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COLLEGE OF PSYCHIATRISTS OF IRELAND

Improving the On-call Training Experience for Psychiatry Trainees

Position Paper

PGT /01/25 Approved by Council May 2025

Summary

In Ireland, on-call duties are a core component of psychiatric training, encompassing urgent mental health care, crisis intervention and inpatient care. The College of Psychiatrists of Ireland's Postgraduate Training Committee oversees the training of psychiatrists, ensuring it is thorough and meets high standards.

The purpose of this position paper is to:

1. Describe the nature of on call for psychiatry trainees in Ireland.
2. Describe the academic literature on the benefits and challenges of on call work for Non-Consultant Hospital Doctors (NCHDs)
3. Establish the literature on how to improve the on-call training experience.
4. To define the roles and responsibilities of trainees and supervisors on call.
5. Make recommendations to Employers and the College of Psychiatrists of Ireland.

Key findings:

1. The on-call experience for Non-Consultant Hospital Doctors (NCHDs) in psychiatry is a complex and variable landscape that urgently demands enhancement**.**
2. The academic literature indicates that, while invaluable for training, on call also poses significant challenges that can impact the well-being of trainees. Furthermore, the challenges NCHDs face on call can have a significant impact on the quality of care experienced by service users on call.
3. Regular feedback and debriefing sessions, collaborative learning and support systems, technological support, on call focussed training, workload management, thoughtful scheduling, organizational support, and duty hour regulations can collectively support performance and well-being among trainees and improve service user outcomes on call.

Recommendations:

- Roles and responsibilities for NCHDs and Consultants on call need to be explicit, consistent, and supported by the Employer and the College of Psychiatrist of Ireland.
- Recommendations for improving workload management on call include increasing the number of crisis nurses working out of hours, increasing non-clinical administrative and bed management support on call and considering a variety of rostering options.
- We strongly support the expansion of interprofessional working as recommended in the NCHD Taskforce. NCHDs have become the default to cover gaps in service delivery, and thus tasked with roles that negatively impact on their ability to deliver patient care, this is particularly evident out of hours.
- We have made several recommendations aimed at improving scheduling practices these include: NCHDs new to psychiatry should only join the on-call rota after 2 weeks, supports for people returning to work after a period of extended leave and the development of protocols in all training centres on NCHDs coming off the on-call rota and trainees falling sick when rostered for on call.
- Discrimination against service users or staff cannot be tolerated and all staff need to utilise incident reporting and risk management systems to ensure discrimination is not tolerated.

- The working environment should be safe and secure. Measures should include secure access to buildings, adequate lighting, and safety protocols in case of emergencies. Trainees should have access to a chaperone if they need to travel outside across a hospital campus.
- Access to technological innovations e.g. Electronic Health Records, Electronic rostering systems, Simulation Training would improve trainee on call experience.

Definition of terms:

Non-Consultant Hospital Doctor (NCHD) & Trainees: We have used the terms interchangeably in this position paper. All trainees are NCHDs but not all NCHDs are currently trainees. A psychiatry trainee works in clinical posts as part of a formal training scheme in the specialty of psychiatry. Interviews are conducted annually to gain entry to specialist training scheme in psychiatry.

Basic specialist training is four years in duration. Trainees on a Basic Specialist Training (BST) scheme are assigned to one of nine deaneries nationally. Each trainee is allocated to a series of six-month training posts. In each post trainees have an educational supervisor and a training centre tutor, and each Deanery has a Vice Dean. The first year of Basic Specialist Training is the **Foundation year**. Trainees receive weekly educational supervision and maintain a portfolio which is reviewed by an Annual Review of Progress Panel. Trainees also complete professional exams. Once trainees have achieved their professional exams which allow them to become members of the College of Psychiatrists of Ireland, and they have also met the requirements of their training portfolio in full they progress to Higher Specialist Training in Psychiatry.

Higher Specialist Training is a minimum of three years in duration. Higher Specialist Trainees maintain a portfolio which is reviewed annually. At the end of Higher Specialist Training a trainee achieves a certificate of completion of specialist training and can apply to be registered on the specialist register of the Irish Medical Council.

An **NCHD working in psychiatry** could be a psychiatry trainee, a general practice trainee or a doctor completing a standalone non training post. Some NCHDs who are not part of a Psychiatry training scheme will work in a psychiatry post for 6 months, while others might work in psychiatry posts for many years.

The College of Psychiatrists of Ireland is responsible for overseeing and managing the training of psychiatrists in Ireland and thus its remit pertains exclusively to trainees in training posts. However, working conditions for all doctors in psychiatry have an impact on patient/ service user care, safety and experience. Also, many doctors working in non-training posts do in time join a Psychiatry training scheme. As such the terms NCHD/ Trainee will be used interchangeably throughout this document.

Service Users/ Patients: The term service user and patients have been used interchangeably throughout this document.

Introduction

In the field of psychiatry, on-call duties are an integral part of a trainee's clinical experience. Psychiatry trainees on call in Ireland deliver urgent mental health and medical care, crisis intervention, and support for distressed service users. These crisis assessments typically occur in emergency departments or acute mental health units. Trainees provide support to service users in psychiatric in-patient units, and in some cases, they deliver consultation liaison care for service users on general medical wards. In many instances, the NCHD on call is the first point of contact and the first line service provider to service users in distress. As such, the NCHD on call may be the 'face' of the mental health service for service users presenting for the first time or in an emergency. It is important therefore for clinical services to consider the reality of service provision on call, both for service users and staff members.

The College of Psychiatrists of Ireland is responsible for overseeing and managing the training of psychiatrists in Ireland. The Postgraduate Training Committee of the College plays a crucial role in ensuring that the training provided to psychiatry trainees is comprehensive, up-to-date, and meets the high standards required for the practice of psychiatry in Ireland. Recently, feedback from trainees and their supervisors indicates that many find on-call duties increasingly challenging, and this is impacting on the quality of care being delivered out of hours to service users. A working group of the Post Graduate Training Committee, with representation from trainers and trainees was formed to examine and make recommendations about how to improve this aspect of training. In this position paper we explore the nature, the challenges, the opportunities associated with on call duties and make recommendations to the College of Psychiatrists of Ireland and the Employers on how to improve on call training experiences.

For the purposes of this paper, when we refer to 'on call' we mean that work which is carried out outside of normal working hours (Monday – Friday, 9am - 5pm), overnight and at weekends, which usually involves emergency presentations, in the context of restricted staffing numbers.

1. Describe the nature of the psychiatry on call experience for trainees in Ireland

The Trainee Committee of the College of Psychiatrists of Ireland conducted a "Rapid Review of On-call Services Operating in Mental Health Services in Ireland' (Appendix 1). As part of this review a survey was conducted to establish the features of the on-call work in training centres in Ireland. The focus of the review was the experience of NCHDs who are 'first on call'; this cohort includes foundation year trainees (first year of basic specialist training) and BST trainee. Though information was gathered from NCHDs at all stages of training i.e. foundation year trainees, basic specialist trainees and higher specialist trainees. Information on 38 training centres was included in the final review. The findings of this survey underscore the heterogeneous nature of on call services, which vary widely in terms of responsibilities, location, frequency, duration, workforce, volume and complexity of clinical work encountered.

The general consensus among psychiatry trainees is that call is a necessary evil, a challenge to endure rather than a positive training experience. In a short survey conducted by the Trainee Committee this sentiment was echoed by GP trainees who almost universally agree that the on-call experience in psychiatry is uniquely challenging even compared to other medical and surgical specialities. The isolation of being the only on-site psychiatry professional, the lack of administrative support, the volume of emergency department referrals and the substantial time and emotional resilience required for each assessment are all noteworthy when considering the trainee's training experience (or lack thereof) when on call.

There have been many changes that have impacted on the nature of on call. Service users and clinicians have higher expectations of the nature of care on call. There is a growing recognition of mental health issues and a reduced stigma surrounding them, leading more people to seek help. However, the resources invested in mental health service development have not increased to meet this demand/expectation. This increased demand translates to more patients requiring urgent psychiatric care. In addition, the national population has grown, it is more culturally diverse, increase in substance use and dual diagnosis, an expansion of the remit of mental health services all while there has been an overall reduction in the number of inpatient beds and no commensurate increase in community mental health services. Finally, there has been a growth in the workload associated with meeting regulatory compliance requirements and it is likely that these will increase with the introduction of the new Mental Health Act.

Variability of the nature of on call

On-call services in Ireland are a mixture of off-site and on-site on call. Most on call in Ireland for the over 18-year-old population is on site. Some on-call services provide care to an emergency department, to general hospitals and to a specific approved centre. While other services only provide care to a specific approved centre. Most training centres provide an on-call service for people aged over 18 years old, with various arrangements in place for young people who present under the age of 18 years. Some large Child and Adolescent Mental Health Services (CAMHS) services have their own on-call rota, while others provide CAMHS on-call service under the care of a general adult teams out of hours. There is no CAMHS consultant on call out of hours in some sites. Most NCHDs are on-call on their own but some services have a second NCHD on-call, either off-site or on-site for a portion of the on-call service. A small number of services have a Clinical Nurse Specialist (Crisis nurse) on call for some duration of the on-call service, though most don't. Very few if any services were identified as

having Allied Health Professionals on call. Some clinical sites provide out of hours care for different satellite residences/ approved centres during on-call.

The number of cases an NCHD on-call can expect to see on call is highly variable and unpredictable. There is significant variation in the sources of on call referrals for NCHDs on call – ED crisis presentation, medical ward patient liaison consults, in patient psychiatry review, in patient psychiatric medical review and review of service users in different clinical sites e.g. high support hostels, Psychiatric Intensive Care Units (PICUs), other residential facilities. Some NCHDs are also expected to provide telephone call support to GP doctors in on-call GP services. Some trainees are expected to provide telephone support directly to service users and families. NCHDs on-call are often asked to liaise with other psychiatry services e.g. receiving an involuntary admission from a different catchment area, identify a bed for a service user if there is none in the clinical centre.

Complexity in crisis presentations is common particularly in terms of addictions, multimorbidity, homelessness and forensic history. Complex cases often need Multidisciplinary team (MDT) involvement, although out of hours access to MDT expertise is often not available. Out-of-hours services can be used to accelerate access or as an alternative to an outpatient appointment with a community mental health service. The survey results indicated that NCHDs in some centres work without adequate subspecialty supervision – e.g. the management of a child or adolescent without CAMHS consultant supervision.

The *National Clinical Programme for the Assessment and Management of Service users Presenting to Emergency Departments (ED) following Self-Harm* recommends that all Community Mental Health Teams (CMHTs) should ensure that each of their patients has a crisis management plan in place, and that there is access to crisis assessments for both patients known to their services and new patients. Furthermore, it recommends that the assessment of and intervention for any associated self-harm or suicide-related ideation should aim to be delivered in a non-ED setting. The emergency department is a very challenging and often unhelpful environment for someone in a mental health crisis. However, there are a lack of alternatives for people looking for in person mental health support out of hours. Furthermore, the absence of alternatives to inpatient care for service users in acute crisis places additional pressure on trainees on call out of hours. The development of alternative services available out of hours for crisis assessments could include crisis cafes (e.g. for an acute psychosocial crises) or crisis resolution teams (e.g. for an acute relapse of mental illness) could reduce the pressure on emergency departments and improve service user experience. In addition, the expansion of crisis resolution teams/ home treatment teams, in all clinical sites would offer genuine alternatives to inpatient admissions for a significant proportion of service users presenting out of hours (Sharing the Vision, 2020; Crowley et al 2024).

Multidisciplinary support

Ireland has lagged international standards in developing advanced practice and autonomous roles for the non-doctor workforce and has failed to deliver a medical system less dependent on NCHDs despite previous reports highlighting this issue (NCHD Taskforce, 2024). The *National Clinical Programme for the Assessment and Management of Service users Presenting to Emergency Departments (ED) following Self-Harm* sets out the importance of Clinical Nurse Specialist (CNS) in Self-harm/crisis or Self-harm in emergency departments both during normal working hours and out of hours. However, many clinical sites without an ED, but who see crisis presentations including service users with self-harm or suicidal ideation, would benefit from CNS on-site to provide specialist service. For those sites that do have a CNS (14/38), only a small proportion have CNSs working out of hours (4/38). Most sites where on call takes place in Ireland do not have any CNS during the day or out of hours. Furthermore, NCHDs reported that when gaps arise in the CNS roster the burden of filling this

gap usually falls back on NCHDs in hours and out of hours. Some clinical sites have more than one NCHD on call, for example, an off-site NCHD is available to come in if required. In some clinical sites Senior Registrar on-call has been used to make up for some deficits in CNS or NCHD service provision. The variation in administrative support on call and in the completion of on call related tasks e.g. sending letters, completing data collection adds significant additional stress for trainees. It can also delay/undermine trainee handover adding additional administrative load and impairing the opportunity for clinical handover and debriefing.

Senior colleague support

All Adult and most CAMHs Mental Health Commission 'Approved Centre's' have a named Consultant on-call for psychiatry as well as an NCHD. Some services have Higher Specialist Trainees who provide senior support offsite on some nights of the week (~ 34% based on recent trainee committee survey). NCHDs report that SRs are supportive on-call both in terms of supporting decision-making in complex service users as well as reducing the load during on-call by directly being involved in care – ward rounds, liaison with allied admissions, negotiating service user transfer, and dealing with bed shortages. Similarly, NCHDs are complimentary of consultant staff who are supportive in decision making as well as "solving" complex issues regarding bed shortages etc. However, it is also clear from the survey and wider review that not infrequently NCHDs on-call provide care to CAMHS service users out of hours without a named CAMHS consultant on-call. On a less frequent basis, service users with intellectual disabilities are managed out of hours without cover from a Consultant in Mental Health for Intellectual Disabilities. Senior decision-making regarding complex issues e.g. bed management, Mental Health Act are required on a frequent basis. There is inconsistency in how decisions are made on when an NCHD contacts a senior colleague on call. These decisions seem to rely more on 'custom and practice' rather than on any agree principles.

Health and safety, risk factors

This review identified that European Working Time Directive (EWTD) breaches continue to occur in Ireland. Unfilled/ vacant NCHD posts can result in gaps in rotas. This can lead to strain on NCHDs providing on-call. Some off-site on-call services are operating as onsite on-call services in practice. While the payment for off-site on call staff is less than for on-site staff, the off-site NCHD who is frequently in the hospital may not benefit from adequate or EWTD compliant rest periods. Emergency departments (ED) are a challenging environment to provide crisis mental health care, however they are more likely than standalone sites to have adequate security personnel, though trainee feedback on this is variable. In the ED there are usually other staff nearby, though with overcrowding and relentless clinical demand it's a challenging place to work. It is generally recognised that busy EDs are not a good location in which to see a vulnerable person with a mental health crisis. Trainees can find themselves under significant pressure to meet ED time targets for seeing service users. Trainees can find themselves with multiple competing clinical and other demands as the ED is often only one of several locations they are 'on call' to (in patient unit, general hospital, psychiatric intensive care unit, community residence. Clinical sites without an ED or a general hospital co-location have fewer or no security personnel out of hours and NCHDs report feeling more isolated and less safe in such circumstances.

Administrative support

In many locations across Ireland, the lack of electronic health records means that trainees often lack proper access to clinical records, which complicates decision-making and makes managing risks and safety more difficult. Furthermore, resources that help bridge these gaps during the day, such as GP,

family, information from other clinical teams, and pharmacy contacts, are typically unavailable outside regular hours. The absence of an electronic health record/ case management system can make sending communication to GPs/ clinical teams more onerous. Furthermore, there is often limited administrative support available to trainees such that they can spend long periods of time on call and post call completing nonclinical administrative tasks. Trainees also report that they worry they have forgotten/made an administrative error on call given the lack of technological/admin supports and unpredictable nature of on call work.

Bed management responsibilities often fall by default on trainees out of hours. This is not the case for NCHDs on call in other hospital specialities, where bed management is a distinct administrative role which doctors have little/ no involvement with. Managing the availability of beds, sourcing beds, negotiating transfers can place a significant additional stress and burden on trainees during the busy on call period.

There is often little if any administrative support for the development or administration of the on-call rota itself. Often this work is also left to NCHDs themselves. There is often no administrative support to find locums to cover gaps in on call rotas. Indeed, some sites reported that they have been told that they are prohibited from sourcing a locum for on call sessions. This can lead to a lot of pressure being applied to trainees to fill in for colleagues at very short notice. This can also lead to no NCHD available on site on call.

Organisational culture

Some trainees reported witnessing discrimination against service users with mental illness on call. They also reported stigmatising attitudes towards mental health services and mental health staff on call. This was not a consistent finding across all clinical sites. However, where it was reported to be present it was found to be undermining to the delivery of high-quality clinical care to people presenting with a mental health crisis.

Disability, returning from a period of leave, less than full time working

Doctors with disabilities or additional health needs may face unique challenges on call. Studies also show that providing support and appropriate accommodations for doctors with disabilities or additional health needs can enhance diversity and inclusivity in the medical field, leading to broader perspectives in service user care and team dynamics. A small number of NCHDs are excused from the on-call rota due to occupational health issues. However, there is inconsistency in the decision-making process for removing individuals from on-call rotas, clarity as to what is required for them to return to on-call as well as variation in the types of support and accommodations available to NCHDs throughout the country. Many services lack robust HR structures to support this process.

Doctors re-entering the workforce or transitioning to part-time schedules can face additional difficulties when on call. Those returning to work after a period of leave can find they need to quickly adapt to the demanding pace and unpredictable nature of on call duties. This can lead to increased stress and anxiety. Additionally, these doctors may experience a sense of professional isolation and reduced confidence, as they familiarise themselves with an often-new work environment after a period of leave. Doctors working less than full time may find it takes longer to find their feet. For these individual's workload management becomes crucial, as balancing a part-time schedule with the unpredictable demands of on-call work requires careful planning and support from the institution to ensure continuity of care and maintain service user safety.

In summary, the on-call experience for Non-Consultant Hospital Doctors (NCHDs) in psychiatry in Ireland reveals a complex and variable landscape that urgently demands enhancement. On-call psychiatry has become more demanding due to increased expectations from service users and clinicians, greater recognition of mental health issues, and reduced stigma, leading more people to seek help. Despite this, resources have not kept pace with the growing demand, resulting in more patients needing urgent care. The national population growth increased cultural diversity, rising substance use and dual diagnoses, and an expanded remit of mental health services further strain the system. Additionally, there has been a reduction in inpatient beds without a corresponding increase in community mental health services. On-call duties often involve direct care in emergency departments, general hospitals, and specialized psychiatric centres. Many centres require NCHDs to operate solo, navigating unpredictable caseloads and diverse referral sources, from emergency crisis presentations to in user medical and psychiatric reviews. The absence of adequate multidisciplinary support, exacerbates the challenge, placing undue pressure on NCHDs, often the most junior clinical members of our multidisciplinary teams to fill these critical gaps, particularly during out-of-hours service. The training aspects of on-call appear to be overwhelmed by the clinical responsibilities. Moreover, safety concerns are pronounced in settings without emergency departments, where security is minimal and NCHDs feel isolated. This situation is compounded by frequent breaches of the European Working Time Directive, highlighting the unsustainable work conditions that may compromise both caregiver and service user safety.

2. Review of the International Evidence

On-call experiences for psychiatry trainees offer valuable training opportunities that contribute significantly to their professional development and preparedness for independent practice. On-call experiences are integral to the professional development of psychiatry trainees, offering numerous benefits for trainee preparedness for independent practice.

Table 1: Potential benefits associated with on- call in Psychiatry for NCHDs

Aspect	Benefits
Exposure to Diverse Cases	On-call rotations expose trainees to a broad spectrum of psychiatric cases, enhancing clinical skills and diagnostic acumen
Skill Development in Crisis Management	Trainees develop critical skills in managing acute psychiatric crises, fostering their ability to think critically and make decisions under pressure.
Interdisciplinary Collaboration	Collaborating with other healthcare professionals during rotations improves communication skills and understanding of holistic service user care
Preparation for Independent Practice	Simulates real-world scenarios, preparing trainees for independent practice by teaching them to manage care and make clinical decisions autonomously
Enhanced Confidence	Handling challenging situations builds resilience and confidence, enabling trainees to adapt to dynamic clinical environments and maintain composure during crises.
Meaningful Clinical Interactions	Provides opportunities to make a significant impact in service users' lives during crises, offering rewarding experiences through compassionate care and positive treatment outcomes.

Exposure to Diverse Cases: On-call rotations expose trainees to a wide range of psychiatric cases, including emergencies and urgent situations. This exposure allows them to encounter diverse service user populations, diagnoses, and treatment modalities. Research indicates that exposure to diverse cases enhances clinical skills and diagnostic acumen among psychiatry trainees.

Skill Development in Crisis Management: On-call experiences provide trainees with opportunities to develop and refine crisis management skills. They learn how to assess and manage acute psychiatric crises, such as suicidal ideation, severe agitation, or psychotic decompensation. These experiences foster critical thinking, decision-making, and the ability to work under pressure, which are essential competencies for psychiatric practice (Albahari D, 2024. Azad, 2020; Locke, 2020; Paes, 2018).

Interdisciplinary Collaboration: On-call rotations often involve collaboration with other healthcare professionals, such as emergency physicians, social workers, and nurses. Trainees learn to function effectively within interdisciplinary teams, fostering communication skills and an appreciation for the holistic approach to service user care (Leonard, 2004).

Preparation for Independent Practice: On-call experiences simulate real-world practice scenarios and prepare trainees for the responsibilities of independent practice. They learn to manage service user care autonomously, make timely clinical decisions, and prioritize tasks effectively. This hands-on

experience is crucial for transitioning from a supervised training environment to independent clinical practice (Locke, 2020; Christancho 2017).

Enhanced Confidence: Dealing with challenging and unpredictable situations during on-call rotations builds confidence and resilience among psychiatry trainees. This can support trainees to adapt to dynamic clinical environments, cope with stress, and maintain professional composure during crises (Locke, 2020; Awali, 2023).

Meaningful Clinical Interactions: Despite the challenges of on-call work, trainees have the privilege of making a meaningful difference in service users' lives during times of crisis. Building rapport, providing compassionate care, and facilitating positive treatment outcomes can be profoundly rewarding experiences for psychiatry trainees.

Table 2: Potential challenges associated with on- call in Psychiatry for NCHDs

Aspect	Challenges	Impact
Workload & Time Management	Unpredictable and demanding workloads, managing emergencies and urgent cases outside regular hours.	Leads to long shifts, sleep disturbances, and disruptions to personal and social life. Increased stress and burnout
Decision Making Under Pressure	Need to make rapid clinical decisions under pressure, often with incomplete information.	Challenges in balancing urgent intervention with careful clinical judgment.
Stress and Emotional Strain	Encountering psychiatric emergencies, dealing with human suffering, aggressive or suicidal service users.	Contributes to psychological distress and compassion fatigue
Sleep Disruption and Fatigue	Disrupted sleep patterns due to on-call duties.	Leads to fatigue, impaired cognitive function, affecting mood, concentration, and decision-making
Professional Isolation	Working independently or with limited supervision, handling complex cases or ethical dilemmas.	Contributes to feelings of professional isolation, requiring reliance on clinical judgment and problem-solving skills.
Risk of Burnout	High workload, stress, and sleep disruption.	Results in emotional exhaustion, depersonalization, reduced sense of accomplishment, affecting well-being and

On-call duty in psychiatry, while invaluable for training, also poses several challenges that can impact the well-being of trainees. Here are some of the key challenges identified in the literature:

Workload & Time Management: On-call duty often involves unpredictable and demanding workloads, with trainees being responsible for managing emergencies and urgent psychiatric cases outside of regular hours. This can lead to long shifts, sleep disturbances, and disruptions to personal and social life. On-call duty can strain trainees' work-life balance, making it challenging to pursue personal interests, hobbies, and relationships. Research has shown that high workload and long working hours are associated with increased stress and burnout among healthcare professionals (Shanafelt et al., 2015). Prioritizing tasks, managing competing priorities, and optimizing workflow efficiency are essential skills for navigating the demands of on-call shifts.

Decision making under pressure: Trainees may encounter situations where they must make rapid clinical decisions under pressure. Balancing the need for urgent intervention with careful clinical judgment can be challenging, particularly when faced with incomplete information or conflicting priorities (Zavala, 2018).

Stress and Emotional Strain: Dealing with psychiatric emergencies and crises can be emotionally taxing for trainees. Witnessing human suffering, dealing with aggressive or suicidal service users, and experiencing feelings of helplessness or inadequacy are common stressors faced by psychiatry trainees on call. Constant exposure to such stressors can contribute to psychological distress and compassion fatigue among trainees (Figley, 2002).

Sleep Disruption and Fatigue: On-call duty often disrupts trainees' sleep patterns, leading to fatigue and impaired cognitive function. Sleep deprivation can affect mood, concentration, and decision-making abilities, compromising service user care and trainee well-being. Studies have demonstrated the detrimental effects of sleep deprivation on cognitive performance and emotional regulation (Walker & Stickgold, 2014).

Professional Isolation: On-call shifts often involve working independently or with limited supervision, which can contribute to feelings of professional isolation. Trainees may encounter complex cases or ethical dilemmas without immediate access to mentorship or peer support, requiring them to rely on their own clinical judgment and problem-solving skills (Crockett, 2019).

Risk of Burnout: The combination of high workload, stress, and sleep disruption increases the risk of burnout among psychiatry trainees. Burnout is characterized by emotional exhaustion, depersonalization, and a reduced sense of personal accomplishment. It not only affects trainees' well-being but also undermines the quality of patient care and professional satisfaction (Dyrbye et al., 2014, O' Connor, 2018).

In summary, psychiatry trainees on call play a vital role in providing timely and compassionate care for service users in crisis. Their responsibilities encompass crisis intervention, triage and assessment, medication management, collaborative care, crisis de-escalation, documentation, and self-care. While on-call duties present unique challenges, they also offer opportunities for clinical skill development, meaningful patient interactions, and professional growth.

3. Research on improving the on-call experience for psychiatry trainees.

Improving on-call training experiences for NCHDs is crucial for their development, well-being, and the quality of patient care they provide. The academic literature on this topic can be categorized into several key themes that offer a range of strategies and interventions. See Table 3. These approaches aim to better prepare trainees for on-call duties, ensuring effective learning and high-quality service user care.

Table 3: Strategies and Interventions that can improve on call experience for trainees.

Structured Feedback and Debriefing: Regular sessions improve skills, manage stress, and enhance job satisfaction.
Collaborative Learning and Support: Mentorship and peer support networks foster professional growth and reduce burnout.
Technological Innovations: Digital tools and simulation-based training enhance decision-making and preparedness.
Workload Management: Adjusting workloads prevents burnout and supports optimal performance.
Scheduling Practices: Thoughtful scheduling improves alertness and work-life balance**.**
Organizational Support: Strong institutional support systems promote trainee well-being.
Duty Hour Regulations: Regulations aim to prevent fatigue and improve balance.

Structured Feedback and Debriefing: Regular and structured feedback sessions help trainees identify their strengths and areas for improvement, enhancing their overall competence and confidence in handling on-call situations (Acharya et al., 2017; Ferorelli et al., 2017). Structured debriefing sessions, particularly after challenging on-call shifts, not only provide immediate learning opportunities but also help in managing stress and emotional turmoil, contributing to better mental health and job satisfaction (Ajjawi et al., 2019; Brook & Calcia, 2016)

Collaborative Learning, Mentorship and Peer Support: Opportunities for interdisciplinary collaboration and teamwork, fostering a collaborative approach to service user care and promoting professional development through shared learning experiences have been demonstrated to support trainees on call. Establishing mentorship relationships provides NCHDs with guidance, emotional support, and career development, have been shown to improve trainee on call experience (Davidson et al., 2022). Peer support networks, debriefing sessions, and wellness initiatives to promote camaraderie, and a sense of community among trainees facing similar challenges and experiences have been demonstrated to improve on call training experience and reduce trainee burnout (Cohen et al., 2023).

Technological Innovations: Access to electronic health records support complex decision making and safety on-call. Implementation of electronic systems to manage on-call schedules, tasks, and information exchange significantly improves the preparedness and efficiency of junior doctors,

reducing stress and potential errors. Utilizing simulation-based training tools helps in preparing junior doctors for a variety of clinical scenarios they might face on-call, enhancing their practical skills and decision-making abilities in a controlled environment (Ajaz et al. 2014, Tong et al. 2021)

Workload Management: Properly managing and occasionally adjusting the workloads during on-call shifts can prevent burnout and fatigue, ensuring that junior doctors can perform optimally and learn effectively (Zhang et al. 2020; Lai & Plakiotis, 2020; Moncayo-Rizzo, et al. 2024)

Scheduling Practices: Thoughtful scheduling that considers rest periods and the circadian rhythms of junior doctors can improve alertness and performance, thereby enhancing both the learning experience and service user care. Balancing on-call duties with personal life is crucial for trainee well-being and job satisfaction. Interventions focusing on flexible scheduling, childcare support, and wellness initiatives have shown promise in promoting work-life balance among medical trainees (Zhang et al. 2020; NCHD Taskforce, 2024)

Organizational Support Hospitals and educational institutions must provide strong support systems, including access to resources, psychological services, and a culture that promotes open communication and feedback (NCHD Taskforce, 2024).

Implementing duty hour regulations: Regulatory policies, such as duty hour limitations, aim to prevent excessive fatigue and promote work-life balance among medical trainees (NCHD Taskforce, 2024).

In Summary, these studies highlight the multifaceted nature of interventions aimed at improving the on-call experience for medical trainees, encompassing workload management, support systems, education, regulatory policies, and work-life balance initiatives.

4. Define the roles and responsibilities of trainees and supervisors on call.

The roles and responsibilities of the Basic Specialist Trainees on call

The foremost goal of all mental health services is to deliver safe and effective care to service users. Psychiatry trainees on call are responsible for providing urgent mental health care, medical care, crisis intervention, and support to distressed service users outside regular hours. It is expected that trainees treat everyone, including staff and service users, with respect, courtesy, and professionalism. Given that we all respond to stress differently, it is crucial during on-call duties to be considerate of people's diverse upbringings, life experiences, cognitive abilities, and cultural backgrounds and how these impact on individual clinical presentations.

1. Out of hours assessments

- Trainees on call often serve as the first point of contact for service users seeking urgent psychiatric care.
- When completing an out of hours assessment trainees are expected to conduct a clinical assessment, mental state examination, and where possible obtain collateral history from family members or other sources.
- The purpose 'out of hours'/ emergency assessment differs from a routine new patient assessment in several important ways.
    - The focus of on call assessments is to establish the urgent mental health needs of the service user.
    - The assessment is likely to be an abbreviated version of a standard new patient assessment with more focus on presenting issues and immediate risk.
    - For example, an on-call assessment will prioritise the identification of acute risks such as suicidality, aggression or severe psychotic symptoms.
    - Interventions will focus on immediate/ short term management of the presentation rather than medium- or longer-term care planning. Service users will be referred onwards for more comprehensive assessment and care as appropriate e.g. Admission to Acute Mental health Unit, Crisis Resolution/ Home Treatment Team, Outpatients, Community/ Primary care services.
- In advance of seeing someone on call trainees are encouraged to gather relevant information – referral information and notes, clinical notes (if available), gather information from nursing/ other colleagues if the service user is known. In many training centres in Ireland, access to comprehensive clinical notes is challenging given the absence of Electronic Health Records and a Unique Patient Identifier. This presents a significant risk to service users and clinicians.
- Trainees are expected to develop a formulation. Formulation provides an understanding of clinical problems, symptoms, and illness over and beyond diagnosis.
- Trainees are expected to develop and agree a collaborative care plan with the service user and if appropriate their family/ supporters.
- Collaborative development of a Safety Plan could be a useful intervention in the on-call setting. Trainees should seek to include the service user and also family/ supporters in plan development.
- The contents of the agreed care plan should be clear to the service user and communicated to the GP and other relevant services e.g. Community Mental Health Team, Psychiatry of Later Life Team.
- Trainees are expected to make onward referrals as specified by the agreed-upon care plan. e.g. to Crisis Resolution Home Treatment Team, Liaison Psychiatry team (if service user a medical in patient).
- Trainee are expected to work collaboratively with ED and other medical / surgical colleagues to support appropriate and safe triaging and management of service users in the ED. For example,

offering advice and consultation on the assessment and treatment of acute behavioural disturbance, acute confusional states to ED and other colleagues to ensure appropriate medical assessment and intervention is completed. This work is often done in parallel with ED and other colleagues.

- Trainees on call should discuss assessments and care planning with senior registrars/ consultant on call as appropriate. The nature of what is appropriate will vary depending on the NCHDs stage of training, prior experience & the nature of the on-call presentation.
- If a service user is being admitted to the approved centre then a full assessment, physical exam, formulation including risk assessment and interim care plan relating to the identified risks should be completed. The interim care plan should be discussed with the senior nurse on the unit.
- It is suggested that a conversation between the NCHD and the senior registrar/ consultant at the start of the on-call shift can support trainee and supervisor decisions with regards to appropriate levels of supervision on call. Given that there is significant variation in the size, scope and dynamic nature of on call rotas it is acknowledged that consultants may not have detailed knowledge of an NCHD on calls experience in advance of completing on call together. However, an introductory phone call will allow for some preliminary discussion and agreement of expectations.
- NCHDs and Consultants on call should have ready access to each other's rotas (ideally electronically) in advance of on call.

2. Regulatory Compliance

- The Mental Health Acts 2001- 2018 and the associated Codes of Practice, Rules and Regulations are associated with a significant workload for NCHDs. This has increased with the recent revision of the Rules of Seclusion and Code of Practice on Restraint. It is anticipated that the workload associated with the implementation of the new Mental Health Act will further increase the workload.
- Some of the tasks have time specific requirements, for example medical review of a service user in seclusion, which if not adhered to is deemed a regulatory non-compliance.
- For NCHDs who are providing urgent assessments in an emergency department this places additional pressures on their workload. This is particularly challenging if the inpatient unit is any geographical distance from the emergency department.
- Emergency departments should be informed that time-specific regulatory requirements will need to be prioritised by NCHDs and an appropriate contingency plan should be agreed between psychiatry and the acute hospital to support this.

3. Physical health care of service users in an approved centre

- Urgent physical health assessments, investigations, and onward referral, to other specialities, arising out of hours are completed by the trainee on call. Routine medical care should be managed in hours by the treating mental health team.
- If a service user is being transferred to the acute hospital the NCHD should ensure clear written information goes with or follows the service user (in an emergency).

4. Medication management:

- Psychiatry trainees on call are responsible for managing medication regimens in those they assess while on call.
- Psychiatry trainees on call are responsible for responding to urgent medication issues amongst service users admitted to an Acute Mental Health Unit e.g. adverse drug reactions/ urgent monitoring requirements/ drug errors.

- Trainees must possess a sound understanding of psychopharmacology, including medication indications, dosing, side effects, and potential drug interactions.
- Medication reconciliation is important, particularly for service users admitted to the approved centre. A trainee may need to review old notes, recent correspondence, contact the GP and or community pharmacy to clarify and confirm.

5. Collaborative care:

- Effective communication and collaboration with service users and their families are essential components of on-call responsibilities.
- Effective communication and collaboration with multidisciplinary teams are essential components of on-call responsibilities.
- Trainees are expected to liaise with nurses, social workers, emergency department staff, family members, general practitioners, gardai and consulting services to coordinate service user care and ensure continuity of treatment.

6. Crisis de-escalation:

- Safety of staff and service users is a priority.
- Trainees should have access to a safety alarm and know how to use it.
- Trainee should have access to a safe, confidential physical environment in which to see service users.
- Trainees on call will often be asked to see service user that are agitated. A trainee should familiarise themselves with the service users notes and request collateral from nursing staff.
- Trainees should consider getting the support of nursing staff/ security to chaperone when assessing an agitated service user.
- Services should ensure appropriate chaperones are available to NCHDs completing on call assessments in all settings.
- Trainees should prioritise service user, their families, personal and staff safety while maintaining a therapeutic and compassionate approach to crisis management.

7. Documentation and legal considerations:

- Accurate, contemporaneous documentation is crucial for ensuring continuity of care and legal compliance.
- Trainees should adhere to ethical and legal standards including service user confidentiality and informed consent.
- Trainees need to ensure adherence with Mental Health Commission regulations, rules and codes of practice in their work.

8. Handover/ Debriefing

- Trainees need to provide a comprehensive handover, ideally written to the NCHD taking over from them. This handover should occur at the start and the end of each shift and be within the paid shift times for NCHDs.
- Trainees should have a conversation with the senior registrar/ consultant on call at the start and the end of the shift. The focus of this communication at the start of the shift is to make each other aware of who is on call, highlight any emerging issues and agree on supervision expectations. At the end of the shift, this communication is an opportunity to complete an informal debriefing and if appropriate agree a plan for further discussion e.g. in their educational

supervision. It may be that in situations where on call has been particularly challenging a more formal structured debriefing will be required. It is important that the time required to conduct this for the NCHD(s) and the Supervisor will need to be acknowledged by the service and protected.

- Trainees need to complete referrals to other approved centres, assisted admissions teams, community mental health teams, liaison service, medical/surgical colleagues and GP.

9. Role of the Higher Specialist Trainee on Call

- The role of the HST on call in Psychiatry varies according to jurisdiction and clinical service configuration, ranging from an on- site role seeing patients and directly supervising junior colleagues (Canada) to providing ''training on-call'' to medical students and junior colleagues (USA) to having duties entirely separate from the inpatient service/hospital (e.g. carrying out assessments in police stations in the UK).
- In Ireland, the HST on call is usually off-site but available to support the on-site NCHD. CPsychI Regulations require HSTs to carry out a minimum number of on-call sessions, between weeknights and weekends; to carry out 50% of weekend on call with their own supervising consultant; to carry out at least 50% of on-call sessions with an NCHD new to psychiatry (i.e. an NCHD with less than one year's experience). On a national basis, there are fewer HSTs than BSTs so generally in clinical services, there is not a HST on call every day or alongside every NCHD on call.
- From a training perspective, the main aim of on call for HSTs is to prepare the HST for the transition to being the consultant on call over the coming years. With this in mind, the main learning objectives for HST on call compared to BST on call are:
    - Managing the overall clinical workload effectively (including monitoring the workload of the NCHD, triaging and assisting where needed).
    - Supporting and teaching junior colleagues. Creating a supportive learning environment for the NCHD on call.
    - Developing further their skills to work with different NCHDs, Nursing staff, MDT members, Emergency department colleagues with different levels of competence and experience on call. Recognising the need to offer different levels of support and input to colleagues depending on the clinical case, the colleague's relevant expertise and the wider context.
    - Ensuring compliance with mandatory requirements (e.g. mandatory reporting, Mental Health Act requirements)
    - Learning how to supervise, teach and assess NCHDs in emergency situations.
    - Reflect on the on-call experience in supervision.

10. Professionalism on Call

- Trainees need to be aware of when they are on call, swap on call when on leave, inform the rota organiser of changes to the rota and promptly inform relevant people when sick or unable to work.
- Trainees should not leave work before/without handover to the next NCHD.
- Trainees should contact the SR/consultant on call at the beginning/end of a shift and as needed otherwise.
- Trainees need to know their own limits and know when to ask for help.

11. Self-Care for BSTs and HSTs on call:

- On-call duties can be emotionally demanding and physically exhausting. It is important that all trainees prioritise self-care (Bamonti et al. 2014.)

- Trainee should ensure that they take breaks to eat, drink and rest during their on-call shift.
- Strategies for self-care may include maintaining a healthy work-life balance, engaging in regular exercise, attending reflective practice groups and accessing peer support.
- Trainees should be registered with a General Practitioner. The Irish College of General Practitioners have a section on their website listing all GPs nationally who will prioritise the acceptance of an NCHD as a patient.
- The employee assistance programme is available to all HSE staff, it is confidential, and staff can self-refer to it. There is also an Occupational Health Service available to employees of each training centre.
- The NCHD Hub provides a workplace health and wellbeing service for NCHDs. These services are available to those who have an NCHD contract with the HSE or private health service. This service can be accessed by self-referral or a referral from the local Occupational Health Service, Medical manpower, National Speciality Director or relevant training body. Reasons for referral may include complex ongoing medical conditions, psychological conditions, work related stress and work and disability advice. More details available on the HSE website.
- There is also an Occupational Health Service available to employees of each training centre which provide assessments for frequent short term sickness absence, long term sickness absence and health related performance issues. Full details available on the HSE website.
- The Practitioner Health Matters Programme operates on a not-for-profit basis and is funded primarily by voluntary contributions and professional associations. Any doctor, dentist or pharmacist in Ireland who has a concern about stress, burnout, mental health difficulties or who may have an alcohol or drug misuse problem can receive confidential help from experts at the Practitioner Health Matters Programme.
- Trainees should recognize the signs of burnout, compassion fatigue, and vicarious trauma, seeking support from colleagues, supervisors, and mental health professionals as needed.
- Each trainee should have an educational supervisor, a tutor, a Vice Dean if they are a Basic Specialist Trainee and a Mentor if they are a Higher Specialist Trainee available for support. Trainees are encouraged to utilise these support structures proactively.

Role of the Consultant Psychiatrist on-call

Introduction

In the main, the role is closest to that of Clinical Supervisor. By its nature, the consultant on-call often has a short-term supervisory relationship with an NCHD/trainee during a particular on call shift. For the consultant, during this short period, there is a line management role but also an important developmental and mentoring role. The short-term nature of the role between consultant and NCHD who may be unknown to each other, allied with the pressures of urgent work being provided outside of normal working hours, often with fewer clinical supports, can present particular challenges. (Irish Medical Council, 2023)

Principal Responsibilities to trainees/NCHDS when on call (adapted from CPsychI Guide for Educational Supervisors):

General (all NCHDs)

- To act as a role model for professional behaviour
- To ensure patient safety is maintained as central as within all areas of training
- To treat all NCHDs with respect and dignity
- To establish good and appropriate relationships with junior colleagues
- To be approachable and available to NCHDs
- To ensure an NCHD is working within their area of competency.
- Within the limits of an on-call setting, to ensure an environment of learning is provided.
- Promote the development of self-reflection and build capacity for self-directed learning.
- Be aware of reporting and support mechanisms in the workplace.
- Be aware of available resources to support the health, well-being and safety of NCHDs.
- Be open to feedback from NCHDs and be prepared to adapt practice as a response to feedback

Specific to the trainee

- As required, to support and participate in appropriate opportunities for Work Place Based Assessments (WPBAs) and portfolio items.
- In relation to appraisal of a trainee's performance, to be thorough, fair and objective.
- When carrying out WPBAs, provide and discuss constructive feedback, which is timely, honest and actionable.
- Attend 'Train the Trainers' events in CPsychI.

Others who have particular responsibilities in relation to NCHDs/trainees on call:

- The Employer
- Irish Medical Council
- National Doctors Training Programme, Health Service Executive
- College of Psychiatrists of Ireland
- The NCHD themselves

Suggested guidance for consultants:

- Telescoping the usual supervisor/trainee relationship into a shorter time period.
- Make initial contact and introduce each other at the beginning of the shift.

- Establish previous experience/ need for supervision.
- Agree an approach for the on-call period – e.g. active issues to handover to each other; how/when to contact each other. See more detail in Roles and Responsibilities of Trainees section of this document.
- When discussing issues on call and within the time available, allow the trainees to present the problem, propose a management plan and work out solutions rather than the consultant providing 'answers'.
- Give clear instructions according to the NCHDs level of competence/experience.
- Be conscious of when the NCHD is struggling and may need additional support. Also be conscious of situations when attending the hospital may be needed e.g. situations when the NCHD may not have sufficient experience/competence to provide safe/adequate clinical care.
- When serious adverse events occur or are at risk of occurring, be prepared to proactively support/direct clinical care.
- Liaise with other senior clinical staff where required.
- At the end of an on-call shift, where possible, have a final wrap-up discussion with the NCHD. It may be useful to ask for the NCHDs reflections/feedback on the on-call experience and/or to give feedback. Where on call has been particularly challenging a more formal structured debriefing may be required. It is important to recognise that the additional time required to conduct this for the NCHD(s) and the Supervisor is significant. The employer needs to support this additional time and effort.
- Where important issues with implications for the future occur during an on-call shift, whether related to the clinical service or the NCHD, consider communicating with appropriate others, such as the Clinical Director/ educational supervisor.

7. Recommendations

Creating an appropriate on-call environment and providing adequate support for psychiatry trainees is crucial for optimising service user care, promoting trainee well-being, and fostering professional development.

Role and responsibilities on call

- All training centres should include in their induction training and induction manual information on the roles and responsibilities of NCHDs on call, this should include information described in this position paper. It should also include any relevant local information e.g. sites covered on call, community services available for onward referral etc.
- Guidance on managing common on call scenarios e.g. presentations with self-harm/ suicidal ideation, psychosis needs to be part of core induction at every training site. Role play/ simulation training appears to be a particularly useful educational approach here and should be encouraged.
- Opportunities to refresh/ augment this training should be supported beyond induction e.g. as part of the rolling NCHD academic programme.
- Foundation year trainees should prioritise the completion of the CPsychI e-learning modules early in their year. These e-modules include material that is relevant to working on call.
- NCHDs on call seeing patients under the age of 18 years old should have access to a CAMHs consultant on call with whom they can discuss the case and agreed a collaborative care plan.
- All new consultants in a training centre should receive induction. This induction should include information on the roles and responsibilities of NCHDs and Supervisors in general and specifically on call.
- An agreed structured handover tool should be utilised by NCHDs in all training centres to handover at the end of an on-call shift.

Workload Management

- Psychiatric Nurses should be on call in all emergency departments in hours and out of hours. The absence of MDT support out of hours is out of keeping with International Best Practice. It is also out of keeping with the recommendations in the National Clinical Programme for the Assessment and Management of Patients Presenting to Emergency Departments following Self-Harm.
- Social Workers should be accessible out of hours to all patients including psychiatric patients presenting with social crisis/ acute social needs.
- NCHDs should not be providing telephone support to service users or families on call.
- The development of multidisciplinary crisis resolution home treatment teams should be extended to all sites.
- Where on call workload is consistently high then consideration must be given to understanding why this is happening e.g. change capacity for acute community based assessments, population based changes, psychosocial pressures. In addition, flexibility in rostering options that can reduce the burden on NCHDs, improve service user experience and support high quality and safe care.
- Many sites are now introducing rosters that involve split day and night rotas- 3 /4 days or nights on call in one week. Consideration needs to be given to the increased isolation a psychiatry

NCHD on call can experience in this new rostering arrangement. This is different from other specialities for the reasons outlined in Section 1 of this paper.

- There are supplementary on call rotas in place across several sites in Ireland. Supplementary on-call rotas are designed to improve the on-call system by adding additional shifts or creating overlapping shifts to support primary on-call trainees.
- Supplementary on call rotas can be used in a variety of ways:
  - Scheduled Overlaps: In this setup, there are specific times during the day or night when the shifts of different trainees overlap. This arrangement ensures that at critical times, such as during shift changes or typically busy periods, there are multiple trainees available.
  - Backup or Standby Rota: These involve having additional trainees or staff on a backup rota who are not at the hospital but can be called in if the situation becomes unexpectedly busy or complex. This system provides a buffer, ensuring that the hospital can handle surges in demand without overburdening the trainees on duty. NCHDs on a standby rota are remunerated for this.
  - Task distribution: Trainees on call at the same time take responsibility for different aspects of the on-call responsibilities e.g. one NCHD completes emergency assessments, while another NCHD looks after the 'Approved Unit' including completing admissions, completing urgent in patient medical/ psychiatric assessments.
- Supplementary rotas are typically rotated among the trainees to ensure that everyone has equal opportunities for rest and professional development. Each training centre should utilise the supplementary rota to best meet the needs at that individual site but should keep same under regular review to ensure utilisation best supports NCHDs and service users.
- Each training centre needs protocols in place, that are agreed between the employer (including line managers and human resources) and if necessary occupational health to address:
  - NCHDs calling in sick when scheduled for on call- how this is managed in the short and medium term.
  - NCHDs who need flexible or reduced on call commitments owing to medical conditions or disabilities.
- Designated administrative support needs to be made available at each training site to complete nonclinical tasks associated with on call e.g. photocopying assessments, sending referrals, inputting into databases. A designated administrator should support the NCHD on call rota.
- The employer needs to identify a specific person responsible for bed management out of hours at each training centre. Bed management should not be the responsibility of an NCHD on call in any training centre in or out of hours.
- When other relevant posts are vacant**-** e.g. Crisis nurses in the emergency department- it is not appropriate for NCHDs to be expected to cover as a default. Local protocols need to be in place to manage staffing gaps in the short and longer term.
- There should be consistency on when the last service user is seen by day team/ by on call at every training site. One hour before the end of the shift is suggested as a minimum cut off after which a new on call assessment will not be commenced. This ensures the NCHD has adequate time to complete paperwork, including clinical notes, onward referrals, and preparation of a written Handover prior to them going off shift.
- Services should endeavour not to leave assessments/ other work that arose during the in hours clinical day to on call NCHDs.
- Circumstances in which routine work e.g. rewriting of Kardex's, are regularly falling to on call staff should be identified and brought to the attention of the supervising consultant and if necessary, the clinical director.

Interprofessional Working

- NCHDs have become the default to cover gaps in service delivery, and thus tasked with roles that negatively impact on their ability to deliver patient care (NCHD Taskforce, 2024). NCHDs continue to carry primary responsibility for many tasks that could be delivered in full or in part by other healthcare professionals e.g. phlebotomy, ECGs, crisis assessments.
- The College of Psychiatrists of Ireland strongly supports Recommendation 7 in the NCHD Taskforce, 2024. This recommendation proposes that a framework needs to be developed to support 'Interprofessional Working to Optimise Patient Care'.
- The Taskforce recommends that this framework should include clear pathways for a comprehensive multidisciplinary approach to deliver specific tasks and to reduce NCHD dependency for service delivery. Psychiatry and mental health services need to be involved in this review, framework development and implementation. Out of hours service provision needs to be a key consideration in this framework.

Scheduling Practices

- Any NCHD new to Psychiatry should not be placed on call for the two weeks after starting in post. Any NCHD new to the Irish health system should not be placed on call for 4 weeks after starting in post. New NCHDs should be given the opportunity to shadow a more senior NCHD on call on at least two occasions before joining the on-call rota.
- Where there are Senior Registrars on call in a service, priority should be given to ensuring they are rostered to complete second on call with new Foundation Years for the first 3 months of their Foundation Year. Furthermore, Senior Registrars should be prepared to provide onsite support for a period of the on-call shift if it is particularly challenging for a new foundation year.
- Rosters must be fair and equitable and must be issued to NCHDs one month in advance of start date for a minimum 13-week period (Recommendation 1 of the NCHD Taskforce, 2024).
- Rosters should not be implemented and managed solely by NCHDs without administrative supports. Rather there should be a designated administrator at each training centre who develops rosters, processes changes and sources locums when there are gaps. It is important that medical staff have oversight over the rostering process, but they should not be required to administer/ maintain it.
- Trainees returning from a period of long absence (12 months or more) need specific consideration when rejoining training. Each trainee's needs upon returning to training will be different and any plan to facilitate/support the return to training should reflect those needs. These needs should be considered in a return-to-work meeting in advance of a trainees return. Some trainees will return to training with no special adjustment and others will require an adjustment to clinical work. An adjustment to on call duties for a period e.g. a month may be recommended, depending on the circumstances following a return to work. The return-to-work plan should be reviewed again with the supervisor and Dean/ Vice Dean/ Tutor after the trainee has returned to clinical practice.
- Consideration needs to be given by the Dean/ Vice Dean/ Tutor to allocations and on call when a trainee is returning from a period of long absence.
- Every training deanery should have access to at least one on call rota with shorter work periods e.g. 12 hours or more flexible on call rotas to support accommodations for trainees with illness/ disability. This on call rota may also be useful for those returning from periods of extended leave.
- Recommendation 5 in the NCHD Taskforce, 2024 recommends the development of a Emergency Roster Planning. A working group will be developed under the NCHD Taskforce auspices. The College of Psychiatrists of Ireland support this recommendation but also believe that interim protocols need to be developed and implemented at each training centre.
- Each training centre needs protocols in place at the start of every clinical rotation to address:

- NCHDs who for on medical or disability grounds require less frequent, shorter or to come off the on call rota. This protocol should include detail on how such applications are made, review periods, accommodations & supports. These applications need to be managed in a clear, consistent and transparent manner.
- NCHDs calling in sick when scheduled for on call- how this is managed in the short and medium term.

Organizational Support

- Each site should consider implementing an NCHD 'buddy system' such that new trainees are provided with the contact details of a more senior NCHD to link in with. These types of relationships often develop informally but each Deanery and training centre should considering developing a more structured system of such support.
- Discrimination against service users or staff cannot be tolerated.
- 'What we permit we promote' Trainees who witness or experience discrimination against a service user, family member or themselves should bring them to the attention of their supervisor and the clinical director..
- The employer incident reporting and risk management systems should be accessible and utilised by NCHDs and consultants. NCHDs should receive induction in how to access and utilise local risk management systems.
- Any patterns of discrimination by individual staff or in specific locations need to be identified.
- If local interventions are not successful, the issue should be escalated to the Executive Clinical Director and the Head of Mental Health.

Duty Hour Regulations

- On site rotas that require NCHDs to complete emergency assessments in emergency departments or in approved centres should not extend to > 13 hours on call. This is in line with Recommendation 2 of the NCHD Taskforce, 2024.
- Off-site rotas that require NCHDs to routinely attend to complete several emergency assessments per shift and who cannot rest should be reviewed and restructured.
- The burden associated with all rosters is dynamic and should be kept under regular review by the employer. Restructuring needs to be considered when any rota becomes overly onerous. This is to ensure safe, high-quality care is available at all training sites and that trainee welfare is protected and supported.

Environment

- Trainees need access to suitable rest facilities where they can sleep, relax, and recover during breaks in their on-call duties. These facilities should be quiet, comfortable, and located away from busy clinical areas to ensure proper rest (NCHD Taskforce, 2024).
- Trainees come for a diverse range of cultural and religious backgrounds. Ensure trainees get regular breaks to facilitate diverse religious practices.
- Trainees should have access to nutritious food and drinks for the full duration of the on call, irrespective of the time of day or day of the week. Meals should accommodate dietary restrictions including vegetarian, halal or kosher meals.
- Trainees should have easy access to medical resources, including patient records, medical libraries and resources throughout the full shift, not just day time hours.
- Trainees need access to work phones/ pagers, and computers, enabling trainees to communicate quickly and effectively with colleagues and supervisors and complete onward referrals/ communications.
- The working environment should be safe and secure, particularly during night shifts. Measures should include secure access to buildings, adequate lighting, and safety protocols in case of emergencies. Trainees should have access to a chaperone if they need to travel outside across a hospital campus.

- Emergency Department assessment rooms must be safe.
- Personal alarms should be provided.
- Safety statements should be in place.
- A risk register should be in place.

Technological Innovations

- Electronic health records would reduce the administrative burden and significant clinical risk for NCHDs working with people in crisis on call. The introduction of Electronic Health Records across all mental health sites needs to be progressed as a priority. The same system should be introduced at all sites.
- Text to type software may assist trainees in completing some on call tasks more efficiently.
- Simulation training has demonstrated significant capacity to support trainees to feel competent and confident on call. All opportunities to expand and enhance psychiatry trainee and supervisor access to simulation training opportunities should be supported. This will require access to appropriate training facilities, recurring funding and protected time for skilled staff who deliver simulation training.
- Electronic rostering should be introduced in psychiatry.

Table 4: Summary of Recommendations of the On Call Working Group

Category	Recommendations	Responsible for implementation	Monitoring
Role and Responsibilities	• Include roles and responsibilities of NCHDs and Consultants on call in induction training and manuals. On call training should be a core part of induction. • There should be a conversation between the consultant on call and the NCHD at the start and end of the shift at a minimum. • Supervision on call should be delivered in line with NCHD experience and case complexity. • Use simulation training for support skill building on common on-call scenarios. • Refresh and augment training through the NCHD academic program. • An agreed structured handover tool should be utilised by NCHDs in all training centres to handover at the end of an on-call shift. • All NCHDs need administrative support to complete on call work. • Bed Management is not the role/ responsibility of an NCHD on call. Each training centre needs to have an identified staff member who has bed management responsibilities out of hours. • New consultants should also receive induction focusing on roles and responsibilities of supervision including on call	• CPsychI • Health Service Executive/ Employer	• Post Graduate Training Committee & Accreditation
Workload Management	• Have psychiatric nurses working in emergency departments out of hours in all sites. • There should be access to social work input for psychiatric patients out of hours in all sites.	• Health Service Executive/ Employer	• Postgraduate Training Committee & Accreditation

	• Designated admins need to be available at all training sites to complete non-clinical tasks associated with on call work e.g. photocopying assessments, sending referrals, inputting into databases.		
Interprofessional Working	• Develop a framework to support 'Interprofessional Working to Optimize Patient Care'. • Psychiatry and mental health services should be involved in this framework.	• Health Service Executive/ Employer	• NCHD Taskforce, HSE
Scheduling Practices	• Any NCHD new to Psychiatry should not be placed on call for the two weeks after starting in post. Any NCHD new to the Irish health system should not be placed on call for 4 weeks after starting in post. New NCHDs should be given the opportunity to shadow a more senior NCHD on call on at least two occasions before joining the on-call rota. • Where there are Senior Registrars on call in a service, priority should be given to ensuring they are rostered to complete second on call with new Foundation Years for the first 3 months of their Foundation Year. • Issue rosters one month in advance for a minimum of 13 weeks. • Senior registrars should differentially support foundation year trainees on call. • Trainees returning from a period of extended leave (>12 months) should be supported to have a period off the on-call rota e.g. 1 month depending on individual needs. • Every training deanery should have access to at least one on call rota with shorter work periods or more flexibility (such	• Health Service Executive/ Employer	• Postgraduate Training Committee & Accreditation • NCHD Taskforce, HSE

	as supplementary or overlapping rotas).
	• Each training centre needs written protocols in place to address:
	  ○ NCHDs coming off the on-call roster, how, when, review periods, accommodations & supports.
	  ○ NCHDs calling in sick when scheduled for on call- how this is managed in the short and medium term.		

Organizational Support	• Implement non-discrimination policies. • Use incident reporting and risk management systems.	• Health Service Executive/ Employer	• Postgraduate Training Committee & Accreditation
Duty Hour Regulations	• On-site rotas should be of less than 24 hours on call. • On call is dynamic, all rotas should be kept under review and open to restructuring if demand and burden increases.	• Health Service Executive/ Employer	• NCHD Taskforce, HSE
Environment	• Ensure access to rest facilities, nutritious food, medical resources, and secure environments. • Provide personal alarms and maintain safety protocols.	• Health Service Executive/ Employer	• NCHD Taskforce, HSE • Postgraduate Training Committee & Accreditation
Technological Innovations	• Prioritize the introduction of Electronic Health Records. • Support the use of text to type software. • Expand access to simulation training opportunities.	• Health Service Executive/ Employer	

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