

# Canterbury

---

## District Health Board

---

Te Poari Hauora o Waitaha

Planning and Funding  
P O Box 1600,  
CHRISTCHURCH

Telephone: 0064 3 364 4130

Fax: 0064 3 364 4165

[Wayne.turp@cdhb.health.nz](mailto:Wayne.turp@cdhb.health.nz)

30 October 2017

Jason

Email: [fyi-request-6540-ecd64ca0@requests.fyi.org.nz](mailto:fyi-request-6540-ecd64ca0@requests.fyi.org.nz);

Dear Jason

### RE Official information request CDHB 9717

I refer to your email dated 5 October 2017 requesting the following information under section 12 of the Official Information Act from Canterbury DHB. (This being a follow up to our response to your OIA request CDHB 9704)

1. **Does the CDHB / CORS policy of diluting methadone takeaways apply to people who are prescribed methadone by a GP or OST Clinic outside of the CDHB region but have it dispensed from a Christchurch pharmacy? IE If someone is prescribed methadone by an Auckland, Masterton or Wellington GP / OST clinic which does not require dilution, and the Doctor specifies DO NOT DILUTE (or even without this specification), does the dangerous CORS policy of requiring dilution apply or overrule the Doctors wishes if the patient has nothing to do with CORS? Do pharmacists in the CDHB region have to dilute out of region methadone patients takeaways when their GP does not require dilution and perhaps even specifies there should be no dilution?**

I think whoever provided the reasoning for dilution of methadone might be a little confused...

2. **How does dilution prevent diversion of takeaway doses? IE the takeaway dose is being taken home anyway so there is no need to divert it... Needle exchanges supply 60ml syringes, and most people have stove tops they can use to remove the added water so it seems like nothing is achieved except endangering the patient by preventing them from verifying they have received the correct dose of medication (something that should be a basic human right).**
3. **Looking at the provided table regarding the dispensing errors am I right in interpreting "unconfirmed" as meaning the CDHB doesn't know what the outcome of the error was? IE the patient may have overdosed, received Naloxone from an ambulance EMT and then refused admission to hospital so it was not linked to the dispensing error?**
4. **It would also be good if you could provide me with copies of any emails, memos, directives, communications etc held by the CDHB relating to the topic of dilution of OST clients methadone doses. Of particular interest would be any communications between anyone from the CDHB / CORS and the National Association of Opioid Treatment Providers regarding the CORS policy of dilution of methadone doses.**

We are writing to confirm that we are providing a response to your request and this response will be sent to you as soon as is reasonably practicable.

Yours sincerely



Wayne Turp  
Project Specialist