DRUG HEALTH & GP LIAISON CLINICAL REFERENCE & DOCUMENTATION SUITE

Clinical Reference & Practice Guidelines

Local Health District Context: Western Sydney LHD (WSLHD), Sydney LHD (SLHD / GLAD Program), South Western Sydney LHD (SWSLHD GP Advice Line).

SECTION 1: HARM MINIMIZATION & BRIEF INTERVENTION

1. Fundamental Principles of Harm Reduction

Non-judgmental Language & Client-Centred Approach

Standard clinical practice requires person-first, non-stigmatising language to foster therapeutic trust and reduce barriers to care.

- **Preferred Language:** "person who uses drugs", "person experiencing substance dependence", "person on OTP", "experiencing a lapse / relapse".
- **Stigmatising Terms to Avoid:** "clean", "dirty", "addict", "abuser", "user", "dirty urine".

Core AOD Harm Reduction Pillars

- **Overdose Prevention:** Universal assessment of overdose risk; provision of Take-Home Naloxone (Nyxoid intranasal 1.26mg) to all at-risk clients and their families/carers.
- **Safer Injection Hygiene:** Education on safe access via Needle and Syringe Programs (NSP) / Needle and Syringe Services (NSS), hand hygiene, single-use equipment, avoiding sharing, and proper disposal.
- **Sexual Health & BBV Screening:** Routine screening for Hepatitis C (HCV RNA), Hepatitis B (HBV status/vaccination), HIV, and STI PCRs.
- **Polysubstance Safety:** Counseling on synergistic central nervous system (CNS) depression risks (e.g., combining opioids with alcohol, benzodiazepines, or pregabalin).

2. Brief Intervention Frameworks

Model	Component	Clinical Application
FLAGS	**Feedback**	Provide clear, objective feedback on substance use risks and physical/psychatric impacts.
	Listen	Actively listen to the patient's perspective, acknowledging their lived experience.
	Advice	Provide clear, non-judgmental medical advice on options for harm reduction or reduction/cessation.
	Goals	Collaborative goal-setting (e.g., safe usage targets, starting OTP, or total abstinence).
	Strategies	Identify practical strategies, coping mechanisms, and support systems.
FRAMES	**Feedback**	Personalised risk feedback based on assessment findings.
	Responsibility	Emphasise that personal change is under the patient's own control.
	Advice	Explicit advice on the necessity of change or risk-reduction practices.
	Menu	Provide a menu of therapeutic options (e.g., counseling, pharmacotherapy, withdrawal management).

Model	Component	Clinical Application
	Empathy	Maintain a warm, empathetic, and reflective therapeutic style throughout.
	Self-efficacy	Support and reinforce the patient's optimism and confidence in their ability to change.
5 A's	Ask / Advise / Assess / Assi...	Systematic framework to **Ask** about use, **Advise** reduction/safety, **Assess** readiness to change, **Assist** with interventions, and **Arrange** specialist or GP follow-up.

3. Setting-Specific Harm Minimization Strategies

Opioid Treatment Program (OTP)

- **Treatment Modalities:** Methadone oral liquid, Buprenorphine sublingual tablets/film (Suboxone), or depot Buprenorphine subcutaneous injections (Buvidal / Sublocade).
- **Clinical Verification:** Confirm active dosing point, treating prescriber, date/time of last dose, and authorized takeaway status before administering or modifying treatment.
- **Missed Dose Protocol:** Missing 3 or more consecutive days results in lost opioid tolerance. Dosing must be held until a mandatory clinical re-assessment is conducted by an authorized prescriber to reduce overdose risk.
- **Take-Home Naloxone:** Educate and provide Nyxoid (1.26mg intranasal spray) upon initiation or review.
- **Storage Safety:** Mandate lockbox usage for oral takeaway doses to prevent accidental pediatric ingestion or unauthorized access.

Withdrawal & Inpatient Settings

- **Symptom Monitoring:** Utilize standardized scales (COWS for opioids, AWS/CIWA-Ar for alcohol) to guide symptom-triggered protocols.
- **Post-Discharge Overdose Planning:** Discharge represents a high-risk period due to reduced tolerance. Ensure clear overdose response plans and Take-Home Naloxone provision prior to discharge.

- **Nicotine Replacement Therapy (NRT):** Integrate smoking cessation strategies into all inpatient pathways.

SECTION 2: CLINICAL WITHDRAWAL ASSESSMENT SCALES

1. Clinical Institute Withdrawal Assessment for Alcohol (CIWA-Ar) / AWS

AWS Clinical Observation Criteria (Scored 0–7 unless noted)

- Nausea & Vomiting (0–7)
- Tremor (0–7)
- Paroxysmal Sweats (0–7)
- Anxiety (0–7)
- Agitation (0–7)
- Tactile Disturbances (0–7)
- Auditory Disturbances (0–7)
- Visual Disturbances (0–7)
- Headache / Fullness in Head (0–7)
- Orientation & Clouding of Sensorium (0–4)

Scoring Thresholds & Management Actions

Severity	AWS Score	Recommended Clinical Action
Mild	< 9–10	Non-pharmacological supportive care. Reassess score every 4 hours.
Moderate	10–15	Consider symptom-triggered Diazepam regimen per local LHD protocol / standing orders. Monitor vital signs closely.
Severe	15+	Urgent medical review required. Regular Diazepam dosing per protocol. High risk of Delirium Tremens and seizures. Administer **parenteral Thiamine**

Severity	AWS Score	Recommended Clinical Action
		(B1) prior to IV glucose to prevent Wernicke's Encephalopathy.

2. Clinical Opiate Withdrawal Scale (COWS)

Assessment Criteria

1. Resting Pulse Rate
2. Sweating
3. Restlessness
4. Pupil Size
5. Bone or Joint Aches
6. Runny Nose or Tearing
7. GI Upset (cramps, nausea, diarrhea)
8. Tremor
9. Yawning
10. Anxiety or Irritability
11. Gooseflesh Skin

Buprenorphine Induction Thresholds

Severity	COWS Score	Clinical Action & Buprenorphine Induction Rules
Mild	5–12	Monitor only. **Do not induce Buprenorphine.** High risk of precipitating acute, severe withdrawal.
Moderate	13–24	**Target range for Buprenorphine initiation.** Ensure objective signs of physical withdrawal are present before administering the initial dose.
Moderately Severe	25–36	Administer initial dose of Buprenorphine / Suboxone per

Severity	COWS Score	Clinical Action & Buprenorphine Induction Rules
		protocol. Monitor closely for symptom relief.
Severe	> 36	Administer Buprenorphine per protocol under medical oversight. Provide supportive medical care.

SECTION 3: COMPREHENSIVE AOD ASSESSMENT FRAMEWORK

1. Patient Demographics & Context

- **Location:** Ward / ED Consultation, Ambulatory Clinic, Community GP Practice, or OTP Dosing Point.
- **Context:** Reason for consultation and identified GP Liaison objectives (e.g., shared care setup, withdrawal management, pharmacotherapy stabilization).

2. Substance Use History

For each substance (Alcohol, Opioids, Methamphetamine/Stimulants, Benzodiazepines, Cannabis, OTC/Prescription meds):

- **Classification:** Primary vs. Secondary substances of dependence.
- **Consumption Patterns:** Frequency and exact quantity (e.g., Standard Drinks, grams, milligrams, points).
- **Route of Administration:** Oral, Injecting (IV/SC), Inhalation/Smoking, Intranasal.
- **Chronology:** Age of first use, duration of regular dependency, and exact time and date of last use.
- **Injecting Assessment:** Vein integrity, history of soft tissue infections, blood-borne virus (BBV) exposure risks, equipment hygiene, and current NSP access.

3. Medical, Psychiatric & Social History

- **Medical Comorbidities:** Hepatic function/cirrhosis, BBV status (Hep B, Hep C, HIV), history of non-fatal overdoses, withdrawal seizures, chronic pain syndromes, cardiac or metabolic conditions.
- **Mental Health Assessment:** Concurrent psychiatric diagnoses, structured self-harm and suicide risk assessment, trauma history, current mental health treatment plans and psychological supports.
- **Psychosocial Screening:**
    - Housing stability and living arrangements.
    - Socioeconomic and financial security.
    - Legal status (e.g., active legal proceedings, probation, MERIT program, Adult Drug Court).
    - Family and social support networks.
    - Child protection or SUPPS (Substance Use in Pregnancy & Parenting Service) involvement where applicable.

SECTION 4: CLINICAL DOCUMENTATION & IMPRESSION TEMPLATE

AOD GP Liaison & Consultation Assessment Template

PATIENT DEMOGRAPHICS & LOCATION

- **Patient Name:** Person
- **DOB:** Date
- **MRN:** [MRN]
- **Assessment Location:** [e.g., Ward 3B / ED / GP Practice Liaison / Outpatient Clinic]
- **Referral Source & Reason:** [e.g., Referral from treating GP for OTP stabilization, withdrawal management, and formal shared care setup]

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1. Substance Use History

- **Primary Substance:** [e.g., Heroin / Alcohol / Methamphetamine / Benzodiazepines]
    - **Quantity & Frequency:** [e.g., 0.5g daily / 15–20 Standard Drinks daily]
    - **Route:** [e.g., IV / Oral / Inhalation]
    - **Last Use:** [Exact Time, Date]

- **Secondary Substances:** [Specify frequency, route, and last use]
- **Overdose History:** [e.g., Non-fatal opioid overdose in 2024 - reversed with Naloxone]
- **Injecting Equipment Access / NSP Status:** [e.g., Accesses local NSP, safe disposal practices confirmed]

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2. Medical & Psychiatric History

- **Medical Comorbidities:** [e.g., Chronic Hep C (untreated), Chronic Pain]
- **Psychiatric Comorbidities:** [e.g., PTSD, Major Depressive Disorder]
- **Current Medications:** [List medications, dosages, and treating prescriber details]

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3. Psychosocial Assessment

- **Living Situation / Housing:** [e.g., Stable private rental vs. Temporary accommodation]
- **Socioeconomic / Financial Support:** [e.g., Disability Support Pension / JobSeeker / Employed]
- **Legal Status:** [e.g., No current legal matters / MERIT program referral pending]
- **Social Supports:** [e.g., Supportive partner, regular contact with primary care GP]

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4. On Examination (O/E) & Clinical Observations

- **Vital Signs:** BP: [/] mmHg | HR: [ ] bpm | SpO2: [ ]% | Temp: [ ]°C | RR: [ ] /min
- **General Appearance:** [e.g., Well-nourished, comfortable, no acute distress, track marks noted on left antecubital fossa]
- **Withdrawal Assessment Scores:**
    - **AWS Score:** [/37] (Features noted: tremor, sweating, anxiety)
    - **COWS Score:** [/48] (Features noted: pupil size, restlessness, yawning)
- **Mental State Examination (MSE):**
    - **Appearance & Behaviour:** [e.g., Neat, cooperative, appropriate eye contact]
    - **Speech:** [e.g., Normal rate, tone, and volume]
    - **Mood & Affect:** [e.g., Euthymic / Anxious, congruent affect]
    - **Thought Content & Process:** [e.g., Logical, goal-directed; no psychotic symptoms or active suicidal ideation]
    - **Perception:** [e.g., No auditory or visual hallucinations]
    - **Cognition & Insight:** [e.g., Alert, oriented x3, good insight into substance dependence]

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5. Clinical Impression Examples

- **[Example A - Inpatient / Withdrawal Liaison]:**"42-year-old male with severe alcohol use disorder admitted for ambulatory/inpatient detoxification. Current AWS score 12 indicating moderate alcohol withdrawal. High risk of severe withdrawal given previous withdrawal seizure history. Parenteral Thiamine replacement initiated."
- **[Example B - OTP / Buprenorphine Induction Liaison]:**"35-year-old female with long-standing opioid dependence (heroin, IV route) seeking initiation on long-acting injectable Buprenorphine (Buvidal/Sublocade). COWS score currently 14 (moderate withdrawal). Verified last heroin use >18 hours ago. Suitable for depot buprenorphine initiation."
- **[Example C - GP Shared Care Liaison]:**"29-year-old male currently stabilized on Suboxone (12mg daily) via public OTP clinic, transitioning to GP Shared Care model. Patient compliant with dosing, negative urine drug screens for 6 months, stable housing and employment."

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6. Plan & Management Recommendations

1. **Pharmacotherapy Plan:**
    - [e.g., Initiate Buvidal 24mg SC / Continue Methadone 60mg daily]
    - Symptom-triggered Diazepam protocol for AWS score >10.
2. **Harm Minimization Interventions:**
    - Provided Nyxoid (Naloxone) 1.26mg nasal spray and educated on opioid overdose response.
    - Provided NSP safety pack and educated on sterile injecting technique and vein care.
3. **Health Promotion & BBV Screening:**
    - Pathology requested: Hep B, Hep C RNA, HIV, LFTs, EUC.
    - Prescribed high-dose Thiamine (Oral 300mg daily / IV Pabrinex if required).
4. **GP Liaison & Communication:**
    - Clinical handover summary sent to treating GP via HealthLink / secure email.
    - Arranged follow-up appointment with GP in 7 days for ongoing shared care monitoring.
5. **Community / Multidisciplinary Referrals:**
    - Referred to Community AOD Counseling / Social Work for psychosocial support.

SECTION 5: LHD DRUG HEALTH RESOURCES & INTEGRATION

Local Health District Service Networks

- **Sydney Local Health District (SLHD):**
  - **GLAD Program:** General Practitioner Liaison Alcohol and Drugs Program. Provides streamlined community GP referrals, inpatient consultation liaison, and shared care setup across Royal Prince Alfred (RPA) and Canterbury OTP clinics.
- **Western Sydney Local Health District (WSLHD):**
  - **Drug Health Services:** Comprehensive services across Westmead, Blacktown, and Cumberland hospitals. Delivers inpatient detoxification, specialist OTP clinics, and consultation liaison.
- **South Western Sydney Local Health District (SWSLHD):**
  - **GP Drug and Alcohol Advice Service:** Direct clinician-to-clinician support, shared care facilitation, and referral triage across Liverpool and Campbelltown Drug Health Services.

Key Advisory & Emergency Contacts

- **Drug and Alcohol Specialist Advisory Service (DASAS):**
  - *Telephone:* 1800 023 687
  - 24/7 medical advice for doctors and health professionals handling complex AOD management.
- **Pharmaceutical Services Branch, NSW Health:**
  - *Telephone:* (02) 9879 5246
  - Authority and prescribing approvals for Schedule 8 drugs and OTP registrations.

SECTION 6: TRAUMA-INFORMED CARE (TIC) IN DRUG HEALTH & GP LIAISON

1. Core Principles of Trauma-Informed Care

- **Safety:** Physical and emotional safety during all consultations, physical examinations, and urine drug screens (UDS).
- **Trustworthiness & Transparency:** Clear communication regarding expectations, limits of confidentiality, mandatory reporting (e.g., child protection/SUPPS), and purpose of procedures.

- **Choice:** Giving patients autonomy over their care plan, dosing locations, injection sites, and examination steps.
- **Collaboration & Equalizing Power Differentials:** Partnering with patients rather than adopting an authoritative approach.
- **Empowerment & Cultural Safety:** Validating strengths, resilience, and respecting cultural identity (e.g., Aboriginal and Torres Strait Islander health pathways).

2. Clinical Communication & Re-framing Strategies

- **Language Re-framing:**
  - *Instead of:* "Why did you relapse?"
  - *Use:* "What was happening for you around the time your substance use increased?"
  - *Instead of:* "Patient is non-compliant / uncooperative."
  - *Use:* "Patient is experiencing barriers to attendance / expressing anxiety regarding clinical settings."
- **Informed Consent for Physical Exams & UDS:**
  - Always explain *why* an examination or UDS is required.
  - Ask: "Is it okay if I check your blood pressure and look at your arm veins today?"
  - Offer choices: "Would you prefer a chaperone or female clinician present during this examination?"
- **Sensitive Trauma Screening Language:**
  - "Many people we work with have experienced difficult or overwhelming life events. Is there anything in your history or past experiences that makes hospital stays, medical exams, or urine drug screens uncomfortable for you?"

3. How to Document Trauma Responsibly & Objectively

- **Objective, Non-Retraumatising Documentation:**
  - Avoid detailed narratives of traumatic events; focus on clinical impact and triggers.
  - *Example:* "Patient reports a history of complex developmental trauma and intimate partner violence. Expresses significant anxiety with invasive physical examinations and rapid clinical decisions. TIC Plan: Informed consent prior to all physical touch, female clinician preferred, detailed explanation of medications provided."

SECTION 7: ADVANCED CNC GP LIAISON GOVERNANCE & CLINICAL EXEMPLARS

1. High-Risk Case Coordination & CNC Governance Framework

- **Complex Case Triaging:**
  - Dual Diagnosis (AOD + Severe Mental Illness).
  - Substance Use in Pregnancy & Parenting Services (SUPPS) liaison.
  - High ED Frequent Attenders / Complex Chronic Pain + Opioid Dependence.
  - Unsanctioned Use & Escalation Pathways (handling missed OTP doses, intoxication on presentation, transfer between dosing points).
- **NSW Legislative & Prescribing Frameworks:**
  - Section 8 Prescribing Authorities (NSW Poisons and Therapeutic Goods Regulation).
  - GP Shared Care Agreements & Transfer of Care Protocols (Methadone to Suboxone / Buvidal depot transitions).

2. CNC VERBATIM CLINICAL DOCUMENTATION EXEMPLARS

EXEMPLAR 1: CNC Hospital Consultation Liaison Assessment & Trauma-Informed Plan

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None
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DRUG HEALTH CONSULTATION LIAISON ASSESSMENT - CLINICAL NURSE CONSULTANT
(CNC)
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PATIENT DETAILS: Jane DOE | DOB: 14/05/1988 | MRN: 9876543 | Ward 4A
(Subacute)
REFERRAL REASON: Referral from Ward Medical Team for AOD assessment,
opioid withdrawal management, and OTP initiation/stabilization.

LOCATION OF CONSULTATION: Bedside, Ward 4A, Westmead Hospital.

1. SUBSTANCE USE HISTORY:
- Primary Substance: Heroin (IV route).
  - Quantity & Frequency: 0.5g–1g daily for 6 years.
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  - Last Use: 22 hours prior to assessment (confirmed via patient history and objective signs).
- Secondary Substances: Alcohol (2–3 standard drinks occasionally), Cannabis (1–2g weekly).
- Overdose History: 2x non-fatal opioid overdoses (last in 2023, reversed with bystander Naloxone).
- NSP & Injecting Safety: Accesses local NSP; reports good hygiene practices but limited vein access in upper limbs.

2. MEDICAL & PSYCHIATRIC HISTORY:
- Medical: Chronic Hepatitis C (RNA positive, untreated; referred to Liver Clinic), superficial phlebitis right cubital fossa.
- Psychiatric: Post-Traumatic Stress Disorder (PTSD) secondary to historical intimate partner violence (IPV); Major Depressive Disorder.
- Current Medications: Sertraline 100mg daily, Simple analgesia.

3. TRAUMA-INFORMED CARE (TIC) SCREENING & CONSIDERATIONS:
- Patient disclosed severe medical-related trauma and mistrust of institutional healthcare settings.
- Identified Triggers: Sudden physical touch without verbal explanation, feeling trapped during clinical procedures, unexpected urine drug screening.
- TIC Strategy Implemented:
  * Full verbal consent obtained prior to physical observations and vein assessment.
  * Explicitly explained the purpose of COWS scoring and UDS.
  * Agreed on a female-led clinical care pathway with primary nurse consistency.

4. ON EXAMINATION (O/E) & CLINICAL OBSERVATIONS:
- Vital Signs: BP: 134/86 mmHg | HR: 98 bpm | SpO2: 98% room air | Temp: 37.1°C | RR: 20/min

- Physical Exam: Moderate lacrimation, rhinorrhea, dilated pupils (5mm), visible piloerection (gooseflesh), restlessness noted. Track marks noted on bilateral upper limbs, no acute erythema or purulence.
- COWS Score: 18 (Moderate Opioid Withdrawal).
- Mental State Exam: Alert, cooperative, anxious affect, logical thought process, no active suicidal ideation or psychotic symptoms.

5. CNC CLINICAL IMPRESSION:
38-year-old female with long-standing opioid dependence (heroin, IV route) and complex PTSD, currently in objective moderate opioid withdrawal (COWS 18). Suitable for initiation on long-acting subcutaneous Buprenorphine (Buvidal Weekly 16mg) following initial test dose or direct Buvidal induction per LHD protocol. High motivation for stabilization and GP shared care transfer.

6. CNC RECOMMENDATIONS & MANAGEMENT PLAN:
1. Pharmacotherapy Induction:
   - Administer test dose Buprenorphine sublingual 4mg; if well-tolerated without precipitated withdrawal, administer Buvidal 16mg SC (Weekly) into abdomen.
2. Harm Reduction & Safety:
   - Supplied Nyxoid (Naloxone nasal spray 1.26mg) + patient/carer overdose education provided.
   - Provided NSP sterile hygiene kit and educational brochure on safe vein care.
3. Health Promotion & BBV:
   - Workup initiated: FibroScan request + Hep C RNA viral load order sent to SLHD/WSLHD Liver Clinic for direct-acting antiviral (DAA) treatment setup.
4. GP Liaison & Transfer of Care:
   - Contacted primary care GP (Dr. Smith, Merrylands Family Practice) to confirm willingness to accept shared care transfer once stabilized on monthly Buvidal depot.

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   - Clinical handover summary documented in eMR and dispatched to GP via
HealthLink.
5. Follow-Up:
   - CNC to review patient tomorrow morning pre-discharge for
post-induction review and outpatient clinic booking.
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EXEMPLAR 2: CNC GP Transfer of Care Letter (SBAR Format)

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DRUG HEALTH CNC LIAISON - TRANSFER OF CARE / CLINICAL HANDOVER (SBAR)
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TO: Dr. A. Smith, General Practitioner | Merrylands Family Practice
FROM: Clinical Nurse Consultant (CNC), Drug Health GP Liaison | LHD Drug
Health Services
DATE: 28/09/2026
RE: Transfer of Care - Depot Buprenorphine Shared Care
PATIENT: Jane DOE | DOB: 14/05/1988 | MRN: 9876543 | Mobile: 0400 000 000

S - SITUATION:
Transferring care of Jane DOE from WSLHD/SLHD Drug Health Clinic to your
primary care practice for ongoing monthly depot Buprenorphine (Buvidal
Monthly / Sublocade) administration and shared care management.

B - BACKGROUND:
Jane has an 8-year history of opioid dependence (heroin). She was
initiated on Buvidal (Subcutaneous Buprenorphine) during a hospital
admission on 14/09/2026. She has successfully transitioned from Buvidal
Weekly 16mg to Buvidal Monthly 64mg SC. She has remained opioid-free, with
complete resolution of cravings and negative urine drug screens for
non-prescribed opioids.
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A - ASSESSMENT:
- Current Pharmacotherapy: Buvidal Monthly 64mg SC (Subcutaneous).
  * Last Dose Administered: 14/09/2026 (WSLHD Clinic)
  * NEXT DOSE DUE: 12/10/2026 (Window: +/- 4 days)
- Injecting Site: Abdomen (alternating quadrants; last site lower left quadrant).
- Medical / Psychosocial Status: Psychosocially stable, living in secure accommodation, attending AOD counseling. Untreated Hep C RNA positive (referral sent to Liver Clinic).

R - RECOMMENDATION & PLAN FOR GP:
1. Prescribing Authority:
   - Please ensure Section 8 Prescribing Application is completed via Pharmaceutical Services Branch (PSB NSW Health) prior to 12/10/2026. S8 Authority approval reference: [Ref # Pending/Attached].
2. Dosing Schedule:
   - Administer Buvidal Monthly 64mg SC into abdominal subcutaneous tissue on 12/10/2026.
3. Missed Dose / Escalation Protocol:
   - If dose is delayed by >2 weeks (>6 weeks total since last dose), contact Drug Health CNC Liaison or DASAS (1800 023 687) prior to administration due to risk of altered tolerance.
4. Harm Reduction & Follow-Up:
   - Nyxoid Naloxone spray provided.
   - CNC Liaison remains available for ongoing telephone advice and clinical consultation: Phone 02 8890 XXXX.
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EXEMPLAR 3: Complex Case Conference & Multi-Agency Risk Management Plan

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None
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DRUG HEALTH CNC - MULTI-AGENCY COMPLEX CASE CONFERENCE & CARE PLAN
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PATIENT: Mark TAYLOR | DOB: 03/11/1982 | MRN: 4561238
STAKEHOLDERS PRESENT: Drug Health CNC (Chair), Community Psychiatrist, Primary Care GP, Social Worker, SUPPS / Child Protection Case Manager, MERIT Case Manager.

1. COMPLEXITY IDENTIFIERS:
- Dual Diagnosis: Severe Methamphetamine & Alcohol Use Disorder + Schizoaffective Disorder.
- Frequent ED Attender (14 presentations in past 60 days for acute intoxication/behavioral disturbance).
- Psychosocial & Legal: Unstable housing, pending court appearance (MERIT program), domestic violence safety order in place.

2. TRAUMA-INFORMED RISK MITIGATION STRATEGY:
- High sensitivity to clinical confrontation and rigid administrative discharge policies.
- Agreed Clinical Approach: Low-threshold access model; consistent primary nurse contact (CNC); non-punitive approach to non-attendance or urine test outcomes.

3. INTEGRATED MULTI-AGENCY ACTION PLAN:
- AOD Pharmacotherapy: Transition from irregular oral dosing to long-acting depot formulation once acute stabilization achieved.
- Mental Health: Community Mental Health Team (CMHT) to manage depot antipsychotic (Paliperidone) synchronized with AOD clinic visits to minimize appointment fatigue.
- Primary Care (GP): GP to oversee physical health monitoring (ECG, Metabolic screen, Liver function) and chronic disease management.
- Psychosocial Support: Social Work referral prioritized for crisis accommodation submission via Link2Home.
- Crisis Escalation Plan: If patient presents intoxicated to GP clinic, GP team to contact Drug Health CNC directly for immediate

diversion/de-escalation rather than automatic ED transfer, unless acute medical/psychiatric risk dictates.

REASSESSMENT DATE: Multi-agency review scheduled in 4 weeks.