SERVICE EVALUATION
NORTH OF ENGLAND
VETERANS' HIGH INTENSITY SERVICE

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COMBAT STRESS
FOR VETERANS' MENTAL HEALTH

NHS
Leeds and York Partnership
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About Combat Stress

Combat Stress is the UK's leading charity for veterans' mental health. Operating for over a century, today Combat Stress provides specialist treatment and support for former servicemen and women from every military branch and conflict, focusing on those with complex mental health issues. Combat Stress operates all over the UK, on the phone, online, in the community, and at our specialist centres.

Founded in 2014, the Combat Stress Research Department is academically independent and committed to producing high-quality and robust research of direct relevance to the veteran community. The Department publishes in peer-reviewed journals and works closely with leading international academic, governmental and defence organisations to contribute to the advancement of the veteran mental health field. Further information on research at Combat Stress can be found at combatstress.org.uk/research.

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Dominic gained his first degree in psychology from The University of Glasgow before joining the team that established the King's Centre for Military Health Research (KCMHR). He gained his doctorate at KCMHR in 2010 and then trained as a clinical psychologist at Royal Holloway. In 2013 he joined Combat Stress where he established and now leads the Research Department, specialising in veteran mental health. He has published over 100 academic journal articles, is a participant in the Five Eyes Veteran Mental Health Consortium and is President of the UK Psychological Trauma Society.

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Acknowledgements

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Declaration

Combat Stress provides a Clinician Advice Line and Family Peer Support as part of the High Intensity Service, the latter of which began operation outside the evaluation period. The authors are not involved in the provision of either service, nor are they included in the scope of this evaluation.

1. EXECUTIVE SUMMARY

The Veterans' Mental Health High Intensity Service provides urgent intervention for veterans who are in mental health crisis, and comprises the third and newest arm of Op COURAGE: The Veterans Mental Health and Wellbeing Service.

Leeds and York Partnership NHS Foundation Trust is the Lead Provider of the pathfinder High Intensity Service in the North of England. The delivery partners are Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust, and veterans' charities Walking With The Wounded and Combat Stress.

The Service provides time-limited, add-on, veteran-specific, wraparound psychosocial care alongside established local crisis services, and is delivered by NHS clinicians and third-sector Veteran Liaison Support Officers. It also provides support when a veteran is an inpatient on a mental health ward or unit.

This evaluation of the High Intensity Service used routinely collected available data to describe the patient population and Service provision in the first twelve months of operation.

KEY FINDINGS

- **180 veterans entered treatment** with the High Intensity Service in the first twelve months of operation.
- The Service demonstrates a high rate of acceptability with **81% of patients completing their treatment**.*
- **Targets were consistently met** on referral response time and length of treatment in line with the service provision framework.
- After discharge from the Service, most patients were **referred to general, rather than veteran-specific, services** for additional treatment.
- The re-referral rate to the Service was low, and the **majority of onward referrals on discharge were to a stepped-down level of care**.
- The most frequently endorsed stressors contributing to patient crises were **relationship problems**, **financial stress**, and **social isolation**.
- **Poor sleep**, **symptoms of PTSD**, **anxiety and depression** were the most commonly reported presenting health problems.
- **Half of patients reported** witnessing or experiencing abuse or neglect in childhood.
- Contemporaneous **maladaptive alcohol use was regarded as notable for 44%** of patients, and **illicit substance use for around a quarter**. Cocaine and cannabis were the most widely used.

*does not include those whose treatment is classed as ongoing at time of publication

2. INTRODUCTION

2.1 Background

There are currently an estimated 2.4 million military veterans in the UK.[1] Whilst the majority transition to a civilian life voluntarily[2] and without any significant health concerns,[3] there are those for whom life after military service will feature significant ill health.

The current understanding of veteran mental illness, comorbid disorders and the possible influencing factors, is both complicated and nuanced.[4-7] Compared to civilian populations, both serving personnel and veterans show a higher prevalence of common mental health disorders (such as anxiety and depression), posttraumatic stress disorder (PTSD) and alcohol misuse.[8-11] Mental and behavioural disorders currently exceed musculoskeletal disorders and injury as the primary or contributory factors for discharge on medical grounds in the British Army and RAF.[12] Furthermore, the act of transition from military to civilian world in and of itself can be psychologically and socially challenging for any serviceman or woman, and their families.[13,14]

The veteran community are as varied as the wider population in their occupational and broader life experiences. Not all mental illness in veterans can or should be attributed to events in past military service. Nor do such difficulties always arise during or immediately post-service, with some veterans waiting many years to seek mental health treatment.[15] Nevertheless, once beyond the gates of the military environment, the responsibly for treatment and support of veterans rests with the civilian healthcare system and charitable sector.

It is significant that military veterans in general appear to display a reluctance to engage with mental health services.[16,17] Lack of awareness of services, stigma around help-seeking and a perception of weakness, and a lack of trust that civilian health professionals will fully understand and appreciate a military context or mindset, have all been cited as potential barriers to engagement.[14,18,19] Although not unique to veterans,[20] qualities highly regarded and encouraged during military service such as mental toughness, self-sufficiency and pushing through adversity, can all become negative influences on whether or not to find help in times of need, to the point where seeking help only occurs once crisis point is reached.[21,22]

There are currently no accurate assessments of the number of veterans living in the UK. The 21 March 2021 Census in England and Wales, for the first time asked whether respondents had previously served in the UK Armed Forces, with a further distinction made between Regular or Reserve past service. Results are expected to be released in stages from late spring 2022.[23] However, current estimates state the veteran population, whilst projected to fall in number over the next decade, is also expected to proportionally become younger.[24] A Government consultation reported a demand for broader recognition, appreciation and accommodation of veterans' needs in both healthcare and in wider society.[25] Accordingly, the requirement for civilian healthcare systems to respond to an ongoing and potentially increasing lifetime demand for military-informed and sensitive mental health provision is clear.

In March 2012, the NHS and the Office for Veterans' Affairs announced[26] the launch of Op COURAGE: The Veterans' Mental Health and Wellbeing Service in order to provide a unified strategy for veterans to access to specialist mental health care. Two arms of the strategy were established previously – the Veterans' Mental Health Transition, Intervention and Liaison Service (TILS),

and the Veterans' Mental Health Complex Treatment Service (CTS). The Veterans' Mental Health High Intensity Service (HIS) comprises the third arm and provides urgent and emergency care and treatment for veterans who are in mental health crisis. A number of pathfinder HIS programmes across England were commissioned in May 2020 as partnerships between the NHS and third sector organisations. Leeds and York Partnership NHS Foundation Trust (LYPFT) was commissioned as Lead Provider for the North of England High Intensity Service establishing a collaboration with delivery partners Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust (CNTW), and veterans' charities Walking With the Wounded and Combat Stress. The Service accepted its first referral on 29 October 2020.

In the North of England, HIS is a value-added service, designed to enhance and work alongside existing local crisis services and mental health inpatient wards from a veteran-centric and informed position. Patients meeting criteria for treatment by HIS must be in or at risk of crisis; be referred from local crisis, mental health inpatient or addiction services; and have an existing local mental health care package in place (such as a crisis or inpatient service). As HIS is not a 24-hour crisis service and as the Service does not have the resources to deploy across the region immediately, the ongoing involvement of local services ensures that risk and treatment including medication remains managed. Acceptance to HIS is contingent on UK Armed Forces veteran status being confirmed and self-referrals are not permitted.

On acceptance, each patient is allocated a lead NHS clinical worker and a Veteran Liaison Support Officer (VLSO) provided by Walking With The Wounded. Intervention is designed to last up to 12 weeks, although treatment time can be extended. This is broadly structured as six weeks of psychological intervention and up to 12 weeks of concurrent broader support. Psychological intervention includes grounding techniques, brief psychoeducation, behavioural activation and harm reduction. The broader support includes facilitating access and involvement with health services, housing and financial advice, and engagement with veteran communities and resources. In the case of mental health inpatients, HIS support may also include input in discharge planning and transition to the community on discharge. Delivery is designed to be primarily conducted in-person, although the frequency and mode of contact varies depending on individual patient need.

Additional support for partners and families can also be facilitated, ranging from advice and psychoeducation, through to service signposting and the provision of an additional VLSO or specific therapeutic intervention. On completion of treatment, the patient is discharged to their GP, returned to the original referring service, or referred onward to secondary or tertiary services.

2.2 Study Methods

A list of all referrals to the High Intensity Service during the first twelve months of operation (29 October 2020 – 30 October 2021 inclusive) was generated and access to the associated electronic patient records granted to the research team. The results presented in this report represent the available data as of 01 December 2021.

The evaluation exclusively used existing data routinely collected by members of the High Intensity Service team. The entirety of each patient's medical record that was available to the research team was manually examined and coded on a set of variables covering demographic and military service information, HIS engagement, and treatment details.

The first 25 patient records on the referrals list were iteratively examined to

generate a set of variables escribing the clinical presentation of those referred to the Service. All variables were agreed on by the authors and LYPFT lead contacts, and were designed to capture the range of presentations amongst the referred population. Twelve stressors including suicidal ideation, relationship problems and physical health were created to reflect the most salient factors in each patient's crisis. An additional twelve presenting problems informed by recorded biopsychosocial clinical formulations were also generated. These included maladaptive alcohol use, adverse childhood experiences, PTSD symptomology, and poor or disturbed sleep. Each patient was coded as positive or negative for each, with additional information (such as a type of illicit substance used) included if possible and appropriate. Patients endorsed multiple factors.

Whilst wholly informed by existing patient record data, this iterative approach ensured as complete and flexible extraction of the required data as possible, resulting in a rich dataset designed to accommodate and reflect the nuance and detail found in the core qualitative information. Data collection was notably comprehensive; unless stated, data for all variables showed over 85% completeness.

Due to restrictions resulting from the COVID-19 pandemic, some telephone contact with patients were categorised as analogous to face-to-face appointments. Where ambiguity or uncertainty arose, clarification and consensus were achieved through discussion with the main HIS contacts and within the research team.

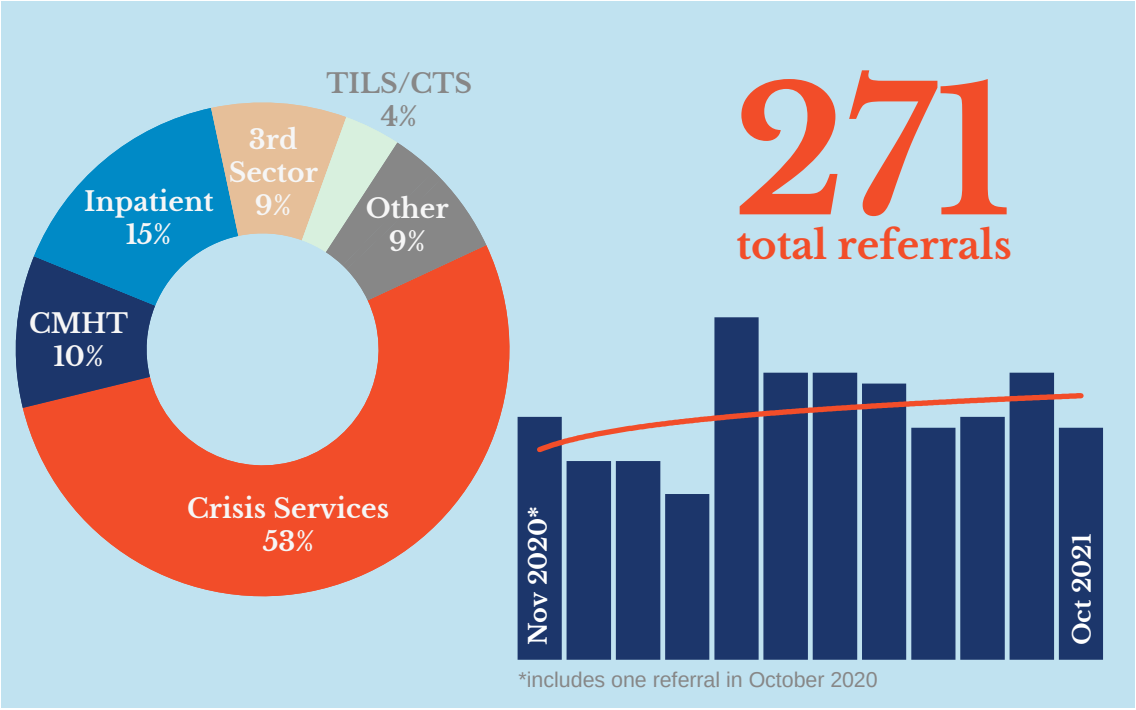
A number of archetypal patient histories were creating by amalgamating case notes, to provide an illustration of the range of patient experiences recorded over the reporting period, whilst maintaining patient confidentiality.

The data were anonymised prior to analysis. Data protection legislation (including UK GDPR) were complied with throughout. Percentages are presented as rounded figures and totals may exceed 100%.

3. RESULTS: Patient Pathways

3.1 Overview, Referrals and Waiting Times

In the first year of operation, 271 referrals were made to the North of England Veterans' High Intensity Service. In total, 254 unique individuals were referred, of which 15 were re-referred (see 3.4). For purposes of analyses, each referral was treated as unique to best capture the presenting profile at time of contact with the Service, which may vary for individuals over time.



The number of referrals made month-by-month gradually increased over the first year of the Service operation. **There was an adjusted average of 21 referrals per month**, with a range of four to seven referrals per week. There were notable peaks of 11 referrals a week on four separate occasions during 2021.

Over half of all referrals came from crisis services (*n*=144), with psychiatric inpatient services accounting for 15% (*n*=42), and CMHT (*n*=27) and the third sector the next most frequent sources (*n*=24). Six referrals were received from TILS and four from CTS, of which one was submitted via crisis services due to uncertainty about the HIS referral pathway.

The remaining 24 referrals came from other sources including GPs, word-of-mouth, non-psychiatric inpatients, single point of access, and local authority services.

Accident & Emergency Department psychiatric liaison services only accounted for eight referrals, although this figure does not include those patients who presented at emergency primary care in the first instance and were subsequently referred to a crisis team.

The majority of referrers received a response from the Service within 48 hours. In 93% of the cases for which data were available, referring sources were contacted by the HIS team on the same or following day that the referral

was made. On nine occasions, referring sources had to wait three or four days for a response.

Three-quarters of patients waited five days or fewer for (an attempted) first contact by HIS (76%; *n*=99, data 72% complete) from time of initial referral.

Around **half of all recorded first appointments between patient and HIS took place within seven days of referral** (52%; *n*=99), with 87% occurring within two weeks. Controlling for outliers, patients who were referred whilst a psychiatric inpatient, did not appear to wait significantly longer on average for their first appointment with HIS.

CASE STUDY: ANDY*

I spent 15 years in the Army, so I felt like I could handle anything, but in the past year my sleep, anxiety and PTSD just got worse and worse. I'd always liked a drink, but I was drinking more and more just to get me through and it was getting out of hand. I was signed off from work and was at risk of being fired. I felt like I was losing everything.

I just couldn't cope and one night decided that I was going to end it all. The police found me in a terrible state and took me to hospital. They found out I was a veteran and referred me to the High Intensity Service who worked with me alongside the crisis team.

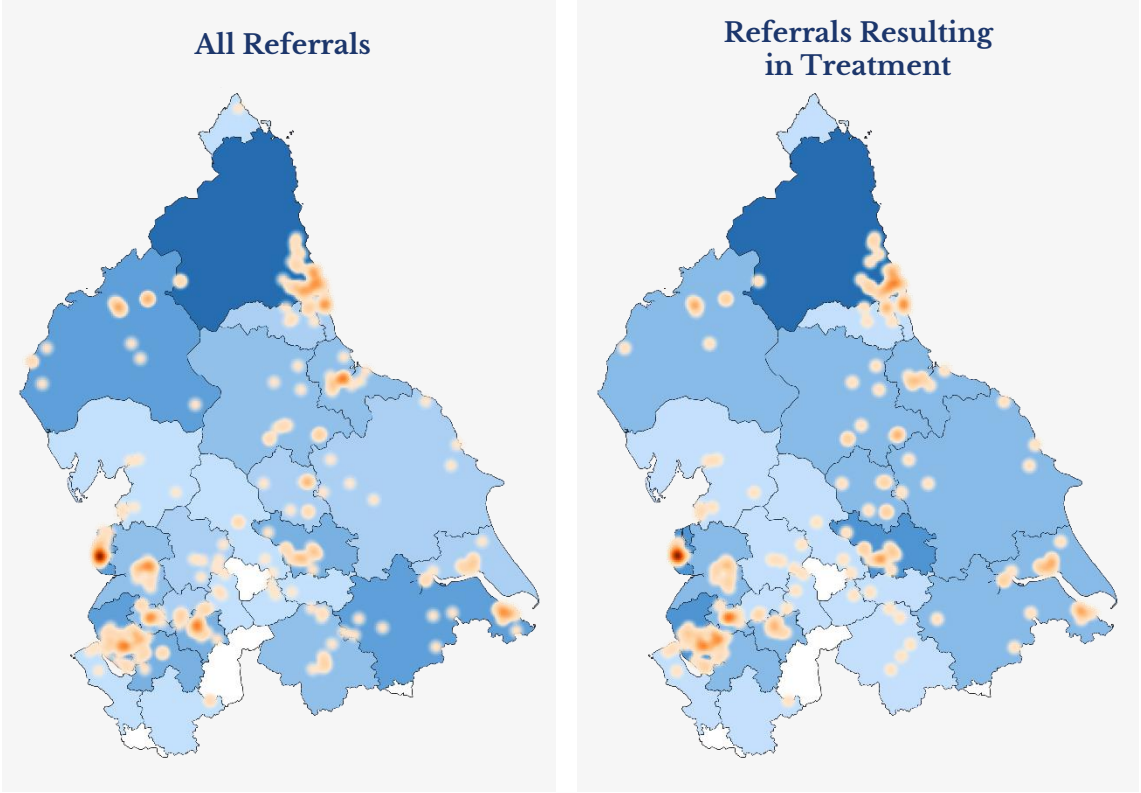
It was the first time I'd spoken to anyone who really understood what I was going through. They helped me to get a handle on my flashbacks and anxious thoughts, helped me go to group treatment to get my drinking sorted and put me in touch with a local veterans' club so I could start getting my life back together.

It wasn't just me though, they involved my wife, made her feel like part of the team and that she was important too. She's now linked in with other people who understand her and what she's going through too.

It's been hard work, and there is more to come, but things feel more stable and I'm starting to feel back in control.

3.2 Geographic Distribution

Using recorded postcodes at time of referral, it is possible to map the geographic distribution of all referrals made to HIS, as well as specifically those referrals which resulted in treatment being undertaken (see 3.3). There was no discernible geographic difference between these two groups.



Heatmaps shown at 5km radial spread Contains Ordnance Survey data & National Statistics data both © Crown copyright & database right 2022, and Royal Mail data © Royal Mail copyright & database right 2022

Referrals covered a broad geographic spread with larger numbers of referrals – represented by darker shading of blue on the maps – seen in the North East, Liverpool, Doncaster and Blackpool postcode areas.

There were no referrals from the Halifax postcode area. Similarly, no referrals were recorded from the Stockport, Shrewsbury or Nottingham areas which border the North of England region.

Clusters of referrals to the Service are evident around major conurbations, particularly Newcastle, Blackpool and the Liverpool-Manchester corridor, as well as the Humber coast.

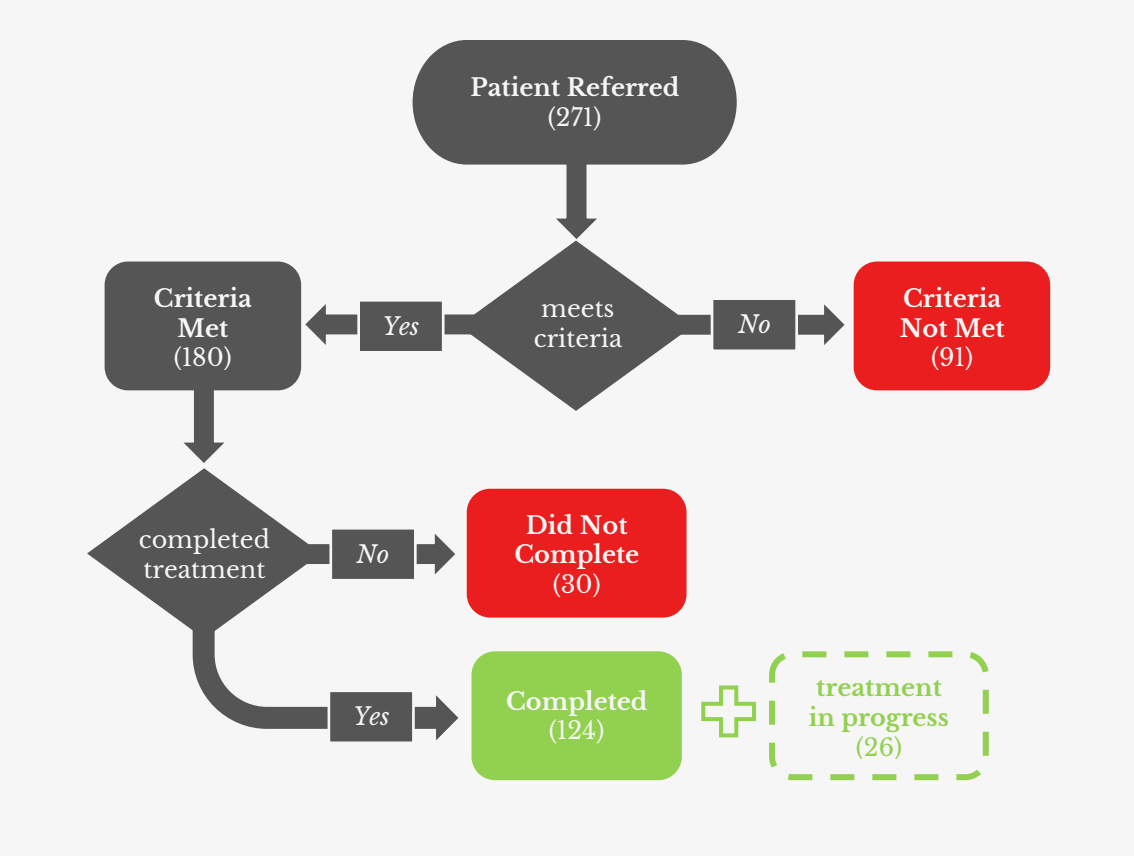
Although the distribution of veterans is unknown, and some areas are sparsely populated, there is a notable lack of referrals of veterans living in the York and Lake District areas.

Over half (59%) of all referrals came from four NHS Foundation Trusts: Cumbria, Northumberland, Tyne and Wear (*n*=56); Tees, Esk and Wear Valley (*n*=38); Lancashire and South Cumbria (*n*=36); and Mersey Care (*n*=29). CNTW alone was responsible for almost a quarter (23%) of all referrals from NHS Foundation Trusts.

Referrals previously from North West Boroughs, were recoded as from Mersey Care or Greater Manchester Mental Health as appropriate.

3.3 Patient Pathways & Trends: Overview

The study identified all possible patient pathways, and referrals were coded appropriately. This coding differs slightly from the Service's own clinical case management categories for simplicity and grouping purposes, and this method is described in the sections below.



Referrals were initially categorised on whether or not they met the criteria for entering treatment; namely being at or near point of crisis and under the care of local services such as crisis or community mental health teams. Patients who were initially accepted for an assessment by the HIS team and then subsequently deemed not to meet criteria are included in the Criteria Not Met group (see 3.7).

Two-thirds of all referrals met the referral criteria and were accepted for treatment by HIS (66%; *n*=180). These patients were further categorised depending on whether they went on to have a mutually agreed and planned discharge from the Service and were thus considered to have completed treatment (see 3.5). Those who did not complete, either withdrew of their own volition or failed to engage with the Service (see 3.6).

Of the patients who met the criteria for HIS involvement, 26 (14%) were classed as having their treatment still ongoing at time of data extract. Twenty-two of these patients had spent under 12 weeks in treatment (see 3.5), of which two had entered alcohol detox and rehabilitation programmes, and two are expected to complete treatment outside the reporting period. As it cannot be confidently stated whether these patients will definitely complete treatment, this group is excluded from analysis in the remainder of this report unless otherwise stated.

3.4 Re-referrals

Fifteen patients were re-referred to the Service during the reporting period, representing a total re-referral rate of only 6%. **Fourteen of the re-referral group met criteria and entered treatment with HIS at some point**, either on initial or subsequent referrals. The sole patient who did not enter the HIS treatment pathway at any point was the consequence of insufficient information being submitted by the referrer on both occasions.

Twelve of the fifteen patients in this group were re-referred once (a total of two referrals each).

Five patients were initially rejected because of insufficient referral information (*n*=1), being referred to HIS in error (*n*=1), or because they were not in crisis and/or did not have a sufficient local package of care in place (*n*=3). All patients went on to subsequently meet criteria and enter treatment on re-referral, of which one failed to complete treatment and disengaged in part due to ongoing complex criminal justice involvement.

Two patients initially completed a course of intervention and were subsequently rejected on re-referral because HIS was deemed not to be the most suitable service to provide further treatment.

One patient with alcohol dependency disengaged after an initial appointment on both referral and re-referral six weeks later. An additional patient asked HIS to withdraw after one appointment feeling they had adequate support in place from other sources. They were assessed as not being eligible for crisis services at time of re-referral and consequently did not meet the criteria for treatment by HIS who signposted to TILS.

Three other patients began but did not complete treatment after first referral.

HIS withdrew from treating one patient to avoid complicating multi-agency care provision. This patient subsequently completed treatment on re-referral approximately two months later, although it is worth noting that a potential relapse in chronic substance misuse is indicated in the clinical documentation immediately prior to the discharge point. The other two patients initially disengaged and have engaged at re-referral, with treatment ongoing at time of reporting.

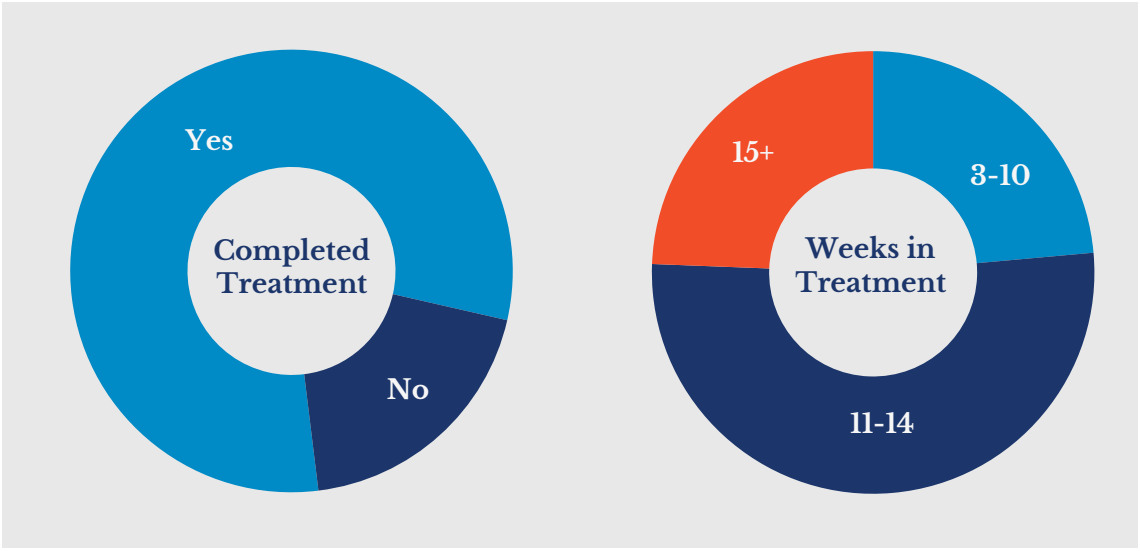
The remaining **two patients in the re-referral group were re-referred twice** (a total of three referrals each).

The first patient was referred twice in the space of a week and did not meet criteria for treatment due to a lack of information and because they were deemed not to be in crisis. They were accepted on third referral one month later whilst a psychiatric inpatient and under the care of crisis and local services. They were undergoing alcohol detox, supported by HIS at time of data extract.

The second patient was initially viewed not to be in crisis and not tolerant to HIS involvement, then entered treatment on first re-referral six months later and successfully completed treatment. Two months after discharge, they were re-referred once more, whereupon signposting to TILS for more appropriate, longer-term intervention was provided.

3.5 Patients Meeting Criteria & Completing Treatment

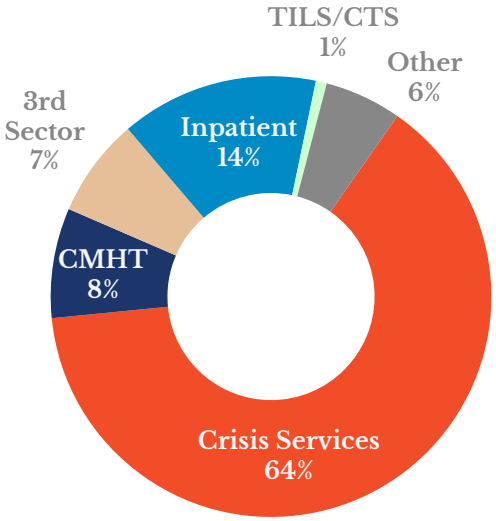
The Service demonstrated good treatment acceptability in the reporting period. The vast majority (81%; *n*=124) of patients who met the criteria for treatment, went on to have a mutually agreed and planned discharge, and were thus considered to have completed the treatment programme. These figures do not include the 26 patients whose treatment is classed as ongoing at time of data extract.



For those completing treatment, the **average length of time in treatment was 13 weeks** (time between first and last appointments). This is in line with the Service model of treatment. The mean treatment time remained stable over time.

Considering the impact of COVID infection control protocols and the potential impact of lengthening treatment times, it is notable that although a quarter of patients (24%; *n*=30) were discharged during week 15 or later, only eight patients exceeded 17 weeks in treatment.

The longest treatment time was 35 weeks. This patient entered a residential alcohol detox and rehabilitation programme after 13 weeks and was retained by HIS to manage discharge and transition. However, broadly there did not appear to be any appreciable difference in treatment length depending on the presenting profile or referring source of the patient (see 4.3 and 6.2.3).



Patients meeting criteria for treatment were primarily referred from crisis services. Eighteen patients were referred from psychiatric inpatient services (including crisis houses), and an additional four individuals in inpatient care settings were referred by CMHT, crisis services or the third sector (see 5.1). **Only one patient referred from CTS entered treatment**.

CASE STUDY: JUSTIN*

When I broke my back, everything changed. I lost my military career, my purpose in life, my first marriage eventually ended because she had to care for me. It all went. Since then, I've felt like I've been bounced from one healthcare team to another. We try our best, but things slip, debts mount up, things round the house get ignored.

Three months ago, an old buddy killed himself and I looked round at my situation and thought 'what's the point?'. I felt like a burden to my wife, I was in constant pain, I've not worked for ages, I could see her kids just thought I'd ruined all their lives. The shame I felt in the hospital was huge, but also the relief when HIS got in touch, explained who they were, that they got what it was like to be veteran and wanted to help.

I hated having those thoughts and I hated feeling worthless. But I've worked with HIS and they helped me realise that those thoughts don't control me, and I don't have spiral down to where things are really bad. I'm not fixed, but I am better and I know that I am able to cope and get through the bad days.

Having the team look at my situation and say 'that's not right' was great. They arranged contact with charities who help military people with injuries like mine, and got a few handrails put in the house to help me move around a bit easier. Little things too, like getting a load of model kits to do instead of sitting at home doing nothing, or a hamper of food over Christmas, even just texts every few days to see how things were. They sorted out my benefits which had been wrong for ages.

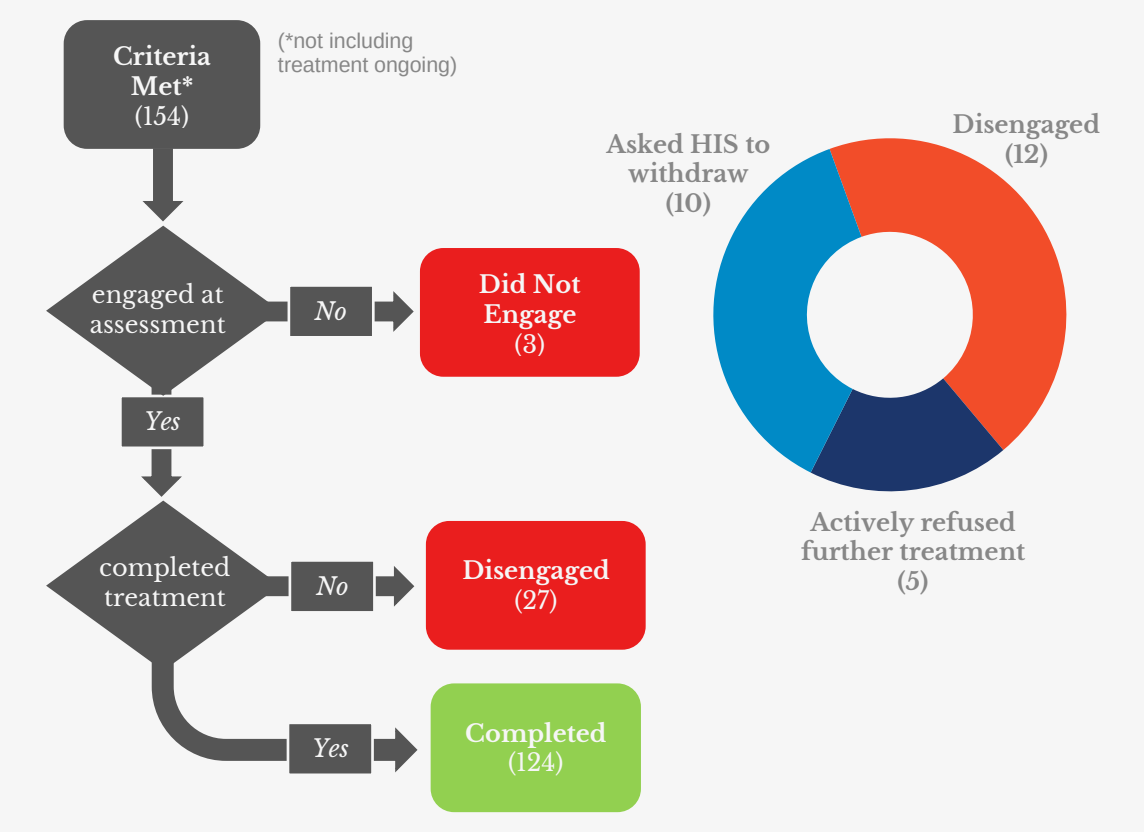
My wife is a veteran herself and has her own challenges. HIS arranged for her to have her own VLSO come visit and work out what could be done to help her.

It was the first time that anyone took the time to bring all the parts of our life that weren't working together and tried to make it work. I've been referred to a specialist pain clinic that I didn't even know existed until now.

All these little things joined together really helped. I've got some optimism back and feel like I'm worth something. I'm even looking at doing some volunteering work with a local group to see if I can help others in a similar position.

3.6 Patients Meeting Criteria & Not Completing Treatment

The proportion of patients who met criteria for HIS treatment but did not complete treatment was 19% (*n*=30). This does not include those whose treatment is ongoing at time of data extract.



Once accepted for treatment, three patients refused treatment or did not respond to attempts to contact them. All these instances occurred during the first three months of Service operation. A further two patients also failed to attend their initial assessment but were coded as not meeting criteria (see.3.7) as they were also viewed not to be in crisis nor have the requisite local care package in place.

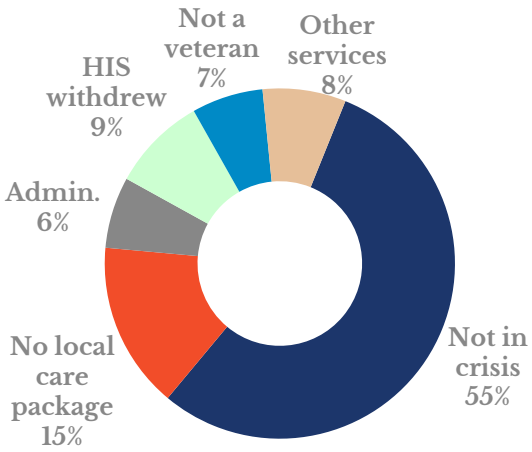
After an initial assessment appointment with HIS, **27 patients were considered to disengage from their course of treatment**. Just over half of these patients (*n*=15) actively refused help and/or asked HIS to withdraw. Reasons cited included feeling overwhelmed by the number services involved in their care, general disillusionment with healthcare teams, and wishing to manage their treatment themselves.

The remaining 12 patients who disengaged all failed to respond to repeated contact attempts. Around half of these patients had a history of poor engagement with healthcare services. However, there were insufficient data to draw any firm conclusions on factors that may predict disengagement.

The majority of all patients who disengaged did so before their fourth appointment (70%; *n*=19).

3.7 Referrals Not Meeting Criteria

Ninety-one referrals did not meet the criteria for treatment. In 70% of these cases, **not being in crisis and/or not having the required local package of care in place were the primary reasons**. Whilst these factors often occurred concurrently, it was possible for a person to be in crisis but not have the required package of care in place, and vice versa.



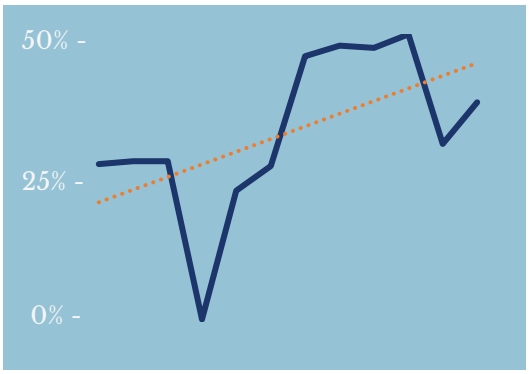
It is noteworthy that HIS team members on several occasions took on a care coordination role to ensure that veterans in crisis were in receipt of, or continued to have, a local care package to fulfil HIS eligibility. Similarly, the Service was frequently willing to provide veteran-sensitive scaffolding and advice to professionals regardless of whether referrals resulted in treatment from the Service itself.

Eight patients had treatment withdrawn by HIS and remained under the care of other services. Despite being initially accepted for treatment, these patients are included in this section as, unlike those who did not complete treatment, HIS withdrawal was not the patient's decision.

Three of these patients were under a Section 2 Mental Health Act 1983 (MHA) admission and one under a Section 3 MHA admission at time of referral. In all cases, it was decided that there was no suitable role for the Service and that ending involvement was the most clinically appropriate action to avoid complicating the multiagency care packages already in place. One other patient was subject to a Section 3 admission during treatment and HIS withdrew on the same basis. Two patients with ongoing substance misuse were deemed not to be capable of engaging effectively with the Service. The final patient was discharged back to a combination of crisis services and CMHT as there was no clear role for HIS.

There was no clearly identifiable role for HIS in seven referrals, where patient needs could or were being met effectively by other services. Five referrals that were meant for TILS or CTS were made to HIS in error, and one had incomplete paperwork.

Six referrals were of individuals who were not UK veterans: three were still actively serving; and three were veterans of non-UK armed forces. There were no instances of patients shown to have made a false claim of veteran status. However, it is worth nothing that a small number of patients had military service recorded on their historical healthcare records which was found to contradict their official proof of military service once obtained by HIS.



The proportion of referrals not meeting criteria each month increased over time, peaking at 50% (*n*=11) on August 2021. Although absolute numbers for individual referring sources and Trusts are too low to draw

accurate inferences, it is worth noting that **half of all referrals from third sector organisations did not meet the criteria for treatment.**

Not including referrals returned to the original referrer, HIS most frequently signposted patients not meeting criteria for treatment to TILS (*n*=22).

CASE STUDY: KYLE*

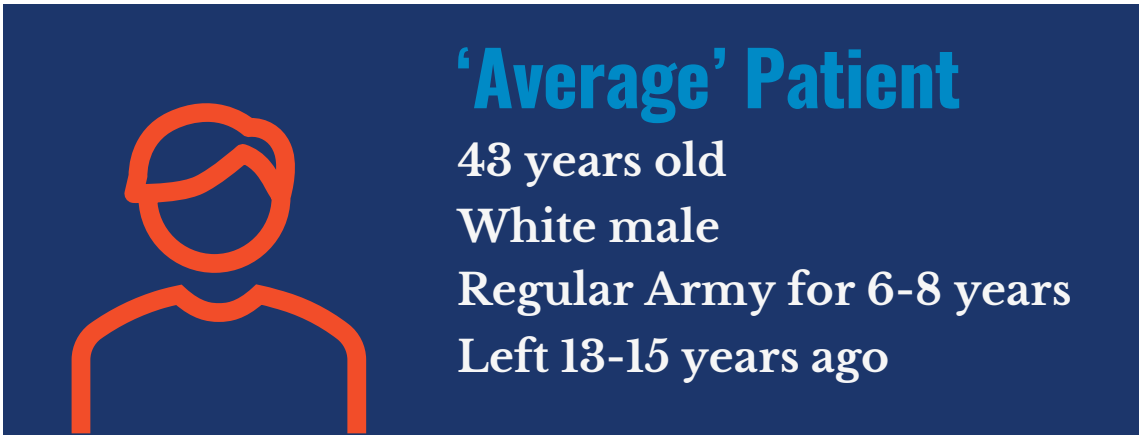
I didn't have the best childhood to be fair, but I just got on with it. I want to be the best dad I can be, but when the baby was born I just seemed to snap. I just felt I was bubbling for a fight the whole time, the pressure in my head was too much. I felt like a failure, angry at everyone and I didn't trust myself to keep safe.

I loved being in the Forces and really I've felt lost ever since I left. I felt like HIS really got it and understood me. The clinician helped me get hold of my emotions better and speaking with a VLSO who had served as well, helped me feel listened to and understood. They even sorted me out with a new bike to help me get to and from work quicker, so I can be at home with the wee one more easily. I only know my girlfriend's family round here, but they've put me in touch with some other lads in the area who served around the same time as me. A few of them have wee kids too, so I might pick up a few skills and drills from them.

I'm not ready to talk about what happened to me when I was a kid, but the HIS team helped me feel in control and have put me in touch with some places when I feel the time is right. For now, I can just concentrate on being the best dad I can.

4. RESULTS: Patient Profiles

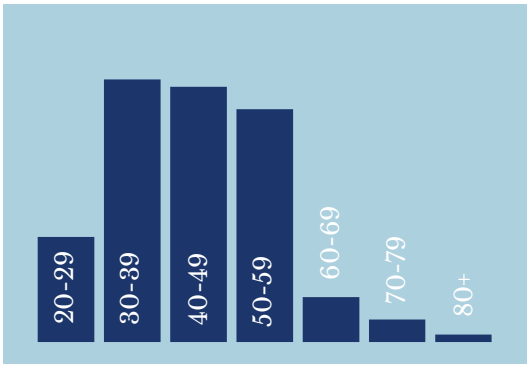
A variety of demographic data including personal, family and military service details, as well as information on crisis and wider health factors were coded and analysed. It is important to consider that the referrals in the evaluation period are specific to the period of time in question. Therefore, caution is encouraged when interpreting these descriptive results and the temptation to draw conclusions beyond the scope of the study. The figures presented are for patients who completed treatment only.

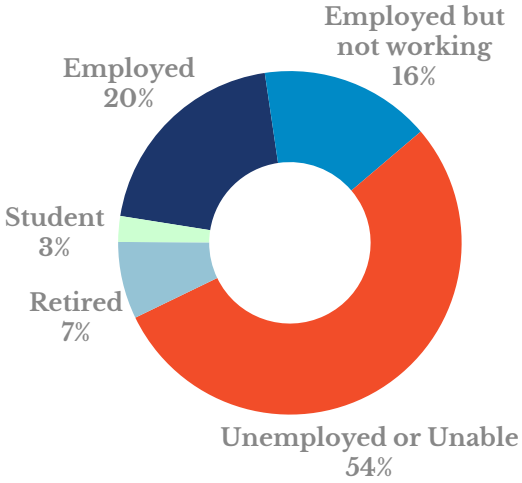


4.1 Personal Characteristics

Patients ranged from 20 to 80 years old, with **the majority aged in their 30s or 40s** at time of referral. Although current estimates state two-thirds of the general UK veteran population are over retirement age,[1,24] only 5% (*n*=6) of patients completing treatment with the High Intensity Service were over 65 years old.

Only 8% of those completing treatment with HIS identified as female, and 6% did not identify as White (British, Irish or otherwise categorised).





Over half of the patients who completed treatment were unemployed or unable to work (*n*=67), with a further 16% classed as employed but on sick leave or furlough at time of referral (*n*=20).

The majority of patients served in the Army (82%; *n*=102), with Royal Navy and Royal Air Force service comprising 15% jointly. Three patients served in the Royal Marines and one was a civilian foreign national who had worked on operations with UK Armed Forces.

Length of military service varied from under a year to 38 years. **Over two-thirds reported being in regular service for up to 10 years** (72%; *n*=88). A fifth of patients were classed as early leavers (22%; *n*=27), defined as having left the military before completing four years of service.

Time since leaving military service similarly varied from a few months to over half a century. **Three quarters of regular service personnel left the military within the last 20 years** (75%; *n*=85), with around half of those leaving in the past decade.

There were insufficient data on rank at point of leaving military service to provide an analysis. In addition, only 51% of patients had the reasons for leaving the military stated on their clinical records (*n*=63). Within this group, around a half were medically discharged (53%; *n*=33). Voluntary and non-voluntary discharge from military service each represented around a quarter (24%; *n*=15).

CASE STUDY: SARAH*

The pandemic was tough in so many ways, but losing my job was the final straw. I already had problems with my ex-partner and I didn't feel safe any more. I already had CMHT visiting me, and they could see I was near breaking point.

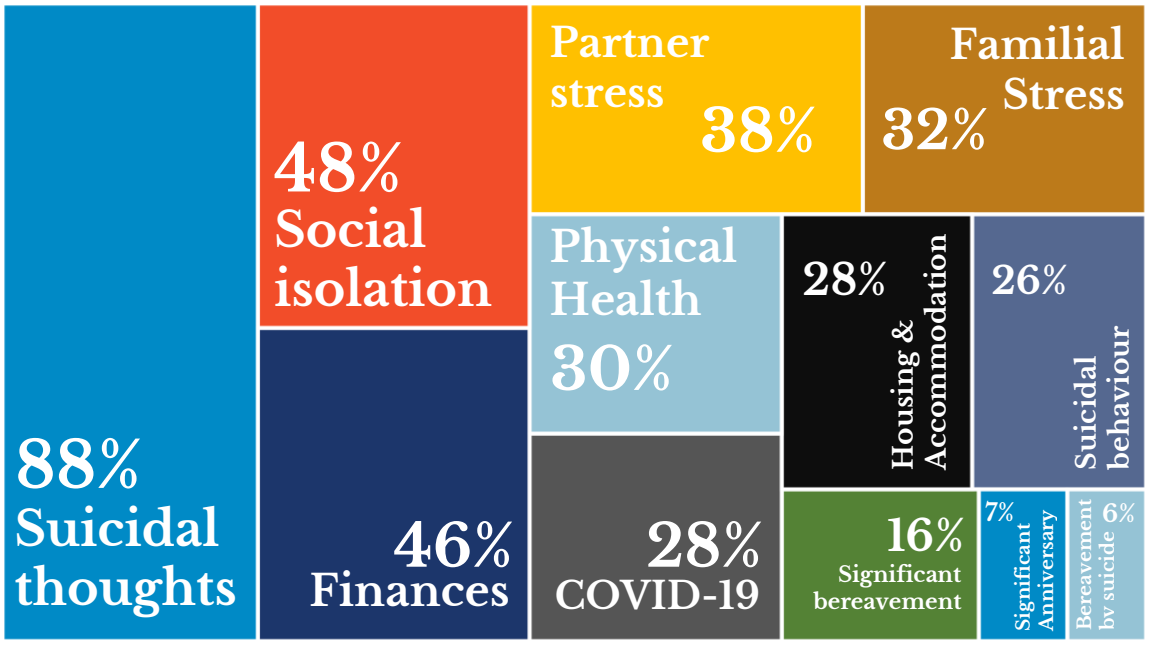
HIS were a lifeline. They helped me and my son find somewhere safe to stay so I could get things sorted. They put in me touch with organisations that could offer help with the legal side of things as well. They've also got me an employment advisor to work out what I can do next.

They helped me learn to better manage those moments where I suddenly felt overwhelmed by everything and felt like there was a threat around me all the time. I really felt like I could trust them knowing they understood some of the things I had been through. I feel so much more in control of everything that is in front of me now, and there are people who can help longer term.

4.2 Stressors Underpinning Current Crisis

Stressors potentially underpinning crisis and the problems facing patients are presented. Due the High Intensity Service not being a diagnostic service, the data should be taken only as an indication of what factors that were most salient to both the patient and clinician.

The figures presented are for patients who completed treatment only. Those who did not complete or have their treatment ongoing (and may therefore be in the early stages) are omitted, as it cannot be confidently stated their presenting and medical profiles have been fully explored and recorded.



Patients may endorse multiple stressors

Active suicidal ideation was endorsed by 88% (*n*=109) of those who met criteria for inclusion at time of referral. As being in or at risk of mental health crisis was a prerequisite for treatment by HIS, this figure is perhaps unsurprising. By comparison, suicidal behaviour related to current crisis was endorsed by a smaller proportion of patients (26%; *n*=32) (see 5.3).

Social isolation, financial stress, and problems in relationships were the most salient stressors in the current crisis for patients. In addition, **patients typically endorsed multiple crisis factors**, with the highest proportion of patients identifying three (24%) or four (20%) factors requiring intervention by the HIS team.

4.2.1 Relationship Stress

Problems in relationships was reported by more than half of patients (56%; *n*=69), making it the most widely reported factor other than suicidal ideation.

The causal relationship between this factor and the current crisis cannot be accurately inferred; it may be both the cause and result of patients' crises. Furthermore, problems in relationships can be characterised in a number of ways including relationship breakdown, ongoing tension, and carer strain. For the purposes of this report, problems in relationships were split into two sub-categories; partner stress and familial stress.

Partner stress (stress between the patient and a significant current or former partner) **was reported in almost**

two-fifths of cases (38%; *n*=47). Half of the patients completing treatment considered themselves to be in a significant relationship of some sort. This includes those actively undergoing separation at time of referral. Partner stress was proportionally highest amongst those currently in marriages/ civil-partnerships and those who reported actively undergoing a separation. However, the absolute numbers were low, so caution against over-interpreting proportionality is advised.

Wider **familial stress**, for example relationships with parents or children, was also **endorsed in around a third of cases** (32%; *n*=40).

It is worth noting that **additional input from the HIS team was recorded as being offered to patients' families in 47 cases**. This input was offered in about half of cases where the patient was considered to be in a relationship (56%; *n*=35) and went beyond standard advice in 16 cases, and most typically involved signposting to other support services such as Ripple Pond. An additional VLSO for the partner or family member was offered in four cases.

4.2.2 Social Isolation

Social isolation was reported by almost half of all patients (48%, *n*=59), of which a third of those considered the impact of COVID-19 restrictions as noteworthy. Whilst the impact of the pandemic may have resulted in increased social isolation for some, an inference of a baseline need for increased social connectedness can be made amongst the patient group.

4.2.3 Financial Stress

Financial stress was particularly widespread (46%; *n*=57) and appeared to stem from a number of causes including under- or unemployment, complications with the benefits system, and historical debt. It is worth noting that of those expressing concern over finances, 60% were unemployed and a further 18% were on sick leave or (temporarily) not working at time of referral, in line with the overall employment figures for those completing treatment (see 4.1).

4.2.4 Health

Physical health problems were reported as a salient factor for 30% of patients and included a variety of conditions. **Two-thirds of this group** (65%; *n*=24) **and a third of patients overall, reported living with chronic pain**.

4.2.5 Other Stressors

The list of stressors is not exhaustive, as patients reported in smaller numbers idiosyncratic stressors and/or stressors related to point-in-time. For example, contemporaneous problems with the criminal justice system were salient for eight patients who entered treatment, five of whom completed at time of recording.

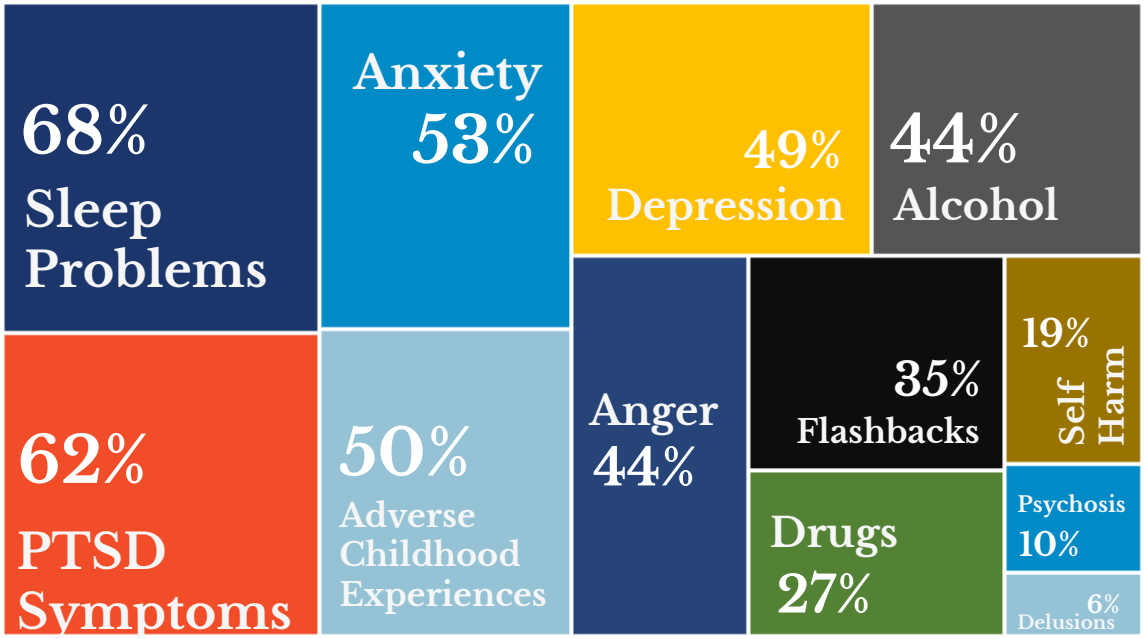
Although the numbers are small, there was a slight increase in referrals in the weeks following the UK withdrawal from Afghanistan in August 2021, with six patients accepted for treatment (three of whom have treatment ongoing) mentioning the withdrawal as a trigger of crisis.

Due to the nascent status of the Service at the time, it is not possible to say what impact national anniversaries such as Remembrance Day, or Bonfire Night acting as crisis triggers may have on the volume of referrals.

4.3 Presenting Problems

Problems potentially acting as predisposing or perpetuating factors for both the current crisis and wider negative health outcomes are presented. Due the High Intensity Service not being a diagnostic service, the data should be taken only as an indication of what factors that were most salient in patient records, biopsychosocial formulations and endorsement by the patient. The factors examined were informed by the existing research corpus on veteran mental and physical health.

The figures presented are for patients who completed treatment only. Those who did not complete or have their treatment ongoing (and may therefore be in the early stages) are omitted, as it cannot be confidently stated their presenting and medical profiles have been fully explored and recorded.



Patients may endorse multiple problems

Problems with sleep, post-traumatic stress disorder symptoms, anxiety and depression were all frequently endorsed by patients who entered and completed treatment. **Half of the patients presented with between four and six problems** (50%; *n*=62). Due to the small overall numbers, and the variation in reporting methods, it is not possible to draw any conclusions beyond levels of incidence.

4.3.1 Sleep & PTSD

Two-thirds of patients endorsed experiencing sleep problems (*n*=84) which included night terrors, and disturbed or reduced/ excessive sleep.

PTSD symptomology was also frequently reported (*n*=77). Care was taken during data extract to adjust for evidently erroneous historical reports in the medical records. However, it is possible that PTSD symptoms were overreported, as confirmation of symptoms was inferred by prior medical diagnosis, self-reported symptoms or presenting symptoms identified during treatment. It was not possible to further categorise PTSD symptoms as resulting from service or wider lifetime trauma (see 5.1).

Although absolute numbers are low, it is of note that disordered sleep was reported in three-quarters (77%; *n*=59) and flashbacks in almost half (48%; *n*=37) of those also reporting PTSD symptoms. Furthermore, PTSD symptoms co-occurred in two-thirds of all cases where personality disorder was

diagnosed or potentially clinically indicated (*n*=12).

4.3.2 Anxiety, Depression & Anger

Anxiety (*n*=66) **and depression** (*n*=61) were both widespread amongst the group and **co-occurred in around half** of all presentations of either problem (53%; *n*=44). Anger or emotional dysregulation was also viewed as salient for a notable proportion of the population (*n*=54).

4.3.3 Adverse Childhood Experiences

Half of veterans made disclosures of adverse childhood experiences to healthcare services, including HIS (*n*=62). Unlike the wider research field, this study defines adverse childhood experiences (ACEs) more narrowly as the experiencing or witnessing of physical, sexual or emotional abuse, or extreme poverty whilst under the age of 18 years old. Taking this is to account, and that not all ACEs are disclosed, it is possible that this may be under-representation of the true proportion.

It is widely reported that veterans tend to report a higher rate of ACEs than compared to the general population.[27,28] However, care should be taken not to overinterpret the causal relationship between early life adversity and trauma, military service, and presentation to health services as a veteran.

4.3.4 Alcohol, Drugs & Addiction

Maladaptive use of alcohol was endorsed by 44% of patients completing treatment (*n*=55). The definition is deliberately wide-ranging and includes any alcohol-use behaviour that is deemed to be of clinical note. This includes reported excessive drinking, regularly using alcohol as a coping method, and those with alcohol dependency.

Based on onward discharge to substance misuse treatment services and informed interpretation of clinical notes, **between a quarter and a third of patients endorsing maladaptive alcohol use are inferred as having alcohol addiction**. This represents approximately 11-15% of all those completing treatment.

Contemporaneous **drug use was reported by around a quarter of patients** (27%; *n*=33). Both cocaine (excluding crack cocaine) and cannabis were the most widely used, reported by around half of those who disclosed using substances. Two patients reported gambling addiction.

CASE STUDY: MARTIN*

I was desperate. Nothing had worked before. Drink had ruled my life for so long, it was a miracle something bad hadn't happened to me before. I ended up in hospital after I'd hurt myself, and went through detox. It was my chance for something different.

I don't know how, but HIS got me a place at a residential treatment centre and some funding from my old Regimental association. It's a long course and the other lads seem ok. I was nervous about going but it's going well so far.

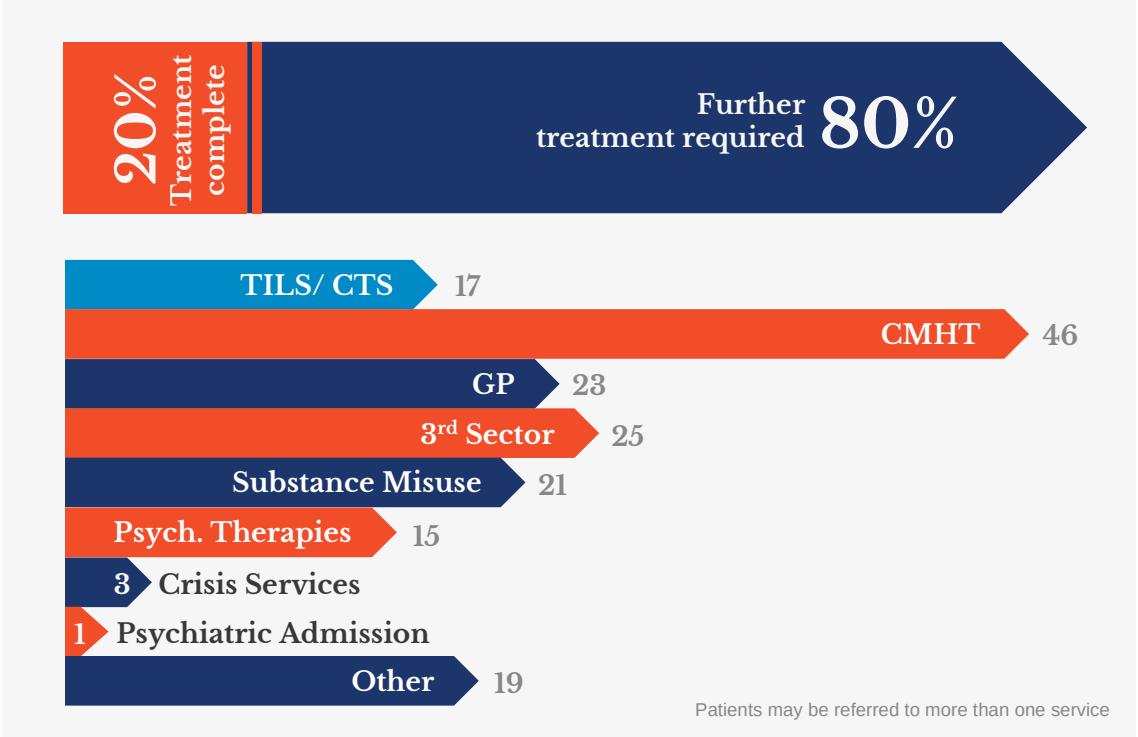
HIS still check in to see how I am doing whilst I'm here on the course and have suggested places I can go for help once I'm done here. I really want to invite them to my graduation in a few weeks.

5. RESULTS: Discharge & Impact

5.1 Onward Referrals After Treatment

The High Intensity Service is designed to be an add-on service, providing additional veteran-informed care at or near time of crisis. As such, it is expected that some patients may continue treatment with other services on discharge from HIS.

Discharge letters were used to gauge onward treatment pathways for those patients who completed HIS treatment. Information was available for all but one patient. The information in these records may not be exhaustive and may fail to mention additional referrals from concurrent services involved in a patient's treatment.



Whilst patients could be referred to multiple destinations, the majority (90%; *n*=111) were referred to just one or two services.

Seventeen (14%) patients completing treatment were discharged to the sole care of their GP. Another seven patients receiving referrals to their GP and third sector organisations (not including drug and alcohol services). These discharge paths imply that no further formal clinical treatment was required for this group.

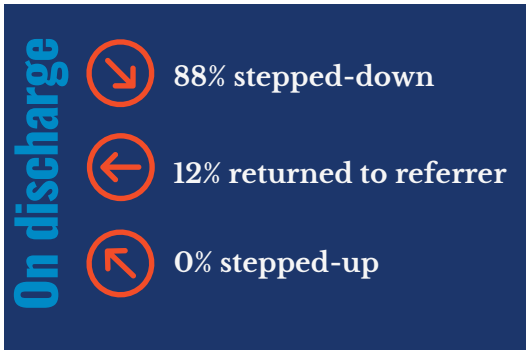
By this metric, **80% of patients were referred for ongoing healthcare support after treatment from HIS was completed** (*n*=99).

Seven patients were referred onward to TILS and 10 to CTS for additional treatment, although these figures do not reflect any past contact with either veterans' service. Therefore, of those requiring ongoing treatment after discharge from HIS, **the majority were discharged to general, rather than veteran-specific, health services** (83%; *n*=82).

46% of patients requiring onward treatment were referred to CMHT (*n*=46). Twenty-one patients were referred to NHS or private drug and alcohol services.

5.2 Impact of HIS Treatment

Due to the large variation in patient presentations it is difficult to effectively quantify clinical changes in the patient sample. However, by comparing referral sources and discharge documents it is possible to infer whether a patient's level of care (and risk) has changed.



By this metric, **88% patients had their care stepped-down on discharge from HIS after completing treatment** (*n*=108). Only 15 patients were discharged back to their referrer, whilst no patients completing treatment were considered to have their care stepped-up on discharge from HIS.

Despite being returned to the care all the original referrer, at an individual level some of the 15 patients also had their comparative level of care stepped-down. Twelve of these patients were discharged back to CMHT, whilst the rest were returned to the care of crisis services. Of the three patients returned to crisis services, one was classed as having their care stepped-down under the crisis service provision model in their area. The second patient returned to crisis services was considered to have made minimal progress in the allotted treatment time, whilst the final patient was a highly complex case with ongoing multi-agency involvement whom HIS discharged at nine weeks having been assessed as having met the limit of treatment efficacy.

Twenty-one of the 22 patients referred whilst a psychiatric inpatient, had been discharged back into the community when HIS treatment had ended. The patient who remained an inpatient was on a lower category of ward and was considered a unique case waiting for overseas repatriation.

5.3 Admissions, Suicidal Acts & Deaths

Due to the range of patients presenting, it is not possible to accurately track how patient risk changes over treatment. However, three metrics can be used for approximate illustration: psychiatric admissions; acts of deliberate self-harm with suicidal intent; and deaths.

Nine patients were admitted to psychiatric inpatient settings *after* they were referred to HIS (7%). Two patients had a long-standing cycle of repeated psychiatric admissions and were admitted during HIS treatment. The remaining seven patients were under the care of and referred to HIS by crisis services. Of these seven patients, five were admitted to psychiatric inpatient care in the days immediately after referral to HIS, but prior to their initial in-person assessment.

In total, **eleven patients deliberately self-harmed with suicidal intent during their time with HIS** (9%). Seven of these patients had previously attempted to end their life in the twelve months prior. Only one patient of the eleven had not previously disclosed an attempt to end their life by suicide during their lifetime. However, neither of these metrics are predictive and represent

under a fifth of patients overall disclosing either behaviours.

There were no deaths of patients during treatment by the High Intensity Service. One veteran died by (probable) suicide while an inpatient for detox treatment, after an alcohol dependency relapse. Their death occurred after approximately 10 weeks of treatment from HIS and three days after discharge to the combined care of crisis services, CMHT, and addiction services. HIS has ended treatment due to the complex nature of the case, the multiple agencies involved and better placed to manage clinical need and risk, as well as an absence of veteran-specific needs. Direct contact with the patient was sporadic during the final two weeks of engagement due to repeat hospital admissions.

A second veteran was referred to HIS, and did not meet criteria for treatment as they were viewed to not be in crisis. A referral to TILS was deemed more appropriate. They ended their life around five weeks later whilst under the care of local crisis services having demonstrated poor engagement.

CASE STUDY: JOE*

I've struggled with my mental health for a long time and ended up being 'sectioned' earlier this year. I spent two months on a mental health ward and although I felt better and ready to leave, all those things I hadn't had to deal with for a while just felt terrifying to me. Home. Bills. Money. Seeing other people.

HIS visited me when I was still on the ward and took the time to listen to who I was. They came with me on some of my days outside the hospital, and I felt really supported. I didn't know that because I had been in the military, there was more help out there for me.

They helped make sure my flat was suitable to live in after I'd been away for those months, as well as making sure my benefits and bills were right. They even arranged for some food parcels to tide me over.

It was great to have familiar faces visiting and helping me once I was back home. They totally understood my fears and worries and helped me to feel like things were going in the right direction. Knowing that both of them had served as well was really good – they got my sense of humour and told me things straight which is how I like it.

I was sad when my time came to and end, but I feel much more prepared to deal with my recovery now I'm back home and I've made contact with other veterans who have had similar experiences. They've made me realise it's ok to ask for help and there are lots of people out there who want to help too.

6. OBSERVATIONS & CONSIDERATIONS

The findings in this report represent a snapshot in time over the first year in operation of the North of England Veteran's Mental Health High Intensity Service. Care has been taken to present the results in an objective manner, and as such caution should be exercised in interpreting the results beyond their descriptive use. It is credit to the high treatment completion rate, that there is an insufficient number of patients who did not complete treatment to confidently make any predictions on factors influencing whether a patient is likely to withdraw or disengage.

In addition to describing the patient population through examination of all available patient records, the authors are positioned to respectfully make a number of observations and present some topics for further consideration.

6.1 Observations

Significant acknowledgement should be made of the completeness of the original data. This is particularly noteworthy for a Service in its early stages, spanning a large geographic area, and multiple NHS Trusts and partners.

So too must attention be drawn to the **dedication and flexibility of care** provided by the HIS team, which consistently appears responsive and adaptive to the needs of their patients. The HIS model requires a highly bespoke approach to individual care, and it clear from the patient records that the HIS team consistently strives to find the best-fit model of care in each case. HIS appears to be run on an inclusion-first basis with staff often working to ensure referrals meet the criteria for treatment so patients were not left without appropriate care.

The use of **veteran-informed staff**, anecdotally appears to **positively foster therapeutic and trusting relationships** with the patient group. This is inferred in part by the low disengagement/ non-engagement rate. In a number of cases, patients reported that their interaction with HIS was the first time they had felt understood and listened to over the course of repeated interactions with healthcare services. Furthermore, the veteran-informed expertise was recorded as being of benefit in inter-disciplinary and team relationships, where HIS took on a care coordination or advisory role in patient care.

This **expertise and approach demonstrated additional benefits**. For example, it was not uncommon to find military service reported erroneously on historical healthcare documents; the wrong branch or service details having been recorded. By HIS requiring proof of military service to be provided, many of these errors can be corrected. Not only can this be of importance to the identity and self-esteem of the veteran in question, but can also build a more accurate picture of their life history which can have vital importance in safeguarding and treatment contexts.

The **advantage of the Service's large geographic footprint** coupled with local knowledge is clear for patients who may move location or sit 'between' other services. Moreover, the strength of HIS being connected to a nation-wide network was also evidenced in the case of one patient. As an inpatient on the verge of discharge in the North of England, their initial request for help was posted on an online forum administered by a third sector organisation involved in a separate High Intensity Service in a different part of the country. That organisation was then able to refer the patient to the North of England HIS directly, ensuring the veteran received the assistance they required, who would

otherwise have potentially gone without veteran-specific care.

The **positive benefits of the Service considering the wider familial context** of a lot of patients was noteworthy, as well as the diligence in making safeguarding referrals where indicated.

6.2 Considerations

The authors acknowledge that the topics offered for consideration are presented from a detached position of review, and that despite the thorough access to patient records granted in the course of this evaluation, may not fully reflect the experience of the Service team in practise. Nonetheless it is hoped that they serve as a starting point for meaningful discussion that may be of utility in the continued development of the High Intensity Service.

6.2.1 Consideration 1: Standardisation of Discharge

The cohesiveness of care from the Service against the challenge of a large geographic area, multiple NHS Trusts, and during a pandemic is of striking. The use of updated biopsychosocial formulations, and bespoke referral and assessment forms provides clear consistency across the Service.

Nonetheless, significant variations did exist in part. There was no observable **standardisation of discharge** letter across the Service. Whilst this may be the result of individual NHS Trust policies or requirements, some discharge letters on completion of treatment included full clinical formulations, whilst others merely detailed the time in treatment and a brief description of interventions completed.

Similarly, referral documents were not always proven to be accurate once a therapeutic relationship was begun. Whilst this is to be expected, CareDirector forms were not always updated to hold the most accurate information. Although this may not directly impact on patient care, it may impact future audit processes.

Clinical notes frequently reflected that veterans were unsatisfied of the need to **repeatedly recount their histories to different professionals**. This is of note considering the high rate of onward treatment indicated on discharge from HIS (see 5.1), the depth of information often shared with HIS, and the stated aim of the Service to provide a 'fully integrated pathway for veterans within secondary services'.[29] The High Intensity Service is often the first veteran-aware service with which the patient has come in to contact, and HIS documents such as Annex A-Veterans Universal Assessment are a rich source of information, much of which is being collated in one place for the first time. It should of course be noted that these circumstances are not unique to veterans or the High Intensity Service, and are a common complaint from patients accessing support for chronic mental health difficulties in general.

It is understood by the authors that the Service is not designed to provide patient diagnoses, and the interventions offered are often transdiagnostic in nature. Proportionally few patients are referred on discharge to veteran-specific NHS services such as TILS and CTS. Therefore, HIS is uniquely placed to facilitate targeted onward referrals to appropriate general services than can more accurately meet the needs of veterans. As part of this approach, HIS is also placed to provide support and advice to these services, to enhance their understanding of the veteran-specific nature and needs of those patients presenting.

With these factors in mind, it may be worth considering whether discharge information could be standardised, or enhanced in a similar vein to the Veterans Universal Passport[30,31] so as to facilitate continuity and applicability of onward care.

6.2.2 Consideration 2: Integration and Relationship with Local Services

Overall, there appeared to be positive integration with local crisis and healthcare services. However, on several occasions it was noted that **local crisis services did not fully understand the need for their continued involvement** to manage risk as a prerequisite for engaging the High Intensity Service. A number of comments are on record questioning whether there was a duplication of resources and input previous provide by local services once HIS became involved. In one case, this confusion appeared to influence the onward discharge from HIS.

There are understandable variations in crisis and local service provision across the HIS area. However, at times it is unclear what protocol is in place when local services end their involvement and risk requires further external management, whilst HIS treatment remains ongoing. This is particularly pertinent in cases where local services appear keen to discharge once HIS become involved in patient care, or when referral is made to HIS near to discharge from an existing service.

It was observed that HIS stated on several occasions that referrals to the Service should ideally be made as early as possible for psychiatric inpatients, so as to promote HIS inclusion in inpatient discharge planning. Although it would be hoped that local services become more aware of how and when to engage HIS, it may be worth further considering and clarifying the communication of when and how HIS (ideally) dovetails with other services in various patient scenarios.

6.2.3 Consideration 3: Treatment Pathways

There was a lack of detailed information in the patient records of the therapeutic interventions delivered to each patient. However, given the high incidence of some stressors and problems (see 4.2 and 4.3), it is of interest how the current interventions offered to patients relate to these findings, and indeed whether **some interventions could be of benefit if offered universally**, such as active intervention on poor sleep.

Although this report was unable to discern any significant effects on patient treatment time or outcomes for those presenting with particular stressors or problems, it is apparent that some groups of patients have slightly differing core needs. Therefore, the Service may wish to examine whether **distinct pathways and timescales** are of utility for different groups of patients.

For example, discharge and transition facilitation is particularly salient for psychiatric inpatients. Similarly, securing and funding placement in detox and rehabilitation programmes is of primary importance for patients who wish to address substance misuse. For these patients, HIS has also been observed on occasion to remain distally involved in their care for a prolonged period of time, so as to mitigate any potential risks associated with possible disengagement from substance misuse treatment programmes.

6.2.4 Consideration 4: Outcome Measurement

Finally, it is worth considering how best to **measure the impact of HIS treatment at both an individual and population level**. Although this report has highlighted a number of common problems and stressors, there is enormous variation in the presentation of the patients referred to the Service.

Currently Outcome Star™ is used as a measure of an individual's level of functioning across multiple dimensions throughout treatment.[32] The self-report scales provide a subjective view of the patient's situation and comprise part of the psychoeducational component of treatment, promoting patient engagement in their treatment goals and

achievements. However, due to its subjective and individualised nature, it is not possible to use the measure to satisfactorily describe the impact of HIS treatment across all patients at population-level.

A wide-range of reliable, validated and standardised measurement tools are available that measure specific facets of a patient's presentation. As such, a hypothetical patient starting treatment with HIS could be administered separate measures for depression, PTSD symptoms, alcohol consumption, sleep behaviour, functioning and well-being, and anger at various points of their treatment. However, it may not be practical or desirable to administer a large combination of tools for an individual patient with a complex history and presentation, who demonstrates a heightened risk of overwhelm and disengagement. Furthermore, the Service is not designed to be an end destination, so little measurable change may be observed in many areas throughout the HIS treatment course.

Accordingly, it is perhaps worth considering what the stated aims of the Service are, as a value-added liaison, advice and support model as set out in the commissioning and service provision frameworks.[29] It is the authors' understanding that HIS is not designed to have clear unitary outcomes, and as such the final desired outcome will vary for each patient.

Therefore, outcomes are perhaps best measured in terms of stabilisation, the veteran's ability to regain agency and responsibility over their future actions, and continued engagement with healthcare provision. With these outcomes in mind, a further exploration of the use of a limited set of standardised psychometric measures in these areas may be of use.

This report has attempted to quantify the impact of the Service by using proxy measurements such as onward treatment pathways, suicidal acts, psychiatric admissions and mortality rates. However, it may be worth considering whether these outcomes could be more formally codified in some way on patient discharge, for example ensuring that risk ratings are entered for every patient to track their trajectory on referral, during treatment and on discharge. Indeed, if distinct HIS treatment pathways are identified (see 6.2.3), it may be the case that finer-grained outcome measures can be created for each specified pathway.

7. REFERENCES AND NOTES

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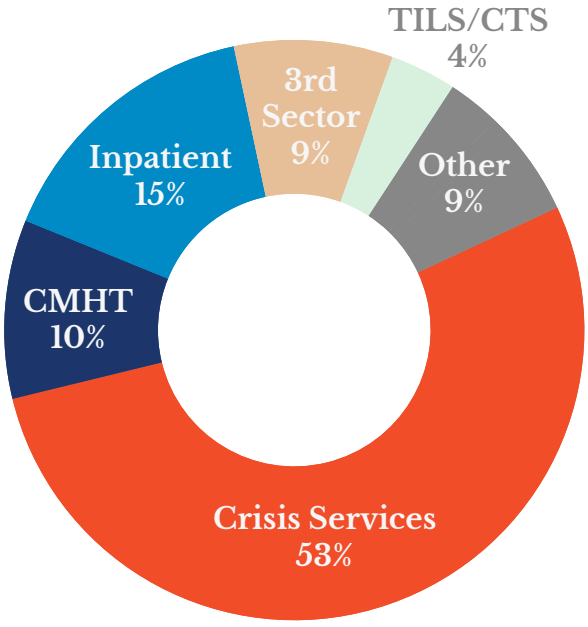
32 Justice Star™ ©Triangle Consulting Social Enterprise Ltd. See www.outcomesstar.org.uk for full details.

8. APPENDIX – FIGURES & CHARTS

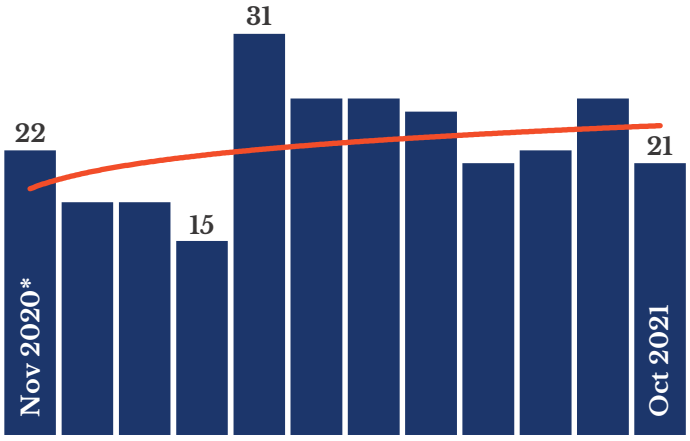
The figures in this report are presented separately in the order they appear in order to facilitate their use outside this report. Some formatting modifications have been made to ease usability.

High Intensity Service Referral Sources



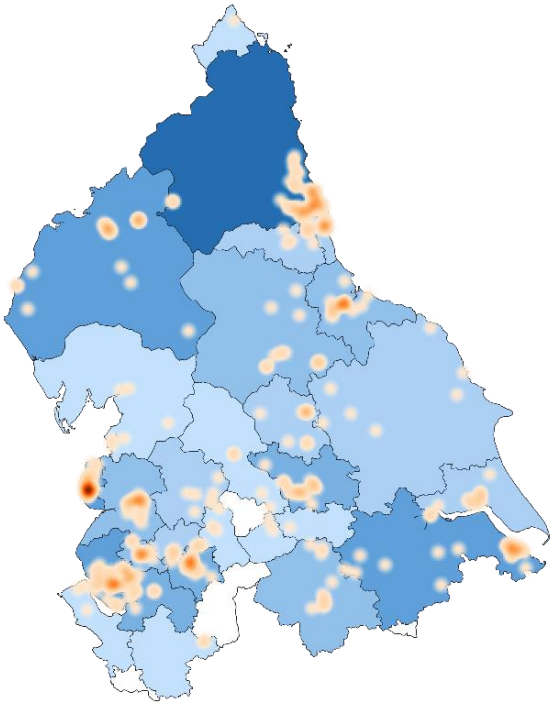
All referrals 29 October 2020 – 30 October 2021. 271 separate referrals. 254 unique individuals.
12 individuals were referred twice. Two individuals were referred thrice.
'Other sources' include A&E psychiatric liaison services, GPs, word-of-mouth, local authority services, and non-psychiatric inpatients. 'Inpatient' are psychiatric inpatient services, including crisis houses.

High Intensity Service Referrals over time



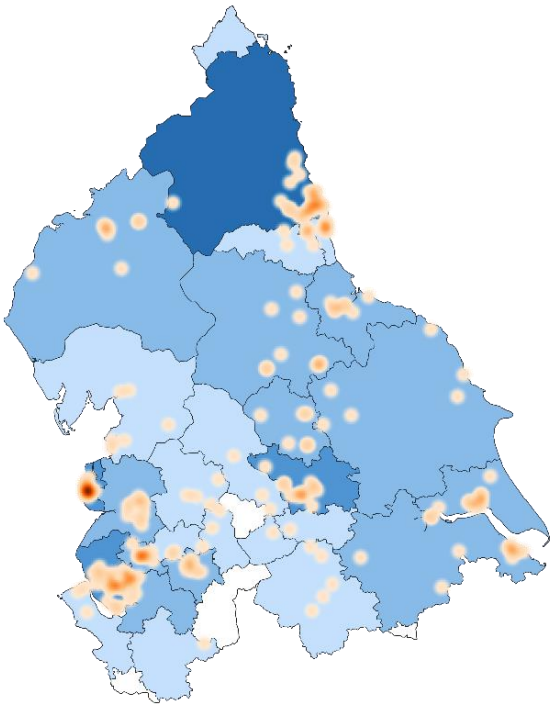
*includes one referral on 29 October 2020. 271 separate referrals. 254 unique individuals.
12 individuals were referred twice. Two individuals were referred thrice.
Peak of 31 in March 2021. Adjusted average of 21 referrals per month.

Geographic Distribution of All Referrals



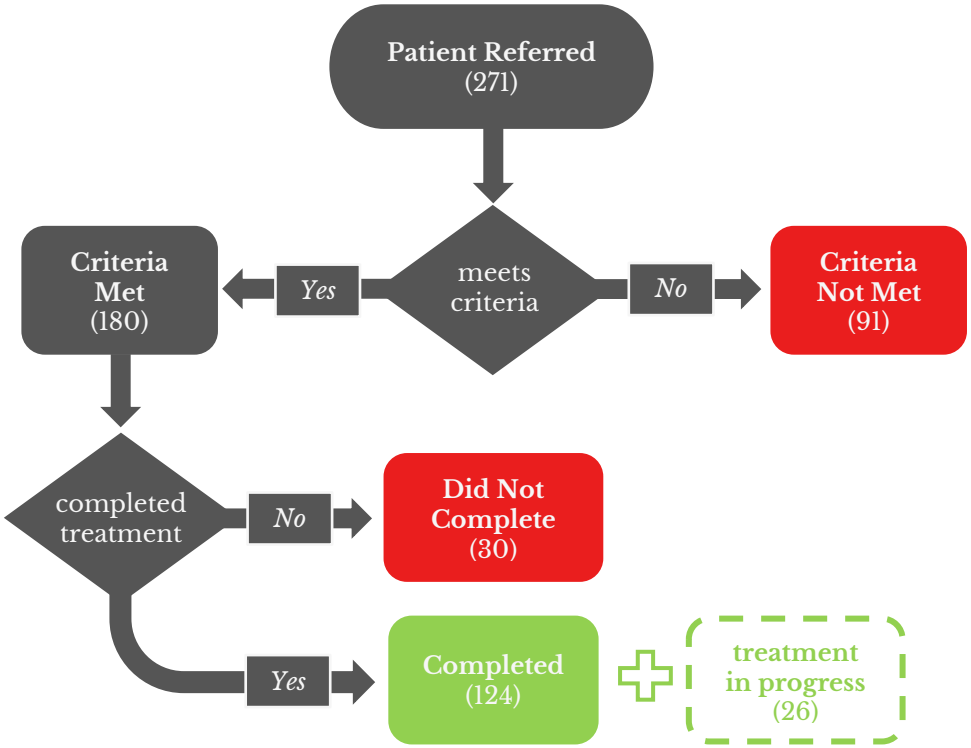
Primary address for 268 referrals. Data not available for three referrals with 'no fixed abode'.
Darker blue shaded regions represent increasing volume by Royal Mail postcode area.
Heatmaps shown at 5km radial spread using Royal Mail postcode sectors. Darker shading indicates greater overlap/ density.

Geographic Distribution of Referrals Leading to Treatment



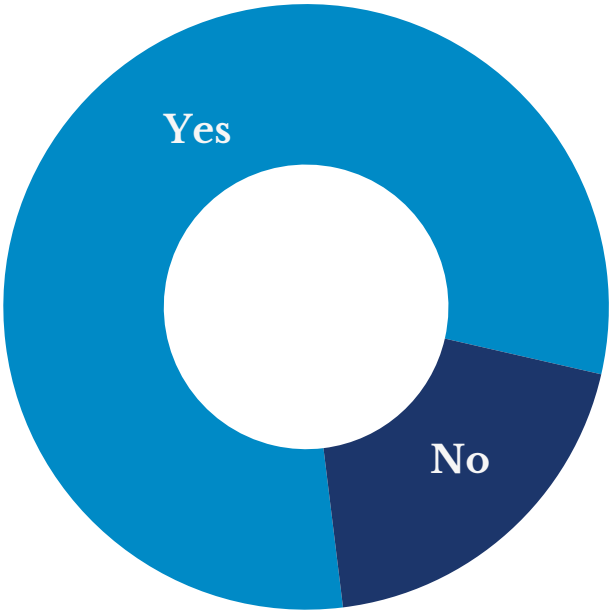
Primary address for 178 referrals. Data not available for two referrals with 'no fixed abode'.
Darker blue shaded regions represent increasing volume by Royal Mail postcode area.
Heatmaps shown at 5km radial spread using Royal Mail postcode sectors. Darker shading indicates greater overlap/ density.

High Intensity Service Patient Pathways



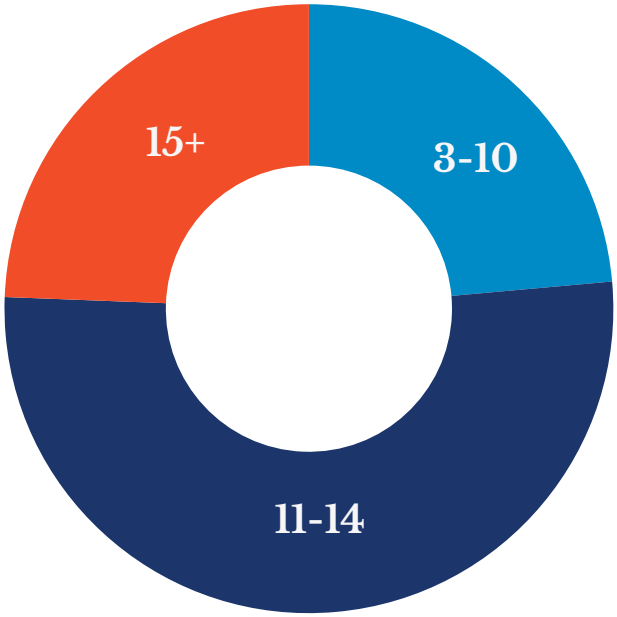
All referrals 29 October 2020 – 30 October 2021. Data as at 01 December 2021. 271 separate referrals. 254 unique individuals. 12 individuals were referred twice. Two individuals were referred thrice.
'Criteria Not Met' includes patients who were assessed by HIS and subsequently deemed not to meet criteria at any point in treatment.

High Intensity Service Patients Completing Treatment



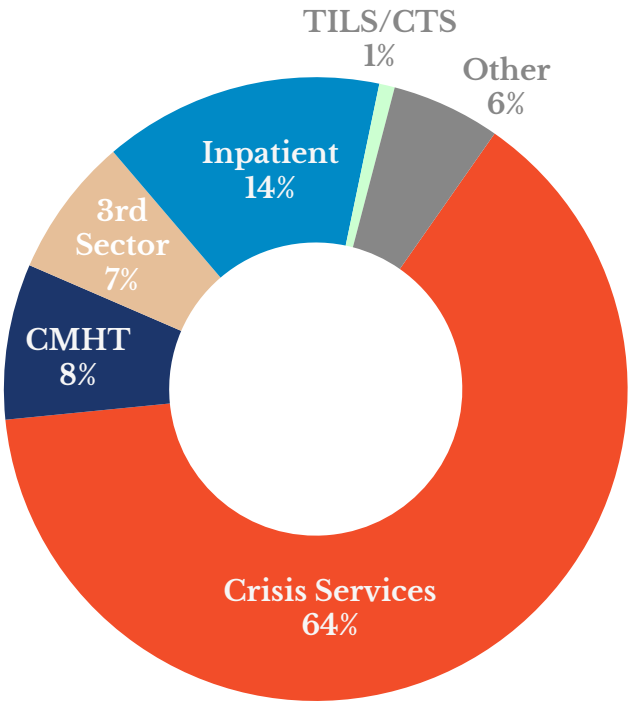
81% of patients completed treatment (*n*=124). 154 patients in total, does not include those classed as 'treatment ongoing (*n*=26). Reporting period: 29 October 2020 – 30 October 2021. Data as at 01 December 2021.

Weeks Spent in Treatment



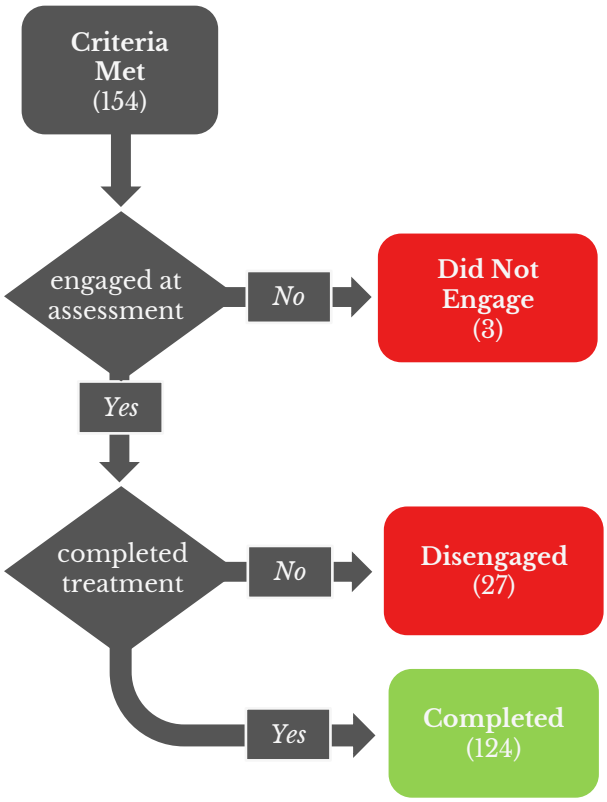
Data for 123 patients completing treatment. Time taken between first and last appointments. Does not include those classed as 'treatment ongoing'. Reporting period: 29 October 2020 – 30 October 2021.
Data as at 01 December 2021. 3-10 weeks, *n*=29; 11-14 weeks, *n*=64; 15+ weeks, *n*=30

Referrals Sources for Patients Completing Treatment



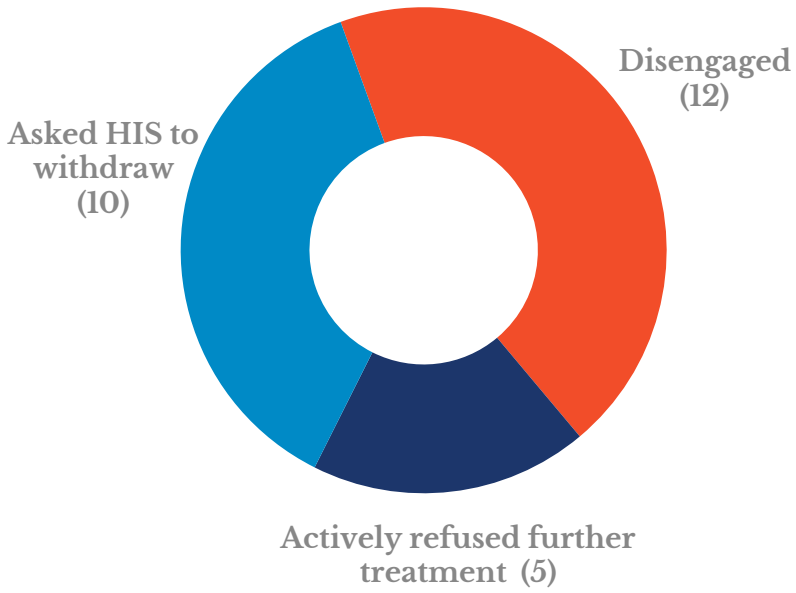
124 separate patients. Does not include those classed as 'treatment ongoing'. Reporting period: 29 October 2020 – 30 October 2021.
'Other sources' include A&E psychiatric liaison services, GPs, word-of-mouth, local authority services, and non-psychiatric inpatients. 'Inpatient' are psychiatric inpatient services, including crisis houses.

High Intensity Service Pathways
Patients Meeting Criteria for Treatment



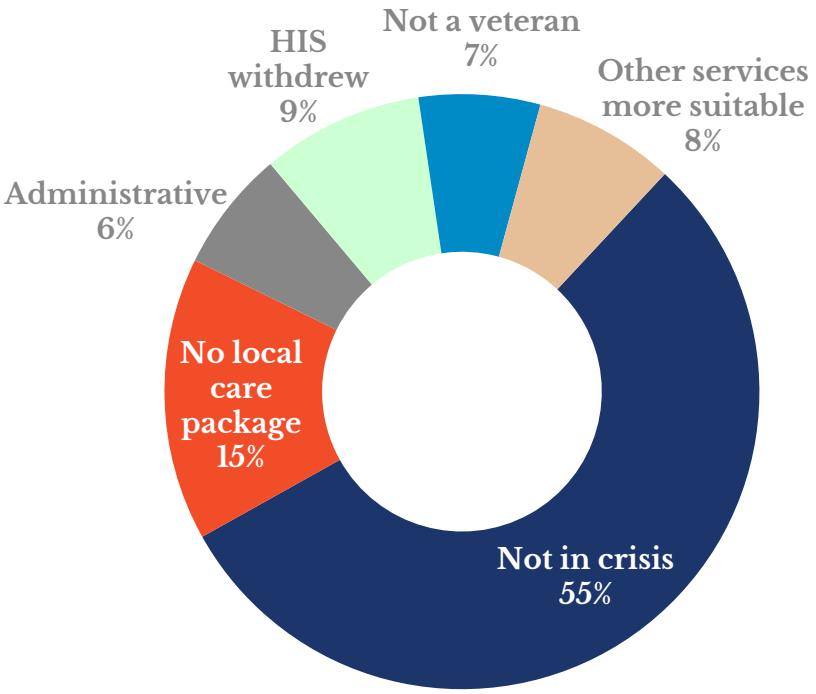
Referrals 29 October 2020 – 30 October 2021. Data as at 01 December 2021. Does not include those patients deemed to have 'treatment ongoing' at time of data extract.

Reasons for Not Completing Treatment



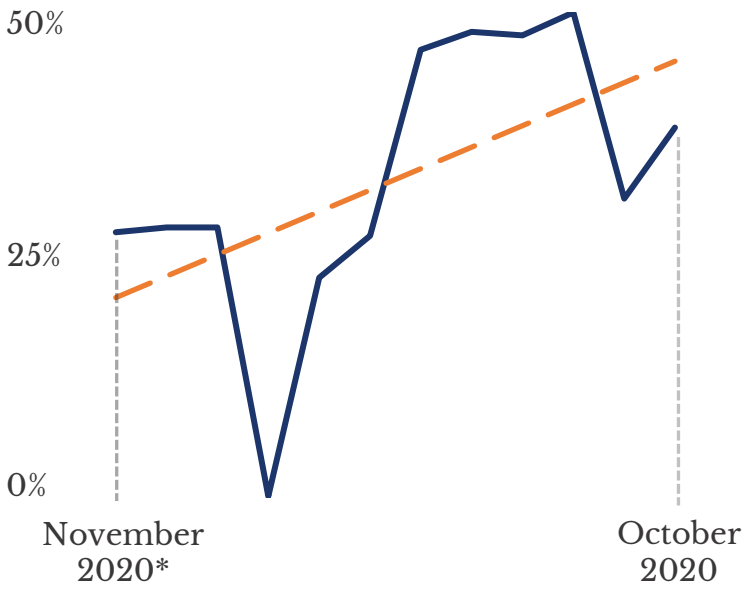
Data for 27 patients classed as disengaging from treatment. Reporting period: 29 October 2020 – 30 October 2021. Data as at 01 December 2021. 'Disengaged' signifies loss of contact with HIS/ no reply. Active refusal of treatment or requesting HIS withdraw commonly due to overwhelm at multiple service input, general disillusionment with health services, and wishing to manage their recovery without support.

Reasons for Patients Not Meeting Criteria for Treatment



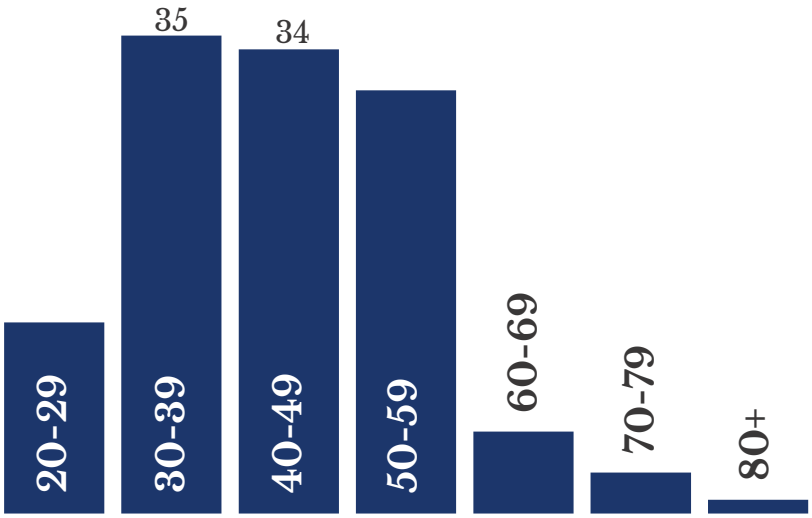
Data for 91 patients classed as not meeting criteria for treatment. Reporting period: 29 October 2020 – 30 October 2021. Data as at 01 December 2021. Some patients may have had an in-person assessment by the High Intensity Service.

Proportion of Referrals Not Meeting Criteria for Treatment



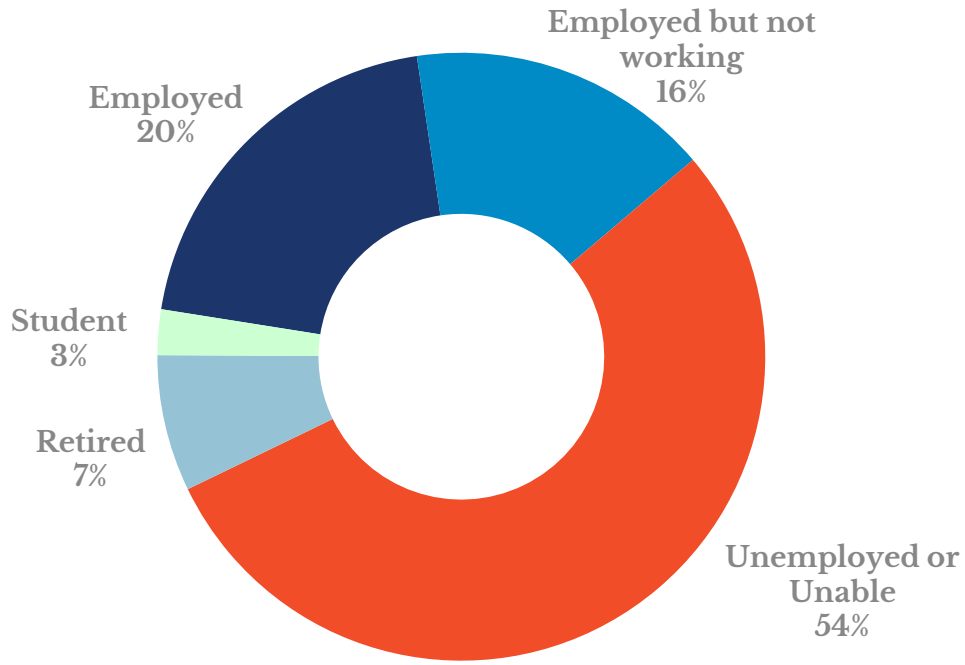
*includes one referral on 29 Ocotober.
Reporting period: 29 October 2020 – 30 October 2021. Data as at 01 December 2021.
Peak of 50% in August 2021 (*n*=11). Caution merited as absolute numbers are low.

Age in Years at Referral of Patients Completing Treatment



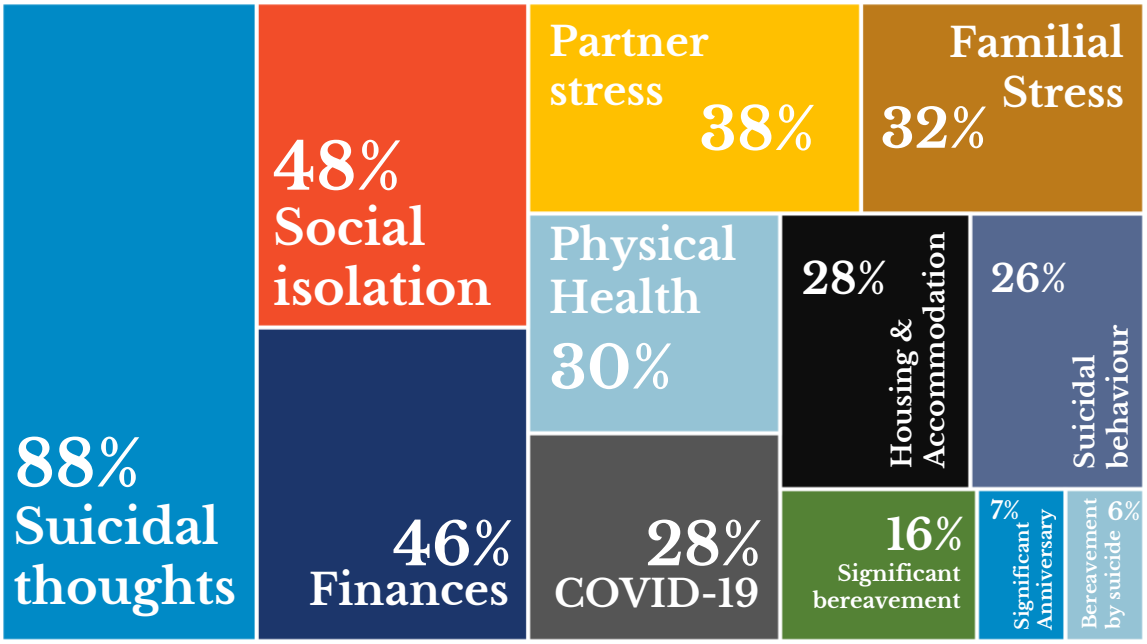
Reporting period: 29 October 2020 – 30 October 2021. Data as at 01 December 2021.
Mean age: 43.9 years. Median age: 42.8 years

Employment Status at Referral of Patients Completing Treatment



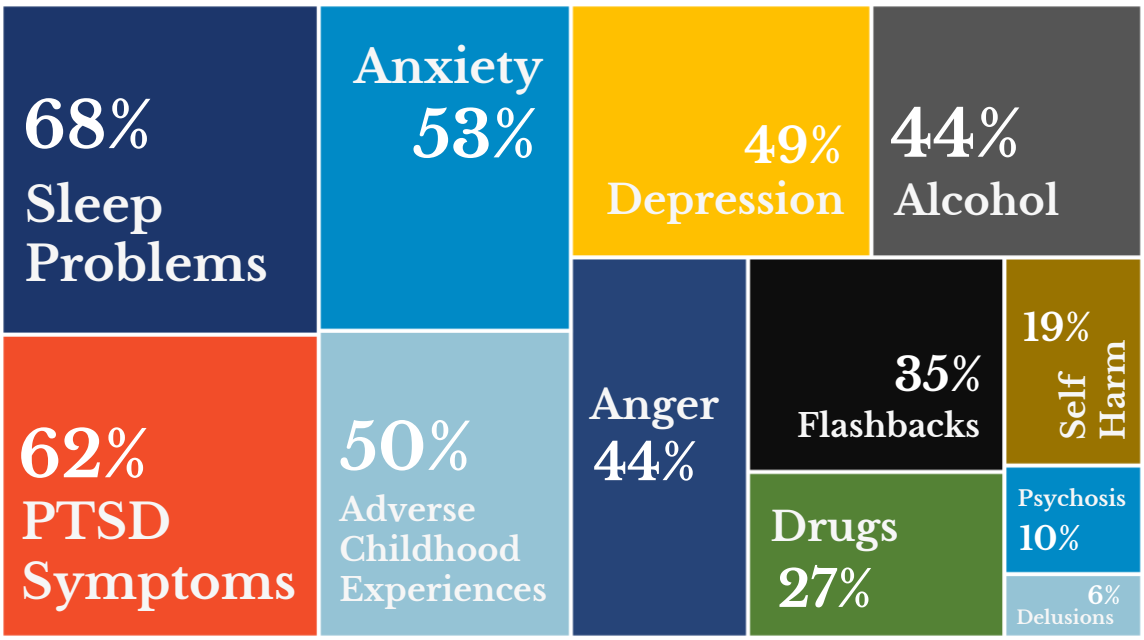
Data for 124 patients. Reporting period: 29 October 2020 – 30 October 2021. Data as at 01 December 2021. Does not include those classed as 'treatment ongoing'. Note that employment status may changeduring treatment. 'Employed but not working' includes those on sick leave or furlough.

Stressors Underpinning Current Crisis



Patients could endorse multiple factors. Data for 123 patients completing treatment. Does not include those classed as 'treatment ongoing'. Reporting period: 29 October 2020 – 30 October 2021. Relationship stress in general reported by 56% of patients (some patients report both sub-groups).

Presenting Problems

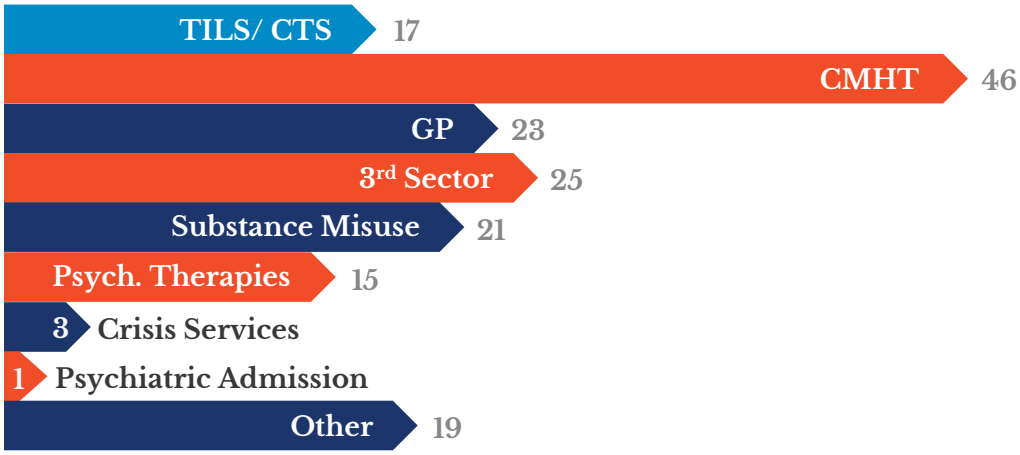


Patients could endorse multiple problems. Data for 123 patients completing treatment. Does not include those classed as 'treatment ongoing'. Reporting period: 29 October 2020 – 30 October 2021. PTSD Symptoms recorded if self-reported, clinically indicated or diagnosed. Adverse Childhood Experiences categorised as witnessing or experiencing physical, sexual or emotional abuse, or extreme poverty.

Patients Pathways on Completion of HIS Treatment

Data for 123 patients. 'Treatment complete' signifies those who were solely discharged to their GP or GP plus third sector organisations. Reporting period: 29 October 2020 – 30 October 2021. Does not include previous contact with any services listed and may not reflect referrals by concurrent services involved in patient care.

Discharge Destinations for Additional Treatment After Discharge from HIS



Patients could be discharged to multiple services. Data for 99 patients and does not include those who were solely discharged to their GP or GP plus third sector organisations. Reporting period: 29 October 2020 – 30 October 2021. Does not include previous contact with any services listed and may not reflect referrals by concurrent services involved in patient care.. 'Other' includes adult social care, psychosis or affective services

Patient Care Level on Discharge from HIS

88% stepped-down

12% returned to referrer

0% stepped-up

Data for 123 patients. Reporting period: 29 October 2020 – 30 October 2021. Reflects primary discharge destination relative to referrer.

Significant Care Events During Treatment

9 psychiatric admissions

11 attempted suicides

0 fatalities

Data for 124 patients. Reporting period: 29 October 2020 – 30 October 2021. Events occurred after referral to HIS, but may have taken place prior to patient contact with patient. 'Attempted suicides' are any action with (potentially) lethal outcome or intent.

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