Management of patient on methadone programme (05HDC09043, 29 March 2006)

Alcohol and drug service ~ District health board ~ Methadone programme ~ Treatment planning ~ Management of care ~ Documentation ~ Safety ~ Reporting to third party ~ Responsibility ~ Standard of care ~ Professional standards ~ Rights 4(1), 4(2)

A man on a methadone programme, who was known to combine his methadone with illicit drugs, was advised by his drug and alcohol service treatment team not to drive, because of the potential effects of his drug-taking behaviour on his ability to drive safely. The man's treatment team did not witness him driving while intoxicated, but were aware that he continued to abuse drugs. Twenty months after his admission to the methadone service, he was the driver of a car involved in a collision, injuring himself and his passengers and killing the driver of another car. The urine test taken in a public hospital was positive for opiates, benzodiazepines, cannabinoids, methadone and amphetamines. The daughter of the driver killed in the accident complained that the drug and alcohol service treatment team did not provide the man with appropriate care.

It was held that the man was at the "difficult end of an already difficult spectrum regarding treatment". It is clear that clinical staff recognised him to be a challenging client. In those circumstances, it was important that there was a clearly defined and structured management plan. By its lack of treatment planning and review, apparent lack of medical review, and poor documentation, the DHB breached Rights 4(1) and 4(2).

The issue of when, if ever, practitioners should take steps to address a patient's potential driving risk is difficult. This case illustrates that practitioners need to make a balanced judgement on all the available information regarding whether to involve other agencies with concerns about a patient's driving. If a practitioner has any doubt as to the ability of a patient to drive safely, the practitioner should take steps to reduce that risk. This should include strongly advising the patient not to drive (and possibly advising his or her family members and support persons) and, if there is concern that the advice is not being followed, considering notification to the Director of Land Transport Safety. Any immediate risk should be notified to the Police.