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LANCASHIRE TRAUMATIC STRESS SERVICE

REFERRAL PROCEDURE

1. The LTSS accepts referrals from CMHTs and aims to undertake trauma specific work in the context of care co-ordination and on-going local service involvement.

2. The following information aims to clarify the two stage referral procedure to the service.

3. Firstly, telephone Rachel Grainey on 01772 647071 to arrange a telephone conversation with a member of the team. Rachel works Wednesdays to Fridays.

4. The conversation with the team member aims to ensure -

   a) that the person is experiencing severe or extreme reactions to an **adult** trauma

   b) that this is a good time for them to do some focussed work on these particular problems and they are motivated to do so

   a) that they can get to Chorley, where the service is located, on a regular basis

   b) that they are over 16 years of age

   c) that they have a care co-ordinator within the CMHT

5. To assist in the conversation please complete the PCL5 (Posttraumatic Stress Disorder Checklist 5) with your client **within the last month** - and have a total score available. The PCL5 is reprinted below and is also available on the service website at www.lancashiretraumaticstressservice.nhs.uk

   PLEASE ENSURE THAT YOU ARE CLEAR ABOUT THE TRAUMATIC EVENT THE PERSON IS HOLDING IN MIND WHEN RESPONDING TO THE QUESTIONS IN THE PCL-5.

6. If the discussion suggests that the involvement of the trauma service may be helpful, we will then offer your patient an initial meeting with us to clarify the difficulties in more detail. As the care co-ordinator, you would be very welcome to come to this meeting.

7. Following the discussion with the patient, the case will then be considered at the next available Friday team meeting and a view taken regarding LTSS involvement.

   Possible outcomes include:

   a) Addition to the LTSS waiting list for more detailed assessment and treatment

   b) Clarification as to why a referral to the LTSS may not be appropriate at this time

   c) Suggestions regarding potential areas of psycho- education, therapy and treatment that may be helpful.

8. These outcomes will be communicated to the patient and the care co-ordinator in ways that seem sensitive and helpful. This will include a written letter to the patient.

9. The above relates to referrals of service users from CMHTs. The LTSS is also in a position to accept referrals from work colleagues who have experienced a workplace trauma – these referrals need to come through Well Being Partners (WBP) (the Occupational Health provider).

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PCL 5

NAME: _____

DATE COMPLETED: _____

Instructions

On the next page is a list of problems that people sometimes have in response to extremely stressful experiences: **keeping your worst event in mind,** please read each problem carefully and then circle once of the numbers to indicate how much you have been bothered by that problem **in the past month.**

CRITERION A
Posttraumatic Stress Disorder

A. Exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways:
   1. Directly experiencing the traumatic event(s)
   2. Witnessing, in person, the event(s) as it occurred to others.
   3. Learning that the traumatic event(s) occurred to a close family member or close friend. In cases of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental.
   4. Experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g. first responders collecting human remains; police officers repeatedly exposed to details of child abuse).

Note: Criterion A4 does not apply to exposure through electronic media , television, movies or pictures, unless this exposure is work related.

Description of the specific event you are holding in mind

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NAME: _____

DATE COMPLETED: _____

In the past month, how much were you bothered by:	*Not at all*	*A little bit*	*Moderately*	*Quite a bit*	*Extremely*
1. Repeated, disturbing, and unwanted memories of the stressful experience?	0	1	2	3	4
2. Repeated, disturbing dreams of the stressful experience?	0	1	2	3	4
3. Suddenly feeling or acting as if the stressful experience were actually happening again *(as if you were actually back there reliving it)*?	0	1	2	3	4
4. Feeling very upset when something reminded you of the stressful experience?	0	1	2	3	4
5. Having strong physical reactions when something reminded you of the stressful experience *(for example, heart pounding, trouble breathing, sweating)*?	0	1	2	3	4
6. Avoiding memories, thoughts, or feelings related to the stressful experience?	0	1	2	3	4
7. Avoiding external reminders of the stressful experience *(for example, people, places, conversations, activities, objects, or situations)*?	0	1	2	3	4
8. Trouble remembering important parts of the stressful experience?	0	1	2	3	4
9. Having strong negative beliefs about yourself, other people, or the world *(for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)*?	0	1	2	3	4
10. Blaming yourself or someone else for the stressful experience or what happened after it?	0	1	2	3	4
11. Having strong negative feelings such as fear, horror, anger, guilt, or shame?	0	1	2	3	4
12. Loss of interest in activities that you used to enjoy?	0	1	2	3	4
13. Feeling distant or cut off from other people?	0	1	2	3	4
14. Trouble experiencing positive feelings *(for example, being unable to feel happiness or have loving feelings for people close to you)*?	0	1	2	3	4
15. Irritable behavior, angry outbursts, or acting aggressively?	0	1	2	3	4
16. Taking too many risks or doing things that could cause you harm?	0	1	2	3	4
17. Being “superalert” or watchful or on guard?	0	1	2	3	4
18. Feeling jumpy or easily startled?	0	1	2	3	4
19. Having difficulty concentrating?	0	1	2	3	4
20. Trouble falling or staying asleep?	0	1	2	3	4

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SCORING SUMMARY SHEET

NAME: _____

DATE COMPLETED: _____

CRITERION	QUESTION NUMBER							TOTALS
INTRUSION SYMPTOMS B	**B1 (1)**	**B2 (2)**	**B3 (3)**	**B4 (4)**	**B5 (5)**			
AVOIDANCE SYMPTOMS C	**C1 (6)**				**C2 (7)**			
COGNITION & MOOD CHANGE D	**D1 (8)**	**D2 (9)**	**D3 (10)**	**D4 (11)**	**D5 (12)**	**D6 (13)**	**D7 (14)**	
AROUSAL & REACTIVITY E	**E1 (15)**	**E2 (16)**	**E3 (17)**	**E4 (18)**	**E5 (19)**	**E6 (20)**		
						TOTAL SCORE		

DSM5 CATEGORIES	
Mild	0-20
Moderate	20-40
Severe	40-60
Extreme	60-80

Criterion B – at least one ≥ 2 **YES/NO**
Criterion C – at least one ≥ 2 **YES/NO**
Criterion D – at least two ≥ 2 **YES/NO**
Criterion E – at least two ≥ 2 **YES/NO**