Whittington Health NHS

Guideline on how to treat patients who present to Primary Health Care Services in Islington with the dual problem of alcohol and opioids

Subject:	Treating patient with alcohol and opioid dependency problems
Policy Number	N/A
Ratified By:	Drug and therapeutic Committee
Date Ratified:	November 2015
Version:	3.0 (Updated version from 2013)
Policy Executive Owner:	Karen Gillan
Designation of Author:	Jeff Fernandez
Name of Assurance Committee:	PCADS Clinical Governance Committee
Date Issued:	November 2015
Review Date:	2018
Target Audience:	Clinical staff working in primary care in Islington
Key Words:	Alcohol, Methadone, detoxification.

Version Control Sheet

Version	Date	Author	Status	Comment
First Version	09/09/2011	Jeff Fernandez	First	Passed at the drug and therapeutic committee Whittington Health
Second version	28/09/13	Jeff Fernandez	Update	Update on dose regime & review date
Final Version	25/11/15	Jeff Fernandez	Final	Nalmefene update

Suggested headings (see below);

- **Criteria for use**

This guideline is for clinicians working in the field of substance misuse where there is a significant cohort who present with alcohol and opioid dependence. This outlines what one needs to consider as risks and how to accommodate this risk and treat patients effectively and safely.

- **Background/ introduction**

Alcohol has been an increasing problem in health care for the UK. There is increasing consumption rates which has led to growing presentations of health problems in the UK for primary care. Below are some statistics looking at alcohol trends.

In England in 2008, 38 per cent of men drank over 4 units on at least one day in the week prior to interview and 29 per cent of women drank more than 3 units on at least one day in the week prior to interview. Twenty two per cent of men reported drinking over 8 units and 15 per cent of women reported drinking over 6 units on at least one day in the week prior to interview.

The average weekly alcohol consumption in England in 2008, was 16.8 units for men and 8.6 units for women. There has been an increase from 54 per cent in 1997 to 75 per cent in 2009 in the proportion of people in Great Britain who had heard of daily drinking limits. Throughout the period, differences between men and women have been slight.

In England in 2009, there were 150,445 prescription items for drugs for the treatment of alcohol dependency prescribed in primary care settings or NHS hospitals and dispensed in the community. This is an increase of 12 per cent since 2008 when there were 134,423 prescription items and 46 per cent since 2003 when there were 102,741 prescription items.

In England in 2008, there were 6,769 deaths directly related to alcohol (An increase of 24 per cent from 2001). Of these alcohol related deaths, the majority (4,400) died from alcoholic liver disease.

Therefore one can see alcohol can cause health problems. In the field of substance misuse this is also a growing problem. As patients stabilise on methadone, alcohol increases to dependent patterns (NTA, 2007). This guideline focuses on this patient group and outline how to treat this cohort effectively and safely.

Objective

The objective of this guidance document is to outline how complex patients with opioid and alcohol dependence can be managed safely

While there has been much written regarding methadone and its effect upon reducing criminal activity and providing health gains for individuals (NTA, 2006), there is less research regarding treatment for patients seeking methadone treatment with a co-existing problematic alcohol use or dependency.

Some research would advocate that this dual presentation is best addressed through the harm minimization approach. This might be through the use of high dose methadone which some advocate as being effective in reducing alcohol consumption (Lubrano S, Pacini, M, Guintoli G, Maremmani I, 2002). Others believe that a

pragmatic approach of addressing a reduction in alcohol consumption, managed through breathalysing the patient, with flexible methadone dosing is useful (Fernandez, 2004). There is a need to address problematic alcohol use due to the negative impact on people's lives through a reduction in the quality of life and increased co morbidity (Wolff, K Marshall, J, 2007). There is much evidence that alcohol, benzodiazepines and opiates are involved in drug related deaths (NTA. 2007).

With this growing presentation this guidance has been written. This guideline is for clinicians working in the area of substance misuse delivering clinical care. It is to ensure that best practice is maintained and alcohol presentations with methadone are recognised as increasing the risk of overdose for the client/patient. Therefore more consideration is needed to ensure effective and safe treatment is delivered for this cohort of patients

➢ Inclusion/ exclusion criteria

Dependent to problematic drinkers are included in this guideline. This should be the targeted population for this guideline.

Dependent patterns

People with moderate dependence have not reached 'relief drinking' (drinking to avoid alcohol withdrawal), but have may have a raised level of tolerance (needing to drink more to reach the same level of intoxication), have developed some symptoms of withdrawal, and have impaired control over drinking. This is usually termed as problematic drinking.

Clients who are prescribed methadone and also have a dependent pattern on alcohol fall into two defined categories:

1) People with severe dependence typically have severe alcohol withdrawal, high levels of alcohol tolerance, and may have withdrawal fits and delirium tremens. These people may be 'relief drinking' to avoid withdrawal. Other features include regular morning drinking, reduced ability to choose when to drink and when to abstain (stereotypical drinking), structuring their life around alcohol, and blackouts (episodes of memory loss) (Abdulrahim et al, 1999). This is known as dependent drinking and is an increasing presentation to drug treatment centres. These patients should be guided to the option of a detoxification regime in the long run. However, they can be managed in a safe and effective way if opioid dependent as this guideline will outline.

2) If the person is not alcohol dependent but has a problematic consumption pattern address their alcohol misuse through safer drinking advice and information interventions. Provide information about the impact alcohol may have on the metabolism of methadone, and other potential complications such as central nervous system depression, respiratory depression and hypotension

The above are criteria which defines and includes patients to which this guideline is applicable.

➢ Clinical management

Best practice dictates that alcohol consumption should be incorporated within an overall substance misuse assessment and associated prescribing plan (DoH, 2007)

The recommendations are consistent with those made by the National Treatment Agency for Substance Misuse and the Scottish Intercollegiate Guidelines Network (SIGN, 2003; Raistrick et al, 2006), and are largely based on expert and consensus opinion. The main measureable points should be part of any alcohol assessment in the field of substance misuse:

a) LFT GGT and AST levels should be checked for signs of damage due to excessive alcohol use. Impaired liver function also delays the metabolism of methadone. In drug misusing populations there is a significant problem associated with prevalence of viral hepatitis and excessive drinking.

b) Raised FBC MCV may, but not always, indicate binge drinking. Binge drinking and high-level alcohol use are particularly dangerous

c) If the person is alcohol dependent offer withdrawal management. Discuss involving a specialist team if necessary (Camden and Islington Foundation Trust “Islington Drug and Alcohol Specialist Service” - IDASS).

There is evidence that the assessment process alone is an effective intervention at reducing the level of alcohol consumption in people drinking above the recommended limits, by altering an individual's perception of their problem and their commitment to change (DH, 2006). This could also be true for people with dependent drinking patterns in the area of substance misuse.

For Illicit drug use (poly-substance misuse) and dependent drinking, is an increasing presentation and can complicate management. Specialist alcohol services will often involve other substance misuse teams that will link people to appropriate services. This can be a useful and effective adjunct to substance misuse treatment. However, drug treatment centres can provide effective alcohol treatment to their patients that

have dependent patterns. Risk needs to be assessed and planned for appropriately to ensure this.

Concurrent use of alcohol and methadone present an increased risk of overdose, as mentioned. Therefore many specialist centres and primary care services delivering drug treatment should always assess the alcohol consumption, if someone presents with an alcohol history from assessment. This can be measured by the use of a breathlyser. This is used to assess the pattern of alcohol consumption a patient may have, and also is used to assess whether someone has some control over their alcohol. On dispensing sites in order to maintain that a patient is at a safe level, the breathlyser is used to ensure that when a dose of methadone is dispensed that the patient is under the drink-drive limit of 0.35 measuring breath alcohol limits.

This is a well used measure by most methadone prescribing services in England and Wales (NTA, 2007), However for clients with a prescribe dose of methadone and a dependent drinking pattern to score under 0.35 maybe difficult.

The challenge is that in terms of dependent drinking, many patients will register above this limit and therefore to try and work with this clinical problem is important. Flexibility is crucial in the early stages of treatment and many centres working with dependent drinkers are flexible with use of increased limits in the short-term (for example to 0.50). Decisions to raise the limit ,whilst ensuring patient safety should always be made with the senior staff and the GP/doctor. Whilst the aim is to continue patient engagement with treatment, the focus must be safety and reduction of the risk of overdose.

If appropriate, a community detoxification off alcohol should be offered if the patient is finding it difficult to control their alcohol whilst in treatment. In some circumstances this may not be possible but the guidelines will indicate the type of patient this should be offered to.

Therefore for patients in treatment with a dependent pattern of alcohol consumption, the following is needed:

1) To breathylse under 0.35 (breath alcohol) to ensure safety and lessen the risk of overdose.
2) If scoring over 0.50, continued monitoring of alcohol use is needed with MET.
3) If the patient scores over 0.50 on more than one occasion any decision regarding continued treatment is to be made jointly with senior nursing staff and GP/doctor.
4) If there is a consistent pattern of scoring over 0.50, a community or in-patient detoxification regime is to be offered.
5) The focus is to try in all instances to continue treatment, but if alcohol consumption is a persistent problem a detox needs to be the preferred mode of treatment.
6) Patients with dependent drinking patterns should be on supervised consumption and communication with the pharmacist could include sharing this information to ensure safe methadone dispensing.

Where possible to option of detoxification from alcohol should be considered by any clinician assessing a patient with opioid and alcohol dependency: The next section is

borough wide guidelines which should be accommodated in any detoxification plan from alcohol in the area of substance misuse.

There is evidence that offering an alcohol detoxification regime for patients with alcohol problems can lead to an effective outcome. Some patients are able to stay 'dry' with the help of disulfiram. Some, if if they do relapse are able to control their drinking better after a detoxification off alcohol (Fernandez J MM Jones, 2010)

Alcohol detoxifications are also an unmet need in the borough and the promotion of more detxes off alcohol is encouraged (Treatment Plan, 2009).

Rationale for community detoxification in a community setting

Community detoxification means a detoxification regime given in a primary care setting and not in-patient. This often entails a comprehensive assessment which would identify a dependent drinking pattern. If a risk assessment indicates a low level of risk then a community detoxification can be seen as a useful treatment plan. Identification and treatment of clients with opioid and alcohol problems needs to be expanded in the borough of Islington to identify patients who can detox and are on a prescribed dose of methadone. For this cohort of patients it is an unmet need.

The criteria below were identified from a small pilot study conducted in Islington in 2009 at the ISIS project, which can be used to identify suitable clients for alcohol treatment (FernandezJ MM Jones, 2010). This study also found that for a cohort of patients offering an alcohol detoxification in the community is a very useful treatment modality for patients with the following characteristics:

1) Prescribed by a know prescriber within the borough of Islington
2) Stable on their prescribed dose of methadone. This means either no use on top of their script or very minimal use.
3) Not severe abnormal liver function. (Gained from recent LFT's within six months)
4) Patient has diagnosed hepatitis C
5) Patient has a good insight into their alcohol pattern usually derived from attempting previous detoxification with some 'dry' time.

Community detoxification is a process by which clients are enabled to withdraw safely from alcohol whilst remaining an out patient.

The process takes between 5 and 8 days. The Specialist Nurse at PCADS/ISIS

offers community detox as part of a treatment package that includes assessment, a reducing regime of medication, ongoing monitoring and support, relapse prevention and rehabilitation to support the patient's goal of being alcohol free.

Criteria for Inclusion

1. Willing to undergo full assessment.
2. Living in a stable environment, with social support
3. Patient agrees to attend aftercare/relapse prevention session with the Specialist Nurse and/or outside agencies e.g. CASA

Criteria for Exclusion

1. Severe physical health problems
2. Severe mental health problems
3. Unstable living environment, e.g. street homeless
4. No additional support
5. A high number of previous failed community detoxes with no change in environmental factors.
6. Evidence of poly-drug use and chaotic lifestyle
7. Evidence of DTs and / or withdrawal fits in the past.

Preparation of Client Procedures

1. Full explanation of the detoxification regime and procedure
2. Emphasis on the community detox as part of a larger process of change for the client
3. Discussion with client of possible withdrawal symptoms, plus coping strategies
4. Completion of decision matrix and drink diaries
5. Explanation of community detox to client's partner / support system
6. Blood tests for FBC, LFTs and GGT reviewed by Specialist Nurse.
7. Where appropriate, abdominal and central nervous system examination

Detox Procedure

The detox Procedure will commence on a Monday or Tuesday to allow for a full week of monitoring. Therefore if there was any reaction to the medication this could be dealt with quickly.

The patient is to be alcohol free for a minimum of 9 hours prior to taking medication.

Medication

The drug of choice is Chlordiazepoxide. 5mg doses are used for greater flexibility. Diazepam can be used and a detox regime can be found in the substance misuse guidelines for ISIS and primary care (2008).

The prescribing regime is flexible but the recommended doses and duration are as follows:-

Men: 10 - 30mgs Q.D.S. in a reducing dose over 5 days

Women: 10 - 20mgs Q.D.S. in a reducing dose over 5 days

Towards the end of the detox the daily frequency of medication is reduced i.e. to tds/bd/nocte.

In some instances it may be necessary to continue the medication for another 2 to 3 days, especially for night restlessness.

The prescription for medication will normally be given on a daily basis, with a two week prescription of Thiamine 100mg bd and Multi B Compound. This can be further prescribed if necessary by the GP.

Night Sedation may be appropriate for two weeks only and can be negotiated with the GP.

Monitoring

For monitoring, the patient must attend the service each day to be seen by a member of the clinical team, preferably the key worker. Whenever possible, the patient's 'helper' should be included in meetings especially in the first two days.

Monitoring appointments should include the following:-

- Checking whether the client has drunk any alcohol, use of breathalyser to verify.
- Use and discussion of craving diary if appropriate
- Checking concordance with prescribed medication
- Introduction of relapse prevention
- Discussion of ongoing support following completion of the community detox (day programme, rehabilitation or PCADS aftercare)

Follow up

1. Client to be offered follow up appointment by Specialist Nurse or GP within 1 week of community detox - completion or otherwise.
2. Acamprosate prescribing to be considered in liaison with the doctor/GP. Disulfiram may also be considered where appropriate.

3. If the client has a history of mental health problems e.g. Depression, a follow up mental health check appointment is to be arranged with the GP/doctor, 2 weeks after the community detox is completed.
4. The key worker to inform the GP/doctor of progress, outcome of detoxification process and future support.
5. Referral to, or liaison with, the day programme or rehab offering post-detoxification support.

- **Further information**

Depending on definition, as many as 70% of people receiving treatment for an alcohol problem will have relapsed at the 6-month follow-up. At 12 months, less than 30% of people will still be in contact with a specialist service. Evidence suggests this can be increased to 80% if follow-up is given by trained staff [Raistrick et al, 2006]. Therefore it is recommended that for a client who has detoxed off alcohol needs to be monitored for a three/six month period.

The literature suggests that observations at the 3-month follow-up are a good guide to how effective a treatment is for a particular person (changes tend to occur in the first 3 months), and at 12 months it will give a better guide to the overall benefit of treatment (Raistick et al, 2006).

Pharmacological interventions

Outlined below are some medications that can be used to enhance a client's chance of staying abstinent when they have completed a detoxification off alcohol:

Acamprosate:

1) Acamprosate is an anti-craving drug which is a useful adjunct to counselling in people who have recently undergone detoxification

2) There is evidence from clinical trials that it is effective in reducing alcohol consumption or maintaining abstinence particularly where the client experiences acute craving post detoxification.

3) It is ranked at number three in the Mesa Grande review on the effectiveness of alcohol interventions.

4) Acamprosate is usually initiated by specialist services such as PCADS in primary care, within a few days of successful alcohol detoxification, and its use may be continued in primary care.

5) The effectiveness of ongoing maintenance with acamprosate should be monitored by the primary alcohol team.

6) If a specialist service in primary care is not available or is not being used, initiation of acamprosate (with continued counselling) should be considered.

7) For more information on prescribing acamprosate, see acamprosate in the Prescribing information section. (SIGN, 2003; Raistrick et al, 2006)

Disulfiram can be used but it is a sensitizing drug, which provokes an unpleasant reaction when alcohol is consumed concomitantly, including tachycardia, headache, flushing, nausea, and vomiting. Knowledge of this reaction deters the person from drinking alcohol. It is sometimes indicated as an adjuvant in the treatment of chronic alcohol dependence, but should only be initiated in a hospital or specialized clinic, or by physicians experienced in its use (ABPI Medicines Compendium, 2005). This is seen as an effective post detoxification drug use that can increase abstinence in dependent drinkers who are on methadone (Fernandez, J MM Jones, 2010)

1. People taking disulfiram should be advised about the need for abstinence, and the unpleasant consequences of drinking alcohol with the drug. They should be warned that serious adverse effects may occur with large quantities of alcohol, including the possibility of arrhythmias, severe hypotension, and collapse.

2. Treatment with disulfiram requires commitment from the person receiving it, and an agreement should be undertaken to continue using the drug even when there is ambivalence. To facilitate this, the taking of the drug should be supervised by a spouse, work representative, or healthcare professional (SIGN, 2003).

3. The evidence for the efficacy of disulfiram is limited to supervised use. It is effective at reducing the number of drinking days and the quantity of alcohol used in people who are compliant, even if they continue to drink.

4. However, surprisingly, there is a lack of evidence that disulfiram increases the proportion of people who maintain total abstinence (Hughes and Cook, 1997).

   It is rated at number 22 in the Mesa Grande comparison of interventions (Raistrick et al, 2006).

Naltrexone is an opioid antagonist that acts as an anti-craving drug in people who are dependent on alcohol. There is evidence that it increases the rates of abstinence, and reduces relapse rates in alcohol-dependent people who are in abstinence-orientated programmes (Schaffer and Naranjo, 1998; Garbutt et al, 1999). In this regard, it compares favourably with acamprosate.

At present, naltrexone is not licensed for the purpose of preventing relapse in alcohol-dependent people, and it should be reserved for use in specialist centres rather than used in primary care (SIGN, 2003).

Nalmefene

This is a new medication introduced for treatment of patients that suffer from alcohol dependence. This can be prescribed by GP's. However, according to Nice guidance it is best practice to offer this with on-going psycho-social support and engagement which indicates reduced alcohol use (www.nice.org.uk). In Primary Care disulfiram and naltrexone are proposed instead of this medication.

The reason being there is clear evidence for these medications. However, if patient preference is for Nalmefene it can be discussed on a case by case basis. Specialist advice should be sought from the contact in these guidelines before prescribing is considered.

- **Contacts (inside and outside the Trust including out-of-hours contacts)**

This policy for providing a guideline on treating alcohol dependence for people on prescribed methadone will be audited through a case notes audit of patient who present with the dual problem of alcohol and methadone. The audit will look at compliance to this guideline and check whether patients are being breathalysed and treated in concordance with the guideline to ensure an equality of service provision.

The monitoring of this policy with be conducted through the clinical supervision group of :

PCADS GP Clinician Lead

Nurse Consultant for NHS Islington (Substance Misuse)

PCADS research and development steering group

The monitoring of this policy will be conducted through the clinical supervision group to ensure that any areas of concern are identified and actioned appropriately.

This meeting will review this guideline every twelve months

In the light of seeking expert advice in the are of substance misuse the following an be contacted :

Jeff Fernandez: Nurse Consultant for drug and alcohol: Whittington NHS Trust

jfernandez@nhs.net Tel: 07795 822773.

➢ References (evidence upon which the guideline is based)

Barratt M (2009) Treatment Plan for Islington services in substance misuse, NHS Islington (Internal Paper)

SIGN (2003) *The management of harmful drinking and alcohol dependence in primary care.* Scottish Intercollegiate Guidelines Network.

Raistrick, D., Heather, N. and Godfrey, C. (2006) *Review of the effectiveness of treatment for alcohol problems.* National Treatment Agency for Substance Misuse.

Lubrano S, Pacini, M, Guintoli G, Maremmani I, (2002) Herion addiction and Relevant Clinical Problems Vol4 no. 2.

Fernandez J, (2004) Alcohol guidelines for primary care www.islingtonpct.org.uk

Fernandez J MM Jones(2010): Detoxification of methadone maintained patients Drug and alcohol today: Pavilion vol 10 no.4,

Fernandez J (2009) Nurse led alcohol detoxifications : Journal of Nursing Research www.JNR,org,uk

NTA, (2007) Review of effective treatments for alcohol problems , www.nts.nhs.uk

NTA (2006) Alcohol treatment pathways www.nta.nhs.uk

NTA (2007) Drug Misuse and dependence-UK guidelines on clinical management, www.nta.nhs.uk

To be completed and attached to any procedural document when submitted to the appropriate committee for consideration and approval

		Yes/No	Comments
1.	**Does the procedural document affect one group less or more favourably than another on the basis of:**		
	• Race	No	
	• Ethnic origins (including gypsies and travellers)	No	
	• Nationality	No	
	• Gender	No	
	• Culture	No	
	• Religion or belief	No	
	• Sexual orientation including lesbian, gay and bisexual people	No	
	• Age	No	
	• Disability - learning disabilities, physical disability, sensory impairment and mental health problems	No	
2.	**Is there any evidence that some groups are affected differently?**	No	
3.	**If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?**	No	
4.	**Is the impact of the procedural document likely to be negative?**	No	
5.	**If so can the impact be avoided?**	N/A	
6.	**What alternatives are there to achieving the procedural document without the impact?**	N/A	
7.	**Can we reduce the impact by taking different action?**	N/A	

If you have identified a potential discriminatory impact of this procedural document, please refer it to the Director of Human Resources, together with any suggestions as to the action required to avoid/reduce this impact.

For advice in respect of answering the above questions, please contact the Director of Human Resources.

Checklist for the Review and Approval of Procedural Document

To be completed and attached to any procedural document when submitted to the relevant committee for consideration and approval.

	Title of document being reviewed:	Yes/No	Comments
1.	**Title**		
	Is the title clear and unambiguous?	Yes	
	Is it clear whether the document is a guideline, policy, protocol or standard?	Yes	
2.	**Rationale**		
	Are reasons for development of the document stated?	Yes	
3.	**Development Process**		
	Is it clear that the relevant people/groups have been involved in the development of the document?	Yes	
	Are people involved in the development?	Yes	
	Is there evidence of consultation with stakeholders and users?	Yes	
4.	**Content**		
	Is the objective of the document clear?	Yes	
	Is the target population clear and unambiguous?	Yes	
	Are the intended outcomes described?	Yes	
5.	**Evidence Base**		
	Are key references cited in full?	N/A	
	Are supporting documents referenced?	N/A	
6.	**Approval**		
	Does the document identify which committee/ group will approve it?	Yes	
7.	**Dissemination and Implementation**		
	Is there an outline/plan to identify how this will be done?	Yes	
8.	**Document Control**		
	Does the document identify where it will be held?	Yes	
9.	**Process to Monitor Compliance and Effectiveness**		

	Title of document being reviewed:	Yes/No	Comments
	Are there measurable standards or KPIs to support the monitoring of compliance with and effectiveness of the document?	Yes	
	Is there a plan to review or audit compliance with the document?	Yes	
10.	**Review Date**		
	Is the review date identified?	Yes	
	Is the frequency of review identified? If so is it acceptable?	Yes	
11.	**Overall Responsibility for the Document**		
	Is it clear who will be responsible for co-ordinating the dissemination, implementation and review of the document?	Yes	

Executive Sponsor Approval			
If you approve the document, please sign and date it and forward to the author. Procedural documents will not be forwarded for ratification without Executive Sponsor Approval			
Name		Date	
Signature			
Relevant Committee Approval			
The Director of Nursing and Patient Experience's signature below confirms that this procedural document was ratified by the appropriate Governance Committee.			
Name		Date	
Signature			
Responsible Committee Approval – only applies to reviewed procedural documents with minor changes			
The Committee Chair's signature below confirms that this procedural document was ratified by the responsible Committee			
Name		Date	
Name of Committee		Name & role of Committee Chair	
Signature			

Tool to Develop Monitoring Arrangements for Policies and guidelines

What key element(s) need(s) monitoring as per local approved policy or guidance?	Who will lead on this aspect of monitoring? Name the lead and what is the role of the multidisciplinary team or others if any.	What tool will be used to monitor/check/observe/Asses s/inspect/ authenticate that everything is working according to this key element from the approved policy?	How often is the need to monitor each element? How often is the need complete a report ? How often is the need to share the report?	What committee will the completed report go to?
Element to be monitored	**Lead**	**Tool**	**Frequency**	**Reporting arrangements**

General guidance regarding formatting of clinical guidelines:

- Font to be Arial 12
- Subheading and bullet points must be clearly identified
- All abbreviations must be written in full the first time they are used, including the most common ones (with the abbreviation in bracket) e.g. intramuscular (IM)
- Job titles should be used instead of individual names, regardless of position. However, in circumstances where guideline is specific to a limited number of clinicians names may be added in brackets in addition to job title
- Relevant Trust guidelines should be referred to where appropriate using the

box below. Please insert names of guideline you wish to refer to:

	Please see Whittington Health Guideline: **6** **'Insert name of relevant guideline'**

- References should follow the Vancouver referencing style:

A number is allocated to a source in the order in which it is cited in the text. If the source is referred to again, the same number is used.

For example:

It has been shown that smoking causes cancer (1), which, proves that smoking is harmful to health (1).

The author's name can also be integrated into the text eg. Smith [2] has argued that...

Style and format:

- either square [ ] or curved brackets ( ) can be used as long as it is consistent.
- superscripts can also be used rather than brackets eg. ...was discovered. 1,3
- numbers should be inserted to the left of colons and semi-colons.
- full stops are placed either before or after the reference number
- References are listed in numerical order in the Reference List at the end of the paper: eg.

1. Smith SD, Jones, AD. Organ donation. N Engl J Med. 2001;657:230-5.

Brown JG. Asphyxiation. Med J Aust. 2003; 432:120-4.

- Algorithms (flow charts) should stand alone, be referred to within the body of the text appropriately and be consistent with the text.

- Any appendices must be clearly referred to within the text and appended to the end of the guideline

Contact numbers of relevant people must be included at the end of the guideline before a list of references. This should include any out-of-hours contacts.