The "PARC" Project; Evaluating an Advanced Mental Health Nurse Practice Candidate Project Supported by Mental Health Nursing, Consultant Psychiatrist' and the CMHT within the North Sector Service of Community Healthcare East.

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1. Background

From **(2018 – 2019)** mental health nursing (MHN) interventions within the north sector mental health service reduced active service user/patient (SU/P) numbers from **(552 – 344)** with the provision of psychosocial interventions. All group and one to one interventions provided by MHN's were evaluated, and demonstrated a clear evidence base in terms of positive therapeutic outcomes and a high level of satisfaction for those SU/P who attended and engaged in treatment. At this time **(208)** SU/P were discharged from the secondary care mental health services and MHN's received direct referrals for **(207)** of those SU/P prior to discharge, to the available evidenced based psychosocial interventions.

Two areas of concern regarding service provision that emerged through the evaluations of these psychosocial interventions were as follows:

- It was observed that out of the **(630)** mental health nursing offers for psychosocial interventions, only **(34)** offers of care were to those with a severe and enduring mental health diagnosis. Therefore **(596)** offers of treatment were to those with mild to moderate mental health diagnosis and **50%** of secondary care service users at that time were of mild to moderate mental health diagnosis.
- Waiting times for interventions ranged from **(1 – 49)** weeks depending on the intervention being provided. SU/P remained in secondary care, were seen at outpatient clinic by the registrar until such a time as the intervention was available and/or completed. When interventions were offered **47%** of SU/P offered did not attend.

As recommended in the Slaintecare Implementation Strategy this care could have been provided in the primary care setting and this could have increased community mental health team (CMHT) input for those SU/P with severe and enduring mental health diagnosis within the secondary care mental health setting (Government of Ireland, 2020). As the auditor and evaluator at that time and based on those facts this author prepared and presented an Advanced Nurse Practice Candidate (ANPC) business case to Dr Daniel De La Harpe Golden (Consultant Psychiatrist Bray Mental Health Team) and Mr Cormac Walsh (Area Director of Nursing, Community Healthcare East) that was viewed as acceptable and appropriate to meet service demands. The ANPC role would allow treatment to SU/P within the primary care setting. This business case was in line with "Slainte Care", "A Shared Vision" and the "National Service Plan" to promote and encourage the main body of SU/P care to be within primary care for those

with mild to moderate mental health disorders and those with severe and enduring mental health conditions can receive specialised care within the secondary care CMHT.

It is crucial to highlight at this point that although this is an ANPC business case, it is not possible to establish this post, role or project without the clinical supervision, and support of a consultant psychiatrist. Dr Edyta Truszkowska a second consultant psychiatrist joined the CMHT in September (2020) and our geographical area increased at this time to include Newtown, Newcastle, Roundwood and Kilpeddar. Dr Truszkowska embraced the business case, providing the supervision and supports required. This consultant psychiatrist support and supervision from both Dr De La Harpe Golden and Dr Truszkowska permitted an expansion for ANPC and the MHN's scope of practice, in line with the Nursing and Midwifery Board of Ireland's standards and guidelines (NMBI, 2015). Psychosocial interventions can be provided within the primary care setting by MHN's under the clinical supervision of ANPC.

2. Introduction:

The PARC Project ***(Positive Advanced Recovery Connections)*** is an ANPC project within the Bray CMHT, supported by MHN, consultant psychiatrist' and the CMHT. It provides direct referral for consultant psychiatrist or general practitioners (GP) to access ANPC psychosocial assessment and specialist psychosocial interventions provided by the MHN discipline. To explain this business case and expanding role it is important to explain ANPC. An Advanced Nurse Practitioner (ANP) is a nurse who has undertaken extra training and achieved academic qualifications to the level of (MSc) in Advanced Nurse Practice which permits the nurse to examine, assess, make diagnosis, treat, prescribe and make referrals for the SU/P who present with undiagnosed or undifferentiated problems (NMBI, 2019). An ANPC as is this principal investigator is a nurse who for three years carries out the above task under the clinical supervision of a consultant psychiatrist. Once the business case was accepted, this author transferred into the role of ANPC and commenced an MSc in Advanced Nurse Practice (ANP) in University College Dublin (UCD).

ANPC can receive diverted referrals from the Consultant Psychiatrists, who triage all CMHT referrals received either from GPs or Emergency Departments within Acute Hospital's. GP's can directly refer for psychosocial assessment where the SU/P needs are more likely to be met with brief goal focused interventions. The referred SU/P to ANPC are seen within one week

of referral and discussed with the consultant psychiatrist within (24) hours, or sooner if the case exceeds the service provision within the PARC project. Where a SU/P is deemed suitable for a psychiatric review or requests a psychiatric review the ANPC completes a referral into secondary care psychiatry and this is decided within supervision of the SU/P case with the treating consultant psychiatrist. SU/P from both secondary or primary care can self – refer for all available interventions.

The available interventions are:

ANPC Psychosocial Assessment

Psychosocial assessment is provided by ANPC and review's the psychological, social, personal, relational and vocational needs of a SU/P and is as an evidence based intervention (Trenoweth and Moone, 2017). The psychosocial assessment includes a general review of the SU/P's social history and a mental state examination (Trenoweth an Moone, 2016). The assessment template was designed by this author utilising the psychiatric assessment template as a cast, removing all medical jargon and updating this assessment with acquired learning on the ANPC MSc programme. The template was reviewed regularly with consultant psychiatrist in supervision and amendments were made based on qualitative SU/P feedback. Psychosocial assessments aim to create a treatment plan which may involve providing psychosocial interventions and/or signposting to community services. The treatment plan is developed with the SU/P within the primary care setting with the ANPC and the SU/P remains under the care of their GP. The SU/P is provided with their treatment plan in writing and the GP is CC'd in this correspondence to be kept up to date with the SU/P individualised treatment plan. ANPC holds the active primary care SU/P and manages their caseload from assessment, treatment to discharge, updating the GP where treatment is completed or in the event the SU/P disengages from treatment. Both consultant psychiatrists provide clinical supervision to all ANPC primary care cases.

Clinical Nurse Specialist, Postgraduate Level, Cognitive Behavioural Therapy

CBT is an evidenced based talking therapy that focuses on how a person's thoughts, behaviours, physical responses and emotions are connected and helps a person become

aware of how these areas may be impacting on the SU/P overall mood (Beck and Alford, 2008). CBT is the most researched form of psychotherapy, with numerous studies demonstrating its effectiveness for a range of psychological problems (Hofmann et al, 2012). The MHN who provide CBT have trained to postgraduate level or clinical nurse specialist level within Trinity College Dublin (TCD) (NMBI, 2015).

The Decider Skills

The Decider Skills were created in (2010) based on service need within Guernsey by Michelle Ayres and Carol Vivyan. This programme teaches individuals in a fun and safe way to recognise the link between their own thoughts, feelings, behaviour and emotions (Ayres and Vivyan, 2016). The Decider Skills Programme provides coping skills in the event of an emotional emergency, increasing independence and resilience, reducing impulsivity and resulting in more positive outcomes for the person (Ayres and Vivyan, 2016). The Decider is strongly grounded in theory and is recognised as being helpful within both the primary and secondary care setting, while also being cost effective (Ayres and Vivyan, 2016). Generally the Decider is facilitated as a group however within this audit Decider Skills were provided on a one to one basis in line with COVID - 19 guidelines (HSE Covid Guidelines, 2020). MHN accessed training in the Decider skills both online and at the Decider (2) day training funded by the Wicklow mental services.

Maastricht Interview

The Maastricht interview is for those SU/P who hear voices that others cannot hear (Corstens, 2012). The interview assists the SU/P to cope with hearing voices from a psychological and social perspective and has three central themes accepting it is a common phenomenon, normalising voices as a reaction to life stress which has a meaning and is best accepted as a dissociative experience and not hearing voices (Corstens et al, 2012). MHN who offered this intervention accessed the three day training in the Maastricht Interview.

Relaxation Group

This is a guided relaxation group ran once weekly by the MHN department. Guided relaxation has proven to be effective for the reduction of anxiety symptoms and improves overall quality of life (Nguyen and Brymer, 2018).

Wicklow Psychology Department Groups

The Wicklow Adult Mental Health and Primary Care Psychology Department facilitate groups regularly for both secondary and primary care SU/P. These groups include a (5 week) Introduction to Mindfulness Based Cognitive Therapy, and a group on CBT Skills (8 weeks). Those who have had either a psychiatric or psychosocial assessment can access these groups through self-referral.

Psychosocial Intervention Referral Process:

All MHN interventions are self-referral since Septembers 2020 due to a high volume of nonattendance and waiting lists no longer exist within the MHN department. Where a SU/P has self – referred, they are offered treatment within a week from the point of referal. If an SU/P requires further support they can acquire booster sessions by self-referral and remain active to PARC for life.

3. Aim:

The present audit aimed to assess outcomes of the PARC project from commencement June 2020 to June 2021. This audit reviews additional MHN duties and does not review the established roles of the MHN which have remained unaffected by the PARC project. This included an analysis of clinical outcome measures utilising the Clinical Outcomes in Routine Evaluation (CORE – OM) inventory and reviewing the SU/P experience via evaluations post intervention. This was achieved by accessing previously collected SU/P data, and reviewing outcomes across ANPC psychosocial assessment, postgraduate level cognitive behavioural therapy and the decider skills. Clinical outcomes and SU/P experience were assessed with each intervention, within both the primary and secondary care settings.

4. Standard:

Barkham, Mellor-Clark, Connell and Cahill (2006) outlined a range of CORE - OM benchmarks (based on NHS primary care provider data) for key indicators of service quality. Individual services can be benchmarked against these. The benchmarks were:

1. Waiting times
2. Outcome measure complete rates
3. Therapy ending types
4. Intervention outcomes
5. Rates of recovery and improvement

Taken together, these indicators form the basis for a simple but robust framework for evaluating the quality of therapy service provision. For the purposes of this audit the CORE - OM benchmark used were as outlined above.

5. Methodology:

Design

This study was an audit, with benchmark standards outlined previously. The audit employed a pre and post mixed method study design, by retrospectively analysing existing anonymised, audit data. Collected data was anonymised, and stored electronically, as part of routine clinical evaluation and audit.

Participants

The population for this study were those SU/P who were referred/self-referred to the PARC project. That is, SU/P who were offered attendance at ANPC psychosocial assessment, one to one postgraduate level CBT or the Decider Skills on a one to one basis, provided by the MHN department within both the primary and secondary care settings.

Measures

- *CORE-OM*

The Clinical Outcomes in Routine Evaluation (CORE – OM) was utilised and is a monitoring tool with 34 items assessing global/generic distress measures, covering areas of: Wellbeing (4

items); Problems and Symptoms (12 items); Functioning (12 items) and Risk (6 items) and includes positively and negatively framed items (Connell et al, 2007).

- *Participant Feedback*

A feedback form was included with the post-treatment measures, to obtain quantitative data on participants' experiences of the one to one interventions (Appendices 1, 2 and 3). A brief self-report questionnaire is included on the feedback form, containing statements scored on a 5-point Likert scale (Boone and Boone, 2012); (1 = **very poor, 2 = poor, 3 = fair, 4 = good and 5 = very good)** and these were used to rate; the helpfulness of the ANPC/MHN, ease of the intervention: ANPC Psychosocial Assessment, Cognitive Behavioural Therapy or The Decider Skills and the waiting time for contact from referral. The participants were then asked if they would recommend the provided intervention to others and provided a yes/no answer. Finally the participants commented on positive or negative experiences in treatment provision and any changes that they would recommend to the service. Questions were the same for all interventions.

<u>*Interventions*</u>

Participants referred to the PARC project could avail of a range of interventions (detailed above). These included:

- ANPC Psychosocial Assessment
- Clinical Nurse Specialist, Postgraduate Level, Cognitive Behavioural Therapy (1:1)
- The Decider Skills Programme (1:1)
- The Maastricht Interview (1:1)
- Relaxation Group
- Access to Wicklow Psychology Department Groups (Group CBT, Mindfulness and Stress Control)

MHN groups were cancelled in May 2020 due to COVID - 19 and the uncertainty regarding restrictions. Groups ranged from drop-in groups to groups that would have a duration of 12 weeks therefore postponing, cancelling or rescheduling would have been unsafe as many SU/P were presenting with self-harm or suicidal ideation. These interventions were offered on a one-to-one basis both virtually online, through the Attend Anywhere platform and in the primary care centre depending on NPHET guidance at the point of referral (NPHET, 2020). This audit

contains data of both referral by CMHT members (June to September 2020) and the revised process of self-referral (September – June 2021). Wicklow Adult Mental Health and Primary care Psychology Department evaluate and report on the groups that they facilitate and that data will not be included in this audit. There was one referral to the Maastricht Interview and the participant when offered did not attend therefore there was no data to analyse for this intervention. The relaxation group was not facilitated in line with NPHET guidance therefore there was no data to report on for this intervention.

Quantitative Analysis:

SPSS, where possible, was used in the analysis of data. Data was initially screened for errors using descriptive statistics and frequencies, and then assessed for suitability for parametric testing. The assumption of normal distribution was investigated using descriptive statistics (mean, 5% trimmed mean, median, skewness, kurtosis), histograms, Kologorov-Smirnov test, and Q plots. The assumption of homogeneity of variance between interventions was investigated using Levene's test. The assumption of Sphericity was investigated using Mauchly Tests of Sphericity. Descriptive statistics were calculated for each participant for all available and relevant variables (e.g. socio-demographic, clinical and outcome variables etc). Difference were analysed using chi-squared analyses for categorical variables and independent t-tests or non-parametric alternative, the Mann Whitney test, for continuous variables, as appropriate.

Qualitative Analysis:

Likert findings were presented on a Microsoft Word Table while the yes/no answer of recommendation were presented on an Excel Pie chart (Gerish and Lathlean, 2015). Reflexive thematic analysis was used to identify, collate and report significant themes and subthemes in the qualitative data (Braun & Clarke, 2006). Themes were coded if they captured an essential element of the data and are considered to offer information pertaining to the overall experience and acceptability of the one to one interventions provided by MHN's. An inductive approach was utilised for data analysis which allowed the results to be guided by both the raw data and the specific objectives of the research (Braun & Clarke, 2006). For face-to-face, post-evaluation of satisfaction questionnaires were administered in person at the end of sessions. For online sessions, post-intervention questionnaires were administered via email/post. Qualitative data was also obtained using open-ended questions on the evaluation to examine the participants' experience of the one-to-one interventions provided by MHN's, their

perceived positives and negatives, suggested improvements and any other relevant feedback they may have. The feedback form aimed to establish the overall acceptability of the interventions provided by MHN's, the delivery experience for participants and satisfaction with the MHN approach to the intervention.

Ethical considerations

Ethical approval was applied for from the local ethics committee and granted. All data has been analysed, anonymised and stored electronically. Due to the unexpected nature of the COVID - 19 pandemic, it was not envisaged that groups could not proceed or that one to one would be delivered in person and online. It was not possible to obtain written informed consent or provide research information leaflets to participants initially, however, all participants verbally consented to completing audit data and received written correspondence confirming this and providing an option to opt – out at any time. Limits of confidentiality and data protection issues were explained to participants at that time.

Data Compliance

Participant data was anonymised and stored on a secure, password protected laptop which was only accessible to the principal investigator and research team. During the write up, no personally identifiable details were included to protect the anonymity of participants.

Public and Patient Involvement

These researchers are working alongside the local recovery education facilitator, aree relaying findings to ARCHES the CHO recovery committee and we are reviewing possibilities of further co – produced research. The participants who access these interventions and provide feedback post treatment, assist in the design and further development of the PARC project.

6. Results:

Sample

Participants were **142** service users who had been referred by CMHT members or self-referred to the PARC project. There were **48** = Male, **94** = Female and **0** = Other. All participants

attending were over **18** years of age. On average the participants of this study were **24** years old with the youngest participant **18** years old and the oldest participant **60** years old.

Referrals Received: Location and Diagnosis

Referrals were broken down to areas (see Figure 1 for referral areas). As Bray was the largest referral point, the referrals for this area were broken into categories of well-known areas, to understand the points of referrals (see Figure 2 for Bray breakdown).

One to ones were delivered across all diagnostic categories (see Fig 3 for primary diagnosis). The average number of one to one sessions offered was 3.91 (range 0 -20). There was no exclusion criteria for one to one participation, other than people were motivated to participate demonstrated by self-referral and that they respected the one to one COVID – 19 protocols. Many participants had the presence of suicidal thinking and safety plans were offered to all participants (see Fig 4 for presence of suicidal thinking).

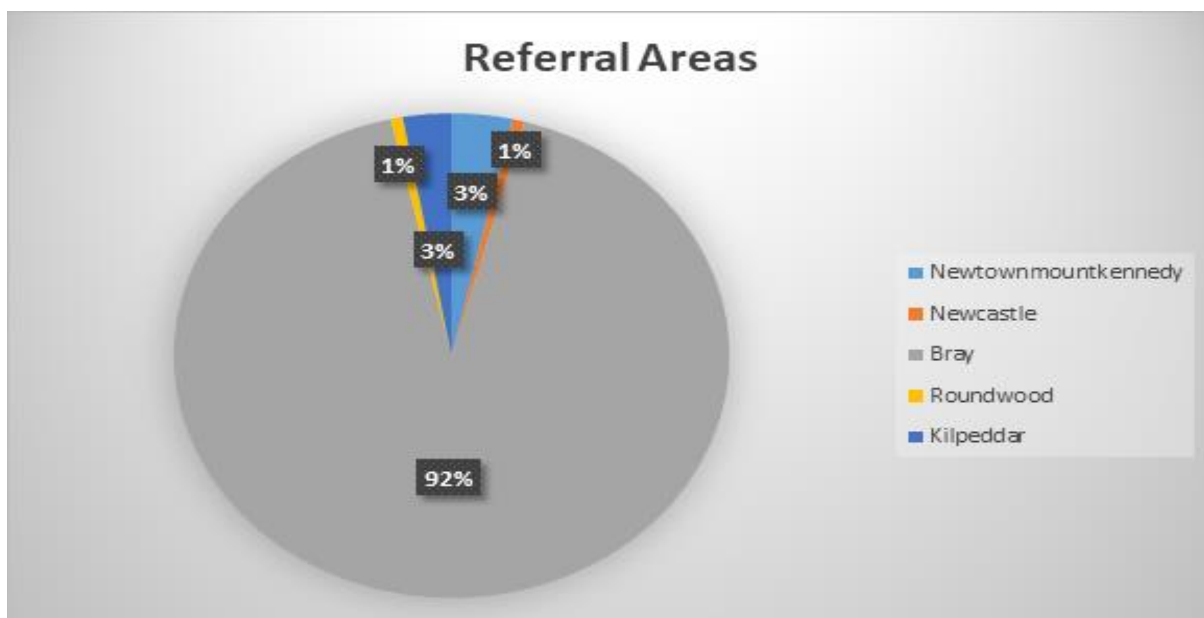

Fig 1

Referral areas of PARC participants:

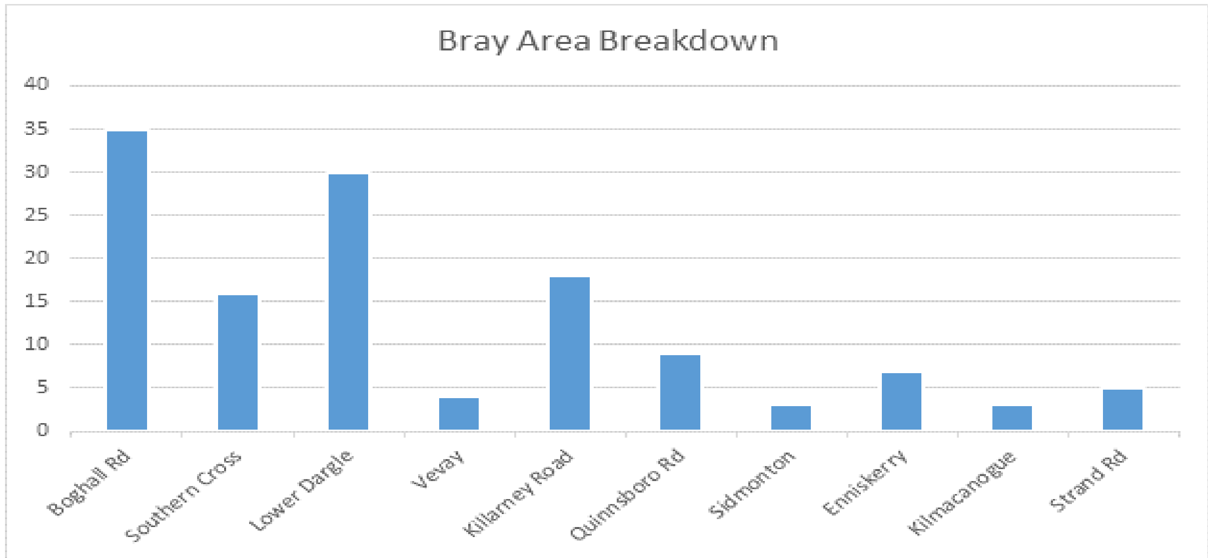

Fig 2

Bray area breakdown of PARC participants:

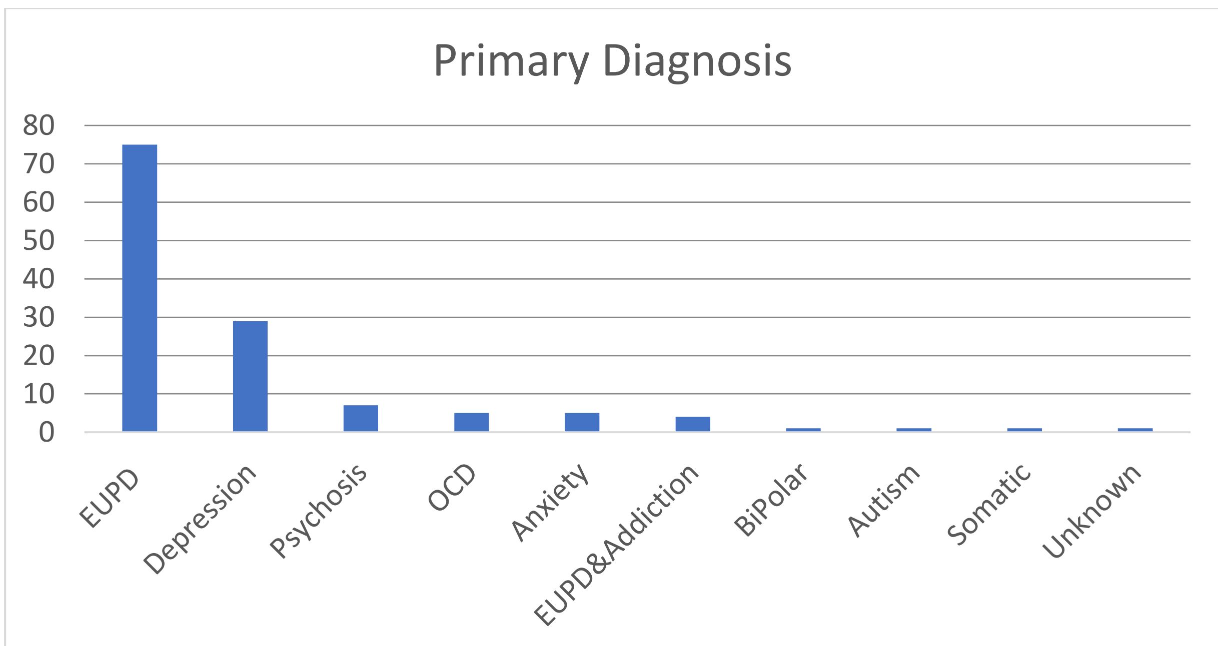

Fig 3

Primary diagnostic category of PARC participants:

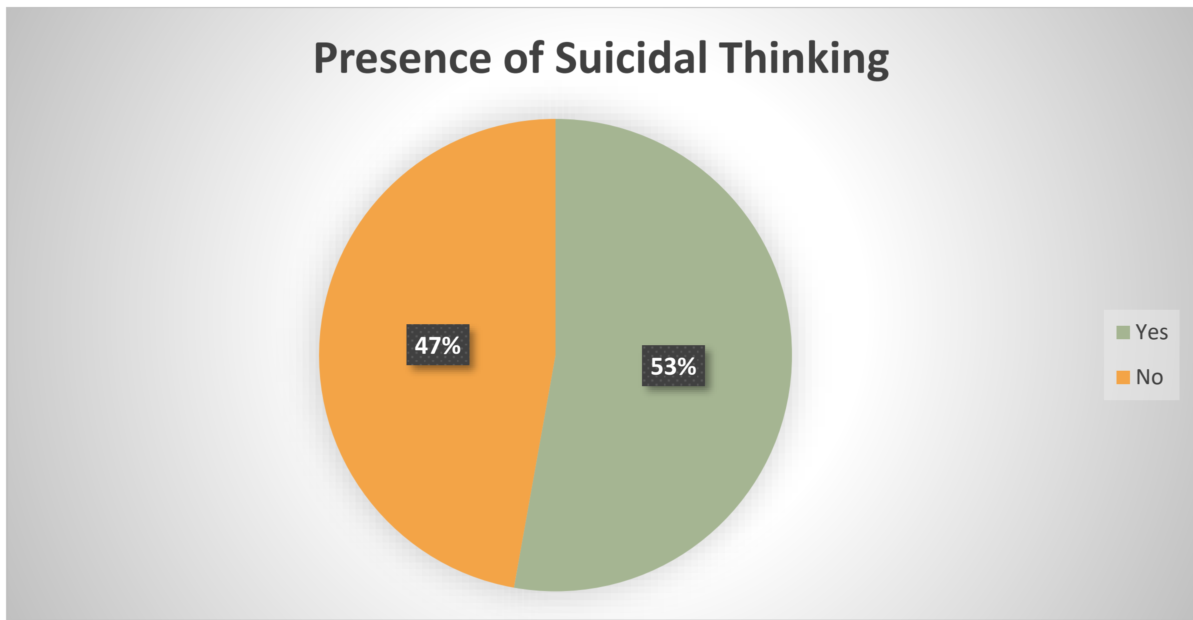

Fig 4

Presence of suicidal thinking of PARC participants:

Pathways of Referral

Participants referred to PARC were either existing SU/P active in the secondary care mental health services, or were new SU/P, referred by GP's to either the secondary care services for a psychiatric assessment or directly for an ANPC psychosocial assessment.

Of the **142** participants referred to PARC, 10.5% (n=**15**) were direct GP referrals to the ANPC. **32%** (n=**45**) were initial GP referrals to the Adult Mental Health Consultant Psychiatrist, but diverted to ANPC. The remaining 57.5% (n=**82**) were self-referrals to PARC (e.g. seen in secondary care and advised to self-refer). (See Figure 5 for a flow chart of participants). **55** (35%) participants remained active in secondary care while referred to PARC, and the remaining **92** participants (65%) were in Primary Care only, under ANPC caseload. Of these, a number had previously been active to secondary care and discharged to PARC; **32** such participants were discharged from secondary care to PARC from routine Out Patient Department Psychiatry Appointments, and **19** were discharged to PARC from Psychiatry New Patient Clinics.

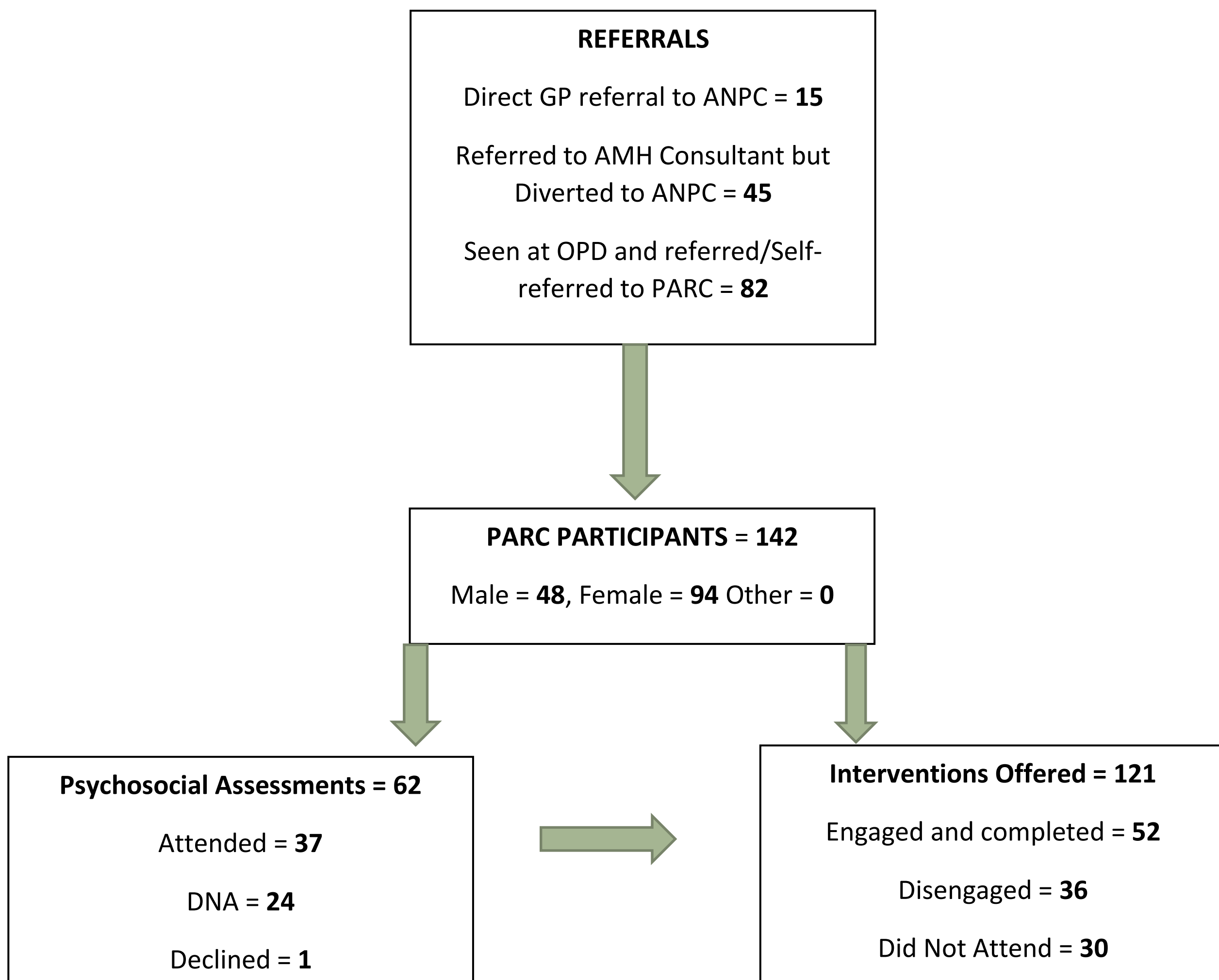

Fig 5

Flowchart of participants through study:PARC Assessments and Interventions

Sixty two participants (43.5%) were referred to ANPC for psychosocial assessment of these, **37** Attended for ANPC psychosocial Assessment and **23** did not attend. One participant was declined ANPC psychosocial assessment due to ongoing alcohol abuse.

One hundred and twenty one participants (85%) were offered interventions through PARC; **65** participants were offered 1:1 Decider skills, **54** were offered 1:1 CBT and **3** participants were offered other interventions (see Fig 6 for interventions offered to PARC participants). Please note; there may be some small discrepancies in numbers overlapping, as some participants were offered Decider Skills and CBT thereafter.

Onward signposting to community services by ANPC are also displayed (see Fig 7 for community signposting). The number of participants who were offered and attended treatment with each MHN was broken down (see Fig 8 for number of participants offered treatment by each mental health nurse) and the number of sessions provided by each MHN can also be

viewed (see Fig 9 for number of sessions provided – ANPC is not included as psychosocial assessments are carried out in one session).

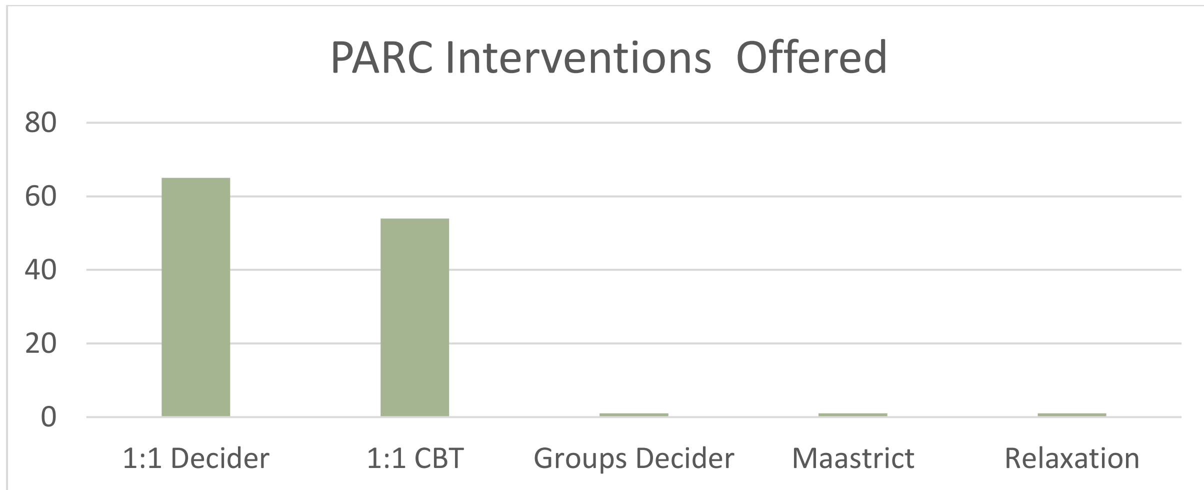

Fig 6

Interventions offered to PARC participants:

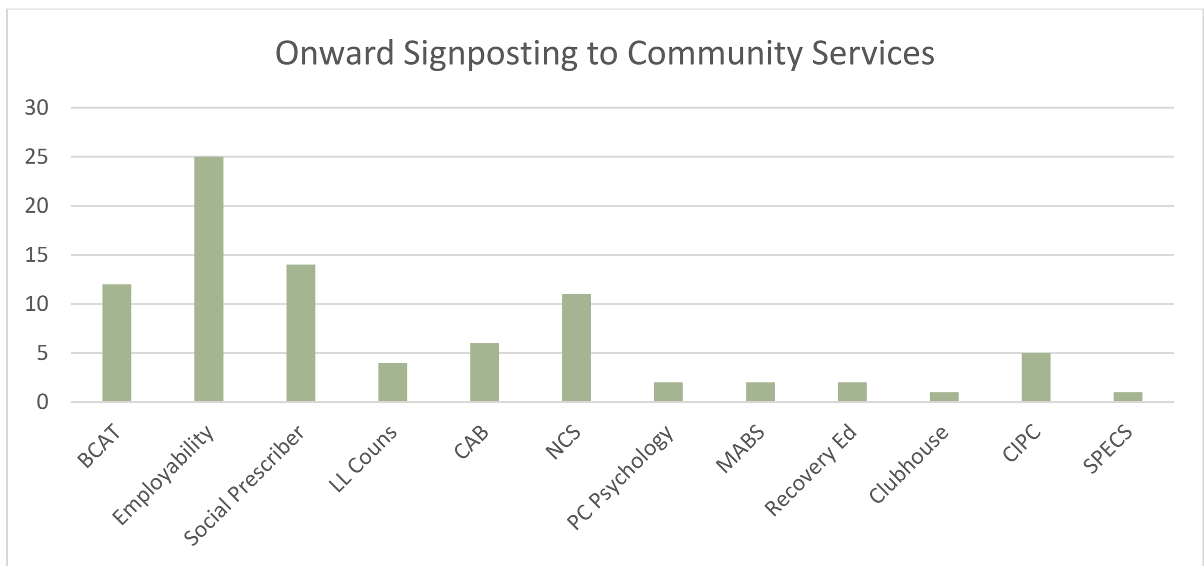

Fig 7

Onward Signposting to Community Services:

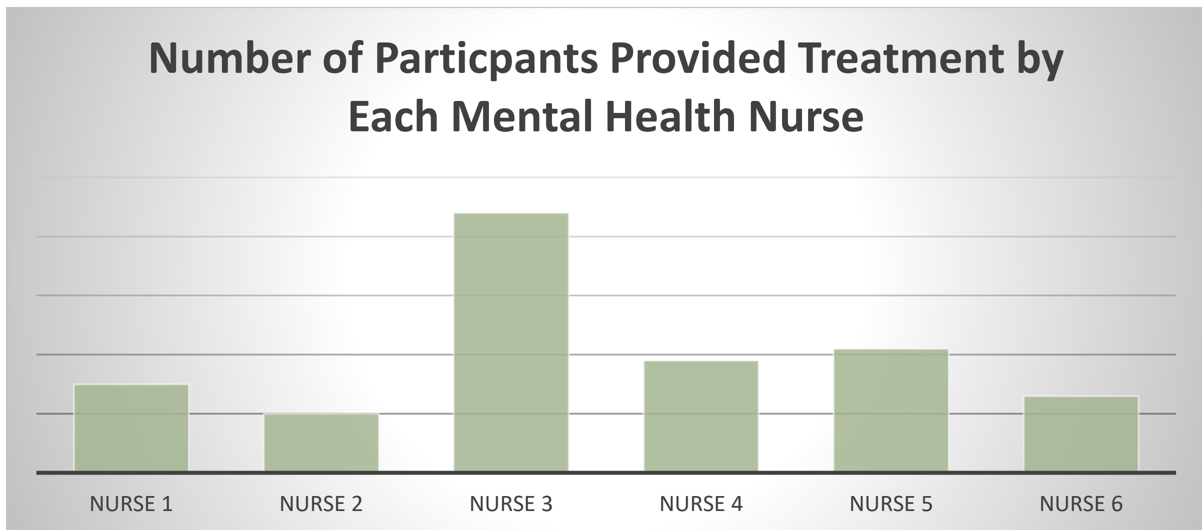

Fig 8

Interventions offered to PARC participants by each mental health nurses:

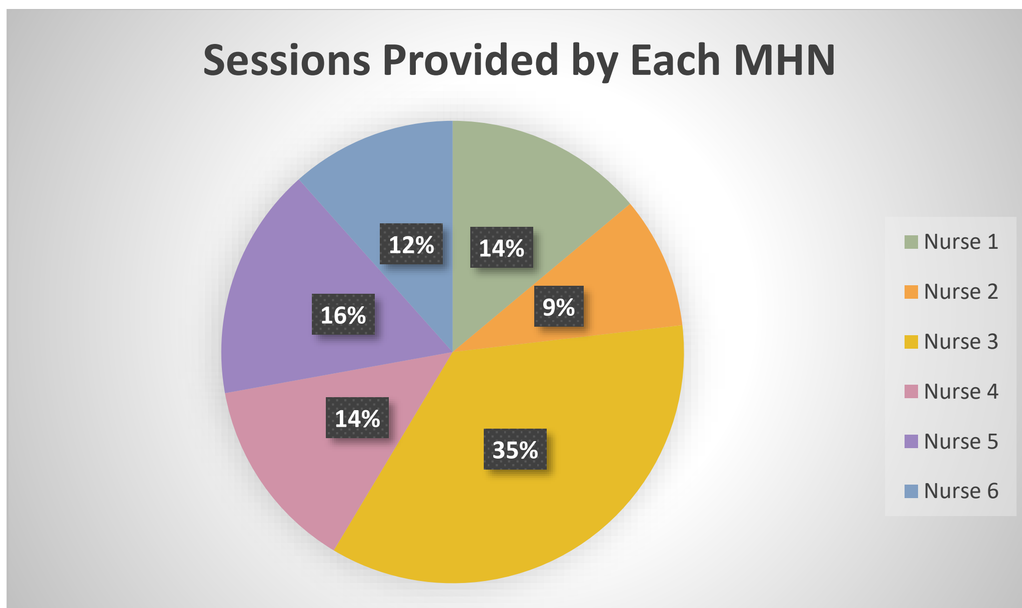

Fig 9

Number of sessions provided by each MHN:

Quantitative Outcomes: CORE OM Benchmark Standards

As previously mentioned, a range of CORE OM benchmarks were used as key indicators of service quality. These included;

1. Waiting times
2. Outcome measure complete rates

3. DNA rates and Therapy ending types
4. Intervention outcomes
5. Rates of recovery and improvement

1. ***Waiting Times***

The average waiting time for an initial appointment with PARC was **4** weeks (range 0-20). Seventy five percent (n = **107**) or participants were offered an initial appointment within **1 week** or less from time of referral. Twenty percent of participants (n = **28**) were seen within **2-4 weeks** and the remaining 5% (n= **7**) waiting **4 weeks or more** for an initial appointment (see Fig 10 for PARC waiting times in weeks by category).

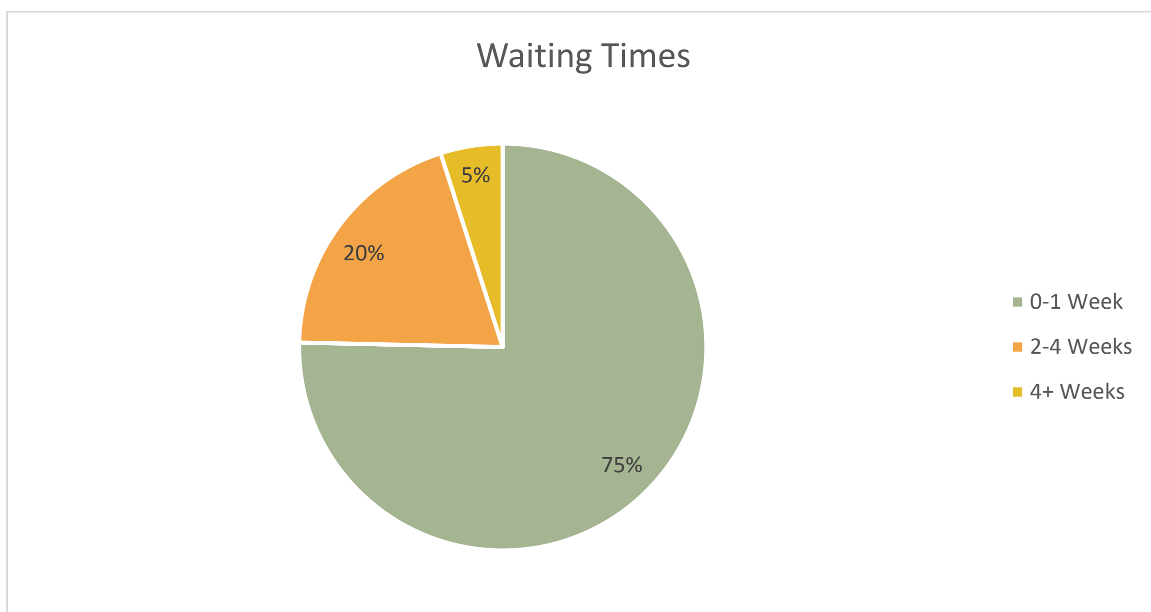

Fig 10

PARC waiting times:

2. ***Outcome Measure Completion Rates***

Of the **142** PARC participants, 65% (n= **95**) completed pre-treatment CORE - OM measures, thus, pre-Core data was missing for 35% of PARC participants. Post CORE - OM measures were completed by 37% of participants (n = **50**) thus 63% post data was missing.

3. ***DNA/Disengagement rates in PARC and Therapy Ending Types***

Of the **142** participants referred/self-referred to PARC, **23** DNA initial psychosocial assessment, **34** DNA any offered intervention session, **36** attended at least one intervention session and then disengaged, and **52** participants remained engaged with PARC and completed

treatment (see Fig 11 for DNA/disengagement rates), however only 50 of these completed Post CORE - OM measures.

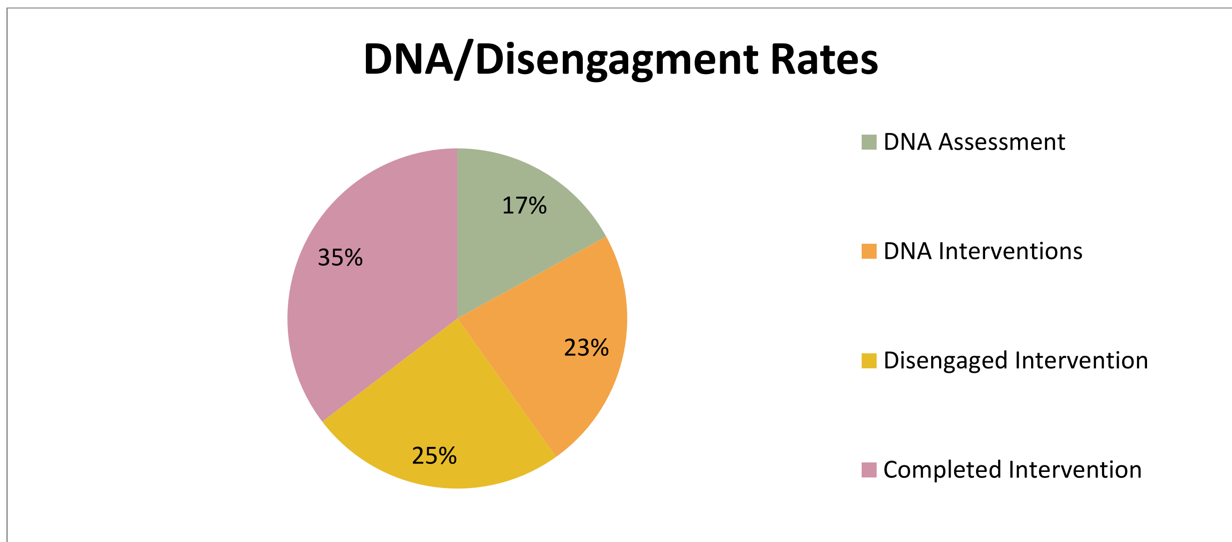

Fig 11
DNA/disengagement rates in PARC:

DNA Psychosocial Assessments

Of the **23** participants who DNA psychosocial assessment, **11** were male and **12** were female. One participant was active to secondary care, whilst the remaining **22** were primary care service users. The primary diagnostic categories were as follows; anger = **1**, anxiety = **1**, depression = **2**, other = **1**, EUPD = **16**. No pre-core data was available for these participants.

DNA Intervention

Of the **34** participants who DNA for intervention, **22** were female and **12** were male. **One** participant was active to secondary care, whilst the remaining **33** participants were primary care SU/P. The primary diagnostic categories were as follows; addiction = **3**, anxiety = **3**, autism = **1**, depression = **7**, EUPD = **16**, psychosis = **2**, somatising = **1**. No pre core data was available for these participants.

Disengaged Intervention

Of the **36** participants who attended PARC interventions and then disengaged, **26** were female and **10** were male. **Fifteen** were active in secondary care, and **19** were primary care SU/P. The primary diagnostic categories were as follows; addiction = **3**, anger = **1**, anxiety = **5**, depression = **6**, EUPD = **21**. The Mean Pre Core Total for these **36** participants was 1.98, comparable to the Mean Pre Core Total of Treatment Completers (1.99).

Treatment Completers

Of the **52** participants who complete treatment, **16** were active to secondary care and **34** were primary care SU/P. Females accounted for **41** participants and **8** were male. The primary diagnostic categories were as follows; anxiety = **5**, bipolar/psychosis = **5**, depression = **13**, EUPD/personality disorder = **24** and OCD = **5**. CORE - OM outcomes, available for 50 participants, are presented (see Fig 13 for CORE – OM outcomes).

Therapy Ending Types

Of the **121** participants offered interventions, 44% (n = **52**) remained engaged with PARC interventions and completed treatment. The remaining 55% did not engage; **30** participants (25%) did not attend for any offered intervention, whilst **36** participants (31%) attended for a number of sessions but disengaged and did not complete treatment. (See Fig 12 for PARC therapy ending types).

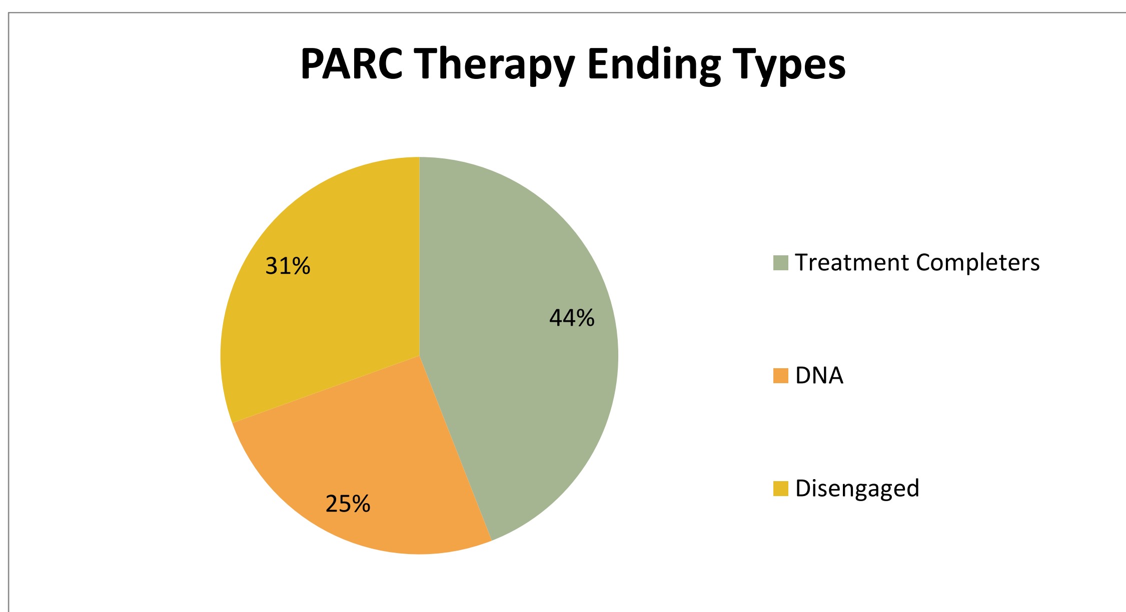

Fig 12
PARC therapy ending types:

4. *Intervention Outcomes*

Pre and Post scores for treatment completers (n = **50**) are presented (see Fig 13 for pre and post CORE OM treatment completers). **Two** participants who completed treatment did not return post CORE measures. It can be seen from Figure 13, that the Total Mean Pre CORE OM score was 1.99, which decreased to 0.92 at Post Treatment. This was a statistically significant change (t =13.28, $p < 0.05$).

There were statistically significant changes on all subscales also. Mean Core F scale (Functioning) changed from pre 1.9 to 0.86 post. Mean Core P (problems) scale change from 2.56 pre to 1.33 post (t - -13.23, $p<0.05$). Mean Core W (well-being) changed from 2.54 pre to 1.18 post and Mean Core R changed from 0.83 pre to 0.98 post (t=-3.6., $p<0.05$).

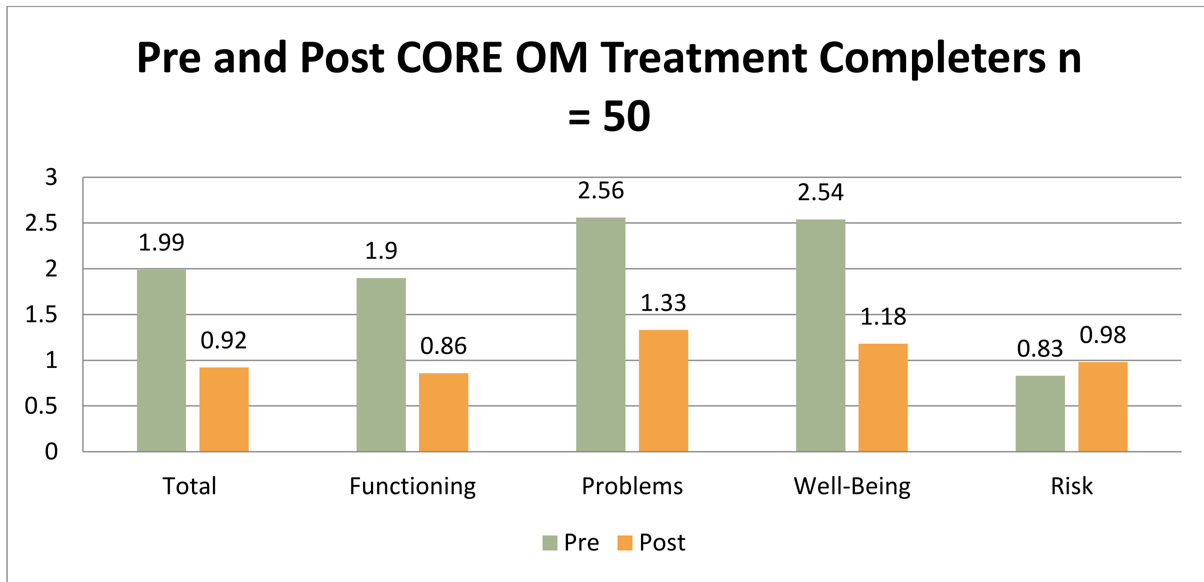

Fig 13

Pre and post mean CORE scores for treatment completers:

5. ***Rates of recovery and improvement***

Rates of recovery and improvement were calculated based on the CORE - OM Reliable Change Index formula, as outlined in the methods (see Fig 14 which outlines the percentage of treatment completers in each reliable change index category on the CORE - OM). It can be seen that 60% of treatment completers (n=**30/50**) can be considered recovered at post treatment (i.e. Mean CORE score in the normal range < 10). Reliable improvement was seen in 28% of treatment completers (n = **14**). That is, their post CORE – OM scores were still in the clinical range, but they showed a clinically significant change of at least 5 points in CORE - OM scores. No change was observed in 12% of treatment completers (n = **6**) and no treatment completers (0%) showed deterioration.

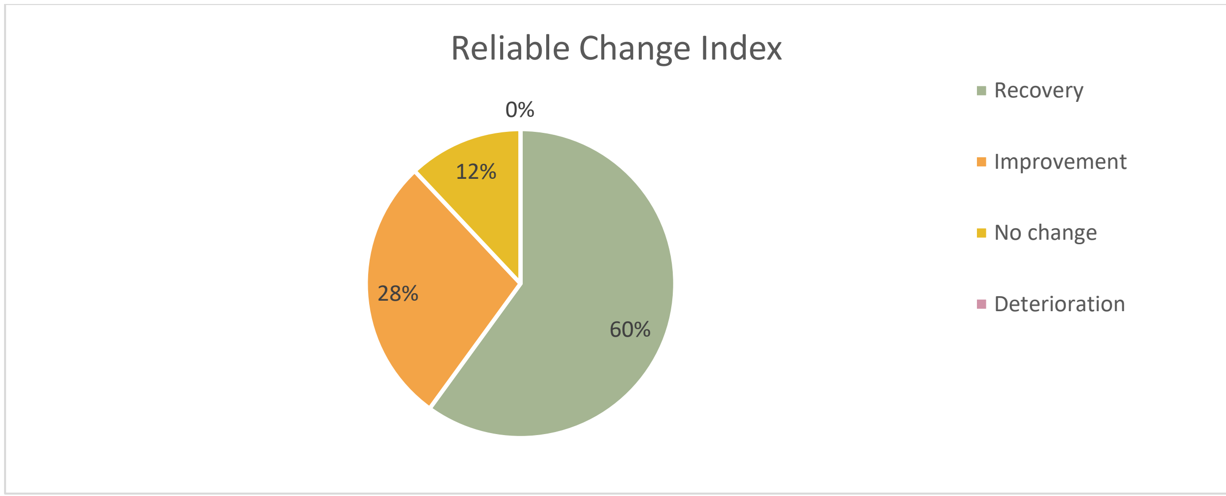

Fig 14

CORE OM scores (n = 50) Reliable Change Index:

Secondary Care Active Caseload:

Prior to the increased psychosocial interventions in 2018 the active SU/P of Bray Mental Health was **(552),** in 2019 = **(344)**, in 2020 = **(252)** and in 2021 = **(282)**. The increase in SU/P 2021 is directly related to the increase in geographical area as discussed previously. The pie charts demonstrate with clarity the active diagnosis within the Bray Mental Health Team (see Fig 15 for 2019 active SU/P, see Fig 16 for active SU/P 2020 and see Fig 17 for active SU/P 2021).

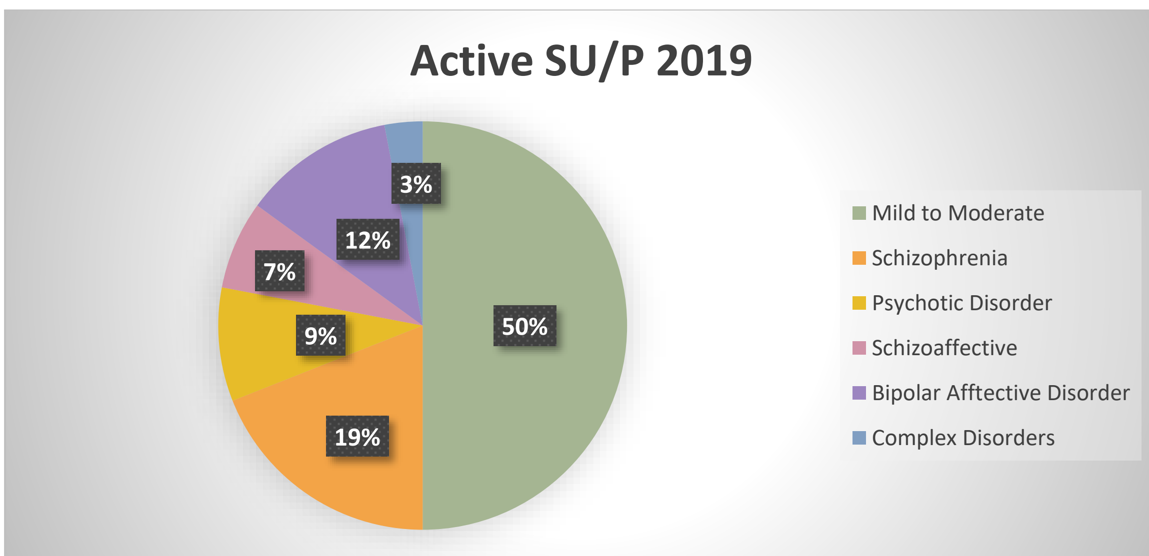

Fig 15

Active SU/P 2019:

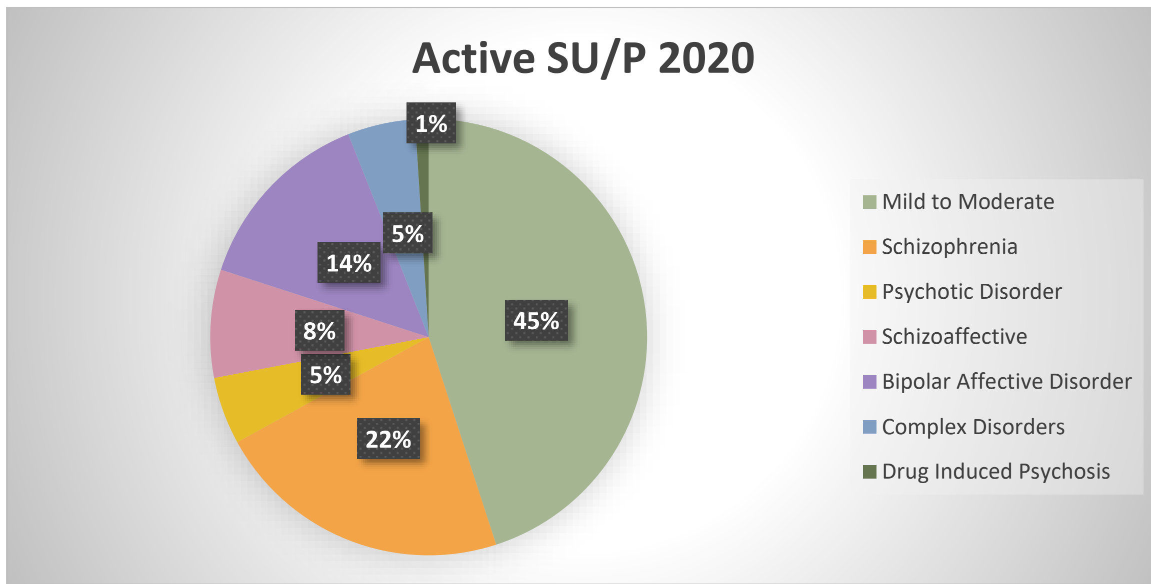

Fig 16

Active SU/P 2020:

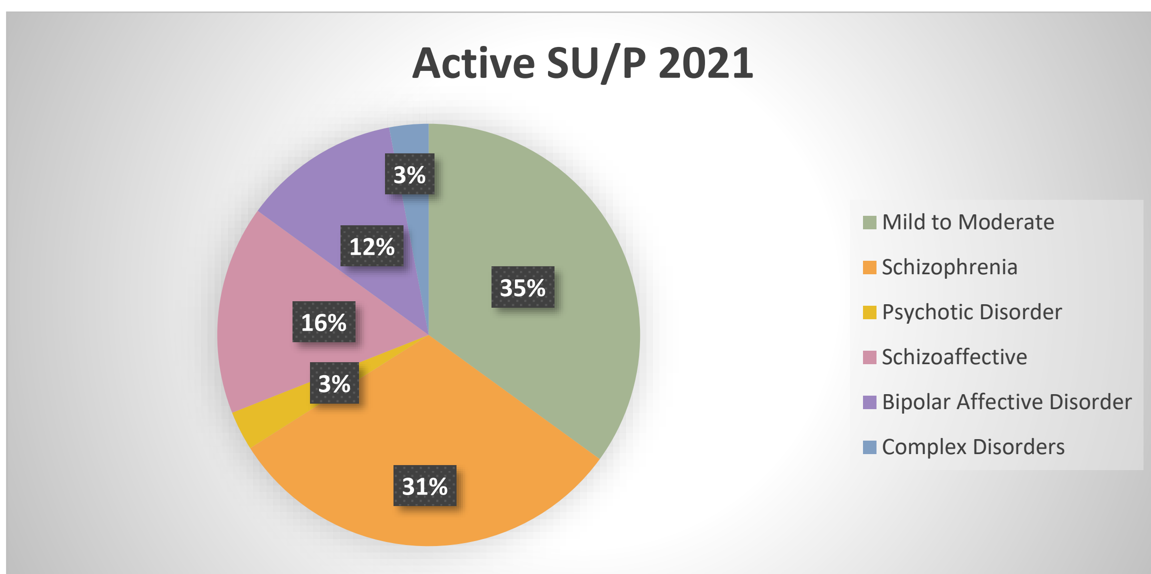

Fig 17

Active SU/P 2021:

Qualitative Findings:

ANPC Psychosocial Assessment:

All participants **(37)** who attended psychosocial assessment were provided with an evaluation questionnaire and there were **(35)** responses. Likert questions resulted in the following findings (see Fig 15 for Likert findings). Participants were asked if they would recommend ANPC

psychosocial assessment to others and were provided with a yes/no answer (see Fig 16 would you recommend ANPC psychosocial assessment to others?) Thematic analysis of participant feedback following **ANPC psychosocial assessment**, found three key over-arching themes and a number of subthemes (see Fig 17 for qualitative table of themes identified by PARC participants):

Questions 1 – 3	Very Poor	Poor	Fair	Good	Very Good
Helpfulness of the Assessor	0%	0%	0%	5%	95%
Ease of the Assessment	0%	0%	0%	18%	82%
Waiting Time for Assessment	0%	0%	5.0%	20%	75%

Fig 15

Likert findings from PARC participant's questionnaire from ANPC psychosocial assessment:

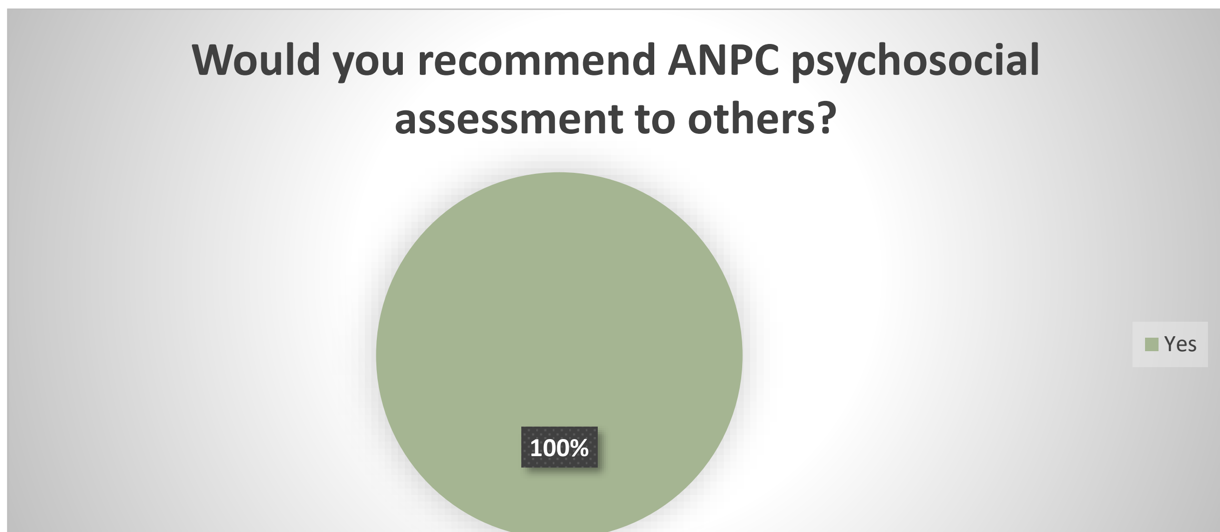

Fig 16

Would participants recommend CANP psychosocial assessment?

Theme Name	How many times this theme was mentioned in the psychosocial assessment evaluation?	How many participants mentioned it in the psychosocial assessment evaluation?
1. Therapeutic Relationship *Subthemes:*		
- ***Safety***	**59**	**29**
- ***Attributes of the Nurse***	**44**	**25**
2. Accessibility *Subthemes:*		
- ***Comprehension***	**34**	**24**
- ***Ease of Access***	**08**	**06**
3. Personal Choice	**13**	**11**

Fig 17

Qualitative table of themes identified by PARC participants from ANPC psychosocial assessment:

1. *Theme 1: The Therapeutic Relationship:*

The first main theme within the ANPC psychosocial assessment identified by participants was the importance of the therapeutic relationship. This emerged out of two subthemes from the data; a feeling of safety and attributes of the nurse.

1.1 Subtheme: Safety:

Almost all participants reported that they felt at ease and safe throughout the psychosocial assessment with participant (1) highlighting:

> *"No feeling of been judged as crazy or stupid. Provide a feeling of relax and security",*

The importance of clear communication and safety were linked when participant (22) reported:

> "*Really lovely woman who made me feel understood and quite at ease" while participant* (23) confirmed:

> *"Questions were asked well and I didn't find it intimidating"*

Participant (31) went on to state:

> *"Questions were explained clearly and asked without judgement".*

In the participants accounts a non – judgemental approach and clear communication were highlighted as creating a safe therapeutic space.

1.2.Subtheme: Attributes of the Nurse:
Several positive nursing attributes were highlighted throughout the text with participant (14) reporting:

> *"Supportive, positive engagement making you feel that what is being said is listened to and understood"*, this was further supported by participant (27) stating:
>
> *"XXXX was only lovely in the time we spoke through our interview and made me feel at ease with everything. She was also amazing explaining each question and was only lovely in taking my feedback, it felt like talking to a really good friend".*

Participant (35) made the following observation regarding communication:

> *"Very open dialogue, felt comfortable to discuss anything that was needed".*

In the participant's accounts of their individual experience attributes of the nurse appeared to impact on engagement and the feeling of safety.

2. Theme 2: Accessibility:
The second main theme identified from the data as important to participants, was accessibility. This emerged out of two subthemes from the data; comprehension and ease of access.

2.1 Subtheme Comprehension:
Comprehension is fundamental to enable informed and active SU/P participation in the treatment plan and clear communication is considered a priority to ensure the SU/P is fully informed (Kreps, 2018). Illustrative examples appear below:

> Participant (23): *"I found the assessment very easy, questions were asked well"*
>
> Participant (19) stated: *"I thought it was good, very direct and to the point".*
>
> Participant (16) reported a clearer understanding of mental health difficulties post assessment: *"The questions were very helpful and made explaining my mental health issues easier".*
>
> While participant (29) highlighted *"Excellent assessment, covers a lot of areas i.e both mental and physical questions, feeling there are solutions to my problems"*

In the participants accounts comprehensible questions within the assessment could potentially assist in explaining both physical and mental health difficulties.

2.2 Subtheme Ease of Access:
Early accessibility was identified as important to participants and is an individual's entitlement to an integrated care system, shifting the main body of the provision of care to the community (Government of Ireland, 2018). Lack of information was highlighted as an issue in terms of accessing treatments.

Participant (8) identified that: *"there is no pressured feeling for time"* and participant (9) reported a *"Rapid response regarding appointment, feeling positive regarding prescribed treatment agreed"*.

Participant (13) reported as helpful the communication between the ANPC and Consultant Psychiatrist to primary care *"she ended the session clearly laying out what would happen next which I appreciated and she also sent it to my doctor"*.

Issues of concern re: accessibility arose when participant (24) describes the lack of online resources *"It might help to have online links provided after the assessment to give a broad idea of the service I will be availing of"* going on to highlight that:

"It was my GP who advised me to ring and self-refer as there does not appear to be any information about the process online, if my GP didn't suggest it I wouldn't know about it" confirming a relevant issue.

In the participants accounts a rapid response to mental health can be helpful whereas lack of online information can leave patients in the dark regarding available treatments and access to services.

3. Theme 3: Personal Choice:

With personal choice comes personal responsibility, which is the foundation of recovery, focusing on an individual's strengths and supporting them to regain control over their own life (Leamy et al, 2011).

Participant (8) stated:

"This is probably the most productive and helpful step I have ever taken in the direction of getting help" while Participant (12) confirmed:

"I felt listened too and that the assessor respected my autonomy regarding the use of medication" also comparing this to previous psychiatric assessments:

"I found this a lot more useful than the two psychiatric assessments I had previously, where the approach was centred around medication and not much else, I am happy this approach is being used as I feel it could be helpful for outpatients who need social interventions and more therapeutic centred supports" highlighting the importance of a holistic approach.

Participant (5) confirmed the importance of the support in changing:

"Lovely to see someone so optimistic about my future and recovery" and Participant (14) remarks on the sincerity of the process:

"The follow up is pro – active reinforcing the sincerity of the overall engagement" with Participant (34) confirming that the assessment experience was:

"Understanding, felt I was listened too and my personal feelings about my own mental health were taken seriously".

In the participants accounts personal choice and sincere support appears important to move forward on the recovery journey.

Cognitive Behavioural Therapy Findings:

All participants **(54)** who attended CBT were provided with an evaluation questionnaire and there were **(23)** responses. Likert Questions resulted in the following feedback (see Fig 18 for Likert findings from PARC participant feedback). Participants were asked if they would recommend CBT to others (see Fig 19 would you recommend CBT to others?). Thematic analysis of participant feedback following **CBT**, found four key over-arching themes and a subtheme (see Fig 20 for qualitative table of themes identified by CBT participants):

Questions 1 – 3	Very Poor	Poor	Fair	Good	Very Good
Helpfulness of the CBT provider	0%	0%	0%	9%	91%
Ease of the CBT process	0%	0%	17%	26%	57%
Waiting Time for CBT Assessment	0%	8%	13%	22%	57%

Fig 18

Likert findings from PARC participant's questionnaire:

Fig 19

Would participants recommend CANP psychosocial assessment?

Theme Name	How many times this theme was mentioned in the CBT evaluation?	How many participants mentioned it in the CBT evaluation?
1. Effectiveness of CBT	**46**	**22**
Subtheme: ***Improvements in daily life***	**9**	**7**
2. Therapist skills	**20**	**9**
3. Challenges	**4**	**3**
4. Accessibility	**14**	**8**

Fig 20

Qualitative table of themes identified within PARC participant feedback:

1. *Theme One: Effectiveness of CBT*

The effectiveness of CBT was demonstrated by participants where they identified learnings such as:

> Participant (1): "*Better way of thinking"* while participant (10) stated they could:
>
> "*See things clearer*"
>
> Participant (8) *"Learned a lot about my thinking, emotions, feelings and behaviour, how they relate to one another, this is important to me"*

The learning and skills attained during the CBT intervention was highlighted in how many participants found CBT to be a positive experience:

> Participant (8) *"I enjoyed every minute of my CBT"*
>
> Participant (15) *"I found it helpful to my wellbeing in various ways"*

Several participants appeared to gain CBT skills:

> Participant (2) *"Made a real difference to me coping much better"*
>
> Participant (11) *"To cope with bad days and appreciate the good days even more"*
>
> Participant (15) "*I have learned good coping skills and techniques to deal with my emotional problems".*

The positive effect of CBT was highlighted throughout the data and learning new skills was noted as important.

1.1 Improvements in Daily Life

Beck and Alford (2008) teaches that therapists must aid their SU/P to identify key cognitions and adopt a more realistic, adaptive perspective, which helps them to feel better. Illustrative examples below:

> Participant (5) *"Thoughts on the track to being healthier".*
>
> Participant (14) *"My mood is improved a lot".*
>
> Participant (15) *"I found it helpful to my wellbeing in various ways".*
>
> Participant (19) *"My life has changed so much, so much for the better".*

CBT skills support the person to cope more effectively with stressful daily events, which is thought to be central to therapeutic change (Barber and DeRubeis, 2001). Illustrative examples below:

> Participant (21) "I've *found myself able to handle stressful situations much better and I am using many of the skills every day".*
>
> Participant (18) "*Really surprised at how effective CBT was".*
>
> Participant (9) "*It has helped my daily life hugely".*
>
> Participant (20) *"I was able to significantly reduce self – harming".*

The CBT model appears to improve daily life and means of coping from the participant feedback.

2. Theme Two: Therapist's skills

The effectiveness of the relationship within the CBT intervention was evident, where these participants commented on the therapist as:

> Participant (6) "*Someone I get on so well with".*
>
> Participant (17) "*Easy to talk too".*
>
> Participant (19) "*XXXX was brilliant".*
>
> Participant (20) *"Really enjoyed working with XXXX, extremely helpful and her kindness, understanding and advice really helped me mentally".*
>
> Participant (22) *"Very welcoming and felt very comfortable to discuss difficult things"*

Core skills and core characteristics were also identified by some of the participants, for instance:

> Participant (6) "*XXX showed me a lot of empathy, made it all normal"*

Participant (10) *"Listened to my problems and didn't judge me"*

Participant (7) "*I was never given up on, patience was always given"*

It appears that the therapist skills appear to provide a positive experience for the participants and improved outcomes.

3. Theme Three: Challenges

Participants noted CBT can be difficult initially, for instance, one participant noted:

Participant (17) "*I found it hard at the start"*.

The responsibility of the participant and therapist appeared to become clearer as the sessions progressed as one participant identified:

Participant (5) *"Possibly the pressure of making progress made me a bit scared of not doing well but overall this was alleviated over time"*.

One participant noted that CBT:

Participant (3) *"Takes a lot of commitment"*.

The therapist following up on homework holds the person accountable to take personal responsibility in their recovery as noted by a participant:

Participant (5) *"Provided me with a weekly check in which was very motivating"*.

CBT appears to be challenging and from the participants feedback takes commitment and personal responsibility.

4. Theme Four: Accessibility

Accessibility was reflected by participants in two ways, in how accessible CBT was and how accessible the PARC project was. Two participants noted the CBT process as:

Participant (1) *"Logical… easy to track progress"*.

Participant (2) *"It was an incredibly easy and helpful process"*.

The PARC project a self-referral project with the availability of booster sessions highlights that due to this process there is support available when a person is experiencing a difficult period which was reflected below:

Participant (4) *"Got me through a difficult period"*.

Participant (6) *"It's great to come back for a booster"*.

Participant (15) "*Possibly not long enough but I do have the option to continue with more sessions in the future if I feel it is needed"*

Two participants identified that it was an approach they wished they had been referred to earlier:

Participant (9) "*Yes I did feel it helped a lot and wish it was something I did earlier in my illness".*

Participant (19) *"I loved my sessions, I wish I knew about CBT years ago".*

There were barriers noted by participants also:

Participant (2) "*as it is on video it was sometimes difficult".*

Participant (6) "*Better in person than online".*

Previous waiting lists were noted to be unhelpful:

Participant (9) "*Wait time was too long and I feel lucky I had other supports, friends etc, otherwise it mightn't have worked as well. I meant to be offered at an earlier stage of my illness".*

Overall, it appears CBT has been helpful but challenging also. There were positives and negatives in terms of accessibility but face to face appears the most satisfactory delivery.

The Decider Skills:

All participants **(23)** who completed the Decider Skills were provided with an evaluation questionnaire and there were **(13)** responses. Likert Questions resulted in the following feedback (see Fig 21 for Likert findings from PARC participant feedback). Participants were asked if they would recommend the Decider Skills Programme to others (see Fig 22 would you recommend the Decider Skills programme to others?). Thematic analysis of participant feedback following Decider Skills, found three key over-arching themes and a number of subthemes (see Fig 23 for qualitative table of themes identified by the decider skills participants):

Questions 1 – 3	**Very Poor**	**Poor**	**Fair**	**Good**	**Very Good**
Helpfulness of the mental health nurse	**0%**	**0%**	**0%**	**7%**	**93%**
Ease of the Decider Skills	**0%**	**0%**	**7%**	**23%**	**70%**
Waiting Time for Decider Skills	**0%**	**0%**	**7%**	**14%**	**79%**

Fig 21

Likert Findings from PARC participant's questionnaire:

Fig 22

Would participants recommend the Decider Skills?

Theme Name	How many times this theme was mentioned in the Decider Skills Evaluation?	How many participants mentioned it in the Decider Skills Evaluation?
1. Therapeutic Relationship	21	10
2. Expected Outcomes		
Subthemes:		
- *Life Changing*	9	7
- *Easy to Comprehend*	7	7
3. Accessibility Within Service	5	5

Fig 23

Qualitative table of themes identified within PARC participant feedback:

1. *Theme 1: The Therapeutic Relationship:*

The first main theme within the provision of the Decider Skills identified by participants was the importance of the therapeutic relationship:

Participant (1) stated *"XXXX was so kind and understanding" while participant (3) commented:*

"The energy of the sessions was great, my nurse brought such a positive energy and was open about her own experiences which made it a very safe environment to be vulnerable".

Participant (9) reported: *"One to one for me was a very positive experience. My mental health nurse made me feel safe to express anything I needed".*

In the participants accounts a positive therapeutic relationship and positive energy from the MHN was an important factor while completing one to one Decider Skills.

2. Theme 2: Expected Outcomes:

The second main theme within the provision of the Decider Skills highlighted by participants was the Decider Skills Content. This emerged out of two subthemes from the data; life changing and fun.

2.1: Subtheme: Life Changing:

Participant (2) commented on the life changing experience:

"I have had a really positive experience and feel like my appointments here have changed the course of my life for the better. Waiting time was good, people are very friendly",

while participant (4) commented:

"Really helpful, recognising tools I have and learning new ways of coping. Excellent, I use these every day, really I do. I really enjoyed the Decider and learned a lot".

Participant (5) commented on the lifelong commitment to change*:*

"Skills I will use for life thank you". Participant (11) described normality for them:

"It helped me with trying to get back to normal living".

In the participants accounts the Decider Skills assisted in making changes that can lead to a new way of life.

2.2: Subtheme: Easy to comprehend:

Participants commented on their understanding of the Decider Skills with participant (6) highlighting that Decider Skills was:

> *"Very easy to understand and has given me depth in the techniques, well needed refresher"*
>
> Pparticipant (7) states:
>
> *"Clear and easy to understand – explained well".*
>
> Participant (9) stated:
>
> "*Life skills that are thought out made me laugh*" while participant (12) stated:
>
> *"Clearly explained life tools for management of OCD, kind and caring".*
>
> Finally participant (13) suggested:
>
> *"Explained Decider Skills in a practical and simple way. It was very easy to understand and follow".*

In participants accounts the Decider Skills was fun and easy to comprehend.

3. Theme 3: Accessibility:

Participants commented on the level of accessibility within service regarding the Decider Skills with participant (3) noting:

> *"The organisation were also very very accommodating and with Covid would suggest doing it over the phone if more comfortable",* with participant (10) stating:
>
> *"Friendly, personal, understanding, very accommodating".*
>
> Participant (6) made reference to the positive impact of a refresher:
>
> "*Well needed refresher"*
>
> Participant (9) reflected:
>
> *"Nothing negative about the one to one, but group, I will say, I wish I could have chatted with people from group but I appreciate this wasn't possible with Covid".*

Easy access to the Decider Skills and a range of available options for delivery of the Decider Skills appears a positive approach from participant feedback.

7. Discussion

7.1 Summary of Main Findings:

This audit evaluated the PARC project, a project recommended by ANPC, supported by MHN, consultant psychiatrist and the CMHT over its first year of service provision. The results of this audit add to the growing hypothesis that MHN's providing evidenced based interventions can and do improve SU/P outcomes and result in a high level of SU/P satisfaction in both primary and secondary care. The clinical outcome measures on the CORE – OM identified that there was a statistically significant change to all areas of emotional wellbeing for SU/P who completed the available interventions and no SU/P deteriorated at post intervention evaluations. The secondary care caseload of mild to moderate mental health diagnosis has continued to decrease with both the Decider Skills and CBT being provided as a first line intervention to those SU/P in primary care as recommended (Ayres and Vivyan, 2010; Government of Ireland, 2020). SU/P levels of satisfaction are positive with all SU/P recommending ANPC Psychosocial Assessment, CBT, and the Decider Skills to others. Qualitative feedback confirmed the therapeutic relationship and positive nursing attributes as fundamental to SU/P within all interventions which of course is the foundation of the MHN (NMBI. 2015). Accessibility both comprehension and service accessibility were noted as positive alongside personal choice and recovery focused care as recommended (Leamy et al, 2011). It was indicated that there is insufficient online information regarding the PARC project which can create a blockade for SU/P. CBT and the Decider Skills noted improvements in daily life, were easy to comprehend, however CBT as expected was noted to be challenging initially (Ayres and Vivyan, 2010; Greenberger and Padesky, 2015). Early access and various means of accessibility were noted as important to the SU/P in terms of attending available interventions as recommended (Government of Ireland, 2020). There were noted difficulties with the Attend Anywhere platform re: connectivity. Diagnostics identified a higher rate of emotionally unstable personality disorder and over half the SU/P had suicidal thinking. Within the yearly audit of the PARC project there were no completed suicides indicating reduced risk during and on completion of treatment.

7.2 Evaluating Results Against the Literature:

A) *Translation for the MHN:*

Within Ireland health policy there is increased emphasis on connecting secondary and primary care services to provide specialist care and early interventions for SU/P experiencing mild to moderate mental health disorders within primary care (Government of Ireland, 2020). MHN has long been established in secondary care and the benefits of integrating MHN within the primary care setting has been recognised as an effective and economic way to manage mild to moderate mental health disorders within other countries such as America, England, Sweden, Australia and New Zealand (Haber and Billings, 1995; Dyer et al, 1997; Badger and Nolan, 1999; Walker et al, 2000; Ely, 2015; Heslop et al, 2016; Reiss – Brennan, 2016; McLeod and Simpson, 2017; & Delaney et al, 2018). Studies have not only introduced MHN in primary care, but they have reviewed the outcomes which support this innovative idea and they have begun to incorporate MHN within primary care at a national level (O' Brien et al, 2006). A systematic review of randomized control trials from (1998 – 2017) identified nine control trials that reported on MHN's delivering evidenced based interventions within the primary care setting (Halcom et al, 2019). The outcomes from those RCT's were difficult to compare as the interventions provided differed with each study, although it was clear that there was significant improvement in at least one SU/P outcome (Halcom et al, 2019). The therapeutic relationship was highlighted as important to create a safe therapeutic environment as recommended (NMBI, 2015). There is evidence internationally that MHN interventions can and do reflect improvement in SU/P outcomes, however there is limited evidence regarding MHN interventions within the primary care setting in Ireland (Halcom et al, 2019). The results of this audit may influence the future development and delivery of MHN interventions from various grades to those SU/P in primary care and add to the growing body of literature in this area.

B) *ANPC Psychosocial Assessment*

The clinical outcomes, and the SU/P evaluation of the ANPC psychosocial assessment appear to meet the aim of a psychosocial assessment, which is to understand the SU/P and provide evidenced based treatments to assist the SU/P to return to their optimal level of functioning (Trennoweth and Moone, 2016; Valderrama et al, 2015). As described in SU/P feedback, safety is a core feature that is required in treatment, which allows the SU/P to openly discuss

their inner most thoughts and feelings and involves creating a safe environment (Hartley et al, 2020). Post assessment the SU/P were signposted to the expert community services confirming a social and mental health assessment as recommended which can significantly improve a SU/P quality of life alongside evidenced based interventions (Trenoweth and Moone, 2016). A large proportion of SU/P were diagnosed with emotionally unstable personality disorder and psychosocial assessment and interventions has within the literature been recognised as a central way to manage self – harm, identifying risks, SU/P individual needs and ensuring early provision of required care (Hunter et al, 2012). The evidence base of Caroll et al's (2016) Cohort Study which concluded that psychosocial assessment is not associated with increased risk of self – harm in the acute hospital setting may be applicable to the community and could be reviewed in future research. An expected outcome was that most important to the SU/P was the therapeutic relationship, the relationship between the SU/P and the therapist. It is central to the role of the MHN, and it is a key factor predicting positive SU/P outcomes (Trenoweth and Moone, 20016). Attributes of the MHN identified were in line with governing bodies recommended skills which include professional intimacy, power, respect, trust and empathy (NMBI, 2015). This was supported further by clear communication and information sharing (Hartley et al, 2020). It is recommended within the literature that if the medical profession can refrain from the use of medical jargon there could be a significant improvement in the delivery of care to SU/P and this clearer understanding of mental health difficulties was noted by SU/P post assessment as being helpful (Pitt and Hendrickson, 2019). By supporting the SU/P to acknowledge their role in the process of recovery they can improve their situation (Leamy et al, 2011). Accessibility, clear communication, and information sharing is vital for SU/P to be able to make an informed decision about their own mental health journey and this was present in the ANPC psychosocial assessment thematic analysis (Leamy et al, 2011).

C) Cognitive Behavioural Therapy Findings:

There was a high level of SU/P satisfaction with CBT where all SU/P would recommend CBT to another person and the clinical outcome measures identified an improvement in levels of emotional distress for those who completed treatment. CBT uses targeted strategies to help SU/P follow more adaptive patterns of thinking and behaving, which leads to positive changes in emotions and decreased functional impairments which was reflected in the CORE – OM findings (Coffey *et al.,* 2015). CBT was noted to be an effective psychosocial intervention,

focusing on current problems for SU/P, using clear underlying models which were delivered in a structured way, with clear plans emphasising a treatment which is built on an effective relationship with the practitioner (Williams and Garland, 2002). The therapist being welcoming, expressing genuine empathy and an overall acceptance of the SU/P, helps to affirm the SU/P feelings, these feelings serve to facilitate a therapeutic relationship (Greenberger and Padesky, 2015). A good therapeutic relationship is recognised as having the greatest impact on treatment outcomes for SU/P who experience mental health difficulties, more so than the therapies themselves and this was evident with the noted improvements in daily life (Hartley et al, 2020). CBT is recognised effective as a first line intervention, and this was confirmed throughout the thematic analysis as being of utmost importance to SU/P and the concern emerged of waiting lists delaying recovery. Blackburn *et al*., (2001) state that the key feature of conceptual integration is that the therapist should aid the SU/P to gain an understanding of the history, triggers, and maintenance of their problems to promote change to their quality of life and this was a recognised achievement in the thematic analyses. Also, Hughes *et al*. (2004) suggests that CBT can be difficult initially, this can be related to developing new skills. CBT was found to be *"challenging",* and this may reflect one of the core components of CBT being homework which is critical to treatment (Beck, 1995) and often involves experiments to test the validity of an SU/P thoughts, beliefs, or assumptions (Greenberger and Padesky, 2015). The weekly check in appeared beneficial and as CBT is a structured approach, this provides predictability to both the therapist and the SU/P, assists in clear and open communication, and helps to socialise your SU/P to the CBT model (Dobson and Dobson 2013). Weekly check in means reviewing progress, supporting the SU/P to stay on track and early access to CBT is deemed as most beneficial. The CBT findings within this audit highlight that CBT was provided appropriately, that expected outcomes quantitatively and qualitatively regarding CBT were present which led to improvements in levels of emotional distress and supported the recovery approach.

D) The Decider Skills Findings:

There was a high level of SU/P satisfaction where all SU/P would recommend Decider Skills to another person and the clinical outcome measures identified an improvement in levels of emotional distress for those who completed the Decider Skills. The teaching of the Decider Skills was, as you would expect described as fun and energetic (Ayres and Vivyann, 2016). In

thematic analysis findings the Decider Skills assisted adults to begin to manage their own mental health by the education provided in session. This education included both Dialectal Behavioural Therapy (DBT) and CBT skills, identifying the link between thoughts, feelings, and behaviours (Ayers and Vivyann, 2016). Ease of access was noted important by SU/P and the Decider Skills within the Bray CMHT is now provided as a first line intervention to both primary and secondary care SU/P by the MHN discipline (Ayeres and Vivyann, 2016). The main goal of the Decider Skills as achieved in Ayres and Vivyann pilot project (2019) were similar for those SU/P who completed the intervention, was reported both quantitatively on the CORE - OM and qualitatively as; easy to understand, fun, life changing by use of coping skills in emotional emergencies as recommended (Ayeres and Vivyann, 2016). Although a large proportion of SU/P were experiencing suicidal thinking there were no completed suicides in this annual report. This may be due to the lack of waiting times and both CBT/DBT being provided as a first line intervention for suicidal individuals (Ayeres and Vivyann, 2010). This audit may add to the growing body of research that recommends that the Decider skills which incorporates both DBT and CBT can reduce suicidal attempts and self-harm episodes (Linehan, 1993).

7.3 Interpreting the Data:

This audit adds to the already established body of evidence that the provision of psychosocial interventions by MHN within secondary care is beneficial. It demonstrates the role that the ANPC and MHN could provide to SU/P in primary care, with the support of consultant psychiatrist' and CMHT via case consultation from secondary care. It was highlighted in the psychosocial thematic analysis that the psychiatric review experienced by a participant focused more so on medications, could this be due to the issues regarding recruitment and retention of the MHN grade , lack of clinical supervision or lack of available psychosocial interventions within services? Exploring this further could be beneficial. The CMHN department over a number of months encouraged all SU/P to attend the primary care centre for the depot clinics managed by CNMII and SU/P have reported a high level of satisfaction with this change increasing independence and social inclusion. This change in practice may have provided the CMHN the necessary time to engage in this project and provide these psychosocial interventions. The efficiency of this project and self – referral is confirmed by the lack of waiting lists to access MHN provided interventions. The SU/P engagement appears to have

increased since the introduction of self – referral. Previously there were many SU/P that did not attend or disengaged from interventions and the reason for this may have been inappropriate referral, encouragement by referrer at clinics to attend when the SU/P was not motivated or it could be linked to the low threshold regarding primary care referrals. It appears the ANPC provides an interface between primary and secondary care by providing a direct link between GP's and consultant psychiatrist that is viewed as imperative by both. Consultant psychiatrists have confirmed that by consultant diversion's and self - referral through PARC for interventions including CBT and Decider there is less burden on the secondary care service. Secondary care specialist services can now increase much needed care to those SU/P with complex needs, however the increased severe and enduring active caseload within secondary care setting will require further resources. The direct referral from GP practices is increasing and the increased pathways of referral through the mental health services via ANPC appears to reduce SU/P risk and improves SU/P outcomes, likely due Psychosocial Assessment CBT and the Decider Skills as a first line intervention. There is clearly a need for further research exploring the role and the effectiveness of specific evidence-based interventions provided by ANPC and MHN's to those SU/P in the primary care setting in Ireland.

7.5 Limitations

There was no control group so it is difficult to compare to outcomes with treatment as usual. Due to the changing guidance related to COVID – 19 pandemic interventions were offered through many means such as face to face, over the phone and on a one to one basis in person, but each of these offerings were not reviewed for outcomes separately. Referral pathways included CMHT referral and self – referral and these were not reviewed separately. The main diagnosis referred was EUPD and there was less research in relation to the use of these interventions in other diagnostic categories. The reasons for DNA or disengagement were not recorded. Self – harm was recorded on initial assessment and post intervention but was not recorded present or absent while the intervention was being provided. The MHN grade and SU/P outcomes were not analysed separately. Booster sessions were not reviewed on their own.

7.4 Recommendations

Policies, procedures and guidelines should now begin to be developed and administration requirements should be provided for this task. This should be completed by including CMHT, community services, GP practices, peer education facilitators through ARCHES and PARC SU/P recommendations. This audit proves the generalisability of this project and the PARC project should be expanded throughout Community Healthcare East "Central PARC" in true quality improvement which requires cohesiveness, equality and efficiency within the service. The reasons for disengagement were not recorded and would be helpful for future research. Self – referral appears to have increased engagement and comparing levels of non-attendance and disengagement next year would be of interest. In general meeting a clinician can be seen as treatment therefore can psychosocial assessment be viewed as a treatment in itself? Further data would be required to explore psychosocial assessment as a solitary intervention. Providing a CORE – OM prior to psychosocial assessment and post assessment if the SU/P does not require other psychosocial interventions would indicate the effect on emotional distress. Post treatment follow up at 12 weeks, 6 months or 1 year may be beneficial to understand the long-term benefit of both community support and evidenced based interventions provided by MHN. The COVID – 19 pandemic has certainly impacted on the mental health service and recording COVID – 19 related referrals may highlight patterns and identify MHN and CMHT training needs. The MHN grade and SU/P outcomes were not analysed separately, which may be helpful to identify further educational needs. Continued self – harm behaviour was not recorded during treatment and this would be important to record for future audits as this would highlight if the new coping skills replace the need to self - harm. There were two referring consultants and the referrals were not recorded specifically for each consultant which may have been helpful to capture patterns of referral. GP practices providing direct ANPC referrals were not recorded and may provide patterns of referral and identify educational or advertisement needs to improve accessibility within the many GP practices. Lack of online information was identified as an issue that will require action. There was an increase in care to those SU/P in primary care but are there other evidenced based interventions that could improve outcomes within secondary care and were absent due to the pressures of the COVID – 19 pandemic, as during this time our CMHT aim was to provide safe and efficient interventions for the vast referrals arriving at secondary care. Qualitative exploration of the MHN's experience including the impact on the level of job satisfaction, anxieties related to the new responsibilities and practice should be further researched. MHN increased roles and responsibilities should be

reviewed by remuneration as there are many grades of MHN providing interventions in this project. The feedback from GP's has been positive but capturing this data through a qualitative study would be helpful. Data analyses was difficult on Excell and SPSS being in place could be most beneficial. Recommendations were reached by those members of the research team who reviewed the data. This audit was transparent from the outset, a review of an ANPC project supported by MHN, consultant psychiatrist' and CMHT that recognises individual roles and outcomes. The research team have been updated regularly regarding the research project, were provided with participant information via PowerPoint presentation by the principle investigator and could opt – out at any time. This is not ANPC auditing MHN established roles and the above transparent approach is likely to have resulted in the audits outcomes.

9. Conclusion:

The PARC project, an ANPC project within the Bray CMHT, supported by MHN, consultant psychiatrist' and CMHT was deemed as acceptable and appropriate to increase SU/P care to those SU/P in both primary and secondary care. An annual audit of the PARC project identified that ANPC psychosocial assessment and interventions delivered by the MHN including CBT and Decider Skills appear to increase the SU/P care to both settings. The ANPC MSc programme supports the ANPC and MHN in increasing their scope of practice and is safely accomplished in conjunction with the clinical supervision provided by consultant psychiatrist and the case consultations available from the CMHT members where required. This audit adds to the growing body of evidence that provision of Psychosocial Assessment by ANPC, CBT and Decider Skills provided by MHN to SU/P within both secondary and primary care are useful and effective. Both the quantitative and qualitative data that was analysed for those SU/P that engaged and completed CBT and Decider Skills indicated a high level of SU/P satisfaction and improved functioning in all CORE – OM measures. Psychosocial assessment resulted in a high level of SU/P satisfaction but further research is required to understand if this intervention by itself is effective. Active secondary care SU/P has increased most likely due to the increased geographical area of the Bray CMHT and further resources may be required. Access to the PARC project could be improved by advertisement in GP practices or online information. We have now co – produced a PARC poster for GP practices with Cathy (education facilitator), Corina Murphy (MHN tutor UCD) and the wonderful MHN students of UCD, that is founded on the principles of the recovery framework model, translating recovery

in practice. The PARC poster will be launched in UCD, October 2021 and will at that point be sent to the GP practices. Policies, procedures and guidelines should be developed in line with best practice. It appears ANPC can create the much needed link between the primary and secondary care settings and may assist in establishing an element of the recommended universal health system.

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commencement of this project. Aishlinn Strahann created a resource folder of all available community resources that has been invaluable information for those SU/P who have received an ANPC psychosocial assessment. Suzanne Kennedy and Aidan Doyle were the most recent to join the MHN department and have in 2021 registered for the CBT postgraduate diploma in TCD facilitated alongside previous Bray consultant psychiatrist, Dr Brian Fitzmaurice (course director). Avril Cahill has used her creative side to develop bright, sparkling and interactive props utilised to teach skills by all MHN. PJ Walsh ensured MHN under his management at busy phlebotomy, ECG and depot clinics were available to facilitate psychosocial interventions under the supervision of ANPC. Audrey Savage our medical secretary provided valuable administration advice from the commencement of the project and has been supportive throughout. Thanks to Jade O Donovan, health care assistant who ensured a safe environment for SU/P and MHN to provide available interventions throughout the COVID - 19 pandemic. The Community Mental Health Team Members have supported this project and have informed many other community agencies of its creation. Catriona Gray CMHN/Psychiatry of Later Life has been an invaluable colleague who has provided much needed collegial support from commencement of this project. Julia Cornejo, staff nurse created a colourful and welcoming information leaflet for SU/P receiving an offer of psychosocial assessment explaining the process and available interventions. Without the SU/P engaging in this project and reporting their experience there would be no data to audit. Cathy Doyle a recovery educator has been on this journey for the past number of years and together we will present the findings of this project at the many requested venues. Cathy co – delivers groups with the MHN team in the Bray sector and provides the lived experience by personal narrative resulting in effective public, patient involvement as recommended. We look forward to working with Cathy soon. To the nursing students in UCD who we have had the pleasure of working alongside to create the fabulous PARC project poster. To their nurse tutor who co – ordinated this collaboration to perfection, Corina Murphy. To the amazing staff in Employability, Social Prescriber, BCAT, NCS, Living Life Counselling, CIPC, SPECS, Clubhouse, CAB, MAB's, Arches, and primary care psychology, thank you for the amazing work you do. Finally, thank you to a very patient man.

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12.3 The Decider One to One Evaluation **52**

Advanced Nurse Practice Psychosocial Assessment Evaluation Community Healthcare East

Name (Optional) ____

Advanced Nurse Practice Psychosocial Assessment

	very poor	poor	fair	good	very good
Helpfulness of the assessor	1	2	3	4	5
Ease of the assessment	1	2	3	4	5
Waiting time for assessment from referral	1	2	3	4	5
Likelihood of you recommending psychosocial assessment to others	Yes		No		

Negative feedback regarding the psychosocial assessment experience

____

____

____

Positive feedback regarding the psychosocial assessment experience

____

____

____

Any changes you would suggest for assessments moving forward

____

____

____

____

Many thanks for completing this evaluation of the service!!

CBT Cognitive Behavioural Therapy Evaluation
Community Healthcare East

Name (Optional) ____

CBT Provider

	very poor	poor	fair	good	Very good
Helpfulness of the CBT provider	1	2	3	4	5
Ease of the CBT process	1	2	3	4	5
Waiting time for CBT contact from referral	1	2	3	4	5
Likelihood of you recommending CBT to others	Yes	No			

Positive feedback regarding the CBT experience?

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____

____

Negative feedback regarding the CBT experience?

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____

____

Any changes you would suggest for CBT One to One?

____

____

Many thanks for completing this evaluation of the service!!

Decider One to One Evaluation
Community Healthcare East

Name (Optional) ____

Decider Skills Provider

	very poor	poor	fair	good	very good
Helpfulness of the mental health nurse	1	2	3	4	5
Ease of the Decider Programme	1	2	3	4	5
Waiting time for Decider from referral	1	2	3	4	5
Likelihood of you recommending Decider to others	Yes		No		

Negative feedback regarding Decider one to one experience?

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Positive feedback regarding the one to one Decider experience?

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Any changes you would suggest for Decider One to One?

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Many thanks for completing this evaluation of the service!!