Psychological Medicine in Primary Care - Stockport
## Who are we?

<table>
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<th>Administrators</th>
<th>Psychiatry</th>
<th>Psychology</th>
<th>Liaison Practitioners</th>
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<tr>
<td>Janet Needham</td>
<td>Dr Mustafa Alachkar</td>
<td>Dr Sophia Kariotaki</td>
<td>Elaine Pitt – Team Leader</td>
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<td>Julie Charlton</td>
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<td>Dr Sara Bardsley</td>
<td>Steven Kellett</td>
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<td>Beth Rowe</td>
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What are our aims

- To improve the health and self-management of people with complex needs in Stockport

- To provide training, education, and support to other staff members working with this group of people
Client group

• Aged 16 +

• People who have “persistent physical symptoms” of any origin or “personality difficulties” whose needs cannot be met elsewhere

• People who frequently access services in distress but are difficult to engage in meaningful work
Inclusion criteria

- People whose difficulties cannot be managed elsewhere due to severity and/or complexity
- People whose use of healthcare is out of keeping with what is expected given the underlying condition
- People who have been referred to, but not benefited from or engaged with, another mental health service (Healthy Minds, CMHT)
- People who do not have an active psychosis
- People who are not open to another mental health service
Interventions

Assessment and Formulation

- Explore and develop a person’s narrative
- Explore what could be affecting the person’s ability to make progress
- May support moving on to a more appropriate service such as Healthy Minds.
- Guide current services and professionals
Case management

- A collaborative care model, working jointly with other health/social care professionals
- Intensive support by Liaison Practitioner including joint visits and formulation meetings
- Supporting people to improve their health and well being
- Focus on community engagement and long term resilience
Psychological interventions

- Range of interventions available
- Focusing on the most complex cases
- Group work
- 1:1
Psychiatric Interventions

- Diagnostic review
- Medication review
- Recommendations and guidance for other professionals
Positive Risk Taking

- Supportive stable relationships
- Relational approach to risk
- Allowing expressions of risk
- Exposure to risk in the context of allowing personal growth and development
We aim to be supportive of staff working with complex presentations.

We will consider working with people who do not fit our criteria if we are the best service to meet their needs.

We will work assertively with patients.

We will take time to build relationships.

We will see patients in local clinics and complete home visits.
Referrals

• Neighbourhoods
  – Via embedded liaison practitioner

• Primary Care
  – Emailed referral form

• Mental health and external services
  – Via link worker
What happens?

- Get background
- Discuss in MDT
- Decision about allocation

Referral

Assessment and formulation
- Seen up to 4 times
- Care plan and formulation
- Back to MDT

Ongoing care
- Case management
- Support for other professionals using care plan
What is unique about us?

• Relational approach: attachment-based and supported by theory and evidence.

• Emphasis on reflection (both for professionals and patients)

• Emphasis on modelling as a way of helping patients

• Working with the ambivalence (rolling with resistance)

• Supervision taken seriously
Some of the challenges

• Embedding liaison practitioners in to the integrated teams (e.g. IT, integrated goals of care, space, photocopiers and printers, attendance at ECM meetings).

• Volume of referrals to date 660 and subsequent waiting list. (both for assessment and for case management).

• Large numbers of ‘inappropriate’ referrals despite visiting all the GP surgeries and other services

• Recruitment problems
Some of the successes!

- Retention of staff
- Successful work with engaging people with complex needs
- Excellent examples of working together collaboratively with GP’s social workers and mental health teams.
- Training for staff inc PIT, DBT skills, Personality disorder, Attachment, trauma, etc.
- Service development and evaluation
- Development of an excellent supervision structure for all staff
Contact details

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Lead Consultant – Dr Mustafa Alachkar – mustafa.alachkar@nhs.net
Case Vignette 1

• Erica is a 72 year old woman with a long history of medically unexplained symptoms such as a chemical fizzing in her head and undulating sensations in her stomach. Classed as a vexatious patient because of demands on GP’s and multiple complaints as she put her symptoms down to diazepam withdrawal. Development of integrated support plan with GP, consultant and liaison practitioner.
Case Vignette 2

- Margaret, 72, pain in legs and walking difficulty. Bed-bound. Referred by social worker due to ‘difficulty in accepting care’, ‘carers’ burnout’ due to difficulty in meeting needs and problematic help seeking behaviour. Often reports suicide in order to elicit care.
Extremely difficult early childhood and worsening symptoms since mum died in 2016.

Poor prognosis 40 years ago!

Working with carers agency, social workers and other professionals.
Case Vignette 3

- Janet, 48, depression and well-planned suicidal attempts.
- Past history of sexual abuse.
- Using alcohol as main way to cope.

- Changing relationship with liaison practitioner – importance of reflective space for Angela.
- Liaison with other services (inpatient ward)
Working together

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