WSLHD DRUG HEALTH · GP LIAISON CNC · COMPANION TO THE PLAYBOOK

GP Contact Kit

Word-for-word scaffolds for every GP conversation: first contact, taking an advice call, case conferences, the written transfer-of-care handover, and the influencing playbook for treatment-option conversations.

Prepared September 2026 · Personal working document

> Scaffolds, not scripts of record. Clinical content must be checked against the current NSW guidelines (Opioid Dependence 2018, LAIB 2024, Withdrawal 2022, Alcohol Treatment Guidelines) and your Medical Officer before use, and letters adapted to WSLHD-approved formats. Nothing here replaces clinical judgement or the escalation pathway.

BEFORE ANY TEMPLATE

Five rules for every GP contact

1. Respect the 90 seconds. A GP between patients has no time for preamble. Lead with the point, offer detail only if invited, and always ask "is now okay, or shall I call back at a better time?"

2. Never let a GP feel judged. A GP who admits they're unsure about buprenorphine has just done something brave. The reply is always "that's exactly what this service is for" — never a correction in front of their own uncertainty.

3. Always leave a safety net. Every ask of a GP is wrapped in "and I remain one phone call away, and the client can come straight back to us if it doesn't work." The guaranteed return pathway is your single strongest asset.

4. End with an agreed next step. Every contact closes with who does what by when — even if the step is "I'll email you the summary today."

5. Document twice. Clinical content into eMR (D&A clinical note, ISBAR), the contact into the KPI tracker — same day.

TEMPLATE A

First contact with a practice

A1 The 30-second opener (phone or front desk)

> *"Hi, I'm **[name]**, the Clinical Nurse Consultant for the new Drug Health GP Liaison service for Blacktown. We give GPs same-week specialist advice on alcohol and drug patients, and shared care for the complex ones — free, funded by the district. Could I get 10 minutes with Dr **[name]** or your practice manager sometime this week to explain what we can take off their plate?*"

If the answer is "leave your details" — leave the one-page flyer and log it as an engagement attempt. Call back in two weeks; the second call converts more than the first.

A2 The practice visit — what to ask THEM

The visit is a discovery conversation, not a pitch. You're mapping their needs so every later contact is relevant:

- ☐ Do you currently have patients on the Opioid Treatment Program, or patients you suspect need AOD help but you're not sure where to send them?
- ☐ What happens now when an AOD issue comes up in a consult — where do you refer, and how does that work for you?
- ☐ Which situations feel hardest — alcohol withdrawal? benzodiazepine tapers? opioid prescribing? methamphetamine presentations?
- ☐ Are any GPs here interested in (or already) prescribing opioid agonist treatment? Would any consider it with specialist backup?
- ☐ Who is the best contact for referrals and follow-up — a practice nurse, the practice manager?
- ☐ What education topic would actually be useful to your team, and does a lunchtime slot work?
- ☐ How do you prefer to hear from me — phone, email, fax through the practice?

Leave behind: the intro letter, referral pathway details, the advice-line number, and one education flyer. **Log:** practice added to the Practices sheet with priority flag and status.

TEMPLATE B

Taking an advice call from a GP

B1 Intake questions (work down the list)

Frame first:

- ☐ GP name, practice, callback number — is this about a specific patient or general advice? (If patient-specific: is the patient consented / identifiable, or shall we keep it de-identified?)
- ☐ "What would be most useful to you by the end of this call?" — advice only, a referral, or taking the patient on?

The substance picture:

- ☐ Which substance(s)? Amount, frequency, route, duration?

When was last use?

- ☐ Previous quit or reduction attempts — what happened? Previous formal treatment (OTP, detox, rehab, counselling)?
- ☐ Withdrawal history — ever had seizures, delirium tremens, hallucinations, or hospital admission for withdrawal? *(This decides whether ambulatory withdrawal is even on the table.)*

The whole patient:

- ☐ Age; pregnancy or breastfeeding?
- ☐ Mental health — diagnoses, current treatment, current suicidality?
- ☐ Physical comorbidities and current medications (esp. sedatives, opioids); allergies; hepatic/renal issues?
- ☐ Social — housing, employment, who's at home; children in the person's care? carer role? driving/occupational issues?
- ☐ What does the patient actually want — abstinence, reduction, safety, or they're not seeking change (harm reduction focus)?

Escalate to the Medical Officer / on-call registrar (don't advise alone) when any of:

- Pregnancy + substance dependence
- Alcohol/benzodiazepine withdrawal with seizure or DT history, or medically unstable
- Acute suicidality or psychosis
- Complex opioid conversion or polypharmacy dosing questions
- Child protection concerns (also follow mandatory reporting policy)

B2 Closing the call — Ask, Offer, Ask

> **Summarise back:** "*So we have a **[age]**-year-old drinking **[amount]** daily, no seizure history, motivated to cut down, on no interacting medications — is that right?*"

> **Offer, anchored:** "*Under the NSW guidance this looks suitable for **[option]**. What I'd suggest is **[plan]**. How does that sit with what you were thinking?*"

> **Safety net + next step:** "*If anything changes — especially **[specific red flag]** — call me straight back, or the intake line after hours. I'll email you a summary of what we agreed today. Shall I also send the referral form in case you'd like us more involved?*"

Then: eMR D&A clinical note (ISBAR), tracker row (GP consult = 1, plus referral supported if applicable), follow-up date if promised.

TEMPLATE C

Case conference with a GP (15 minutes)

C1 Agenda — send ahead when possible

- ☐ **1 min** — Patient, consent status, purpose of today's discussion
- ☐ **3 min** — Progress since last contact: attendance, doses, urine drug screens / outcome measures, patient-reported goals
- ☐ **3 min** — Risks and changes: new medications, mental health, social changes, missed doses/DNAs
- ☐ **5 min** — Decisions needed today (list them before the call)
- ☐ **3 min** — Agreed plan: who does what by when; next review date

Document in eMR as a case conference; tracker: case conference = 1. If the plan changed treatment, send the GP a two-line confirming email the same day — GPs act on what's in writing.

TEMPLATE D

Written handover — transfer of care to

GP

The document that makes or breaks an OTP transition. A GP who receives a complete handover once will take a second patient; a GP left guessing never will. ISBAR order throughout.

D1 Transfer of care letter

Dear Dr **[name]**,

Re: [patient, DOB, address] — transfer of care from WSLHD Drug Health to your practice, with ongoing GP Liaison support

I — Introduction: I am the Drug Health GP Liaison CNC coordinating this transfer with **[prescriber, clinic]**. The patient has consented to this transfer and to the sharing of this summary.

S — Situation: [Patient] is transferring to your care for continued **[e.g. buprenorphine maintenance / completed treatment follow-up]**, assessed by their prescriber as stable and suitable for community-based management.

B — Background: Diagnosis: **[e.g. opioid use disorder]**. Treatment episode: commenced **[date]**, current regimen **[medication, dose, last administration date]**. Relevant comorbidities and medications: **[list]**. Relevant history: **[brief]**.

A — Assessment (evidence of stability):

- Stable dose since **[date]** (**[n]** months)
- Attendance: **[e.g. no missed doses in X months]**
- Urine drug screens: **[pattern]**
- No unsanctioned/high-risk use since **[date]**; takeaway status **[current level]**
- Psychosocial: **[housing, work, supports — brief]**

R — Recommendations:

- Continue **[medication and dose]**; scripts at **[interval]**; dosing/dispensing via **[pharmacy, arrangement e.g. staged supply / takeaways]** — pharmacist **[name]** is briefed and expecting your scripts
- Suggested review frequency: **[e.g. monthly initially]**; things worth monitoring: **[list]**

- Early-warning signs that warrant a call to us: **[e.g. missed doses, requests for early scripts, deterioration in mental state]**
- **Return pathway (guaranteed):** if concerns arise at any point, phone me on **[number]** — we will re-engage the patient without a new referral process. After hours: **[intake line]**.

I will call you in **[2 weeks]** to check how the first scripts have gone, and I remain available for advice at any time. Thank you for taking on this shared care — it makes a real difference to this patient's life.

Kind regards,
[Name], CNC — Drug Health GP Liaison, WSLHD · cc: **[prescriber]**, **[pharmacy]**

Attach: current treatment plan, recent results, patient contact details. eMR: discharge referral community + D&A note. Tracker: OTP Transitions — Completed date filled. Diarise the 2-week follow-up call (that call is also a logged GP consult).

TEMPLATE E

The influencing playbook

GPs are not persuaded by pressure — they are persuaded by **evidence, ease, and a safety net**, in that order, and by the sense that you respect their clinical judgement. The method is Ask–Offer–Ask: ask what they know and what concerns them, offer the evidence anchored to a named guideline, then ask what they think — and let them reach the conclusion. A GP argued into a treatment abandons it at the first bump; a GP who chose it defends it.

Common objections and the responses that work

GP SAYS	YOU SAY (ACKNOWLEDGE → REFRAME → SUPPORT)
"These patients are difficult / drug-seeking."	"Some presentations are hard, absolutely — that's why we only transfer patients their prescriber has assessed as stable, and you see the stability evidence before you say yes. And you can hand back at any time with one phone call. You choose the patient; we carry the risk

	with you."
"I don't have time for this."	"A stable patient is a standard consult on a normal schedule — the unstable phase already happened at our clinic. And advice calls to me typically save you time: two minutes on the phone instead of a workup you weren't sure how to start."
"I'm not confident / not trained in this."	"That's exactly what this service exists for. We'll do the first consult alongside you if you like, I'm on the phone for every script decision until you're comfortable, and I can run a lunchtime session for the whole practice. Nobody starts confident — they start supported."
"What if they relapse?"	"Then they come straight back to us — guaranteed, no new referral, one phone call. A relapse under shared care gets caught earlier than a relapse after a patient drops out of a clinic they couldn't keep attending."
"What about the medico-legal risk?"	"You'd be prescribing inside the NSW clinical guidelines, on a documented plan endorsed by an addiction specialist, with specialist backup in writing. That's a stronger position than most prescribing decisions a GP makes alone."
"My practice doesn't really want this cohort in the waiting room."	"The patients we're talking about are already in your waiting room — they're existing patients whose substance use hasn't been asked about. Shared care doesn't change who comes in; it changes how well it goes."
"The injectable sounds complicated."	"It's simpler than it sounds — a monthly injection under the NSW LAIB guideline, and I'll walk you through storage, ordering and the first administration, or arrange it through the pharmacy. Most GPs say it's easier than managing daily dosing ever was."

Treatment-option pitches — the two-sentence versions

Each pitch = the frame + the guideline anchor + the support offer. Verify current clinical specifics with your MO before using dose- or eligibility-level detail.

OTP TRANSFER TO GP PRESCRIBING

Frame: "This patient has done the hard part — months stable, clean screens, reliable attendance. What they need now is a normal doctor for a normal life, and that's you. Staying in a specialist clinic they no longer need actually holds them back — and holds a clinic place another patient is waiting for."

Anchor: NSW Clinical Guidelines: Treatment of Opioid Dependence (2018) — community-based care for stable patients. **Support:** full written handover, briefed pharmacy, 2-week check-in call, guaranteed return pathway.

LONG-ACTING INJECTABLE BUPRENORPHINE (LAIB)

Frame: "One injection replaces the daily pharmacy visit — for a patient who works, or lives far from a dosing point, that's the difference between staying in treatment and dropping out. It also takes daily-dose decisions, missed doses and diversion worries off your desk entirely."

Anchor: NSW Health LAIB Guideline (2024). **Support:** I coordinate the switch with the prescriber, walk you through the first administration, and stay on call.

ALCOHOL PHARMACOTHERAPY IN GENERAL PRACTICE

Frame: "For alcohol dependence there are PBS-listed medications GPs can prescribe that meaningfully cut relapse — and they're dramatically under-used. You likely have patients who'd accept a tablet from you who will never walk into a drug and alcohol clinic."

Anchor: national/NSW alcohol treatment guidelines (naltrexone, acamprosate; disulfiram in selected cases). **Support:** I'll help you pick suitable patients and set up the counselling adjunct; withdrawal planning goes through us first if there's any seizure/DT history.

TAKE-HOME NALOXONE

Frame: "For any patient on opioids — prescribed or otherwise — take-home naloxone is a free, no-prescription safety net that reverses an overdose while the ambulance is coming. It's the seatbelt conversation of opioid care: offering it isn't an accusation, it's standard practice."

Anchor: the national Take Home Naloxone program. **Support:** I'll send the practice the supply pathway and a 5-minute brief for your nurses.

The close that never fails: "You don't have to decide today. Let me send you one patient's summary, you look at it, and we talk next week. If it's not for you, that's completely fine — the advice line stays open either way." *The GP who feels free to say no says yes far more often.*

Companion to the GP Liaison Playbook. Sources: SLHD GLAD Model of Care (DHS_SLHD_PCP2024_016) · Draft WSLHD Drug Health GP Liaison Service Model of Care · NSW clinical guidelines as named. Personal working document — verify clinical content against current guidelines and your Medical Officer; not an official NSW Health or WSLHD document.