and the wider community in promoting the dignity of, and respect for, those who are drug dependent. West Heidelberg has a long history of high alcohol and drug use in the population, often continuing through generations. In 1998, Drug and Alcohol Services were introduced to West Heidelberg through the Banyule Community Health Service.<sup>1</sup> In June 2002 funding was granted for a Pharmacotherapy Prescribing Service which aimed to employ General Practitioners to prescribe Methadone and Buprenorphine and to increase the provision of pharmacotherapy dispensing outlets by way of pharmacies throughout the area.<sup>2</sup>

The safety and efficacy of the opioid agonist methadone in maintenance treatment has been unequivocally established.<sup>3</sup> In Victoria, mostly general practitioners and community pharmacies provide the methadone program with patients receiving their doses through pharmacies. The service is in high demand with more than 7,000 Victorians and 25,000 people nationally undergoing methadone maintenance treatment.<sup>4</sup>

While drug dependency is most commonly viewed as a health issue, this discussion paper hopes to demonstrate that the discrimination experienced by pharmacotherapy participants can and should also be contextualised within a legal human rights framework. The legal mechanisms of complaint available to clients discriminated against on pharmacotherapy programs are inefficient and ineffective; while service providers are presumed to be accountable there are questions surrounding to whom, and through what mechanisms. The Pharmacy Board of Victoria publishes guidelines which recommend that clients should be made aware of the complaint resolution mechanism for that particular pharmacy.<sup>5</sup> This includes the Health Services Commissioner and the Pharmacotherapy Advice and Mediation Service (PAMS) run by the Victorian Drug Users Group VIVAIDS. While PAMS is a valuable service there is some frustration that there is no overarching body which can quickly and effectively deal with breaches of pharmacy protocols or guidelines. Making a complaint to the Health Services Commissioner is often a prolonged and complicated process and is not considered an effective form of redress where there is the threat that treatment could be terminated pending the outcome of a complaint.

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<sup>1</sup> *Discussion with Allied Health Professional on June 6 2006 as part of clinical placement with co-located Banyule Community Health Service*

<sup>2</sup> *ibid*

<sup>3</sup> O'Brien S. (2004) *Treatment Options for Heroin and Other Opioid Dependence: A Guide for Frontline Workers*. Commonwealth Department for Health and Aging for National Drug Strategy Australian Government, Canberra, p3

<sup>4</sup> Department of Human Services "Improving Health, Reducing Harm" *Victorian Drug Strategy 2006-2009*, Melbourne, Victoria, p2

<sup>5</sup> Pharmacy Board of Victoria *Guidelines for Good Pharmaceutical Practice Effective from 1 February 2005* [www.pharmacybd.vic.gov.au/publications.asp](http://www.pharmacybd.vic.gov.au/publications.asp) p15

## **The Nature Of Drug Dependency**

Drug dependence has been recognised by the World Health Organisation as a brain disorder that affects and impairs brain structure and function inhibiting a person's ability to make positive choices.<sup>6</sup> Internationally, the United Nations Human Rights Committee and the United Nations Committee on Economic, Social and Cultural Rights have consistently stated that non-discrimination is a right which extends to people with disabilities.<sup>7</sup> At the federal level in Australia, there exists the *Disability Discrimination Act 1992* (Cth) which seeks to protect individuals who suffer a disability from discrimination. Australian Courts have accepted that drug dependency is a legitimate form of disability and the United Nations Working Group on the Protection and Promotion of the Rights and Dignity of Persons with Disabilities also considers that "drug addiction" should be considered a "disability" within the meaning of the draft United Nations Convention on the Rights of Disabled People.<sup>8</sup>

While these legal frameworks provide avenues of redress and help to promote the norm of non-discrimination for those who are or have been drug dependent, they have little impact on the practical reality of those who may be experiencing discrimination on a frequent basis. While drug dependency should be included in discrimination law as a legitimate form of disability and such discrimination is in contravention of international human rights standards, it is important to note that in the context of drug dependent people challenging allegations of discrimination on the basis of drug dependency through the court system, it is extremely unlikely such a marginalised group would seek legal support for a highly discriminating and stigmatized behaviour.<sup>9</sup>

## ***PHARMACOTHERAPY PROGRAMS AND HARM MINIMISATION STRATEGIES***

The Victorian methadone program is conducted in accordance with the *Drugs, Poisons and Controlled Substances Act 1981* and the *Drugs, Poisons and Controlled Substances Regulations 1995*. Harm minimisation is the approach adopted by the Australian Federal and State governments which informs their policy and program response to licit and illicit drug use. The National Drug strategy defines harm minimisation as "involving a range of approaches to prevent and reduce drug-related harm, including prevention, early intervention, specialist treatment, supply control, safer drug use and abstinence."<sup>10</sup>

It is important to note that abstinence and harm minimisation are not mutually exclusive. While harm minimisation recognises abstinence as a valid outcome; it does not encourage or condone drug use. Harm minimisation acknowledges the complexity of drug use and recognises that it occurs along a continuum of use.<sup>11</sup> Dependent drug use manifests from a complex set of behaviours and

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<sup>6</sup> World Health Organisation [www.who.int/substance\\_abuse/en/](http://www.who.int/substance_abuse/en/)

<sup>7</sup> United Nations Rights Committee, *General Comment 18: Non-Discrimination*, UN document HRI/GEN/1/Rev.5 (2001) 134-137 [www.umn.edu/humanarts/gencomm/hrcomm18.htm](http://www.umn.edu/humanarts/gencomm/hrcomm18.htm); United Nations Committee on Economic, Social and Cultural Rights, *General Comment 5: Persons with Disabilities*, UN Doc HRI/GEN/1/Rev.5 (2001) 29 [www.umn.edu/humanarts/gencomm/epcomm5e.htm](http://www.umn.edu/humanarts/gencomm/epcomm5e.htm)

<sup>8</sup> *ibid*

<sup>9</sup> *Submission to the Senate Legal and Constitutional Committee, VIVAIDS* [www.aph.gov.au/senate/committee/legcon\\_ctte/completed\\_inquiries/2002-04/disability/submissions/sub64.doc](http://www.aph.gov.au/senate/committee/legcon_ctte/completed_inquiries/2002-04/disability/submissions/sub64.doc), p 5

<sup>10</sup> Australian Institute of Health and Welfare (2002) *2001 National Drug Strategy Household Survey*. Canberra

<sup>11</sup> *VAADA submission to senate committee on the Disability Discrimination Bill* [www.aph.gov.au/senate/committee/legcon\\_ctte/completed\\_inquires/2002-04/disability/submissions/sub12.doc](http://www.aph.gov.au/senate/committee/legcon_ctte/completed_inquires/2002-04/disability/submissions/sub12.doc)

circumstances encompassing social, psychological, biological, economic and political issues.<sup>12</sup> There is no stereotypical substance dependent person. To label and stereotype drug users is a destructive way of identifying people with substance use problems. Persons with substance abuse or a dependence problem come from a broad spectrum of the community with poverty, unemployment and social dislocation often contributing to drug dependence.<sup>13</sup>

Treatment of those who are drug dependent incorporates a number of stakeholders. There are the service providers and consumers, State and Federal governments and the wider community. In many ways it appears to be difficult to reconcile the myriad of differing and sometimes competing perspectives of these stakeholders, however upon examination a number of parallels and similarities can be drawn between all those with a vested interest in the success of pharmacotherapy programs.

### **Consumers' Perspective**

A client who had been a long-term pharmacotherapy consumer stated that he had seen other pharmacotherapy clients made to wait until all other customers in the pharmacist had been served and had left the store. This was also an observation made by Professionals during clinical placement.<sup>14</sup> Issues were also raised about the times that pharmacies were open and a perceived lack of flexibility in operating times and clients not being forewarned when their prescriptions were due to expire.<sup>15</sup> In response, one professional emphasised the need for client responsibility and a degree of self-management.<sup>16</sup> It is important to note that there are some excellent pharmacists who work collaboratively with other health professionals toward the best outcomes for clients. What is problematic however is lack of consistency and lack of redress for clients who do experience discrimination. As one individual on the pharmacotherapy program stated;

“They get you with the ‘liquid handcuffs’... You are still on a drug which is addictive. For them [the pharmacist] to have the right to throw you off [the program] like that...it’s just not right.”

There seemed to be resentment on behalf of pharmacotherapy clients at the power the pharmacist was felt to wield over their ability to remain in treatment.

### **Cost Of Programs**

One of the most common complaints made about participation in pharmacotherapy programs is the cost of the program.<sup>17</sup> In Victoria, clients most commonly get their treatment through community pharmacies and have to pay for this service. Only the cost of methadone and buprenorphine are

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<sup>12</sup> Reid G, Crofts N and Hocking J “*Primary Health Care Among the Street Drug-using Community in Footscray: A Needs Analysis*” The Centre for Harm Reduction, Macfarlane Burnet Institute for Medical Research and Public Health, Melbourne, Australia, p 5

<sup>13</sup> Bentler, PM (1992) “Etiologies and Consequences of Adolescent Drug Use: Implications for Prevention” *Journal of Addictive Diseases*, Volume 11(3) p 88

<sup>14</sup> Discussion with Allied Health Professional on June 6 2006 as part of clinical placement with co-located Banyule Community Health Service; Discussion with Social Worker on May 10 2006 as part of clinical placement with co-located Banyule Community Health Service

<sup>15</sup> Lord, S. 2006 Conference: *The VIVAIDS Pharmacotherapy Advocacy Mediation and Support Service (PAMS)*,

[www.vaada.org.au/resources/items/2006/03/69079-upload-00001.ppt](http://www.vaada.org.au/resources/items/2006/03/69079-upload-00001.ppt) last updated 2/3/2006

<sup>16</sup> Discussion with Allied Health Professional on June 6 2006 as part of clinical placement with co-located Banyule Community Health Service

<sup>17</sup> Lord, S. 2006 Conference: *The VIVAIDS Pharmacotherapy Advocacy Mediation and Support Service (PAMS)*,

[www.vaada.org.au/resources/items/2006/03/69079-upload-00001.ppt](http://www.vaada.org.au/resources/items/2006/03/69079-upload-00001.ppt) last updated 2/3/2006

subsidised under section 100 of the Pharmaceutical Benefits Scheme. This means that these drugs are supplied free for administration at state government-run hospitals and by extension to pharmacies. Clients are required to pay a dispensing fee which averages approximately \$5 per day.<sup>18</sup>

Evidence indicates that dispensing fees is the main source of complaint reported by people on pharmacotherapy programs. Most of the disputes between pharmacists and consumers made to Pharmacotherapy Advice and Mediation Service (PAMS) relate to late payments.<sup>19</sup> An evaluation of community-based methadone programs in Victoria in 1996, found that payment for the program was a significant irritant to both those being treated and as well as those dispensing the medication, and as discussed later in this paper is one of the perceived barriers to pharmacists providing pharmacotherapy services.<sup>20</sup> Many clients are on low incomes and the weekly dispensing fees can cause financial hardship. For those who pay treatment fees and are unemployed, the cost of treatment is over 15 per cent of their total income.<sup>21</sup> For this reason, it is the recommendation of this paper that dispensing fees should be subsidised by the government, particularly for those on low income health care cards. There are also strong arguments in favour of further government subsidies to fund the costs of pharmacists and providing more substantial Medicare rebates. Drug dependence can be a chronic disease, often characterised by remissions and relapses over a period of years.<sup>22</sup> Clinical evidence consistently shows that people who remain in treatment tend to do better than those who do not, with maintenance treatments retaining clients for longer and having less risk of mortality in the event of relapse.<sup>23</sup> Considering the costs involved to the community of heroin dependency, it seems both fiscally and socially responsible to publicly fund most, if not all, the costs of providing treatment to people who may benefit from it.

### Community Perspective

There is a pervasive and insidious perception in some areas of the community that it is acceptable to discriminate against drug users. Drug treatment experts have commented that despite the fact substance addiction is a complex problem requiring a range of approaches and responses; it can be difficult to convey this complexity to the community when drug dependence is often deemed a 'self-inflicted' harm.<sup>24</sup> The Victorian Alcohol and Drug Association maintains that "while it is true to say that people make choices and decisions about their substance use and are not always blameless for the position they find themselves in, they are rarely deserving of the condemnation and damnation which is so often attributed to people with these problems."<sup>25</sup>

Society has drawn a marked distinction between licit and illicit drugs and this in turn impacts upon how drug use is perceived in the community. While alcohol and tobacco are responsible for 97 per

<sup>18</sup> Muhleisen, P. Clark N., Teo A and Brogan D. Turning Point Alcohol and Drug Centre, Victoria "Opioid Substitution Therapy: Considering the Costs to Consumers" *Of Substance* vol 3 No 1 2005 p5

<sup>19</sup> Thompson N. (2003) *The Pharmacotherapy Advocacy and Complaints Resolution Service (PACS) report for period 1 July 2002 to 30 June 2003*, VIVAIDS, Melbourne p 16

<sup>20</sup> Lintzeris N. et al (1996) *Report on the Evaluation of Community Methadone Services in Victoria*. Turning Point Alcohol and Drug Centre, Melbourne p7

<sup>21</sup> *ibid*

<sup>22</sup> Muhleisen, P. Clark N., Teo A and Brogan D. Turning Point Alcohol and Drug Centre, Victoria "Opioid Substitution Therapy: Considering the Costs to Consumers" *Of Substance* vol 3 No 1 2005 p6

<sup>23</sup> *ibid*

<sup>24</sup> *VAADA submission to senate committee on the Disability Discrimination Bill* [www.aph.gov.au/senate/committee/legcon\\_cttee/completed\\_inquires/2002-04/disability/submissions/sub12.doc](http://www.aph.gov.au/senate/committee/legcon_cttee/completed_inquires/2002-04/disability/submissions/sub12.doc)

<sup>25</sup> *ibid*

cent of drug related mortality in Australia,<sup>26</sup> and research documents the extent to which legal or licit substance misuse (particularly alcohol) causes enormous economic and social harm in the Australian community,<sup>27</sup> the legalisation of these substances correlates with community tolerance of their abuse.

The model which underpins the Australian health system considers excessive or harmful drug use as “one of a number of problems faced by individuals which can be influenced by the economic, social and cultural environment in which that person lives – including poverty, unemployment, availability of drugs and family conflict.”<sup>28</sup> A national survey conducted in 1995, found 80 per cent of the adult population supported methadone programs which attempted to induce abstinence but only 18 per cent supported indefinite maintenance.<sup>29</sup> This reflects a failure in the community to appreciate the often chronic nature of drug dependency and the role that maintenance treatment programs can have in facilitating the reintegration of individuals who are drug dependent back into the community.<sup>30</sup> Research compiled by the Alcohol and other Drugs Council of Australia has demonstrated that factors which lower the risk that a person will use drugs in a harmful way include “connectedness to community, good family relationships and feeling loved and respected.”<sup>31</sup> Therefore, such community attitudes are particularly detrimental to the long-term treatment of those who are drug dependent. Drug dependency is a complex issue and is often interrelated with co-morbidity and mental health issues, homelessness, poverty and disadvantage. As such, drug treatment needs “to be integrated into a greater holistic health framework embracing well resourced programs which respond to housing, financial services, unemployment, social isolation, ill health and poor education”.<sup>32</sup>

### **Pharmacist Perspective**

As mentioned briefly earlier in this paper, many community pharmacists feel that there are a number of barriers to providing pharmacotherapy programs. Research conducted by the National Illicit Drug Training for Pharmacy Project identified a number of practical barriers indicated by pharmacists and pharmacy workers relating to gaps in knowledge, skills and understanding. There were also concerns about remuneration and facilities for the provision of services to illicit drug users.<sup>33</sup> Universally, pharmacists expressed the view that the economic rewards were less than the economic cost of providing the service.<sup>34</sup> There was also a request for a clearer and stronger regulatory framework, delineating their rights and responsibilities. This provides support for what is one of the main recommendations of this paper, namely that guidelines must have an overarching regulatory body

<sup>26</sup> Wodack A. (2004) Alcohol and Drug Service St. Vincent’s Hospital ‘*The Disability Discrimination Amendment Bill from a Drug Treatment Service Perspective*’

<sup>27</sup> Australian Institute of Health and Welfare (2002) *2001 National Drug Strategy Household Survey*. Canberra

<sup>28</sup> Victorian Alcohol and Drug Association (2003) ‘*The Links between Alcohol and Drug Use and Poverty: VAADA’s submission to the Senate Inquiry into Poverty*. Melbourne.

<sup>29</sup> Caplehorn, J., Lumely T., Irwig, L. and Saunders J. “Changing Attitudes and Beliefs of Staff Working in Methadone Maintenance Programs” *Australian and New Zealand Journal of Public Health*, 1998 vol 22 no 4 p 508

<sup>30</sup> *ibid* p 508

<sup>31</sup> *Alcohol and Other Drugs Council of Australia (ACDA) – Policy Submission Paper 2.1*, [www.adca.org.au/policy/policy\\_positions/2.1Prevention\\_9.11.03.pdf](http://www.adca.org.au/policy/policy_positions/2.1Prevention_9.11.03.pdf)

<sup>32</sup> *Submission to the Senate Legal and Constitutional Committee, VIVAIDS* [www.aph.gov.au/senate/committee/legcon\\_ctte/completed\\_inquiries/2002-04/disability/submissions/sub64.doc](http://www.aph.gov.au/senate/committee/legcon_ctte/completed_inquiries/2002-04/disability/submissions/sub64.doc)

<sup>33</sup> Reid G, Crofts N and Hocking J “*Primary Health Care Among the Street Drug-using Community in Footscray: A Needs Analysis*” The Centre for Harm Reduction, acfarlane Burnet Institute for Medical Research and Public Health, Melbourne, Australia p 15

<sup>34</sup> *Pharmaceutical Society of Australia* [www.psa.org.au/ecms.cfm?id=121](http://www.psa.org.au/ecms.cfm?id=121)

which is capable of enforcing such guidelines and has efficient and effective mechanisms to deal with breaches of such guidelines.

A number of expressed concerns in research conducted by the Pharmaceutical Society of Australia included:<sup>35</sup>

- that dispensing methadone would make pharmacies a target for theft or violence; Pharmacists and their staff link often drug problems with these incidents and this can make them less sympathetic towards the servicing the needs of people using illicit drugs.
- moral opposition to methadone treatment and needle and syringe programs despite the endorsement of the National Drug Strategy and substantial evidence which supports the benefits to drug users and the community
- dealing with intoxicated patients

It is important to acknowledge that pharmacists are no different to the general public in the diversity of views on the illicit use of drugs. The attitude of pharmacists and their staff has a great impact on the both their participation and effectiveness in methadone and other illicit drug use services.<sup>36</sup>

While the Pharmaceutical Society of Australia has a number of guidelines governing how treatment should be administered, these guidelines are not enforceable and there is little remedy available for pharmacotherapy consumers who are subject to breach of the guidelines. Community pharmacies are private enterprises that are permitted to conduct their business in any way they consider appropriate. While the guidelines provide standards that are supposed to be adhered to there is no efficient and effective way of enforcing compliance. They are *recommended* protocols for pharmacies and case studies such as those included in this report suggest that such protocols are often breached.

While the Pharmacy Board of Victoria and the Pharmaceutical Society of Australia have taken steps to ensure that their members are educated and trained to deal with the needs of clients in pharmacotherapy programs, it is imperative that individuals who participate in such programs are afforded the protection of their basic human rights and are provided with avenues of recourse for when they are discriminated against. While PAMS works as a mediator between pharmacies and clients when there are disputes, there is no way of legally enforcing any breach of protocol because such guidelines are only recommendatory.

### **Issues Within The Current System**

There is a shortage of doctors across the spectrum in the community health sector making it difficult to recruit sufficient numbers of pharmacotherapy doctors to participate in programs.<sup>37</sup> Furthermore, Medicare does not recognise the significant amount of follow-up work which needs to be done when dealing with drug dependent patients who have complex needs.<sup>38</sup> Pharmacotherapy doctors are having to work as general practitioners, bereavement counsellors and psychologists; it is demanding work and remuneration must be made attractive enough in order to attract and retain staff.<sup>39</sup> The current Medicare rebate is insufficient for this purpose. The inadequate funding provided by governments means that it is not possible to offer sufficient remuneration to attract qualified pharmacotherapy doctors. As of January 2003 there were 416 doctors approved to prescribe pharmacotherapy treatment.

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<sup>35</sup> *ibid*

<sup>36</sup> *ibid*

<sup>37</sup> *Discussion with Allied Health Professional on June 6 2006 as part of clinical placement with co-located Banyule Community Health Service*

<sup>38</sup> *ibid*

<sup>39</sup> *ibid*

Of these 287 are currently practicing.<sup>40</sup> The reasons for not taking up pharmacotherapy include practice issues, personal issues and staffing issues. This means the sector is highly under resourced.

### **RECOMMENDATIONS**

- Legalise pharmacotherapy program guidelines for service providers so that clients are protected
- Implement education initiatives which emphasis and encourage the mutual relationship and need for cooperation between service providers and clients
- That the Government subsidise dispensing fees for those on low incomes
- An increase in Government funding in order to attract and retain qualified pharmacotherapy staff
- Funding pharmacotherapy programs for particular needs groups including pregnant clients, HIV positive clients and those with an active psychiatric or medical condition
- The Medicare rates to be adjusted to reflect the needs of clients with complex and special needs and the time involved in the follow-up of such clients

### **Conclusion**

Drug dependency is a multifaceted affliction and is often the manifestation of complex and interrelated biological, social, psychological and economic issues. The law has role to play in protecting the legal rights of those in our society who may be subject to discrimination. The Victorian Government's Drug Strategy Report for 2006-2009 acknowledges that "social disadvantage, including unemployment, homelessness, insecure housing and poverty, is linked to poorer health, including smoking, alcohol misuse and illegal drug use...Preventing disadvantage and poverty is therefore an important measure to reduce drug use and drug-related harm."<sup>41</sup> As a consequence there needs to be a holistic and integrated approach to drug treatment thorough understanding of local community and client needs and of the complementary roles of local providers in meeting these needs.

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<sup>40</sup> ibid

<sup>41</sup> Department of Human Services "Improving Health, Reducing Harm" Victorian Drug Strategy 2006-2009, Melbourne, Victoria p 4

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