Decision 23HDC02431
28 November 2025

HEALTH & DISABILITY COMMISSIONER
TE TOIHAU HAUORA, HAUĀTANGA

Involuntary reduction and cessation of opioid substitution therapy

1. In September 2023, the Health and Disability Commissioner (HDC) received a complaint referred from the Office of the Ombudsman relating to the care provided to Mr A by Health New Zealand | Te Whatu Ora (Health NZ) Hauora a Toi Bay of Plenty Addiction Service (BOPAS) in 2021.

2. Mr A had been receiving methadone[1] as part of opioid substitution treatment[2] (OST) for approximately 30 years. He had been under the care of BOPAS since late 2014.

3. In June 2020, Mr A initiated a self-directed, progressive reduction of his methadone dose, with the goal to cease OST eventually. Mr A began reducing methadone directly with his dispensing pharmacy in Tauranga and pharmacist Mr B, and subsequently this was supported by BOPAS.

4. After 10 months of gradual reduction, in May 2021, BOPAS informed Mr A that owing to his lack of engagement with the service, Mr A's remaining prescribed methadone dose would be withdrawn rapidly unless engagement improved. Involuntary rapid withdrawal of methadone was implemented on 7–14 August 2021 until Mr A's dose was reduced to zero.

5. Around six weeks later, in late September 2021, Mr A died from 'mixed drug toxicity'. Post-mortem toxicology testing confirmed a level of methadone that 'can be toxic to an individual who does not have a tolerance to the drug', as well as other drugs in Mr A's system at the time of his death.

6. This report discusses the standard of care Mr A received from Mr B at the dispensing pharmacy and from BOPAS. I have found Mr B in breach of Right 4(2)[3] of the Code of Health and Disability Services Consumers' Rights (the Code) for dispensing reduced doses of methadone without written authorisation from the prescriber, in breach of the New Zealand Practice Guidelines for Opioid Substitution Treatment 2014 (NZ OST Guidelines).[4] Further, I have found Health NZ in breach of Rights 4(1)[5] and 4(4)[6] of the Code for involuntarily

[1] An opioid used for maintenance therapy in opioid dependence and for chronic pain management.
[2] Treatment that offers people with dependence on opioids (such as heroin) an alternative, prescribed medicine — most typically methadone or buprenorphine — which is swallowed rather than injected.
[3] Right 4(2) states: 'Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards.'
[4] New Zealand Practice Guidelines for Opioid Substitution Treatment 2014 (superseded in October 2025 by the New Zealand Practice Guidelines for Opioid Substitution Treatment 2025).
[5] Right 4(1) states: 'Every consumer has the right to have services provided with reasonable care and skill.'
[6] Right 4(4) states: 'Every consumer has the right to have services provided in a manner that minimises the potential harm to, and optimises the quality of life of, that consumer.'

Names have been removed (except Health New Zealand Hauora a Toi Bay of Plenty and the independent advisor on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

withdrawing Mr A's treatment without reasonable grounds or exploration of all alternative strategies, at a dangerously rapid rate, and without appropriate advice or support.

7. However, I am satisfied that Health NZ's care was appropriate during the period of Mr A's voluntary methadone reduction. In this respect, I have relied on advice from an independent addiction psychiatrist, Dr Ivan Srzich (Appendix A). Dr Srzich considered that the actions taken by BOPAS in response to Mr A's request to withdraw from OST were appropriate. He said that the rate of reduction was appropriate and that Mr A was provided with appropriate information and options, including about the Service's concerns regarding the combination of opioids and cyclizine[7] and the option to cease cyclizine and remain in the OST programme. I accept this advice.

Responses to provisional decision

8. Health NZ, Mr B, and members of Mr A's family were given the opportunity to comment on relevant sections of my provisional decision. Their comments have been incorporated into this decision where appropriate.

9. Noting that this matter relates to two providers – the dispensing pharmacist and Health NZ – this opinion discusses each provider in turn.

Voluntary reduction: Mr B — breach

10. In June 2020, Mr A decided to withdraw from methadone gradually as he was finding the conditions of the OST programme burdensome. This was in part because of Mr A's contentious use of cyclizine, which meant that he was not eligible for 'takeaway' doses and therefore had to attend the pharmacy each day for his medication. Mr A was also resistant to having to 'report to services' for case manager and medical review as a condition of receiving treatment. This is discussed further below in the section relating to Health NZ.

11. Section 9 of the NZ OST Guidelines sets out the responsibilities and functions of the pharmacist in supporting the community-based management of clients in OST. Section 9.3.4 provides that only prescribers may make changes to prescriptions, including altering doses. In this case, the prescriber of Mr A's OST medication was BOPAS, not Mr B.

12. Having reviewed the evidence, I find that Mr B dispensed reduced doses of methadone to Mr A at his request without authorisation from the prescriber (BOPAS) on several occasions, in contravention of the OST guidelines.

13. The prescription records show that the usual practice was for the BOPAS prescriber to provide a prescription authorising a daily dose of methadone for a period of 28 days. The prescription records show that, on 29 May 2020, BOPAS prescribed Mr A 70mg of methadone per day for the period 29 May to 26 June 2020. On 27 June 2020, a new prescription authorised a continued dose of 70mg of methadone per day for the period 27 June to 25 July 2020.

[7] Cyclizine is an antihistamine used to treat nausea or vomiting from motion sickness. It is a pharmacist-only medicine. Cyclizine also enhances the effect of opioids and is sometimes used for this purpose in methadone-maintained populations.

14. The pharmacy records show that, between 25 June and 24 July 2020, Mr A's dispensed dose was reduced from 70mg per day to 55mg per day. The reduced doses were dispensed by Mr B. BOPAS records show that it was unaware of this reduction until 16 July 2020, when Mr A disclosed this during a medical review. Mr A's case manager documented this discussion in the progress notes: '[Mr A] did tell the doctor that he had been reducing with the pharmacist and was now down to 60mg. This was news to both myself and the doctor.' The prescription records provided by both the dispensing pharmacy and Health NZ show that a written change to Mr A's prescription authorising a dose reduction to 55mg was provided to the dispensing pharmacy on 25 July 2020.

15. The dispensing pharmacy said that Mr B's recollection is limited, but he recalls BOPAS agreeing to Mr A's request to reduce his methadone dose and that 'prescriptions were annotated accordingly advising the pharmacy of this'. There is no record of this agreement or annotated prescriptions prior to 25 July 2020. Additionally, on 25 and 26 June 2020, there is a discrepancy between the pharmacy's electronic dispensing records and Mr B's annotations on the prescription; on these days, the electronic records show that Mr A was dispensed a reduced dose of 65mg, but Mr B has written on the prescription that he dispensed the prescribed dose of 70mg. There is no evidence that these discrepancies were reconciled.

16. In response to the provisional decision, Mr B said that, as he was no longer working at the dispensing pharmacy when this complaint was made, he was not involved in the recovery of information to respond to the complaint. As such, Mr B considers there were 'many notes and records' that were not provided as part of this investigation.

17. Between 25 July 2020 and 5 August 2021, BOPAS supported Mr A to reduce his methadone dose gradually to 35mg per day (a 50% reduction over approximately 13 months). During this period, there were three instances[8] in which the monthly prescription did not authorise a dose reduction, yet Mr B nevertheless dispensed reduced doses to Mr A during these periods.[9] I infer, from the usual practice of the prescriber annotating prescriptions when doses were authorised for reduction that, on those occasions where there was no such annotation, the dose reduction was not formally authorised by the prescriber.

18. In response to the provisional decision, Mr B said:

> '[On] most of [Mr A's] scripts there was a note from the prescriber that a reduction of 5mg, per month I believe, could be given at the [Mr A's] request … I believe that several scripts were also not annotated as such and that I reduced the dose, unfortunately I cannot recall my series of procedures and what was done during the months where scripts were not annotated as such, and would like to think that I was liaising with [the prescriber] at this time, however [due to the time that has passed] I cannot unfortunately recall what was done …'

[8] These prescriptions were issued for the following periods: 24 August–20 September 2020, 21 September–18 October 2020, and 9 April–3 May 2021.

[9] Reduced doses without authorisation by prescription were dispensed during the following periods: 4–22 September 2020 (50mg/day dispensed against a prescription for 55mg/day), 23 September–18 October 2020 (45mg/day dispensed against a prescription for 55mg/day), and 17 April–3 May 2021 (32mg/day dispensed against a prescription for 35mg/day).

19. Mr B also said: '[T]here were several occasions where I had to remind [the BOPAS prescriber] to reflect the changes in [Mr A's] doses when he would repeat a script at an old dose.'

20. The dispensing pharmacy told HDC that it would not be usual practice to decrease doses of methadone without authorisation from the prescriber. The dispensing pharmacy's standard operating procedure requires that the pharmacy receive written confirmation of any methadone dose changes communicated via telephone and that only a prescriber may authorise any changes to the prescription. Moreover, the prescribing requirements for controlled drugs (including methadone) are tightly regulated under the Misuse of Drugs Regulations 1977 and Misuse of Drugs Act 1975, and verbal orders are not currently allowed by the legislation (except in very limited circumstances, which do not apply to Mr A's situation).

21. I acknowledge Mr B's submission that there may be records that were not provided to HDC during this investigation. However, HDC has reconciled the prescription records provided by Health NZ and the dispensing pharmacy, which show an unbroken chronological record of prescriptions from 1 May 2020 to 10 August 2021. I consider it implausible that the records of both Health NZ and the dispensing pharmacy are missing prescriptions that authorised the dose reductions in question.

22. As outlined above, between 25 July 2020 and 5 August 2021, there were three occasions on which Mr B dispensed a reduced dose but there is no record of written authorisation from the prescriber. After considering Mr B's submissions, I accept that, on these three occasions, Mr B may have received a verbal order from the prescriber before dispensing the reduced doses. While it is important to note that a verbal order would not be sufficient for the purposes of relevant standards and legislation, if a verbal order was received on these occasions I would be reassured to the extent that the prescriber had at least been involved and that this was done in the context where the prescriber and the pharmacy were aware of an agreed and ongoing voluntary reduction.

23. However, in weighing the evidence, I remain of the view that Mr B dispensed reduced doses of methadone to Mr A between 25 June and 24 July 2020 without authorisation from the prescriber. This is on the basis that:

- the prescription records from Health NZ and the dispensing pharmacy show that during this period the prescriber had authorised a dose of 70mg of methadone per day with no authorisation for reductions;
- The BOPAS progress notes document a conversation with Mr A on 16 July 2020 in which he advised his case manager and the prescribing doctor that he had been reducing his dose 'with the pharmacist' and that 'this was news to [the case manager] and the doctor'; and
- In the prescription records of both Health NZ and the dispensing pharmacy, the first prescription authorising a dose reduction is dated 25 July 2020.

24. Under Right 4(2) of the Code, as a registered pharmacist Mr B was required to provide services that complied with relevant professional and legal standards, including the OST Guidelines

and prescribing regulations. I find that, by dispensing reduced doses of methadone without written authorisation from the prescriber on several occasions, Mr B failed to provide services that complied with the NZ OST Guidelines and prescribing regulations and, accordingly, breached Right 4(2) of the Code.

Involuntary reduction: Health NZ Hauora a Toi Bay of Plenty — breach

Decision to reduce involuntarily

25. The possibility of involuntary withdrawal of Mr A's treatment (that is, withdrawal directed by Health NZ) was first suggested at a medical review in November 2020. During this appointment, Mr A's continued use of cyclizine was discussed, and he was reminded that although he was reducing methadone, under the OST treatment agreement he had an obligation to attend appointments while he remained in treatment. It was noted that Mr A would not commit to ongoing attendance. In a letter written to Mr A's general practitioner, the BOPAS psychiatrist wrote:

> 'I suggest that [Mr A] be tasked to be in contact with the Service to meet up once a month face to face. In other words, we will not set appointments for him. Putting the responsibility onto him for his treatment is only aligning it with his presumed authority in the situation. … If he is unable to accept this responsibility, [then] he will be discharged. Methadone will be reduced in days not weeks and he will have a stand down period from BOPAS during which time he cannot access any treatment for drug addiction in any other setting.'

26. It should be noted that Mr A was a habitual user of cyclizine, an antihistamine known to enhance the effects of opioids (and therefore regarded as a drug of abuse by people using methadone). Mr A was consistent in his assertions that he regularly used cyclizine to combat seasickness when fishing.

27. My advisor, Dr Srzich, noted that 'it is not clear whether this plan [putting responsibility on Mr A for his treatment] was discussed with Mr A in any collaborative way'[10] and advised that the requirement for monthly meetings did not appear to be clinically warranted. At this point, Mr A was stable in his treatment, undertaking a voluntary managed dose reduction, and there were no evident risks or challenging behaviours. Dr Srzich acknowledged Mr A's ongoing cyclizine use and stated that while this is not condoned, it did not raise clinical risks.

28. Health NZ's BOP OST Pathway protocol suggests that, during ongoing OST, service users are to meet with their case manager every four to six weeks and no less than every eight weeks.

29. Dr Srzich noted that, in the 21 months leading up to the November 2020 medical review, Mr A attended nine face-to-face meetings with his case manager, with no documentation of non-attendance. There were no significant concerns noted. He had missed one medical review on 28 October 2020. Dr Srzich also noted that the Service had not arranged four- to six-weekly

[10] A postscript on the November 2020 letter states that the letter was dictated after Mr A had left and asks that the letter not be provided to Mr A as it was expected to anger him.

reviews for some time[11] and that, in view of this, and Mr A's evident stability, the plan for Mr A to attend monthly meetings was unreasonable.

30. Health NZ said that the plan for Mr A to arrange monthly in-person meetings was not a requirement but rather a suggestion, with the intention of reallocating responsibility to Mr A for continuation of his treatment. Health NZ maintains that monthly contact with an OST case manager is a standard timeframe and that the obligations and options outlined to Mr A aligned with Health NZ BOP's Risk Assessment protocol.[12]

31. I agree that it is important for OST service users to be active participants in their care and to have responsibility and authority for their treatment. However, in this case, it was known that Mr A was finding the requirements of the OST programme onerous. This was why he initiated voluntary withdrawal from treatment. In this context and noting Dr Srzich's advice that Mr A was stable in his treatment with no apparent clinical risks, it would appear counterproductive to suggest that Mr A increase contact to the maximum frequency in Health NZ's OST Pathway protocol. This plan effectively gave Mr A more responsibility with less authority and autonomy. Coupled with the threat of involuntary discharge if the 'suggestion' of monthly meetings was not complied with, this was, in my view, a punitive approach that was more likely to harm than help the therapeutic relationship, and I accept Dr Srzich's advice that this was unreasonable.

32. On 12 May 2021, BOPAS advised Mr A that owing to his 'very limited contact with the service in the last six months', it was assumed that he was no longer willing or able to engage in the OST programme. The letter states, '[T]he OST service agreed with you last year that you would … arrange appointments on a monthly basis' and noted that Mr A had attended only one appointment in the past six months. Mr A was advised that OST medications would be withdrawn rapidly unless he arranged an appointment with the Service. He had not attended a medical review since November 2020.

33. Following this, Mr A arranged and attended an appointment with his case manager on 21 May 2021. Mr A felt that a rapid reduction of methadone was unrealistic and stated that his goal was to continue reducing his dose gradually until reaching zero. He was noted to be agreeable to making monthly appointments, attending medical review appointments, and ceasing cyclizine use. He wished to continue reducing methadone.

34. Mr A did not make any further appointments with his case manager. He also missed two medical appointments, one scheduled on 21 June, which Mr A stated he could not attend because he was unwell, and another on 2 August 2021 (which he later claimed was a result of him having mixed up the dates).

[11] Including over a period of COVID-19 lockdown.

[12] The Risk Assessment protocol states that the management of risk should address the immediate risks and identify ongoing management, future preventative actions, challenging behaviours and strategies to deal with this, and the context, opportunity, means, and motivation of the individual.

35. On 3 August 2021, BOPAS advised Mr A that owing to his lack of engagement, he was being discharged from the OST service involuntarily, and his methadone dose (25mg/day at the time) would be withdrawn rapidly at 5mg per day until reaching zero.

36. On 5 August 2021, Mr A contacted BOPAS with concerns that the reduction was 'unfair and cruel'. The dose reduction was implemented at a rate of 5mg/day on 7 and 8 August 2021 (down to 15mg/day). On 9 August 2021, Mr A told his case manager that he 'still [didn't] understand why it ha[d] come to this and that he ha[d] never heard of people [being] reduced at such a rapid rate'. Following this, after considering Mr A's concerns about the rapid rate of reduction, between 9 and 14 August 2021, the rate of reduction was slowed to 2mg/day until reaching zero.

37. Dr Srzich advised that Mr A's involuntary discharge was not appropriate and was a moderate departure from accepted practice. Dr Srzich noted that the decision was contrary to the NZ OST Guidelines and Health NZ's BOP OST Pathway, which provide that involuntary discharge should be undertaken only as a last resort owing to the risks to the service user, including the increased risk of fatal overdose.

38. The NZ OST Guidelines [13] outline several examples of situations in which involuntary withdrawal may be considered, including when a client 'repeatedly displays an inability to keep to the safety requirements of the OST provider (e.g., … repeated lack of attendance at appointments)'.

39. Dr Srzich stated that while there is an obligation for an OST service to see clients regularly, a client's challenging engagement does not warrant involuntary withdrawal. He stated that services can accept that client participation will vary, and in this situation there did not appear to have been any need for close follow-up. He considered that the risk threshold for involuntary withdrawal was not met and that it did not appear that other 'contingency management' strategies were considered, such as 'holding a dose'[14] or returning Mr A to general practitioner (GP) prescribing,[15] as he remained engaged with his GP and there were no evident risks other than unquantified cyclizine use.

40. The BOPAS progress notes document that Mr A's dose had been held on 17 November 2020 to encourage Mr A to first attend an appointment with his case manager that day. It appears that this was not successful; the progress notes document that the pharmacy had 'dosed [Mr

[13] Section 3.9.2.

[14] Section 9.3.5 of the NZ OST Guidelines provides that doses of OST medication may be cancelled or withheld to re-establish contact with a client where all other attempts have failed.

[15] OST clients who have achieved dose stability may be transferred to 'shared care' between the specialist OST service and the client's GP. In this arrangement, the GP is authorised and supported by the specialist service to prescribe OST medication to the client, although the specialist service remains the responsible provider. The aim of a shared-care arrangement is to support clients to live as normal a lifestyle as possible within the constraints of treatment. Previously, Mr A's treatment had been provided under a GP shared-care arrangement in and prior to 2015 and again in 2018.

A] regardless'.[16] There is no evidence in the clinical records that this strategy was considered again.

41. Health NZ said that while holding doses can be effective to encourage client attendance to meet treatment obligations, in Mr A's case it was considered that this would most likely result in a complete withdrawal from methadone rather than a scheduled withdrawal, and that 'the risks and results of undertaking such a strategy may have been the same'.

42. Further, Health NZ said that cyclizine in conjunction with methadone is a known recreational drug combination, and, as such, represents a risk to a service user's mental state and safety. Health NZ said that use of cyclizine is therefore 'grounds for considering whether the service user meets the threshold of "stability"'.

43. I acknowledge that Mr A's engagement with the service and use of cyclizine were less than ideal. However, I accept Dr Srzich's advice that these factors did not meet the risk threshold for involuntary withdrawal. The NZ OST Guidelines state[17] that regular use of other drugs is not usually an indication for involuntary withdrawal from OST. The clinical records document that Mr A's cyclizine use, while not condoned, had been tolerated by the Service since 2018 and had not caused any realised concerns. Mr A had been managing a gradual self-directed methadone reduction with no apparent safety issues and, while engagement could have been better, he remained in contact with his case manager. Taking these factors into account, it appears that the risks of involuntary withdrawal far outweighed the risks of ongoing cyclizine use and patchy engagement.

44. Under Right 4(1) of the Code, Health NZ had a responsibility to provide Mr A with services with reasonable care and skill. I find that by implementing an involuntary withdrawal of Mr A's methadone treatment, without the circumstances having met the appropriate risk threshold and without first exploring all alternative strategies, Health NZ failed to provide services to Mr A with reasonable skill and care. Accordingly, I find that Health NZ breached Right 4(1) of the Code.

Rate of reduction and support

45. Dr Srzich advised that the rapid rate of reduction during the involuntary withdrawal period was not appropriate (initially 5mg/day, then 2mg/day). He considered that this was a moderate departure from accepted practice and contrary to the NZ OST Guidelines, which state that a rapid dose reduction is not recommended, and a gradual reduction should be undertaken unless is it unavoidable (such as in the case of violence on the part of the client). Dr Srzich stated that, while there are no clear guidelines regarding an appropriate rate of methadone withdrawal, in Mr A's case there was not sufficient risk to warrant a rapid withdrawal from treatment.

---

[16] The dispensing pharmacy told HDC that it could not comment on this as Mr B had no recollection of this. The prescription records show that Mr A's previous prescription had ended on 15 November 2020. The following prescription, for the period 16 November–13 December 2020, was received by the dispensing pharmacy on 17 November 2020, but it is not clear what time this was received. Dispensing records show that Mr A's methadone dose was dispensed on 16 and 17 November 2020. My criticisms about Mr B dispensing medication off-script have already been noted.

[17] Section 3.9.2.

46. It should also be noted that withdrawing a client from OST treatment is risky, noting that it may increase the risk of fatal overdose, bloodborne viral infection, ill health, financial insecurity or debt, social instability, or criminal offending.

47. Health NZ said that following the change from a reduction of 5mg per day to 2mg per day, Mr A 'signalled he was satisfied with this arrangement' and did not indicate that he wished to return to the OST programme.

48. On review of the clinical records, it appears that once the rate of reduction was reduced to 2mg per day, Mr A demonstrated a degree of acceptance about this.[18] However, Mr A had also expressed that he preferred to continue a self-directed gradual reduction and that he did not understand why an involuntary reduction was being initiated at all. In this context, I consider that Mr A's 'satisfaction' with the dose reduction at 2mg per day was more likely a resignation to accept the best outcome he could expect in what would understandably have felt like a powerless position. In any case, Health NZ had an obligation to make sound clinical decisions that minimised the potential harm to Mr A, and a client's reluctant acceptance of a clinical decision does not negate this responsibility. I accept Dr Srzich's advice that the rate of reduction during the involuntary withdrawal was too rapid, and I consider that this resulted in an increased risk of harm for Mr A.

49. Dr Srzich also considered that BOPAS did not provide adequate support or advice to Mr A during the involuntary withdrawal process. There was no discussion of the risks of overdose from reduced opioid tolerance, no mention of the provision of naloxone to manage possible opioid overdose, no discussion about a standdown period from treatment or how Mr A could re-engage with treatment if he wished to,[19] and no offer of a consumer advocate for support. It appears that Mr A was offered medication for relief from withdrawal symptoms, but it is not clear what this was. Dr Srzich considered that the limited support offered to Mr A during the withdrawal process was a mild to moderate departure from accepted practice. I accept this advice.

50. Under Right 4(4) of the Code, Health NZ had a responsibility to provide Mr A with services in a manner that minimised the potential harm to him.

51. As a result of the deficiencies identified in Health NZ's care of Mr A, he experienced acute and unnecessary distress. Six weeks after his treatment was withdrawn rapidly, Mr A died from a mixed-drug overdose, including methadone to which he would have decreased tolerance. I am highly critical that Mr A's treatment was withdrawn involuntarily contrary to accepted standards and practice, at a dangerously rapid rate, and without appropriate discussion of the risks of opioid overdose, management of possible opioid overdose, or how Mr A could re-engage with treatment or obtain support from a consumer advocate. Noting that Mr A was already undertaking a stable and voluntary managed dose reduction, I find Health NZ's

[18] A progress note on 9 August 2021 documents that, upon being advised by his case manager that the reduction would slow to 2mg per day, Mr A stated, '[S]o the [BOPAS psychiatrist's] ego has got the better of him has it,' after which he thanked the case manager and terminated the call. A progress note on 10 August 2021 documents that Mr A was 'not appearing in distress with this reduction'.

[19] On 12 August 2021, BOPAS wrote a letter to Mr A's GP advising of Mr A's involuntary discharge from services. The letter stated, '[S]hould [Mr A] wish it we would of course reassess him,' but there is no indication of timeframes or whether this was communicated to Mr A.

decision to proceed with a high-risk rapid involuntary withdrawal of medication particularly concerning. On this basis, I consider that Health NZ failed to provide Mr A with services in a manner that minimised the potential harm to him, and, accordingly, breached Right 4(4) of the Code.

Other comment

52. In October 2023, HDC wrote to the Director of Mental Health and Addiction, Dr John Crawshaw, expressing concerns that many OST services were being provided in a way that is inconsistent with people's rights under the Code. The letter highlighted that OST consumers were not always being respected as partners in their care and that treatment planning or decisions to amend or discontinue treatment were being made without consumers being involved in those discussions. Specific concern was also expressed about the involuntary withdrawal of methadone at rates that were far from gradual and for reasons not clear to consumers. Poor communication was also a feature of HDC's complaint data.

53. As a consequence of this letter and following a cross-agency meeting on the issues, it was agreed that, in an upcoming review of the NZ OST Guidelines, consideration would be given to enhancing their language to better reflect shared decision-making. Consideration was also to be given to how the three-yearly OST Service audits (as undertaken by the Ministry of Health) could be better utilised to drive and monitor improvement.

54. HDC will continue to monitor these agreed actions.

Changes made

55. Mr B told HDC that, since these events, he has been involved in updating the Standard Operating Procedures at other pharmacies relating to methadone administration to promote effective communication between all healthcare professionals involved with methadone patients' care and ensure that any changes to a patient's prescription are documented effectively. Mr B also said that, after reflecting on the events of this complaint, he reviewed the OST Guidelines to ensure that his practice complies with the recommended procedures.

Recommendations

56. This investigation has been conducted simultaneously with another investigation (HDC case number 23HDC01722), which raised similar concerns about OST care provided by BOPAS. Several recommendations for improvement were made in case 23HDC01722, which I consider will also address the deficiencies identified in this report. The recommendations in case 23HDC01722 include that Health NZ Hauora a Toi Bay of Plenty:

a) Use this case as a basis for developing education/training for the OST service, with reference to the World Health Organization's publication 'Guidelines for the psychosocially assisted pharmacological treatment of opioid dependence' and with a focus on the following aspects of the New Zealand Practice Guidelines for Opioid Substitution Treatment 2014:

- Optimal starting and ongoing methadone doses (sections 3.1.1 and 3.3.1)
- Planned withdrawal (section 3.9.1)
- Involuntary cessation of OST (section 3.9.2)

- Measuring methadone serum levels (section 5.5)
- Managing problematic substance use (section 6.1), including continued opioid use (section 6.1.1)
- Rights of people receiving OST (section 11.3)
- The complaints procedure (section 11.4)
- Managed withdrawal (Appendix 8)
- Recovery-oriented treatment (Appendix 10)

The training should also include discussion of risk management, harm reduction, and risk tolerance continuums. If possible, this training is to be facilitated externally and held with OST consumer advisor or advocate participation. Evidence confirming the content of the education/training (eg, training material) and delivery (eg, attendance records) is to be provided to HDC.

b) Include the Te Pou online module 'Training Programme for the Opioid Substitution Treatment Workforce' as mandatory training for current and future OST staff. Evidence of current staff completing this training, in the form of completion certificates, as well as confirmation that this has been included in mandatory training for all staff involved with the provision of OST, is to be provided to HDC.

c) Consider requiring the current Health NZ Bay of Plenty OST team's prescribing psychiatrist to become a member of the National Association of Opioid Treatment Providers (NAOTP), or, alternatively, advise that they are already a member. HDC is to be advised of the outcome of this consideration, the reasons for the outcome, and any plans to implement the outcome or future consideration.

d) Consider requiring a member of the current Health NZ Bay of Plenty OST team to attend/participate in at least two NAOTP meetings per year (occurring three times per year) for at least two years. HDC is to be advised of the outcome of this consideration, the reasons for the outcome, and any plans to implement the outcome or future consideration.

e) Consider establishing an addiction-specific consumer advisor and liaison role in the Addiction Service, with a view that the role would assist OST clients to liaise with the Addiction Service, including appealing decisions to cease OST against the client's wishes, and be involved with policy writing, complex care reviews, and quality improvement processes. HDC is to be advised of the outcome of this consideration, the reasons for the outcome, and any plans to implement the outcome or future consideration.

57. In light of the recommendations made in 23HDC01722, I recommend that Health NZ Hauora a Toi Bay of Plenty provide a written apology to Mr A's family for the breaches of the Code discussed in this report, with reference to the shortcomings identified by Dr Srzich. The apology is to be sent to HDC within three weeks of the date of this report, for forwarding to Mr A's family.

58. I recommend that Mr B:

a) Complete the Pharmaceutical Society of New Zealand (PSNZ) course 'Opioid Substitution Treatment in Community Pharmacy'.[20] Evidence of completion (eg, a completion certificate) is to be provided to HDC within two months of the date of this report.

b) Complete the Te Pou online module 'Training Programme for the Opioid Substitution Treatment Workforce'.[21] Evidence of completion (eg, a completion certificate) is to be provided to HDC within two months of the date of this report.

Follow-up actions

59. A copy of the sections of this report that relate to Mr B will be sent to the Pharmacy Council of New Zealand.

60. A copy of this report with details identifying the parties removed, except Health NZ Hauora a Toi Bay of Plenty and my independent advisor, will be sent to the Australasian Chapter of Addiction Medicine (Royal Australasian College of Physicians), the Addiction Practitioners Association Aotearoa New Zealand (DAPAANZ), Medicines Control (Ministry of Health | Manatū Hauora), the Director of Addiction Services (Ministry of Health | Manatū Hauora), the Pharmacy Council of New Zealand, the Health Quality & Safety Commission Te Tāhū Hauora, the Pharmaceutical Society of New Zealand, the New Zealand Pharmacovigilance Centre, and Te Pou o te Whakaaro Nui and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Morag McDowell
Health and Disability Commissioner

[20] https://www.psnz.org.nz/Product?Action=View&Product_id=931
[21] https://www.tepou.co.nz/initiatives/opioid-substitution-treatment.

Appendix A: Independent clinical advice to Commissioner

The following independent advice was obtained from psychiatrist Dr Ivan Srzich:

'**Independent clinical advice to Health and Disability Commissioner**

Complaint:	**Mr [A] (deceased)**
Our ref:	**C23HDC02431**
Independent advisor:	**Dr Ivan Srzich**

I have been asked to provide clinical advice to HDC on case number C23HDC02431. I have read and agree to follow HDC's Guidelines for Independent Advisors.

I am not aware of any personal or professional conflicts of interest with any of the parties involved in this complaint.

I am aware that my report should use simple and clear language and explain complex or technical medical terms.

Qualifications, training and experience relevant to the area of expertise involved:	MBChB Otago 1990 FRANZCP 2004 I have been employed by the Te Whatu Ora Waitematā Community Alcohol and Drug Service (CADS) since January 2017 and since June 2017 have been in the role of lead clinician for the Auckland Opioid Treatment Service.
Documents provided by HDC:	1. Letter of complaint dated 12 July 2023 2. Response from Te Whatu Ora Hauora a Toi Bay of Plenty (Te Whatu Ora) dated 8 November 2023 3. Clinical records from Te Whatu Ora 4. Further information from complainant dated 6 October 2023
Referral instructions from HDC:	<u>Dr [C]and Te Whatu Ora</u> 1. Whether the actions taken by Dr [C] and Te Whatu Ora in response to Mr [A]'s request to withdraw from treatment were appropriate. 2. What information should have been provided to Mr [A] in relation to the use of cyclizine combined with methadone, and whether the information provided to Mr [A] was adequate? 3. Whether the rate of reduction in methadone and the dosages were appropriate.

4. Whether a second opinion from an independent addiction medicine specialist should have been sought in relation to the reduction of methadone.
5. Whether Mr [A] was adequately supported with the withdrawal, including whether any advice/support offered was appropriate.
6. Whether the consultation Te Whatu Ora had with Mr [A]'s GP, the community pharmacist, and Mr [A]'s support persons was appropriate.
7. Whether the involuntary discharge of Mr [A] from the OST programme in August 2021 was appropriate.
8. The adequacy of Te Whatu Ora's policies.
9. Any other matters in this case that you consider warrant comment.

Summary of complaint

In brief, the complainant, Ms [D], wrote to the Ombudsman on 12 July 2023 about her concerns regarding the care provided to Mr [A], a client of the Bay of Plenty Addiction Service; specifically his treatment with methadone as opioid substitution treatment (OST). Ms [D] felt the service demonstrated a "failure to comply with terms of contract as provider of service to supply methadone doses, 7 days per week as specified in client's prescription and wilful reckless disregard of client safety causing death of [Mr A] some three weeks later". Her letter goes on to note her concerns that, in her view, the BOPAS is punitive and controlling, and that the decision to withdraw Mr [A] from OST was inappropriate.

Summary of provider response

In reply to a letter from […], HDC Complaints Assessor, […], Senior Advisor Governance and Quality, Te Whatu Ora Bay of Plenty, responded:

Re: The rationale for withdrawing Mr [A] off the treatment and the rate of reduction, and other options that were considered and/or offered:

BOPAS did not initiate the process of withdrawing Mr [A] from methadone. Mr [A] initiated the reduction, at least in part because of Service concerns regarding his ongoing use of cyclizine, a methadone potentiator.

Mr [A] attended a medical review on 16 November 2020. By that time he had reduced his methadone from 70mg to 40mg.

Mr [A] did not attend further medical reviews and missed several case manager reviews.

On 21 May 2021 he was informed in writing by […], Clinical Lead for the Service, that due to his limited contact the team "presume that you are no longer willing or able to engage in OST treatment. If this is the case the team will proceed with the plan for a rapid withdrawal from OST medications. If, however, you do wish to engage in treatment, please contact the OST team as soon as possible to arrange an appointment time."

Mr [A] missed two subsequent medical officer appointments, on 21 July 2021 and 2 August 2021.

On 3 August 2021, [the Clinical Lead for the Service], informed Mr [A] in writing that due to non-attendance he was in breach of his OST treatment agreement and that if he did not contact the Service, an involuntary withdrawal regime from methadone would begin.

On 9 August 2021 Mr [A]'s case manager spoke to Mr [A] to convey the decision that he would be prescribed methadone 12mg, reducing by 2mg daily until he was off methadone. Mr [A] did not appear concerned at the rate of methadone reduction.

Mr [A] did not have contact with the service after 9 August 2021.

Re: Your insights into the consistency of this decision with the expectations in the current NZ OST Guidelines and Mr [A]'s rights under the Code of HDC Consumers' Rights:

Mr [A] initiated his methadone reduction, and his reduction, from 70mg to 30mg, was at a rate determined by him.

Mr [A] was informed twice in writing, 12 May and 3 August 2021, that he would be involuntarily withdrawn from the OST programme.

He was advised in writing on 3 August 2021 that his dose would be reduced by 5mg per day until zero. On 5 August 2021 he spoke with his case manager asking for a slower reduction. On 9 August 2021 his case manager spoke with Dr [C] who agreed to slow the reduction, reducing to 12mg daily then by 2mg daily until zero. Mr [A] signalled he was satisfied with this arrangement and at no time during conversation with Service staff did he indicate he wished to resume his OST programme agreement.

Re: Please advise whether you sought a second opinion from an independent expert before proceeding to withdraw Mr [A] from treatment:

Service user's presentation, circumstances and points of tension with services are discussed in multidisciplinary team meetings (MDTs). The Service MDT note of 10 August 2021 — "*Involuntary discharge, obligatory reduction@2mgs per day until zero. Discussed second opinion regarding treatment/reduction. Client not appearing in distress with this reduction. Symptomatic relief offered*".

There was no second opinion scheduled because there was no dispute between Mr [A] and the Service that he wished to withdraw from methadone.

Re: Please advise how Mr [A] was involved in decision-making in the lead up to and including the decision to withdraw him from the methadone programme, and what was communicated to Mr [A] regarding this withdrawal.

The decision to withdraw from methadone and from the oversight of the Service was made by Mr [A]. Mr [A] was provided appointments during the period of his self-directed withdrawal from methadone.

Re: What plans were put in place for Mr [A] to manage his withdrawal from methadone including any related physical or psychological issues.

Mr [A]'s methadone withdrawal regime was initiated by himself and progressed at a rate chosen by him and his community pharmacist. The regime commenced prior to July 2020 and continued until 15 August 2021. He was offered review appointments but missed many.

Re: Please advise how Mr [A]'s dosages were reduced, including the timing, rate (in mg/ml) and percentage of reduction:

Reduction schedules attached.

Re: Whether any safety netting advice was provided to Mr [A] regarding any side effects he might experience:

OST programmes work to protocols to support, monitor and assist service users engaged with the programme. Mr [A] consistently did not attend meetings to review and offer support.

Re: What advice was provided to Mr [A] or his support people in relation to appealing the decision to withdraw him from the methadone programme or to make a complaint:

A range of brochures and posters are viewable and available to advise service users how to make a complaint.

Mr [A] did not advise anyone in the service that he wished to lodge a complaint and the Service view was that he wanted to withdraw from methadone.

Re: Ms [D]'s concerns Mr [A] was not offered alternative support:

The service had multiple meetings and phone discussions with Mr [A] after his meeting with Dr [C] and case manager […], on 16 July 2020. He reported managing well with reductions of 5mg at a time, until 3 March 2021, when he reported "*struggled a little*" with his last 5mg drop, so was considering reducing the reductions to 3mg.

On 18 May 2021 he had a phone discussion with [another] case manager […], during which he reported that he remained frustrated with his removal of takeaways, and he continued with the goal of coming off OST. He had read the letter from the service and felt a rapid reduction off methadone was unrealistic.

Other options made available to Mr [A] by the Service were detailed elsewhere in the Service response.

Re: Ms [D]'s concerns that clients were not given a timely methadone reduction schedule but taken off immediately:

Ms [D] did not have detailed knowledge of Mr [A]'s treatment and was not authorised to receive confidential information.

Re: Your usual practice for involuntarily withdrawing a consumer from the methadone programme:

Hauora a Toi BOP Addiction Service protocols were attached.

Mr [A] had a self-directed withdrawal from methadone between July 2020 and 5 August 2021. Involuntary withdrawal regime was initiated by the BOPAS only after 3 August 2021.

As at 3 August 2021 Mr [A]'s methadone had reduced from 70mg to 15mg. On 9 August 2021 Mr [A] was prescribed methadone 15mg, reducing by 2mg per day until zero.

Re: Any comments you wish to make:

As noted through the response, Te Whatu Ora Hauora a Toi Bay of Plenty believes that Mr [A] was not in a relationship with the complainant, [Ms B], during the period 2020–2021.

Summary of clinical notes

At the time of his discharge from the Hauora a Toi Bay of Plenty Addiction Service (BOPAS), in August 2021, Mr [A] was a 65-year-old man, living with his partner and self-employed, working full time in a roofing business. He had a long history of opioid dependence, dating back to the 1980s, with periods on opioid substitution treatment (OST). He had an adult son, from a previous relationship, working with him.

The notes provided indicate Mr [A] had been prescribed methadone 70mg daily by his GP, Dr [E], but because of service/funding changes (I am unsure what) he was brought back to BOPAS prescribing in late 2014. He was cooperative with this process but frustrated with the return to specialist service prescribing, as this meant he was required to attend the pharmacy twice weekly to have observed medication consumption on pharmacy premises (COP), while when in GP prescribing this had not been required. This appears to be because the GP prescribing was deemed to be for pain, rather than dependence/addiction.

Risk assessment forms, initially dated 9 December 2014 with regular updates, note polysubstance use since at least 1985, no intravenous substance use since his 30s, past hepatitis C treated with interferon, cirrhosis and glomerulonephritis secondary to hepatitis C. He had no history of suicide attempts or aggression.

Dr [G], BOPAS OST doctor, saw Mr [A] in January 2015. In her letter to Dr [E], she noted that he reported initially being on methadone due to past heroin addiction, and that he also had back pain, which was why the methadone was being prescribed in tablet form, rather than liquid, which is the norm when used as OST. He was also noted to have benzodiazepines in a urine drug screen (UDS) which he explained as being related to use for a plane trip.

In 2015 a Contract/Consent to Receive OST from BOPAS form indicated that Mr [A] had received and read the Client Information Booklet and agreed to accept and abide by the conditions (I did not receive a copy of this booklet).

Medical officer reviews, by [BOPAS OST doctor], and treatment plans between 2015 and 2018, indicate Mr [A] appeared stable in terms of substance use, comfortable on methadone 70mg, with no concerns regarding illicit substance use. He was noted to have been "open and honest" in interactions with [the BOPAS OST doctor].

Multiple UDSs over this time were negative for all substances apart from methadone, apart from one, in March 2017 which was positive for cannabis. Mr [A] was adamant, at that time, he had not used cannabis, and it was considered a possible laboratory error.

Given his stability, attempts were made to return him to GP shared care (GPSC) with Dr [E] prescribing methadone, with BOPAS oversight. Dr [E] was initially not able to provide the service due to funding and capacity issues, but Mr [A] eventually returned to GPSC, in November 2017. He was prescribed methadone 70mg daily, with two COP and five takeaway doses per week.

During this time his methadone was switched from tablet form to liquid, in a 5mg/mL solution, which is the usual form of administration. His other medications included cilazapril, amlodipine and metoprolol.

A GPSC review template in July 2018 indicated that Mr [A] remained stable, with no illicit substance use and one COP weekly.

A UDS was negative for illicit substances.

A 6 November 2018 risk review noted reports from the community pharmacy that Mr [A] was buying cyclizine on a regular basis, stating this was for fishing, and collecting his methadone early, so the Service returned him to their care, with daily observed consumption of methadone.

(Of note, cyclizine is an antihistamine used for motion sickness. It is also a potentiator of opioids and is known to be abused by people using methadone or other opioids. "Early pick up" of medication occurs when clients ask for medication to be dispensed before they are due and can indicate that medications are not being taken as prescribed.)

[Ms F], case manager, reviewed Mr [A] on 10 December 2018. It was noted that Mr [A] appeared disgruntled but engaged. He appeared frustrated at being required to attend the pharmacy daily. He reported that he had not used any illicit substances and continued to "insist that he was unaware that he should not be using cyclizine". There were no risks identified at the review and no changes to his treatment.

[A] BOPAS OST doctor, reviewed Mr [A] on 11 February 2019. She noted that Mr [A] had been on OST for some years, and in GP shared care until the end of 2018. She noted concerns regarding the use of cyclizine, which had been confirmed with UDSs.

It was noted that he had been attending his pharmacy irregularly, and that the difference in two methadone blood levels, a random one of 750nmol/L followed by one taken after four days of observed consumption, of 1590nmol/L, raised questions regarding the regularity of his consumption of methadone.

[The BOPAS OST doctor] tried to explain the test results, and the service concerns, but she noted that Mr [A] was "quite belligerent and refused our explanation". She tried to explain the pathway back to GPSC and asked that he discuss any issues that might affect his stability.

[The BOPAS OST doctor] noted a plan to try to re-introduce takeaways slowly and build a therapeutic relationship with Mr [A].

[Ms F]'s note of the meeting indicated that Mr [A] felt the discrepancy in blood methadone levels was laboratory error, and that he had been prescribed methadone for pain, and that he would be on it for life. He also felt the dose was not 'holding him'. These notes indicate a regular takeaway dose was provided to Mr [A].

[Ms F] phoned Mr [A] the following day to ask which day he would like a takeaway (Sunday). Mr [A] apologised for his behaviour the previous day and asked that these apologies be passed on to [the BOPAS OST doctor].

On 13 March 2019 a multidisciplinary team meeting (MDT) note indicated that Mr [A] was given two takeaways to attend WOMAD, with plans for serum methadone levels following this.

From Mr [A]'s "methadone summary form" it appears his Sunday takeaway was removed in early April 2019, returning him to daily pharmacy attendance.

On 4 June 2019 Mr [A] met with [Ms F]. He appeared well engaged, stated he felt comfortable on his methadone and denied other substance use.

It was noted that three of his previous four UDSs were positive for cyclizine. Mr [A] stated that he had been placed on "dailies" (daily dispensing of methadone) due to not being aware he was not supposed to take cyclizine but decided that he "might as well stay on dailies and use the cyclizine for fishing trips."

Mr [A] appeared otherwise well, with good physical and mental health, stable relationship and work.

Further review with [Ms F] on 8 August 2019 was similar, with Mr [A] remaining unhappy about removal of takeaways but engaging well. There was no evidence of illicit substance use or risk identified. A UDS was negative for illicit substances but not tested for cyclizine at that point.

Later that month Mr [A] contacted [Ms F] reporting that he had been diagnosed with a nephropathy, with plans for a kidney biopsy and requesting takeaways to attend hospital, if needed.

On 28 August 2019 Mr [A] saw Dr [G] for review, with [Ms F] and a medical student. Her letter to Dr [E] recorded that Mr [A] remained unhappy about being on daily consumptions and was "belligerent and angry" when discussing concerns regarding him taking cyclizine. He did not understand why he should discontinue this, stating he used it

for seasickness, when fishing. Dr [G] suggested that alternative management of motion sickness was an issue his GP might consider.

Dr [G] noted that Mr [A] became quite personal and negative so the interview was terminated, with the plan to continue the same dose of methadone and ongoing case manager review.

[Ms F] noted that Dr [G] tried to explain that his UDS results were consistent for cyclizine use and his low serum methadone levels led the team to believe that he may not be using methadone as prescribed. Mr [A] denied this.

An MDT note on 2 September 2019 noted that "should [Mr A] continue to use cyclizine to potentiate methadone, then methadone dose will be reduced. On 3 September 2019 it was noted that Dr [G] had discussed Mr [A]'s situation with her peers and the consensus was that there was no concern currently about IV use, though the injecting site might be hidden. Questions were asked regarding what treatment was achieving and that there should be a clear expectation that cyclizine use needed to stop.

It appears that in early 2020 two medical reviews were cancelled due to lack of available doctors.

On 12 March 2020 Mr [A] had a medical review with Dr [H], consultant psychiatrist. She noted that Mr [A] had previously had a good record of stability but in 2019 there were frequent UDSs positive for cyclizine. At their meeting he was adamant that he used to cyclizine for sea sickness, when fishing, not to enhance the effect of methadone.

Mr [A] expressed dissatisfaction regarding having takeaways removed due to his reported cyclizine use. He said he had not used cyclizine since December 2019, as he had had a busy summer and had not done much fishing. Mr [A] expressed that he was most upset about his perceived unfair treatment and accusations about things he had not done.

Dr [H] noted there had been a UDS positive for cyclizine in late 2019, though the date was not clear. The option of a change from methadone to buprenorphine was discussed, with the possibility of greater freedom for takeaways. He was happy to have another UDS and review in three months. She planned to have a discussion regarding takeaways with the MDT.

In March 2020 texts were received by [Ms F] from Mr [A] stating that because of his age, nephrotic syndrome, high blood pressure, and being a long-term smoker, he was fearful about attending his pharmacy during the Covid lockdown. Dosing protocols in Covid were discussed, with a plan for takeaways to be discussed in MDT.

On 16 July 2020 Mr [A] met with Dr [C] and [Ms F].

Mr [A] continued to state that he had not used cyclizine since late December 2019, though [Ms F]'s notes record that tests in early 2020 and July 2020 were positive for cyclizine.

Mr [A] reported that he had been decreasing his methadone, with his community pharmacist, and down to 60mg. The OST service was not aware of this.

Dr [C] 's letter of the meeting reported that Mr [A] was somewhat "weary and irritable" and described that Mr [A]'s relationship with the OST Service had "hit a rough patch" and Mr [A] reported this occurring over the previous 18 months, particularly around the issue of cyclizine.

Dr [C] noted that the OST team had informed Mr [A] that cyclizine was abused by people using methadone, as it enhanced the opioid effect, but Mr [A] stated he used it for motion sickness when fishing. Dr [C] noted that he continued to use it, as evidenced by urine drug screens, despite Mr [A] being informed that this would lead to him being seen as unstable in terms of criteria for takeaways from the pharmacy.

Dr [C] noted a concern that Mr [A] might, through his weariness with the process, reduce his methadone in an "angry riposte to the service", which would only cause him problems.

Dr [C] made suggestions including ongoing regular contact with his case manager, an observed UDS and finding alternatives to cyclizine.

On 19 August 2020 Mr [A] met with [Ms F] for review. Notes indicate that he was pleasant and well engaged. He reported decreasing his dose by 5mg when comfortable with the previous drop. The option of decreasing by smaller amounts, as his dose dropped, was discussed. A discussion around appropriate behaviour while dealing with the service was noted.

A September 2020 MDT note recorded that Mr [A] would continue reducing his methadone dose but he needed to engage in treatment as per the service "Consent to Treatment" requirements, along with monthly case manager appointments and regular UDSs.

At review on 14 October 2020 [Ms F] noted that Mr [A] made good eye contact and generally engaged well. He had been decreasing his methadone at 5mg per month, from 80mg to 45mg and this had gone well. Mr [A] reported that while he initially wanted to stop OST due to organisational restrictions, he now needed to get off for his own health needs, as he had reached retirement age and had health issues. He felt confident with the reductions and that as long as he took it slow and steady, he would be able to get off treatment. He denied substance use but acknowledged that he had used cyclizine, with a positive UDS. He apologised for his behaviour at the previous medical review.

On 28 October 2020 Mr [A] did not attend a medical review. When contacted by [Ms F] he apologised and said he had been "knee deep" in paperwork. [Ms F] noted that he "sounded genuine" and Mr [A] asked for the meeting to be rescheduled.

Dr [C] wrote to Mr [A] that day, outlining his recall of the previous meeting, where Mr [A] said he would prefer to reduce methadone as opposed to stopping cyclizine. Dr [C] noted that at his current rate of reduction it would take nine months to come off methadone 45mg.

Dr [C] noted that even though Mr [A] was planning to reduce dose and exit the service, the service had a responsibility to continue to review him over that time.

Dr [C] suggested that if Mr [A] was unable to attend meetings "it would make sense to speed up the reductions" or, if he were to continue with a 5mg per month reduction, he could attend the clinic more frequently. Another option was to stop his reduction and remain on the programme.

Mr [A] met with Dr [C], [Ms F], case manager, and a nursing student, on 16 November 2020.

Dr [C]'s letter of the meeting discusses Mr [A]'s response to Dr [C]'s letter of 28 October 2020, with Dr [C]'s view that Mr [A] had not reevaluated his position with regard to treatment.

Mr [A] stated that he planned to continue reductions "as he sees fit" and "did not commit to ongoing attendance".

Dr [C] summarised his view of Mr [A] having a "contemptuous narcissistic presentation." Dr [C] suggested that Mr [A] "be tasked to be in contact with the Service to meet up to once-a-month face to face. In other words, we will not set appointments for him. Putting the responsibility onto him is only aligning it with his presumed authority in the situation" and that if he did not meet this "responsibility" his methadone would be reduced in days not weeks and he could have a stand down period.

Dr [C] noted in a postscript that he felt Mr [A] should not be given a copy of the letter, as it would be "dreadfully wounding to him".

A 17 November 2020 MDT noted Mr [A]'s plan to continue reducing methadone, while also continuing with cyclizine use, which he felt was "not hurting anyone". He was noted to be disengaging from the service and reluctant to attend appointments. A plan was made to encourage him to take responsibility for organising appointments and being more involved in his treatment plan.

As a separate issue, it was noted that Mr [A]'s pharmacy had allowed him to decrease his dose without discussing with the OST service and had given him a methadone dose when the script had been "held" to support him attending a medical review. The team had a plan to follow these issues up with the pharmacy.

At a 3 March 2021 meeting with [Ms F], Mr [A] appeared well engaged and pleasant with no evidence of intoxication or sedation. He stated that he had not used any substances and been too busy to go fishing so had not used cyclizine.

Mr [A] had continued with a dose reduction of 5mg per month. He was considering reducing by smaller increments, 3mg, as he had struggled a little with the previous reduction. He reported doing less physical work, with his son now doing this, and spending more time in the office. [Ms F] reminded Mr [A] that he needed to arrange for an MO review, which he said he would.

On 11 May 2021 an MDT noted that Mr [A] was not engaging with the OST team and was using cyclizine despite being told this was not acceptable. There had been a plan for him to make his own appointments, which he had not done. Reference was made to Dr [C]'s letter in November 2020.

The team plan was to write to Mr [A] regarding the need for him to participate in his treatment and arrange appointments, or he might be forced to reduce off methadone faster and be forcibly discharged.

On 12 May 2021 the BOPAS addiction team leader, [Mr I], sent a letter to Mr [A] noting that he had only attended one appointment in the previous six months. He also noted that the previous case manager had reminded Mr [A] that it was his responsibility to make an appointment with the medical officer and that he had been reminded that if he was unable to attend appointments his methadone reduction would be increased in rate.

[Mr I] wrote that the team had reviewed Mr [A]'s treatment and, given his very limited contact, the team presumed that he was unwilling to engage in treatment. If that was the case the team would plan for a more rapid withdrawal from OST. If Mr [A] wanted to remain in treatment, he needed to contact the service as soon as possible.

On 18 May 2021 [Ms K – case manager] returned a call from Mr [A]. Mr [A] had received the letter from [Mr I] and, while engaging appropriately during the conversation, appeared aggrieved and disputed aspects of the letter. He said he was not aware why he should stop cyclizine and did not know he was supposed to arrange monthly keyworker meetings. He noted that he sometimes did not hear from his keyworker for "9 months at a time".

Mr [A] acknowledged that his anger had built up and that Dr [C] "copped it."

Mr [A] felt a rapid reduction in methadone was unrealistic and wanted to continue with his current rate of reduction until zero.

Mr [A] asked to be booked in to see Dr [C] to discuss the plan. [Ms K] planned to meet with Mr [A] and then book him to see Dr [C].

On 21 May 2021 Mr [A] met with [Ms K]. He engaged well during the meeting. While he had "gripes" with the team, he was agreeable with monthly keyworker meetings, seeing the doctor, and completing a UDS, which he said would not contain cyclizine. While he remained keen to decrease off methadone, slowly, he was concerned about how he would manage his chronic back pain. [Ms K] discussed the possibility of switching from methadone to long-acting injectable buprenorphine, but Mr [A] was not keen.

A 3 June 2021 MDT noted a plan to continue the methadone reduction "driven by" Mr [A] with keyworker support.

On 21 June 2021 Mr [A] did not attend a scheduled appointment, leaving a message that he had flu symptoms and asking for another one to be rescheduled. It is unclear whether this was planned to be a keyworker or doctor review.

22 June 2021 [Ms K] discussed Mr [A] with the OST team — the plan was to await contact from Mr [A] regarding an appointment.

On 2 August 2021, a note was made that Mr [A] did not attend a doctor's review meeting.

On 3 August 2021 (Tuesday), an MDT note was made of Mr [A]'s cancelling his appointment on 21 July (?June) with no contact until "last week" then not attending again on 3 August 2021.

It was noted that he had been sent a letter advising of the possibility of a rapid reduction off methadone and the plan was to advise him that reductions would start that day, 3 August.

On 3 August 2021 the addiction service team leader, [Mr I], sent a letter to Mr [A] noting that as he had not engaged with the service as required, he was being involuntarily discharged, with a plan to reduce his methadone by 5mg per day until zero.

On 5 August 2021 (Thursday) [Mr J], counsellor, received a call from Mr [A] stating that he would be reducing by 5mg per day. Mr [A] felt this was unfair and cruel. He stated he had been attending meetings, cancelled one appointment and missed a second appointment as he "just got the dates mixed up."

[Mr J] told Mr [A] he would discuss the plan with a doctor, to see whether the service would continue their plan, whether the doctor would review Mr [A] or whether the service would supply supportive medication.

That day [Mr J] discussed the situation with a doctor, who decided to continue the reductions until Sunday (8 August 2021) then hold the dose at 15mg, until he had an opportunity to discuss with Mr [A]'s case manager, [Ms K]. Mr [A] was upset about this plan.

On 9 August 2021 (Monday) [Ms K] received a call from Mr [A]. Mr [A] stated he did not understand why "it has come to this" and he had never heard of people having such a rapid rate of methadone reduction. He reported the community pharmacists were "shocked."

Mr [A] explained that he had missed the two appointments, one because he was unwell and another because of a mistake. [Ms K] noted that she had spoken to the community pharmacists who reported that Mr [A] did not look unwell, when he stated he was.

Mr [A] stated he felt he would not be able to reduce at the rate proscribed. [Ms K] agreed to discuss this with Dr [C] and the team.

Later that day [Ms K] phoned Mr [A] to advise that Dr [C] had prescribed methadone 12mg, reducing by 2mg per day until zero. Mr [A] stated, "*so the ego has got the better of him*", thanked [Ms K] and ended the call.

On 10 August 2021 at MDT, Mr [A]'s involuntary discharge with an obligatory of 2mg daily until zero was discussed. Discussion regarding seeking second opinion around treatment

and reduction was noted. "*Client not appearing in distress with this reduction. Symptomatic relief was offered*".

On 12 August 2021 Dr [C] wrote to Dr [E], GP, noting that Mr [A] had been discharged from the OST service through "repeated non-engagement". Dr [C] noted that Mr [A] had not attended a doctor's appointment for nine months and only attended 25% of key worker appointments that year, despite letters outlining his responsibilities around being in treatment. "*We take the lack of impact these had on his behaviour to be wilful and obstructive. Even when we started the methadone reductions, he was unable to engage with his nurse in a constructive and insightful fashion*". Dr [C] noted that the service was willing to reassess Mr [A], should he wish it.

Mr [A]'s last dose of methadone was 2mg on 14 August 2021.

On 25 August 2021 it was noted that Mr [A] had not contacted the OST since the countdown and not gained medication from his GP. He was discharged.

Question 1: Whether the actions taken by Dr [C] and Te Whatu Ora in response to Mr [A]'s request to withdraw from treatment were appropriate.
List any sources of information reviewed other than the documents provided by HDC:

New Zealand Practice Guidelines for Opioid Substitution Treatment 2014 (NZ OST Guidelines)

Advisor's opinion:

In the notes provided it is apparent that the decision to withdraw from treatment was made by Mr [A], first noted in the letter Dr [C] wrote to Mr [A]'s GP regarding their meeting on 20 July 2020, and [Ms F]'s note of the same meeting. Both record that Mr [A] had stated he had started a dose reduction, without the clinical team's awareness, through his dispensing pharmacy. Mr [A] planned to reduce by 5mg, when he felt comfortable with the previous reduction.

Dose reductions at client request are generally supported by services.

The initial rate of reduction, undertaken by Mr [A], was appropriate, given the dose he was on, 70mg. His rate of reduction was supported by the service, and in later meetings with his key worker, Mr [A] noted that as his dose reduced, he would need to reduce by smaller increments. This is appropriate practice, with smaller dose reductions at lower doses, spaced out such that they are well tolerated by the client. This appears to have been the case with Mr [A]'s decision to reduce, and wish to ultimately cease, methadone.

In addition to attempting to support Mr [A] with his wish to reduce and cease methadone, the option of stopping the reductions and remaining on the OST programme was offered to Mr [A].

Of note, the dose reductions appear to have been initially undertaken by Mr [A] with his community pharmacist support. A variation in dosing not on a script is outside of acceptable pharmacy practice. It is recorded, later, that this was discussed with the

pharmacy, though not recorded in Mr [A]'s clinical notes. Similarly, there was an incident, documented on 18 November 2020, when the pharmacy dispensed Mr [A]'s methadone despite there being a 'hold' on it to support his attending an MO review.

What was the standard of care/accepted practice at the time of events? Please refer to relevant standards/material.

I believe that actions taken by Dr [C] and Te Whatu Ora in response to Mr [A]'s request to withdraw from treatment were appropriate.

As per the NZ OST Guidelines Sec. 3.9.1 Planned Withdrawal (italics mine):

"Withdrawal from OST should ideally occur when a client has achieved their treatment goals and attained levels of stability and recovery capital that give them a reasonable chance of achieving abstinence from opioids, if that is their goal. The best outcomes are achieved when *a client ceases OST voluntarily after a planned and gradual, stepped dose reduction (rather than a rapid dose reduction) and is able to control the frequency and amount by which their dose is reduced.*"

"Completion of methadone withdrawal is more likely to be successful if undertaken slowly over a long period of time, through a gradual stepped tapering regime involving dose reductions in only 25–50 percent of the weeks of the reduction process. *As a guide, the reduction rate might be between 5 and 10 percent of the current dose every 1–4 weeks depending on the individual characteristics of the client.*"

As noted, it was apparent that Mr [A] chose to reduce his dose, with the goal of cessation, and the rate of reduction was appropriate, with his case manager supporting him with this, and advising of options.

While it appears the initial decision to reduce methadone dose may have been contributed to by Mr [A]'s frustration with the OST service, as the reduction continued, he appeared more clear that he was ready to come off methadone due to his age, health and other issues.

Other issues regarding relapse prevention and supports were not clearly addressed, due to the subsequent initiation of an involuntary withdrawal by the OST service, discussed below.

Was there a departure from the standard of care or accepted practice?

- No departure;
- Mild departure;
- Moderate departure; or
- Severe departure.

I believe that the service response, when Mr [A] advised of his wish to reduce methadone, was not a departure from accepted practice.

How would the care provided be viewed by your peers? Please reference the views of any peers who were consulted.

I believe my peers would agree that the response by Dr [C] and the service was appropriate.

Please outline any factors that may limit your assessment of the events.

My opinion is based on the clinical notes and letters provided, along with the response of Te Whatu Ora.

Recommendations for improvement that may help to prevent a similar occurrence in future.

No recommendations.

Question 2: What information should have been provided to Mr [A] in relation to the use of cyclizine combined with methadone, and whether the information provided to Mr [A] was adequate?

List any sources of information reviewed other than the documents provided by HDC:

Advisor's opinion:

Mr [A]'s cyclizine use was discussed with him on numerous occasions, at least since Feb 2019, when Dr [G] tried to discuss this with him. Later notes indicate that the service's concerns regarding its use were discussed with him, with concerns that it was often used in methadone using clients to potentiate methadone and suggesting alternatives.

[Ms K]'s note of 18 May 2021 records Mr [A] "denied knowing why he should not use cyclizine until he recently researched it himself" however it is documented in previous notes and letter, for example Dr [H]'s letter of 12 March 2020.

I believe the information provided was appropriate. The notes indicate that service's concerns regarding the combination of opioids and cyclizine was discussed with Mr [A].

It would have possibly been of benefit to discuss the frequency of his use, but discussions around this appear to have been limited, with Mr [A] becoming irritable when questioned.

What was the standard of care/accepted practice at the time of events? Please refer to relevant standards/material.

The service response, in terms of informing Mr [A] of the concerns regarding his cyclizine use were in keeping with accepted practice.

The service's response to his ongoing use is discussed below.

Was there a departure from the standard of care or accepted practice?

- No departure;

- Mild departure;
- Moderate departure; or
- Severe departure.

No departure.

Please outline any factors that may limit your assessment of the events.

While it is recorded that Mr [A] consistently had cyclizine present in UDS screens, I did not receive information regarding the frequency of tests, or indeed any test results showing the presence of cyclizine.

Recommendations for improvement that may help to prevent a similar occurrence in future.

No recommendations.

3. Whether the rate of reduction in methadone and the dosages were appropriate.

List any sources of information reviewed other than the documents provided by HDC:

New Zealand Practice Guidelines for Opioid Substitution Treatment Guideline 2014 (NZ OST Guidelines)

NSW Clinical Guidelines: Treatment of Opioid Dependence 2018 (NSW Guidelines)

Advisor's opinion:

The initial rate of methadone reductions, undertaken by Mr [A] and supported by the service, were appropriate.

As noted above, the NZ OST Guidelines Sec 3.9.1 Planned Withdrawal notes (italics mine): "Completion of methadone withdrawal is more likely to be successful if undertaken slowly over a long period of time, through a gradual stepped tapering regime involving dose reductions in only 25–50 percent of the weeks of the reduction process. *As a guide, the reduction rate might be between 5 and 10 percent of the current dose every 1–4 weeks depending on the individual characteristics of the client.*"

Generally, it is considered acceptable to reduce doses by around 10% every two to four weeks, as the client tolerates or wishes. As doses decrease the size of the dose reduction generally decreases, as the relative percentage of the decrease increases. This was noted and discussed with Mr [A], in [Ms F]'s note of their 19 August 2020 and 3 March 2021 meeting.

Mr [A] was prescribed methadone 70mg prior to July 2020 and had decreased, at his request, to 25mg in early August 2021.

The rate of reduction in the involuntary withdrawal is discussed below.

NZ OST Guidelines notes, regarding involuntary withdrawal: "*The rate of reduction in the case of involuntary withdrawal will depend on the circumstances, but rapid dose*

reduction is not recommended. A gradual reduction, as described in the case of a planned withdrawal, should be undertaken unless it is unavoidable (eg, in cases of violence on the part of the client)."

The NSW Guidelines note (italics mine): "Where treatment is being discontinued with an involuntary discharge and cessation of OAT, the rates of dose reduction will depend on the circumstances, but a gradual taper of medicine is preferred if possible. *Only where there are persistent and high-level safety concerns should a rapid reduction occur (over 1–14 days based on risk assessment).* Patients being involuntarily discharged must be warned about the risks of opioid drug use, of possible reduced tolerance to other opioids such as heroin, morphine and fentanyl, and informed of other treatment options. Consideration may also be given to overdose management and education, including the provision of naloxone."

When the decision was made to initiate an involuntary withdrawal, Mr [A] was being prescribed methadone 25mg. The initial plan was to reduce by 5mg daily, until zero. Mr [A] called the service the following day, reporting that this was "unfair and cruel". A decision was subsequently made to change the rate of reduction to 2mg daily, from 12mg.

As noted, per the NZ OST Guidelines and NSW Guidelines, rapid dose reduction is not recommended unless it is unavoidable, for example in cases of violence.

I believe the rate of methadone dose reduction, during the involuntary withdrawal, was not appropriate.

While Mr [A] appeared to not be engaging with the service, he had been managing a slow reduction and there were no evident safety issues — for example no acts of violence or other substance use warranting immediate safety concerns. (His cyclizine use, while not condoned, had been tolerated by the service since 2018).

Reducing methadone by 5mg daily, or even 2mg daily, will cause significant withdrawals and distress for a client.

There are no clear guidelines regarding an appropriate rate of methadone withdrawal, however, as per the NSW Guidelines, a reduction and cessation over 1–14 days is considered rapid. The initial plan was for Mr [A] to reduce by 5mg daily, from 25mg, ie, over 5 days, while even at a reduction of 2mg daily, he was withdrawn over 9 days, between 6 August and 15 August 2021.

I believe that at a dose of 25mg, a reduction of 2mg every four days could be considered, though even this would be in circumstances where there is significant evident risk, of the kinds noted. I do not believe these risks were present in Mr [A]'s situation.

What was the standard of care/accepted practice at the time of events? Please refer to relevant standards/material.

Please refer to NZ Opioid Guidelines above.

As noted, the process of involuntary withdrawal is a balance between managing risks of ongoing OST with causing withdrawals and distress for the client, which carries its own risks in terms of possible return to other opioid use. There do not appear to be clear protocols for the rate of methadone reductions.

Please outline any factors that may limit your assessment of the events.

There is limited evidence around rate of reduction in involuntary withdrawal.

Recommendations for improvement that may help to prevent a similar occurrence in future.

Establishment of clearer protocols around rates of rapid withdrawal could be considered, though these are limited, given the differing risk issues associated with each client.

4. Whether a second opinion from an independent addiction medicine specialist should have been sought in relation to the reduction of methadone.

List any sources of information reviewed other than the documents provided by HDC:

New Zealand Practice Guidelines for Opioid Substitution Treatment 2014 (NZ OST Guidelines)

Advisor's opinion:

I believe that a second opinion should have been sought in this situation, with regards to the initiation of an involuntary withdrawal. As noted below, in the response to question 7, involuntary withdrawals are an option of "last resort", and second opinions are helpful to review and suggest other management strategies.

In Mr [A]'s case the primary issue seems to have been a breakdown in the relationship between the client and the service, with Mr [A] apparently unwilling to engage, particularly with medical reviews. An external, second opinion, would possibly have been helpful for the reasons noted above.

As per New Zealand Practice Guidelines for Opioid Substitution Treatment 2014 Sec 3.9.2 (italics mine):

"The final decision to cease OST should be made by the prescribing doctor with the key worker and the MDT, including the service manager or the primary health care team (whichever applies), and *preferably after a second opinion from an independent addiction medicine specialist (ie, one from a different service or DHB) or equivalent.*

A second opinion can consider alternative strategies to avoid involuntary withdrawal. To make best use of this opinion, service providers should seek it before making a decision to cease treatment."

It is 'best practice' and encouraged for a second opinion to be sought prior to the initiation of an involuntary withdrawal. As noted in the Guidelines, this should be done to seek advice on options other than an involuntary withdrawal.

However, I am aware that this practice is not consistent in New Zealand and in the NZ OST Guidelines it is recommended, rather than considered mandatory.

The BOPAS OST Service MDT note of 10 August 2021 shows consideration being given to a second opinion — "*Involuntary discharge, obligatory reduction@2mgs per day until zero. Discussed second opinion regarding treatment/reduction. Client not appearing in distress with this reduction. Symptomatic relief offered*".

This is the only note I could find regarding seeking a second opinion. It is documented after the involuntary withdrawal was already begun. In general, as noted, second opinions should be sought early, to look at options other than involuntary withdrawal and so, in this case, I believe it was too late.

The MDT clinical note states "*Client not appearing in distress with this reduction*" — this does not appear to be in keeping with the clinical notes of conversations with Mr [A] on 5 August when he felt the reduction was "*unfair and cruel*" and 9 August when he reported "*he has never heard of people being reduced at such a rate and even the pharmacists are shocked. … he doesn't feel he'll be able to reduce at such a rate*".

What was the standard of care/accepted practice at the time of events? Please refer to relevant standards/material.

As noted, second opinions are encouraged but not mandated. I am aware that there is variability in different services around New Zealand but believe that they are generally expected.

Was there a departure from the standard of care or accepted practice?

- No departure;
- Mild departure;
- Moderate departure; or
- Severe departure.

I believe the failure to obtain a second opinion is a mild departure from standard care, acknowledging that second opinions, while preferred, are not considered compulsory in the NZ OST guidelines.

How would the care provided be viewed by your peers? Please reference the views of any peers who were consulted.

I have had informal discussions with peers, involved in OST, who agree that a second opinion should be sought to consider alternatives to involuntary withdrawal.

Please outline any factors that may limit your assessment of the events.

My opinion is limited by working from the clinical notes. There may have been other considerations to getting a second opinion, though they are not documented.

Recommendations for improvement that may help to prevent a similar occurrence in future.

I believe that in Mr [A]'s case, a second opinion may have been helpful in clarifying the issues, with regards to the challenges in engagement, with possible suggestions around management.

5. Whether Mr [A] was adequately supported with the withdrawal, including whether any advice/support offered was appropriate.

List any sources of information reviewed other than the documents provided by HDC:

New Zealand Practice Guidelines for Opioid Substitution Treatment 2014 (NZ OST Guidelines)

NSW Clinical Guidelines: Treatment of Opioid Dependence 2018 (NSW Guidelines)

Advisor's opinion:

As per the NZ OST Guidelines Sec 3.9.2:

"When a specialist service imposes involuntary cessation of OST, it needs to:

- give the client reasons for the withdrawal of OST in writing
- caution the client about risks of overdose (due to reduced tolerance) and driving and operating machinery during the withdrawal process
- offer the client support during the withdrawal process
- provide the client with a future-directed specific treatment plan
- inform the client of other treatment options available and assist with referral where appropriate.

Service providers should give clients the opportunity to appeal against the decision to cease OST against their wishes. Wherever possible, the service should retain the client in the programme pending resolution of the appeal. The service should provide the client with information about accessing a consumer advocate for the purposes of this process.

In all cases of withdrawal from OST (planned or involuntary), service providers must document a discharge plan once it has made the decision to withdraw. In each case of involuntary cessation of OST, the service provider should initiate discussion about how the client might best re-engage in OST and should document this discussion in the client's clinical notes."

In the NSW Guidelines it is noted — "Patients being involuntarily discharged must be warned about the risks of opioid drug use, of possible reduced tolerance to other opioids such as heroin, morphine and fentanyl, and informed of other treatment options. Consideration may also be given to overdose management and education, including the provision of naloxone."

[Mr I]'s letter to Mr [A], on 12 May 2021, regarding the possibility of a rapid withdrawal from methadone outlined the reasons for possible involuntary withdrawal. Mr [A] then contacted the service and initially re-engaged, seeing his case manager on 21 May 2021.

Mr [A] contacted the service to say he would not be able to attend a scheduled medical review, on 21 June 2021, then missed another appointment on 2 August.

[Mr I] wrote to Mr [A] on 3 August 2024 stating that the involuntary withdrawal had commenced.

It does not appear that Mr [A] was offered an appeal regarding the decision to undertake the involuntary withdrawal, though one could view that [Mr I]'s letter on 12 May was an implicit offer to appeal, in that it requested Mr [A] contact the service if he did not want to have a rapid methadone withdrawal. However, while Mr [A] did contact the service following the letter, there was no evidence of a formal review, involving Mr [A] or, for example, a request for an independent second opinion.

Through this process, and once it had started, I could not find evidence of discussions around risks of overdose, from reduced opioid tolerance, or any discussion with Mr [A] about a standdown period from treatment or how he might reengage in treatment. The provision of naloxone, to manage possible opioid overdose, was not mentioned and there was no apparent offer of support with a consumer advocate.

Mr [A] was clearly unhappy with the involuntary withdrawal and rate of reduction. It appears that his case manager discussed this with Dr [C] but there was no change to the plan, other than to slow the reduction.

In terms of medication support to manage opioids withdrawal it is recorded in [Mr J]'s note of a phone discussion with Mr [A], on 5 August 2021, "I advised the client I would discuss with the MO … if he would supply some medication to support withdrawal" and in the MDT note of 10 August 2021 "Symptomatic relief offered". It is not clear what medications were offered.

Dr [C] wrote to Dr [E], GP, on 12 August 2021, informing him of Mr [A]'s involuntary discharge from care. Dr [C] notes "… should he wish it we would of course reassess him." This shows the OST service was happy to review Mr [A] though there is no indication of time frames or whether this was communicated to Mr [A].

Overall I believe that Mr [A] was not adequately supported with the withdrawal process.

What was the standard of care/accepted practice at the time of events? Please refer to relevant standards/material.

Please refer to the section of the NZ OST Guidelines above.

Was there a departure from the standard of care or accepted practice?

- No departure;
- Mild departure;
- Moderate departure; or
- Severe departure.

I believe the limited support offered to Mr [A] during the withdrawal process is a mild/moderate departure from accepted practice.

How would the care provided be viewed by your peers? Please reference the views of any peers who were consulted.

I believe my peers would hold similar views.

Please outline any factors that may limit your assessment of the events.

My opinion is based on the clinical notes and letters. There may have been more detailed discussions with Mr [A] regarding support medications etc, as is noted in the MDT note on 10 August 2021, but the notes do not detail these. It is also apparent that Mr [A] was frustrated or angry with the decision and may have chosen to disengage with the team, as he terminated the call with [Ms K] on 9 August 2021.

Recommendations for improvement that may help to prevent a similar occurrence in future.

Services should be encouraged to refer to the NZ OST Guidelines regarding the supporting of clients through involuntary withdrawals.

List any sources of information reviewed other than the documents provided by HDC:

New Zealand Practice Guidelines for Opioid Substitution Treatment 2014 (NZ OST Guidelines)

Advisor's opinion:

Through the clinical notes it is clear that the OST service had regular contact with Mr [A]'s pharmacy and his GP was informed of progress through regular letters following medical reviews.

While the notes regarding the community pharmacy are limited, there was clearly frequent communication, with changes in dosing, dose holds and the pharmacy contacting the service, in 2018, with their concerns regarding Mr [A]'s purchasing of cyclizine. It is not unusual for these contacts to not appear in the clinical notes, as they may be recorded in other documentation, eg copies of faxes or emails.

The service's contact with Dr [E], GP, would be considered usual practice, unless there were more clear clinical concerns, for example the GP prescribing opioid analgesia. This does not appear to have been the case.

While involvement of a client's support person is encouraged, this is at the client's choice and it is not clear that Mr [A] wanted his partner, or another support, consulted about or involved in his care.

The NZ OST Guidelines note: "Decisions relating to termination of treatment should be initiated only after input from a number of other sources (including the community pharmacist, the client's GP and the client's support people) …

The decision to initiate involuntary withdrawal from OST appears to have been based on Mr [A]'s reluctance to engage with the requirements outlined by Dr [C]. Further consultation with Mr [A]'s community pharmacy and GP may have provided insight into the reasons for his disengagement, and options for improvement in his relationship with the service though this is speculative.

Overall, I believe the consultation with Mr [A]'s pharmacy and GP was adequate. It is difficult to comment upon the apparent lack of involvement of a support person.

What was the standard of care/accepted practice at the time of events? Please refer to relevant standards/material.

Expectations around communication between services and community pharmacies are outlined in the NZ OST Guidelines Sec 9.1.

The NZ OST Guidelines Sec 1.3 outline the components of a recovery orientated system of care which include involving family in the treatment process and building support structures.

Was there a departure from the standard of care or accepted practice?

- No departure;
- Mild departure;
- Moderate departure; or
- Severe departure.

No departure.

How would the care provided be viewed by your peers? Please reference the views of any peers who were consulted.

I believe my peers would share my views.

Please outline any factors that may limit your assessment of the events.

I was only able to refer to the clinical notes provided. These are likely an underreporting of the service's contact with Mr [A]'s pharmacy, in particular.

Recommendations for improvement that may help to prevent a similar occurrence in future.

6. Whether the involuntary discharge of Mr [A] from the OST programme in August 2021 was appropriate.

List any sources of information reviewed other than the documents provided by HDC:

New Zealand Practice Guidelines for Opioid Substitution Treatment 2014 (NZ OST Guidelines)

NSW Clinical Guidelines: Treatment of Opioid Dependence 2018 (NSW Guidelines)

Advisor's opinion:

The decision to involuntarily discharge Mr [A] from OST treatment appears to have been made based on his non-attendance at medical reviews and other appointments. This was first documented in Dr [C]'s letter on 28 October 2020, and then further documented in his letter of 16 November 2020 "*If he cannot or will not remain in contact* (with the service) *this medication will be rapidly withdrawn.*"

Notwithstanding his non-attendance at medical reviews and some face-to-face manager meetings, he appears to have engaged with his keyworker and was cooperative with them. There was no note of significant clinical risk, for example, he did not appear intoxicated when he attended his pharmacy and there was no concern regarding other substance use, other than cyclizine.

Mr [A] was informed in writing of the possibility of an involuntary withdrawal in [Mr I]'s letter of 12 May 2021 and subsequently contacted his case manager. After missing two subsequent medical appointments the decision was made, on 3 August 2021, to initiate an involuntary withdrawal process. Another letter was sent to him that day, informing him of the decision.

As per the NZ Guidelines Sec 3.9.2 (italics mine):

"Providers should approach a decision to withdraw a client from OST medication against their wishes with caution. This course of action may increase the risk of fatal overdose, bloodborne virus infection, ill health, financial insecurity or debt, social instability or criminal offending. *Involuntary cessation of OST should be a last resort.*

Decisions relating to termination of treatment should be initiated only after input from a number of other sources (including the community pharmacist, the client's GP and the client's support people), and after all attempts have been made to resolve influencing issues.

Examples of situations that may lead to consideration of involuntary withdrawal include the following:

- a client's pattern of frequent overdose or significant intoxication is so uncontrolled that opioid substitutes cannot be dispensed with sufficient safety (although it is important to note that lapses and relapses are features of addiction, and do not alone justify involuntary withdrawal)
- a client threatens violence, or is violent towards staff, other clients, a prescriber or a pharmacist (review of the circumstances associated with aggressive behaviour should always precede any decision to withdraw a client from OST)
- a client repeatedly displays an inability to keep to the safety requirements of the OST provider (eg, repeated diversion of medication or loss of doses, failure to keep doses secure or repeated lack of attendance at appointments).

Each situation requires exploration and consultation with the client, his or her support people and others involved in the client's care.

Injection of methadone or regular use of other drugs is not usually an indication for involuntary withdrawal from OST. Specialist services are expected to work with clients to reduce or cease illicit opioid use and other problematic substance use."

The NSW Guidelines Sec 2.4.12 notes:

"Involuntary cessation of treatment should only be a last resort and only be used in situations such as violence or significant threat of violence against staff or other patients.

Where possible, other treatment should be offered for the patient, due to the imminent and significant risk of severe opioid withdrawal as well as the risk of opioid overdose (with changes in tolerance and resumption of illicit opioid use)."

As per the referenced guidelines, involuntary withdrawal from treatment is seen as a last resort, only undertaken when continuation of treatment is highly risky for the client, or treatment cannot be provided safely, due to violence.

Involuntary withdrawal as a "last resort" is included in the BOPAS OST Pathway CPM.M9.4.

Mr [A] appears to have been withdrawn from treatment due to dis-engagement from the service, particularly medical appointments. There does not appear to have been clear risks related to substance use, his health, or harm to others.

While there is an obligation for an OST service to see clients regularly, and it is part of the agreement when clients commence OST, I do not believe a client's challenging engagement warrants involuntary withdrawal.

One of the possible reasons for involuntary withdrawal within the NZ OST Guidelines is if "a client repeatedly displays an inability to keep to the safety requirements of the OST provider (eg, repeated diversion of medication or loss of doses, failure to keep doses secure or *repeated lack of attendance at appointments"*; however I do not believe that, in Mr [A]'s situation, missed appointments constituted an inability to keep safety requirements, particularly given he missed only two medical appointments and remained in touch with his case manager, with no clinical concerns noted.

Dr [C] noted the possibility of rapid withdrawal in his letter of their meeting on 16 November 2020. I do not believe the rationale, in the letter, was warranted. There were other options to try to engage Mr [A] or at least get him to attend appointments.

Strategies such as "holding a dose", meaning a client does not get their medication until they attend an appointment, while seen as coercive, can be used to encourage attendance. This strategy appears to have been used once, in November 2020, but was unsuccessful as the community pharmacy dispensed Mr [A]'s methadone despite his dose being "held". Nevertheless, this could have been tried again.

Given the above, I do not believe the decision to involuntarily discharge Mr [A] was appropriate.

What was the standard of care/accepted practice at the time of events? Please refer to relevant standards/material.

Please refer to the NZ OST Guidelines, above.

In the situation of a client who appears unwilling to engage with necessary medical reviews and general engagement, "contingency management" such as dose holding should be considered. Services can accept that client participation will vary, and in this situation, there does not appear to have been any need for close follow up. Consideration could have been given to returning Mr [A] to GP prescribing, with limited takeaways, as he remained engaged with his GP and there were, as noted, no evident risks other than unquantified cyclizine use.

Was there a departure from the standard of care or accepted practice?

- No departure;
- Mild departure;
- Moderate departure; or
- Severe departure.

I believe the involuntary withdrawal was a moderate departure from accepted practice. I do not believe the risk threshold for involuntary withdrawal was met, nor does it appear that other management strategies were considered.

How would the care provided be viewed by your peers? Please reference the views of any peers who were consulted.

I have discussed Mr [A]'s involuntary withdrawal with peers, who believe that involuntary withdrawal was not warranted.

Please outline any factors that may limit your assessment of the events.

I have based my opinion on reviewing the medical letters and clinical notes. It is possible there were other factors considered, that are not documented.

Recommendations for improvement that may help to prevent a similar occurrence in future.

I believe reference to the NZ OST Guidelines would provide direction regarding appropriate situations in which involuntary withdrawal could be considered.

7. The adequacy of Te Whatu Ora's policies.

List any sources of information reviewed other than the documents provided by HDC:

New Zealand Practice Guidelines for Opioid Substitution Treatment 2014

Advisor's opinion:

The NZ OST Guidelines establish the standard of practice in OST around New Zealand. It is generally referred to when establishing local service practice and when different services discuss expectations of care.

The NZ OST Guidelines are currently being updated, with an expectation of publication by the end of 2024.

What was the standard of care/accepted practice at the time of events? Please refer to relevant standards/material.

N/A

Was there a departure from the standard of care or accepted practice?

- No departure;
- Mild departure;
- Moderate departure; or
- Severe departure.

N/A

How would the care provided be viewed by your peers? Please reference the views of any peers who were consulted.

N/A

Please outline any factors that may limit your assessment of the events.

N/A

Recommendations for improvement that may help to prevent a similar occurrence in future.

N/A

8. Any other matters in this case that you consider warrant comment.

List any sources of information reviewed other than the documents provided by HDC:

Advisor's opinion:

Dr [C], in his letter of 16 November 2020, suggested "that he (Mr [A]) be tasked to be in contact with the Service to meet up once a month face to face. In other words we will not set appointments for him."

It is not clear whether this plan was discussed with Mr [A] in any collaborative way, but it appears to be the basis by which Mr [A] was subsequently withdrawn from treatment.

As previously noted, Mr [A] was stable in his treatment, and undertaking a managed dose reduction, by choice. Apart from unspecified cyclizine use, which while not condoned, did not raise clear clinical risks, there were no evident risks or challenging behaviours.

The decision that Mr [A] needed to be seen once a month does not seem to be clinically warranted. The BOPAS OST Pathway protocol notes that keyworker appointments should occur 4–6 weekly … but no less than every 8 weeks.

During the period 11 February 2019 until 16 November 2020 Mr [A] had nine face-to-face meetings with his case manager. This was a period of 21 months, with no clear documentation of non-attendance at scheduled meetings. He missed one medical officer appointment, on 2 November 2020, and also had two medical reviews cancelled by the service, in early 2020. He had phone discussions with his case manager, with no significant concerns.

Given that the service had not arranged 4–6 weekly reviews for some time (some of that time included Covid lockdowns) and given Mr [A]'s evident stability, I do not believe Dr [C]'s decision regarding Mr [A] needing monthly meetings was reasonable.

…

Signature:

Name: Dr Ivan Srzich

Date of Advice: 13 June 2024'