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Evaluating referral pathways to a specialist trauma service

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Purpose

Lengthy and complex routes to specialist care may negatively affect clinical profiles of trauma survivors accessing mental health services. This evaluation aimed to: describe the characteristics and referral pathways of a cohort of clients accepted by a specialist trauma service in England; and investigate the associations between referral pathways and clients' clinical profiles, namely pre-treatment levels of post-traumatic stress, depression, anxiety, stress, and post-traumatic growth.

Design/methodology/approach

Data on 117 consecutive, accepted referrals were extracted from clients' clinical records. Information on demographics, trauma histories, clinical presentations, and referral pathways was synthesised through summary statistics. Correlational analyses were conducted to test associations with pre-treatment scores.

Findings

Clients accessing the service were highly complex and mostly experienced prolonged, interpersonal trauma. Pathways to the service varied, but 50% of the sample had at least four 'steps' in their referral histories and seven previous clinical contacts. The average time between trauma and specialist referral was 16.34 years. The number of referral steps positively, significantly and moderately correlated with anxiety and stress at pre-treatment.

Research limitations/implications

Limitations include issues around collecting past referral information, the small sample size for clients with available pre-treatment outcome data, and the lack of post-treatment scores.

Originality/value

This evaluation provides an informative overview of the characteristics and referral pathways of clients accessing a specialist trauma service. It also offers preliminary insights on the relationship between clients' routes into the service and their clinical profiles. Practice, commissioning, and research implications are discussed.

Introduction

Life events that are experienced as *traumatic* are often characterised by threat to self and/or others, lack of control, breaches of trust, powerlessness and coercion, as well as responses of fear, horror and helplessness (Regel and Joseph, 2017). An estimated 42.2% of the population in the United Kingdom (UK) have experienced a traumatic event in their lifetime (McManus *et al.*, 2009).

Trauma exposure can result in Post-traumatic stress (PTS), a pattern of reactions including re-experiencing, hyperarousal, and avoidance symptoms and negative cognitive

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3 and mood alterations (American Psychiatric Association [APA], 2013). If symptoms persist
4 for at least one month and cause significant distress and impaired functioning, Post-
5 traumatic stress disorder (PTSD) can be diagnosed according to the Diagnostic and
6 Statistical Manual of Mental Disorders – fifth edition (APA, 2013). The International
7 Classification of Diseases – eleventh revision introduced Complex Post-traumatic stress
8 disorder (CPTSD) as a distinct diagnosis characterised by additional difficulties in
9 regulating emotions, sustaining relationships, and self-functioning, and typically resulting
10 from repeated or prolonged traumatisation (World Health Organization [WHO], 2018).
11 Although the two disorders significantly overlap in terms of aetiology, there is evidence that
12 interpersonal trauma, particularly childhood abuse, is more strongly related to the
13 ‘complex’ form (Cloitre *et al.*, 2013), which is associated with greater severity, comorbidity,
14 and functional impairment (Brewin *et al.*, 2017). A recent UK-wide study found a 5.3%
15 prevalence for PTSD and 12.9% one for CPTSD (Karatzias *et al.*, 2019). Unsurprisingly,
16 higher prevalence rates were found in clinical samples, such as clients referred to a
17 specialist trauma clinic in Scotland (24% and 76%, respectively; Karatzias *et al.*, 2017).
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30 A diagnosis-focused understanding of trauma responses has been increasingly questioned
31 with the growing evidence for negative health outcomes well beyond PTSD; in fact,
32 common sequelae include anxiety, depression, eating disorders, relational problems,
33 physical health complaints, self-harm, and substance misuse (e.g., Copeland *et al.*, 2018).
34 This highlighted the need for professionals to routinely consider the role of trauma within
35 case formulation, irrespective of diagnosis (Division of Clinical Psychology, 2011).
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43 The care provision for trauma-exposed clients in the UK National Health Service (NHS) is
44 governed by the relevant National Institute for Health and Social Care (NICE, 2018)
45 guidelines. Albeit focused on PTSD, the latest update added recommendations for the
46 management, assessment, and treatment of traumatised clients with complex needs,
47 including those who experienced multiple traumas and present with substance misuse,
48 high risk, and comorbid mental health difficulties.
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55 In keeping with NICE guidelines, General Practitioners (GPs) are typically responsible for
56 the initial care-coordination of traumatised clients accessing primary care, establishing
57 whether a referral to secondary services and comprehensive assessment are needed.
58 Clients assessed to have less complex presentations can access low-intensity
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3 psychological treatments, including short courses of Cognitive Behavioural Therapy (CBT)
4 and Eye movement desensitisation and reprocessing (EMDR), within Improving Access to
5 Psychological Therapies (IAPT) services.
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9 The referral pathway of those who either have more complex needs or do not respond to
10 low-intensity input typically involves being 'stepped' to secondary care. This is known as a
11 *stepped model of care*, i.e., psychological treatment services are organised in tiers of
12 increasing severity and complexity (Bower and Gilbody, 2005). In the first instance, more
13 intensive interventions are usually offered by Local/Community Mental Health Teams
14 (L/CMHTs), with the option of further referring people to 'Step 4' services; for traumatised
15 clients, these include specialist Trauma and Psychology/Psychotherapy services. A survey
16 by Murphy *et al.* (2013) reviewed 13 specialist trauma services across the UK, of which ten
17 were NHS-funded.
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26 Whilst a stepped care approach may effectively extend the reach of trauma-focused
27 interventions to non-specialist settings, improve access to early interventions (Zatzick *et*
28 *al.*, 2011) and increase the number of mental health services they receive (Belsher *et al.*,
29 2016), such an approach may present specific challenges for traumatised clients. For
30 example, an IAPT service evaluation showed that those clients who reported childhood
31 sexual and/or physical abuse were more likely to experience greater complexity and PTSD
32 co-occurrence, higher intensity of treatment received, and poorer clinical outcomes
33 compared to those without such history (Verbist *et al.*, 2021). Complex clients who do not
34 benefit from lower intensity interventions may find themselves receiving 'revolving door'
35 care, with repeated referrals, assessments, and treatments (Cotton, 2019). For
36 traumatised clients, this may translate into having to discuss their traumatic experiences
37 several times, being rejected due to complexity, transitioning between services that focus
38 on different presenting difficulties, and having multiple experiences of 'failing' treatment.
39 This may add to personal barriers, such as shame and societal stigma, that hinder
40 treatment-seeking amongst some trauma populations (e.g., Kulesza *et al.*, 2015).
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54 Finally, it has been suggested that an unhelpful route through the mental health system,
55 including lack of post-incident support, chronicity of untreated trauma symptoms, poor
56 assessment and formulation, inadequate therapeutic input, and absence of relapse
57 prevention strategies, can contribute to clinical complexity for trauma survivors (Regel,
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3 2019). Therefore, it is paramount to formally investigate pathways of access to specialist
4 care for this client group.
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8 *Service context*

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10 This evaluation was conducted in a specialist trauma service, which will be referred to as
11 the 'Trauma Centre' (TC) throughout. The TC, a collaboration between an NHS Trust and
12 a University in England, provides specialised assessment and therapy to adult trauma
13 survivors. Therapies include Trauma-focused CBT, EMDR, Narrative Exposure Therapy,
14 Compassion Focused approaches, and client-centred and integrative psychotherapy,
15 although treatment plans are typically developed flexibly depending on client need.
16 Additionally, the TC offers trauma-focused consultancy to a range of partners, provides
17 training to healthcare professionals and Police forces, and has been involved in numerous
18 research activities.
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27 Due to long-standing funding issues, the TC currently operates on a part-time basis with a
28 small team including the clinical lead and service manager, administrative staff,
29 psychotherapists, qualified and trainee clinical psychologists, and a psychiatrist. Current
30 commissioning only covers clients registered with GPs in the local County, limiting access
31 for clients living in the City area, except if they have access to ad hoc funding or are former
32 Armed Forces Personnel. The latter is because the TC has also managed the local
33 Veterans' Service, and thus receives specific funding for this group. People can be
34 referred by their GP, another mental health service, or Occupational Health departments
35 for traumas experienced in the workplace. Clients present with various trauma-related
36 presentations; although some may have PTSD or CPTSD diagnoses, this is not essential
37 as the TC is not diagnosis-driven.
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48 Anecdotally, clinicians report that clients are highly complex and tend to access the TC
49 relatively late, after being stepped across numerous services. At initial assessment, clients
50 are asked about previous experiences of therapy, and frequently describe lengthy histories
51 of service utilisation, several assessments, extensive waiting times, unhelpful treatments,
52 and general dissatisfaction with their route to trauma care. Such experiences may result in
53 feelings of hopelessness and negatively affect how clients engage in and respond to
54 trauma-focused treatments.
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3 In light of the above, it is important to understand clients' referral pathways to the TC and
4 whether the current referral model is meeting their needs. This is also in line with the local
5 Trust goal to make referral processes more client-centred, a key aspect of the Community
6 Mental Health Framework for adults and older adults (NHS England, NHS Improvement &
7 the National Collaborating Central for Mental Health, 2019)
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13 *Aims*

14 This evaluation aimed to:

- 15 • describe the characteristics of a cohort of consecutive accepted referrals and chart
16 their pathways into the service.
 - 17 • determine whether referral pathways, defined as the number of steps and previous
18 clinical contacts in clients' referral histories, were associated with client clinical
19 profiles.
 - 20 • investigate whether the time between the trauma and the current referral was
21 associated with client clinical profiles.
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31 **Method**

32 *Ethical issues*

33 This study was screened through the Health Research Authority decision tool and deemed
34 an evaluation, as it involved routinely collected data; therefore, NHS ethics approval was
35 not required. Nonetheless, the project was registered with the local Research department
36 before commencing secondary data collection. All data were anonymised and stored
37 securely as per Trust policy.
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45 *Sample size*

46 A power calculation was conducted in G*Power to determine the number of referrals to
47 review. The purpose was twofold: to allow for sufficient power in the analyses exploring the
48 impact of the variables of interest on clinical profilesoutcomes; and to avoid bias when
49 selecting referrals. Based on this calculation, 119 consecutive, accepted referrals were
50 selected from the TC referrals list. As two were excluded for being duplicates, data were
51 extracted on 117 referrals. These were received between September 2018 and May 2021.
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59 *Design*

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3 The evaluation used a cross-sectional design and data were extracted from NHS
4 electronic records (RiO) through a tailor-made proforma. Where possible, this was
5 supplemented by paper records held by the TC.
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10 *Measures*

11 *Client information*

12 Client demographic and clinical information was extracted from RiO. Demographics
13 included age, sex, ethnicity, refugee/asylum seeker and army veteran status. Ethnic
14 backgrounds were classified according to the macro-groups recommended by the UK
15 government and used in the 2011 Census of England and Wales, with the addition of the
16 'Not stated' category. Clinical information included trauma history (e.g., index trauma type,
17 additional trauma etc.), presenting difficulties and any mental health diagnoses.
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25 *Referral pathway characteristics*

26 Data on clinical contacts and number of steps up to the current referral were extracted
27 from RiO; where additional contacts with services that use different record systems (e.g.,
28 SystemOne in IAPT) were mentioned, these were added to the count. The delay in
29 accessing the TC was measured as the number of years between the index trauma and
30 the referral; this information was extracted by referral letters, core assessments or
31 progress notes. In this context, 'index trauma' was defined as the traumatic experience(s)
32 mentioned as the referral reason. Other collected information included referral source,
33 status (e.g., awaiting assessment), type of previous referrals, and time between referral
34 and TC assessment. Electronic records were also searched for any qualitative information
35 on routes to the service that could help contextualise the findings.
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46 *Clinical profiles*~~*Outcome measures*~~

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49 ~~The~~The TC routinely collects data on three ~~questionnaires~~~~outcome measures~~, namely the
50 Impact of Event Scale-Revised (IES-R; Weiss and Marmar, 1997), the Depression, Anxiety
51 and Stress Scale – 21 (DASS-21; Lovibond and Lovibond, 1995), and the Psychological
52 Well-Being – Post-Traumatic Changes Questionnaire (PWB-PTCQ; Joseph *et al.*, 2012).
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58 The IES-R is a self-report measure of PTS consisting of 22 items where distress
59 associated with intrusion, avoidance, and hyperarousal symptoms over the past week is
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3 rated on a five-point Likert scale. The scores are then summed to produce a total PTS
4 severity score, where higher scores are indicative of greater severity. Although not a
5 diagnostic tool, the IES-R has been found to discriminate between individuals with and
6 without PTSD (Creamer *et al.*, 2003) and showed good reliability and validity (Beck *et al.*,
7 2008). The severity score range is 0-88, with ≥ 33 indicating clinical caseness.
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13 The DASS-21 is the short form of the 42-item scale, a self-report measure assessing
14 depression, anxiety, and stress symptoms over the past week on a four-point Likert scale.
15 DASS-21 scores are multiplied by 2 to produce full-scale ones; higher values indicate
16 more severe symptoms. Subscale scores range between 0 and 120 and cut-offs for
17 'severe' levels are as follows: ≥ 21 for depression; ≥ 15 for anxiety; and ≥ 26 for stress
18 (Lovibond and Lovibond, 1995). The instrument has shown adequate reliability and validity
19 (Henry and Crawford, 2005).
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27 The PWB-PTCQ is an 18-item self-report measure assessing positive change following
28 trauma, also known as post-traumatic growth (PTG; Tedeschi and Calhoun, 1996).
29 Changes in self-acceptance, autonomy, purpose in life, relationships, sense of mastery,
30 and personal growth are rated on a five-point Likert scale. Scores range between 0 and
31 90, with ≥ 54 suggesting PTG. The scale has shown high reliability, good validity and
32 ability to predict clinical caseness (Joseph *et al.*, 2012).
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39 For the purpose of this evaluation, clinical profiles ~~were~~ ~~ing~~ ~~was~~ defined as the pre-
40 treatment severity and post-traumatic growth scores on the above ~~outcome~~ measures. The
41 IES-R, DASS-21, and PWB-PTCQ are typically administered at initial service assessment.
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46 *Analysis*

47 Data were analysed in PSPP, the free statistical software available in the local Trust. Data
48 on clients' characteristics and referral pathways were synthesised through summary
49 statistics. Associations between each of the variables of interest (i.e., number of 'steps' in
50 referral pathways, number of clinical contacts, and years since index trauma) and clinical
51 profiles ~~outcomes~~ (i.e., pre-treatment ~~severity~~ scores on the IES-R, DASS-21, and PWB-
52 PTCQ ~~outcome measures~~) were tested using Pearson's r for normally distributed data and
53 Spearman's r_s for non-normally distributed data. Two-tailed tests were used, and statistical
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3 significance was assessed at 0.05. As PSPP does not provide p values for Spearman's
4 correlations, significance was tested using the relevant critical values (Ercolani, 2007).
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10 **Results**

11 *Characteristics of accepted referrals and routes into the service*

12 Findings on demographics are displayed in **Table I**. Information on clients' referral
13 pathways is presented in detail in **Table II**. GPs and L/CMHT clinicians together made up
14 more than three-quarters (78.6%) of referrers. The impact of Army Service related
15 experiences and traumatic bereavements were the most frequently mentioned reasons for
16 referring clients (both 16.2%), followed by childhood physical and emotional abuse (9.4%).
17 Similar percentages of clients were seeking support following a single-event trauma (35%),
18 multiple events of different nature (27.4%), and chronic traumatisation (37.6%), such as in
19 the context of prolonged abuse. At the time of data collection, most clients were awaiting
20 assessment (33.3%) or currently in treatment (20.5%); the status of remaining referrals
21 was pending, assessment in progress, awaiting treatment, or discharged/pending
22 discharge.
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34 Both the number of referral steps and of previous clinical contacts were not normally
35 distributed and varied considerably; 50% of clients had been through at least four steps
36 and had at least seven clinical contacts within the mental health system before the TC
37 referral. L/CMHTs (57.3%), IAPT (41%), and Crisis (37.6%) were the most common
38 previous referrals.
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44 Data on the number of years between the index trauma and the TC referral were available
45 for 111 clients and approximately normally distributed. On average, clients waited for
46 16.34 years (SD=14.27) before they were referred to the service. The waiting time for a
47 first assessment at the TC was 3.67 months (SD=2.14), although 29 clients (24.8%) had
48 not yet been offered an initial assessment at the time of data collection.
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54 Findings on clients' trauma histories and clinical presentations are detailed in **Table III**.
55 Approximately three-quarters of clients (75.2%) had experienced other traumatic events in
56 addition to what indicated as the reason for seeking treatment. The majority of clients had
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3 experienced their index trauma after the age of 18 (48.7%), followed by those who had
4 been traumatised in both childhood and adulthood (39.3%).
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8 Clients reported multiple presenting difficulties, including PTS, depression and anxiety
9 symptoms, dissociation, somatic complaints, disordered eating, self-harm and suicidality.
10 The distribution of these data approached normality; on average, clients reported 3.56
11 difficulties (SD=1.33). Data on the number of confirmed mental health diagnoses were not
12 normally distributed and the median was 1. At the time of the TC referral, 105 (89.8%)
13 clients had mental health diagnoses, of which 30.8% were PTSD and 7.7% CPTSD. The
14 'other diagnosis' category included mood, anxiety, personality, neurodevelopmental, and
15 functional neurological disorders.
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24 Pre-treatment ~~outcome~~ data were only available for 23, 18, and 19 clients for the IES-R,
25 DASS-21, and PWB-PTCQ, respectively. One client had pre-treatment data on different
26 questionnaires available in Arabic. ~~D~~Outcome data were approximately normally
27 distributed for all three measures. The mean IES-R total score was 58.52 (SD=16). DASS
28 mean scores were: 30 (SD=11.23) for depression; 26.22 (SD=9.77) for anxiety; and 31.8
29 (SD=8.43) for stress. Finally, the mean PWB-PTCQ score was 42.79 (SD=11.80).
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36 Results for correlations are shown in **Table IV**. The number of referral steps was positively
37 and significantly associated with the pre-treatment DASS anxiety ($r_s=.56, p<.05$) and
38 stress ($r_s=.51, p <.05$) scores. The correlations with the IES-R and PWB-PTCQ scores
39 were both non-significant. There were no significant associations between any of the pre-
40 treatment scores and number of clinical contacts or years since trauma.
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46 **Discussion**

47 This evaluation explored the characteristics and referral pathways of a cohort of clients
48 accepted by the TC. It also aimed to investigate whether clients' routes to the service were
49 associated with their clinical profiles (pre-treatment levels of PTS, depression, anxiety,
50 stress, and PTG). The main findings and related potential implications for practice,
51 commissioning, and future evaluations are discussed below.
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58 *Client demographics*

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3 Younger and older clients and female and male clients were approximately equally
4 represented amongst the accepted referrals. The latter finding is in contradiction with
5 studies showing that women are overrepresented in trauma populations (e.g. Perkonigg *et*
6 *al.*, 2016), whilst other studies have found no such difference (Wolf *et al.*, 2015).
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11 Although results were affected by the lack of ethnicity data for some clients, the findings
12 align with evidence that people from ethnic minorities in the UK are less likely to be
13 referred to specialist mental health services (Bhui *et al.*, 2003). Obstacles to access
14 typically include services' poor cultural competence (Dowrick *et al.*, 2009), cultural models
15 of mental health and stigma (Gary, 2005; Keating and Robinson, 2004), communication
16 barriers, and perceived discrimination (Suresh and Bhui, 2006). The TC already makes
17 regular use of interpreters to address linguistic barriers; however, the implementation of
18 additional strategies, such as outreach initiatives for hard-to-reach communities, could be
19 beneficial.
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29 A similar point applies to refugees and asylum seekers, who only made up a small
30 percentage of accepted referrals. As it is well known that this group is more likely to have
31 experienced traumatic events compared to the general population and show higher rates
32 of PTSD, anxiety and depression (Bogic *et al.*, 2015), the reported figure is likely an
33 underestimation of the actual level of need. Therefore, it is important to highlight barriers
34 existing in the local area and develop strategies to address them (e.g. considering
35 alternative routes for refugees/asylum seekers who are not registered with a GP). This
36 should ideally be supported by specific commissioning, given that the current TC provision
37 is greatly impacted by the small size of the team and unstable funding.
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46 Conversely, it is reassuring that the findings on Veterans' referrals matched the TC's
47 commitment and dedicated funding to provide trauma-focused care to this group. This is
48 especially important given that fear of being perceived as weak and beliefs about self-
49 reliance and discussing feelings have historically affected Veterans' help-seeking and
50 service utilisation (Kantor *et al.*, 2017). It is recommended that the TC maintains good links
51 with TILS professionals and third sector organisations supporting ex-military personnel.
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58 *Referral pathways, trauma histories and clinical presentations*
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3 The range of referral sources is encouraging, as it implies that referrals were prompted by
4 professionals from different services screening for trauma and related symptomatology.
5 This may be a result of Trauma-informed care increasingly receiving attention across UK
6 mental health services (Sweeney *et al.*, 2016).
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11 However, the fact that referrers and previous referrals included services that often provide
12 high-intensity trauma treatments themselves (e.g. L/CMHTs, Step 4, and other specialist
13 services) may mean that some clients have not benefitted from an already substantial level
14 of input and that their level of need could not be met elsewhere. This is concerning for
15 clients living in geographical areas (in this case, the City) for which there is no equivalent
16 specialist trauma service. Data on mental health prevalence, services, and funding in
17 England showed that inconsistencies in service provision across locations are likely to
18 contribute to access inequality (Baker, 2020). Therefore, a potential implication of the
19 findings is that extending commissioning to the whole local area would fill an existing gap
20 in service provision. This recommendation would be strengthened by comparing this
21 evaluation with an equivalent one looking at the referral trajectories of trauma-exposed
22 clients in the City area.
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34 Although there was substantial variability in referral histories and years since trauma, the
35 findings showed that clients' routes to the TC tended to be lengthy and non-linear. This is
36 consistent with the anecdotal evidence gathered from clinicians and clients, and, for some
37 people, possibly reflected a 'revolving door' scenario.
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43 The average length of time between trauma and referral in the present cohort (16.34
44 years) was greater than the one found in a similar evaluation previously conducted at the
45 TC (12 years; Brabbins *et al.*, 2013). Such delays may be a consequence of
46 conceptualisations of extreme behaviour and distress as symptoms of discrete disorders,
47 rather than possible coping adaptations to trauma. This may result in clients accessing
48 multiple disorder-specific services and treatments before their trauma histories are
49 adequately considered. Alternatively, the delay in referring clients to specialist care may be
50 due to perceptions of their readiness to change. In Tedeschi and Calhoun's (2004)
51 Transformational Model of change, trauma survivors need to be in a position to begin
52 constructively re-evaluating their pre-trauma beliefs to be able to consider the impact of
53 trauma on their identity; this, in turn, enables them to begin the process of adjusting to
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3 adversity and reassert control over their lives. Similar considerations possibly underpinned
4 decisions around the timeliness of trauma-focused treatment, which is undoubtedly an
5 emotionally demanding experience.
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10 The number of clients still awaiting assessment and the waiting times for assessment at
11 the TC were likely affected by the Covid-19 pandemic. Given the already extensive waits
12 for referrals, it is recommended that clinicians maintain as regular as possible contacts
13 with clients on the waiting list and signpost them to interim support.
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18 Traumatic events reported in the sample were diverse but were almost entirely
19 interpersonal, and the majority of clients experienced prolonged or chronic traumatisation.
20 Although single events were also indicated as index traumas, a large percentage of the
21 sample described other traumatic experiences in addition to the reason for referral. This
22 suggests that, in some cases, individual incidents might have precipitated pre-existing
23 distress associated with previous traumatic exposure.
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30 For the most part, clients had multiple presenting difficulties and established mental health
31 diagnoses upon referral. The mean level of pre-treatment PTS, as assessed by the IES-R,
32 fell well above the cut-off for a probable diagnosis of PTSD (33; Creamer *et al.*, 2003) and
33 the severity that can suppress immune functioning (37; Kawamura *et al.*, 2001).
34 Additionally, the DASS mean scores indicated extremely severe levels of depression,
35 anxiety, and stress (Lovibond and Lovibond, 1995), and the PTWCQ score showed that,
36 on average, clients at pre-treatment had not experienced PTG (Joseph *et al.*, 2012). In
37 light of the above, the prevalence rates of PTSD and CPTSD in the sample are likely
38 underestimating the portion of clients who would meet the respective diagnostic criteria. It
39 could also be argued that a distinction between 'simple' and 'complex' forms of PTS in the
40 current sample is somewhat artificial; this differentiation has received criticism for lacking
41 sufficient empirical support (Resick *et al.*, 2012), although this has also been disputed
42 (Brewin *et al.*, 2017).
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55 Taken with those on past referrals, the findings on trauma and clinical features showed a
56 picture of high complexity. This is consistent with the expectations for a specialist trauma
57 service and provides evidence for the importance of such provision.
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Associations with clinical profiles

Results showed that the more steps clients had gone through in the mental health system before being referred, the more anxious and stressed they were upon accessing the TC, whilst this was not true for PTS and depression. The strength of the association was moderate for both anxiety and stress (Dancey and Reidy, 2007). Conversely, the number of previous clinical contacts and time since trauma were not significantly related to any of the pre-treatment scores.

Although causation cannot be inferred, an interpretation of the results is that multiple transitions between services are not helpful for traumatised clients, and may even be iatrogenic in terms of psychological distress. It may be that PTS and depression levels are not affected because symptom severity is better explained by peritraumatic factors (Regel and Joseph, 2017). However, multiple clinical contacts prior to specialist trauma care may not be beneficial either, as they do not appear to mitigate symptom severity or increase PTG.

For some clients, previous engagement with services involved stabilisation interventions. This raises important questions about whether a phased approach to trauma treatment, in which trauma processing is preceded by a symptom stabilisation phase, is always warranted. Although this approach is generally supported by current guidelines on complex trauma (UKPTS, 2017), some have argued that evidence that phased treatments are superior to non-phased ones is lacking (De Jongh *et al.*, 2016).

It also worth considering an alternative explanation for the positive association between referral steps and levels of anxiety and depression. It is possible that this a reflection of clients experiencing more severe and enduring distress requiring input from different services or being more likely to be rejected by services and referred elsewhere.

The present findings are insufficient to support a significant change in the current referral pathway to the TC, which follows a stepped model. However, the TC might consider strengthening its consultative role around trauma-focused assessment, formulation, and treatment with clinicians working in lower-tier services. Although some people would likely still require specialist care, this 'top-down' approach might reduce the need to escalate clients through the system and limit unhelpful transitions. A Cochrane review on 'consultation liaison' in primary care (i.e., where an mental health specialist offers

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3 consultative support) found that this model improved treatment adherence and client
4 outcomes and satisfaction (Gillies *et al.*, 2015).
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10 *Impact of the Covid-19 pandemic*

11 The review of clients' clinical records highlighted a number of ways in which the Covid-19
12 pandemic affected the service provision and, consequently, the data available for the
13 present evaluation. These included: a number of clients wanting to wait for face-to-face
14 appointments, as opposed to opting for engaging with the service via telephone or
15 videoconferencing; assessments/treatments being put on hold due to health reasons;
16 disruption in service provision in the pandemic early stages, resulting in waiting list
17 backlog; clinicians not regularly working from the service base and consequent delays in
18 uploading measuresquestionnaires on RiO; and low return rate for ~~outcome~~ measures
19 sent via post or email.
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29 *Strengths, limitations, and future evaluations*

30 This evaluation examined the cohort of accepted referrals across several domains, which
31 provided a rich and informative overview of clients accessing the TC. Referral routes were
32 operationalised and measured both in terms of referral steps and previous clinical
33 contacts, allowing for a nuanced understanding of how clients reached the service. These
34 represent areas of strength of the present evaluation.
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41 Several limitations must also be considered. IAPT referrals and contacts not being formally
42 recorded on RiO mean that the reported figures might have incorrectly estimated them.
43 Furthermore, this evaluation made no distinction between types of clinical contacts (e.g.,
44 assessments only versus assessments plus treatments) and did not account for more
45 'informal' professional support (e.g., telephone contacts). The findings on correlations are
46 also limited by the constraints of PSPP; for example, testing further prediction hypotheses
47 was not possible due to the lack of appropriate non-parametric functionalities. The main
48 limitation was the small number of available ~~outcome~~ data on clinical profiles. The findings
49 would be strengthened by repeating the evaluation with a larger sample number of
50 ~~outcome data~~ and including post-treatment scores; the latter would allow for investigating
51 correlations between referral pathways and clients' clinical outcomes. This may highlight
52 whether clients' routes into specialist trauma care are linked to how they respond to
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3 treatment. Finally, the present quantitative findings could be supplemented and
4 contextualised by qualitative evaluations, including by formally collecting and analysis
5 clients' feedback about their experiences of accessing care.
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Table I. Cohort demographics (N=117)

<i>Demographic</i>	<i>Statistics</i>
Median Age (range)	41 (20-80)
Sex	Female: 60 (51.3%) Male: 57 (48.7%)
Ethnicity Category	Not stated: 28 (23.9%) White: 75 (64.1%) Black, African, Caribbean or Black British: 4 (3.4%) Asian or Asian British: 6 (5.1%) Mixed or Multiple ethnic groups: 1 (0.9%) Other ethnic group: 3 (2.6%)
Refugee/Asylum Seeker	4 (3.4%)
Veteran	19 (16.2%)

Table II. Referral information (N=117)

Information	Statistics
Referral source	General Practitioner: 57 (48.7%) Veterans' TILS: 5 (4.3%) L/CMHT: 35 (29.9%) Personality Disorder Service: 1 (0.9%) IAPT: 3 (2.6%) High Intensity User Worker: 3 (2.6%) Crisis Service: 6 (5.1%) Step 4 Psychology/Psychotherapy: 3 (2.6%) Perinatal Service: 2 (1.7%) Other: 2 (1.8%)
Referral reason / index trauma	Medical trauma: 7 (6%) Traumatic bereavement: 19 (16.2%) Army service related: 19 (16.2%) Other occupational trauma: 9 (7.7%) Childhood physical/emotional abuse: 11 (9.4%) Childhood sexual abuse: 10 (8.5%) Traumatic birth: 4 (3.4%) Sexual assault - adulthood: 9 (7.7%) Physical assault – adulthood: 5 (4.3%) Domestic abuse: 8 (6.8%) Childhood abuse and adulthood domestic abuse: War and torture: 6 (5.1%) Road traffic collision: 4 (3.4%) Other: 4 (3.4%) 2 (1.8%)
Index trauma type	Single-event: 41 (35%) Multiple experiences: 32 (27.4%) Chronic/prolonged experiences: 44 (37.6%)

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Referral status	Provisionally accepted for assessment – awaiting funding or further information:	
	Awaiting assessment:	2 (1.8%)
	Assessment in progress:	39 (33.3%)
	Awaiting treatment:	8 (6.8%)
	Treatment in progress:	14 (12%)
	Discharged or awaiting discharge:	24 (20.5%)
		30 (25.7%)
Type of referral steps	IAPT:	48 (41%)
	Crisis services:	44 (37.6%)
	L/CMHT, including Early Intervention:	67 (57.3%)
	Step 4 Psychology/Psychotherapy:	20 (17.1%)
	Other specialist service:	10 (17.1%)
	Inpatient services:	15 (12.8%)
	Forensic services:	9 (7.7%)
	Drug and alcohol services:	5 (4.3%)
	CAMHS:	5 (4.3%)
Median number of referral steps (range)		4 (1-49)
Median number of previous clinical contacts (range)		7 (1-656)
Mean time since index trauma, in years (SD, range) (n=111)		16.34 (14.27, 0-58)
Mean time between TC referral and first assessment, in months (SD, range)		3.67 (2.14, 1-8)

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Notes. CAMHS = Child and Adolescent Mental Health Service; L/CMHT = Local/Community Mental Health Team; IAPT = Improving Access to Psychological Therapies; TILS = Transition, Intervention and Liaison Service.

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Table III. Trauma and clinical information (N=117)

<i>Information</i>	<i>Statistics</i>	
Experienced additional trauma	Yes:	88 (75.2%)
	No:	17 (14.5%)
	Unclear:	12 (10.3%)
Age of index trauma	Childhood only:	14 (12%)
	Adulthood only:	57 (48.7%)
	Both:	46 (39.3%)
Mean number of presenting difficulties (SD, range)	3.56 (1.33, 1-7)	
Median number of confirmed diagnoses (range)	1 (0-3)	
Type of confirmed diagnosis	PTSD:	36 (30.8%)
	Complex PTSD:	9 (7.7%)
	Other:	60 (51.3%)
Mean pre-treatment IES-R total score (SD, range) (n=23)	58.52 (16, 12-79)	
Mean pre-treatment DASS scores (SD, range) (n=18)		
Depression	30.0 (11.23, 8-42)	
Anxiety	26.2 (9.77, 6-40)	
Stress	31.8 (8.43, 18-42)	
Mean pre-treatment PWB-PTCQ score (SD, range) (n=19)	42.79 (11.80, 22-73)	

Notes. DASS = Depression, Anxiety and Stress Scale; IES-R = Impact of Event Scale-Revised; PWB-PTCQ = Psychological Wellbeing – Post-Traumatic Change Questionnaire; PTSD = Post-traumatic Stress Disorder.

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60**Table IV.** Correlations with pre-treatment *clinical outcome profile scores*

	IES-R (n=23)	DASS Depression (n=18)	DASS Anxiety (n=18)	DASS Stress (n=18)	PWB- PTCQ (n=19)
Number of steps in referral history	.33	.02	.56*	.51*	.22
Number of previous clinical contacts	.28	-.19	.38	.14	.33
Time between index trauma and referral, in years	.14 [†]	.28 [†]	.24 [†]	.22 [†]	.10 [†]

Notes. * = significant at .05; [†]= Pearson's r.