Appendix 1. Members of NCPSH Advisory Groups

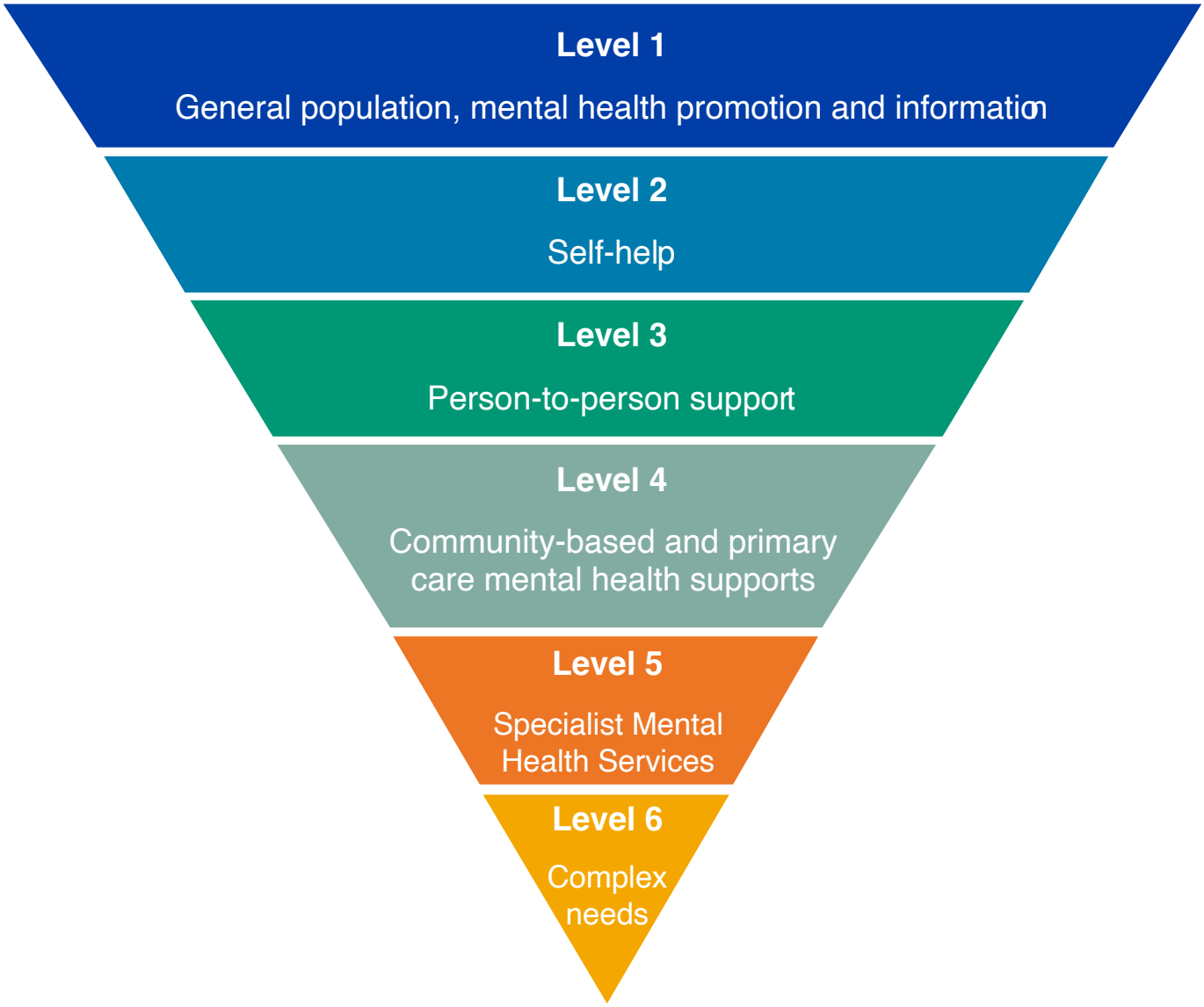
Implementation Advisory Group

Dr. A. Jeffers (Chair), National Clinical Lead
Dr. James O'Mahony, National Nurse Lead
Ms. Rhona Jennings, Programme Manager
Dr. Katerina Kavalidou, Data Manager
Dr. Brian Osborne, ICGP Mental Health Lead
Ms. Ciara Acton, HSE Mental Health Operations
Ms. Antoinette Barry, Mental Health Head of Service
Ms. Danni Burke, Peer Worker Service Development Advocate
Mr. Derek Chambers, HSE Connecting for Life Lead
Dr. Padraig Collins, Principal Primary Care Psychologist
Dr. Leonard Douglas, Consultant in Psychiatry of Later Life
Ms. Aisling Duffy, HSE Mental Health Engagement and Recovery Office
Ms. Teresa Harte, Clinical Nurse Specialist in SCAN and the NCPSH
Dr. Eric Kelleher, Consultant Liaison Psychiatrist
Mr. Ned Kelly, Area Director of Nursing Adult and CAMHS CHO4
Mr. Peter Livingstone, Clinical Nurse Specialist in NCPSH
Dr. Siobhan MacHale, Consultant Liaison Psychiatrist
Dr. Gerry McCarthy, Emergency Medicine Programme Clinical Lead
Dr. Brendan McCormack, Executive Clinical Director
Ms. Eileen Ní Shúilleabháin, Principal Mental Health Social Worker
Dr. Natasha Nor, Consultant General Adult Psychiatrist
Ms. Siobhan O'Carroll, Family Member Service development Advocate
Dr. Anne-Marie Waldron, Clinical Director, North Dublin CAMHS

Research and Audit Committee

Dr. Anne Jeffers (Chair), National Clinical Lead
Dr. James O'Mahony, National Nurse Lead
Ms. Rhona Jennings, Programme Manager
Dr. Katerina Kavalidou, Data Manager
Professor Ella Arensman, UCC and National Suicide Research Foundation
Dr. Helen Barry, Consultant Liaison Psychiatrist
Dr. Catherine Corby, Consultant Liaison Psychiatrist
Dr. Paula Corcoran, UCC and National Suicide Research Foundation
Ms. Marie Cotter, Clinical Nurse Specialist in the NCPSH
Professor Anne Doherty, UCD and Consultant Liaison Psychiatrist
Professor Louise Doyle, TCD School of Nursing and Midwifery
Ms. Kate Gaffey, Clinical Nurse Specialist in the NCPSH
Dr. Eve Griffin, UCC and National Suicide Research Foundation
Dr. Aine Horgan, School of Nursing & Midwifery University College Cork
Dr. Sutha Jain, Higher Specialist Trainees in Liaison Psychiatry
Dr. Erica Maguire, Higher Specialist Trainee in Liaison Psychiatry
Professor Kevin Malone, UCD and St Vincent's University Hospital, Dublin
Professor Fiona McNicholas, UCD and Consultant in Child and Adolescent Liaison Psychiatry
Ms. Michelle O'Donoghue, Clinical Nurse Specialist in the NCPSH

Appendix 2. Mental Health Support and Services in Ireland



Service/Support	Type	More Information
Yourmentalhealth.ie	Website, information, signposting	www.yourmentalhealth.ie
Keep Well	Campaign, website, information, signposting	www.gov.ie/en/campaigns/healthy-ireland
Minding Your Mental Health (multilingual)	Online videos	www.translateireland.ie
Union of Students in Ireland	Website, information, signposting	www.mentalhealth.usi.ie
College of Psychiatrists in Ireland	Online videos	College of Psychiatrists in Ireland
SpunOut.ie	Website, information, resources and signposting	www.spunout.ie
Mental Health Ireland	Telephone, website, information, resources and signposting	01 2841166 Minding our mental health during Covid-19
Inclusion Ireland	Website, information, resources and signposting	www.inclusionireland.ie
Aware	1800 804848, supportmail@aware.ie, www.aware.ie	
BeLonGTo Youth Services	Website, information, peer support, signposting	www.belongto.org
Age Friendly Ireland	www.agefriendlyireland.ie	

Level 1 General population

General population, mental health promotion and information services for all

Service/Support	Type	More Information
Minding your Wellbeing	Online programme	Minding your Wellbeing Programme
Stress Control	Online programme	HSE Health and Wellbeing
HSE Eating Disorder Self Help App	Mental Health App	HSE Eating Disorder Self Help App
MindShift App (by Anxiety Canada)	Mental Health App	MindShift on the App Store MindShift from Google Play
HeadSpace App	Mental Health App	HeadSpace from the App Store HeadSpace from Google Play
Clear Fear App	Mental Health App	Clear Fear from the App Store Clear Fear from Google Play

Level 2 Self-help

The resources at this level provide people with advice and guidance around activities they can engage in themselves.

Service/Support	Type	More Information
Samaritans	Telephone Email	116 123 jo@samaritans.ie www.samaritans.ie
Text50808	Text	Text HELLO to 50808 www.text50808.ie
Grow Mental Health Recovery	Peer support	www.grow.ie, 1890 474 474
Wellness workshops from Suicide or Survive	Online workshops	www.suicideorsurvive.ie
HSE Mental Health Recovery Colleges	Peer support	HSE Recovery Education
Shine	Telephone, email	phil@shine.ie www.shine.ie/covid-19
LGBT Ireland	Telephone, email, instant messaging	1890 929539 info@lgbt.ie, www.lgbt.ie
Childline	Telephone, email, text, instant messaging	Text 50101 1800 666666 www.childline.ie
Bodywhy	Telephone, email, online	01 2107906 alex@bodywhys.ie www.bodywhys
Exchange House	Telephone, online	01 8721094 www.exchangehouse.ie
Barnardo's	Telephone	1800 910 123, 01 4732110 www.barnardos.ie
Alone	Telephone	0818 222024 www.alone.ie
Alzheimer Society of Ireland	Telephone	1800 341341 helpline@alzheimer.ie

Level 3

Person-to-Person Support

Service/Support	Type	More Information
Traveller Counselling Service	Telephone, online	www.travellercounselling.ie
Together 4 Cancer Concern	Telephone	1800 200700 HSE National Cancer Control Programme
Practitioner Health	Telephone, email	confidential@practitionerhealth.ie, www.practitionerhealth.ie
Connect	Telephone	1800 477477 www.connectcounselling.ie
Minding Creative Minds	Telephone, online	www.mindingcreativeminds.ie
MyMind	Online counselling	hq@mymind.org, www.mymind.org
Turn2Me	Online counselling, online support groups	www.turn2me.ie
Jigsaw	Telephone, email, online	1800 544729 help@jigsaw.ie, www.jigsaw.ie
Pieta	Telephone, text, counselling	1800 247247 Text HELP to51444 www.pieta.ie
Irish Hospice Foundation	Telephone	1800 807077 www.hospicefoundation.ie

Level 4
Community-based and primary care mental health services*

Services at this level are delivered by people with a suitable qualification and include counselling services that can be accessed directly by members of the public.

* The difference between level 3 supports and level 4 relates to the accreditation or professional qualification of people delivering the services at level 4. Supports at level 3 are delivered by peers or trained volunteers.

Appendix 3. Clinical Audit conducted by the NCPSH

3a) An audit of assessment rooms for mental health assessments in Ireland's emergency departments

This audit was published in the Irish Journal of Psychological Medicine.

Jeffers, A., Jennings, R. & O'Mahony, J. (2020). An audit of assessment rooms for mental health assessments in Ireland's emergency departments. *Irish Journal of Psychological Medicine*, 1-6.

The following are extracts from that publication.

Objectives. To audit compliance of mental health assessment rooms in Irish adult emergency departments (EDs) which are open 24 hours on 7 days a week with standards identified by the Psychiatric Liaison Accreditation Network (PLAN).

Methods. A self-audit tool was sent via email to Clinical Nurse Specialists and Consultant Psychiatrists in Ireland's 26 Adult EDs that are open 24 hours on seven days a week. Results were collated and are presented ensuring anonymity.

Results. A response rate of 100% was achieved. Full or substantial compliance with PLAN standards was recorded in 73% of services. In seven services, the rooms used for mental health assessments were unsuitable when measured against the PLAN standards. A number of services identified the presence of ligature points within the rooms.

Conclusion. The Health Service Executive (HSE) National Clinical Programme for the Assessment and Management of patients presenting to the ED following self-harm is committed to achieving 100% compliance with PLAN standards in all services. Recommendations include introducing formal ligature risk assessments and risk assessments of the use of the assessment rooms. The Chief Executive Officers of all hospital groups were informed of the results of the audits and advised on recommendations for each hospital ED.

Table 1. Psychiatric Liaison Accreditation Network Criteria

- The assessment room should be located within the Emergency Department:
- Have at least one door that opens outwards and cannot be locked from the inside. Whilst not mandatory,
- PLAN highly recommends assessment facilities should have 2 doors to provide additional security.
- Have an observation panel or window allowing staff outside the room to check on the patient or staff member, and at the same time ensure privacy from the public is maintained. A common and effective approach is to use obscured toughened glass with a small clear section or built in adjustable blinds.
- Have a panic button. (Or staff use personal alarms.)
- Only include furniture, fittings and equipment which are unlikely to cause injury to the patient or staff member.
- Avoid the following– sinks, sharp-edged furniture, lightweight chairs, tables, cables, televisions or anything else that could be used as a missile.
- Does it have a suspended ceiling made of tiles, or does it include any fittings through which a ligature could be looped?

Table 2. Compliance with Psychiatric Liaison Accreditation Network standards

Standard	Full Compliance	Substantial Compliance	Not Compliant
	12	7	7

Table 3. Compliance with individual Psychiatric Liaison Accreditation Network Standards

Standard	Compliant	Not Compliant
The room is located within the ED	25	1
At least one door is opening outwards and is unlockable	22	4
There is an observation panel/window that provides privacy	22	4
There is an alarm or panic button available to staff	23	3
Furniture cannot be used to cause harm.	17	9
There are no ligature points 15 1 1	15	11
Decoration provides a sense of calmness	16	10

Table 4. Risk assessments of ceiling and use of the room

Has the ceiling been risk assessed	Yes	11	No	15
Has there been a formal risk assessment of the use of the room		8		18

Table 5. Characteristics of rooms that are non-compliant with Psychiatric Liaison Accreditation Network standards

No. of Hospitals	Compliance	Non-compliance
3	Room is located within the ED. Alarm is available	One door, which does not open outwards. No observation panel. Furniture is light and mobile. Several ligature points in the room.
2	Room is located within the ED Door opens outwards. Observation panel is present. Alarm is available.	Furniture is light and mobile There are multiple ligature points including sinks and oxygen portals The room is not available, used for medical cases
1	Room is located within the ED	Doors do not open outwards Light mobile furniture Multiple ligature points
1	Door opens outward Observation panel is in place Alarm is available. No ligature points.	Located outside the ED adjacent to reception area, Staff could be isolated Furniture is light and mobile

3b) An Audit of the Emergency Care Plan within the National Clinical Programme for patients who present to the Emergency Department following Self-Harm

Introduction

When the Clinical Programme commenced in 2014 services were advised to develop Emergency Care Plans. The Standard Operating Procedure stated that a written Emergency Care Plan (ECP) that addresses clinical needs and risks should be formulated and documented. The patient, and wherever possible their carer/next-of-kin, should be involved in the determination of this. A copy of this written ECP should be offered to every patient and family member/carer unless clinically inappropriate, and should be sent by secure fax and/or secure email (health-mail) (depending on local arrangements) to the patient's GP surgery. Patients who are not registered with a GP should be supported in registering.

The Model of Care (2016) states that an **Emergency Care Plan (ECP)** that addresses short-term and medium-term needs and risks should be formulated and documented. The patient, and wherever possible their carer/next-of-kin, should be involved in the determination of this. An ECP with clear, written information on how to access services, including specific contact details and telephone numbers of next step care e.g. clinic, day service and named mental health team clinician, in particular for out-of-hours presentations. The family member/carer/ significant other should be involved in this. The patient and the significant other should be advised on what to do should a further crisis occur.

The Review of the Operation of the Clinical Programme (2017) reported: Almost all services reported developing ECPs. They ranged from writing routine appointments and emergency numbers on a blank piece of paper, to providing a highly structured safety plan which included a modification of Stanley and Brown's safety plan in the first person, known as My 8-Step Safety Plan (Stanley and Brown, 2012).

> *A safety plan document is created collaboratively by a patient and clinician and typically consists of written strategies and sources of support that patients can use to alleviate suicidal urges or other safety crises. A commonly used model is Stanley and Brown's Safety Planning Intervention (SPI), which includes six components: (1) recognize warning signs of an impending suicidal crisis, (2) employ internal coping strategies, (3) utilize social contacts as a means of distraction from suicidal thoughts, (4) contact family members or friends who can help resolve the crisis, (5) contact mental health professionals, and (6) reduce the potential use of lethal means (Stanley & Brown, 2012). A cohort comparison trial of suicidal ED patients in US veteran's hospitals found that Safety Planning and phone follow-up reduced suicidal behaviours and increased treatment engagement in the intervention condition. (Stanley et al 2018.)*

The SPI is presented as a strategy to illustrate how to prevent a future suicide attempt, and identifies coping and help-seeking skills for use during times of crisis.

This audit measures what items are included in ECPs and how well ECPs are being completed. In some services the focus is on the treatment offered and in others the focus is on treatment and maintaining safety. Following this first phase of the audit cycle – new standards will be developed and in 6 months a re-audit will audit against these standards.

Methodology

In September 2019 all CNSs and Clinical Leads within the Clinical Programme were sent an Audit Tool and requested to complete an Audit on 10 Emergency Care Plans (ECP) by choosing consecutive notes from the previous two months until 10 ECPs were audited. Inclusion Criteria: All people who were discharged from hospital after they receive a mental health assessment following presentation at the ED

following self-harm or with suicidal or self-harm ideation. This is a retrospective Emergency Care Plan audit. A small number of services who scored 100% compliance on almost all items were contacted to discuss the value of including specific items in a national template.

Results: 22 of 24 services completed the Audit. 1 service has not introduced Emergency Care Plans and the other service was unable to complete the audit.

The following are the National results. For each items the mean % compliance was calculated and is shown in column 2. The number of hospitals that scored 100% on each item is shown in column 3. The number of hospitals that either scored 0% or rated the item as Not/Applicable is shown in column 4.

No	Item Audited	Nat. Aver	No. of Hosp 100%	No. of Hosp. 0 % or n/a
1	There is a written ECP in the patient's notes.	87%	13/22	0/22
2	The ECP was completed by a CNS	66%	6/22	1/22
3	The ECP was completed by an NCHD	34%	1/22	6/22
4	The date of assessment is on the ECP	97%	18/22	0/22
5	There is evidence (either in the notes or on the ECP) that the ECP was written in collaboration with the patient	93%	15/22	0/22
6	The development of the ECP has input from the family/ Chosen adult. (Evidence in the notes or on the ECP).	65%	4/22	0/22
7	The ECP is signed by the assessing mental health professional (MHP)	89%	17/22	2/22
8	The name of the MHP is written legibly on the form	90%	15/22	1/22
9	There is evidence in the notes the individual was given a written copy of the ECP	73%	9/22	1/22
10	The ECP details the individual discharge plan.	88%	17/22	1/22
1 1	The ECP details triggers for Self-Harm/Suicidal/Self-Harm Ideation	52%	6/22	6/22
12	The ECP identifies warning signs for Self-Harm/Suicidal/ Self-Harm Ideation	52%	5/22	7/22
13	The ECP identifies internal coping strategies.	53%	8/22	6/22
14	The ECP identifies ways to keep the environment safe.	62%	8/22	4/22
15	The ECP identifies time and date for next care appointment	34%	0/22	5/22
16	The ECP identifies supportive family/friends.	65%	6/22	3/22
17	The ECP identifies contact numbers for emergency support.	88%	14/22	0/22
18	The ECP states the patients will receive a follow up phone call within 24 hours.	49%	3/22	4/22
19	All items on the ECP were completed	77%	12/22	3/22
20	There is evidence in the notes that a copy of the ECP was sent to the patient's GP.	54%	7/22	9/22

Discussion

Personalised collaboratively developed risk management planning has been identified by the National Confidential Inquiry into Suicide in the UK as one of the factors in reducing suicide (NCISH 2016).

This audit was completed to identify a baseline of what services in Ireland are including in an Emergency Care Plan, and also to support development of a national template with a set of minimum recommendations.
A number of items w
ere present in over 85% of ECPs audited, and it is recommended that any national recommendations would include these items. These items were: having a copy of the written ECP in the patient's notes; each ECP should contain the date, the legible name and signature of the mental health professional; there should be evidence in the notes that the plan was developed in collaboration with the patients and details of the discharge plan. 88% of the ECPs included contact numbers for emergency contacts, it is agreed that services should ensure all numbers recommended are for reliable and available services.

That the development of the ECP had input from the family was present in 65% of ECPs. In 4 services this item was present in 100% of the ECPs audited, and there were no services that did not have at least one ECP with it included. While it may not always be possible to involve family members, the NCP does recommend that every possible effort is made to involve family or a supportive adult. A booklet Would you know what to do if someone told you they were suicidal? had been developed by the National Office of Suicide Prevention. An item could be included identifying if family have been included, and if this booklet was given to the family.

In 73% of ECPs there was evidence that a copy of the ECP had been given to the patient. It is recognised that not all patients wish to take written material with them. An item identifying that the patient was offered a copy of the ECP, and whether they took same could be included.

Only 62% of ECPs recorded an item on keeping the environment safe and 4 services did not have this item on any ECPs. While not the only intervention in suicide prevention, reducing access to means is an effective way of reducing suicide, preventing impulsive action and giving the person an opportunity to stop and seek help. Identifying means to keep the environment safe such as removing firearms and reducing available tablets is effective, particularly if the person has identified a plan to use these items. Raising this topic may lead to anxiety in family members, this is understandable and family members should be supported in sharing their concerns, at the same time supported in helping provide a safe environment. It is recommended that a general item "Staying Safe" would be included in a national template. This could include having a safe environment.

Whilst 88% documented having Individual discharge plans, only 34% documented including time and date of next care appointment. Many CNSs have identified difficulty in obtaining time and date for next care appointment, it can be argued that having this is one of the most effective measures in ensuring engagement with next appointment, and therefore should be included in national recommendations. Compliance with this will depend on greater cooperation from community, addiction and mental health teams. `Triggers, warning signs and internal coping strategies were each recorded as present in just over 50% of ECPs. 5 services recorded all in 100% of ECPs, but 6 services did not record any of these on any ECP.

The 5 services that recorded all 3 in 100% of cases were contacted for further explanation. They reported including them from recommendations on safety planning, (Stanley and Brown 2012). They commented that internal coping strategies were helpful, but they felt triggers and warning signs do not contribute to this short term emergency care plan, and including them often involved unnecessary repetition for the patient. One CNS, who has trained in DBT, encourages use of personal strategies such as distraction and self-soothing. Stanley and Brown, comment on the value for the patient in identifying their own coping strategies in improving self-efficacy. This is also an opportunity to include personal resources or strengths. This would suggest the national template should include internal coping strategies/personal resources as part of staying safe, but leave out triggers and warning signs.

Only 49% of ECPs referred to receiving a follow-up phone call from the CNS the following day. The NCP recommends that all patients, except where it is not clinically appropriate, should receive a follow up phone call within 24 hours. The combinations of having a Safety plan and receiving a follow up phone call has been shown to reduce the incidence of repeat self-harm and improve engagement with services (Stanley and Brown 2018.) As not everyone receives this call, it may be appropriate to recommend it as an individual item included in Next Mental Health Care section.

In 54% of ECPs is it documented that a copy of the ECP is sent to the patient's GP. In 9 services the ECP was never sent to the GP. This point was raised at a meeting with the ICGP. GPs reported valuing seeing a copy of the ECP. Some GPs reported they would use see a place for using ECPs in General Practice, particularly for sharing information form out of hours services. The national template should include a section identifying that a copy was sent to the patients GP.

Based on these results the following example is recommended as minimum standard for all services

- A written Emergency Care Plan should be completed on each patient.
- ECPs should have the date, the patients name, the Mental Health Professionals name and signature.
- There should be evidence, either on the ECP or in the patient's notes that the ECP was completed in collaboration with the patient.

There should be a place on the Care Plan to state if family have been part of the care plan, if the patient has asked family be excluded, and if the person and family were given a copy of or a link to Would you know what to do if someone told you they were suicidal?

The patients should be given a written ECP, and this fact should be recorded in the notes. Keeping Safe should be included in the ECP. Place and phone number of next care appointment should be included.

The ECP should identify Emergency numbers, including national numbers that are recognised as being reliable and available, supportive family/friends.

The ECP should include a section on Mental Health Care – this should include discharge plan, and all effort should be made to include time and date of next care appointment. In some cases this will include the fact the person will receive a phone call from the CNS the following day.

A copy of the ECP should be sent to the patients GP and this should be documented in the notes.
Agreed at Research and Audit Committee and Implementation Advisory Group on 5.12.19.

Example of an Emergency Safety Plan

Patient's Name: **Date of Birth:**
Mental Health Professional (MHP) Name:
ESP completed in collaboration by the MHP and the patient: **Yes ❑ No ❑**
Family member/supporter has been part of the care plan: **Y ❑** N ❑

	RESPONSES	**ACTIONS**
Keep safe	Individual Family member/supporter GP /SCAN	*(e.g. Remove firearms, tablets, means of self-harm. Stay with relatives/supportive friend. Identify internal/personal coping strategies.)*
Emergency numbers		*(Include numbers for Samaritans 116123; daytime numbers for CMHT and GP; and for supportive family members or friends who can be contacted in an emergency.)*
Mental Health Support		*(e.g. Name of place and phone number for next appointment; plan for what the next communication will be with the patient.)*

Patient has requested family member is not included: **Y ❑** N ❑
Family member given a copy of *Would you know what to do if someone told you they were suicidal? (NOSP)*: Y❑N❑
Copy of the ESP given to the patient: **Y ❑** N ❑
Signed (MHP)
Signed (Patient – *optional*)

c) Audit of Follow-up phone calls

Audit of follow up phone-call for patients assessed by Clinical Nurse Specialists and by NCHDs out of hours.

Introduction

For individuals presenting to the ED following self-harm, the period after discharge from hospital is marked by heightened vulnerability for further suicide attempts/behaviour. Effective care following presentation can significantly reduce risk. The National Clinical Programme for Self-Harm (NCPSH) identifies four areas for improving care including recommending that all patients who self-harm and present to the ED receive a compassionate, empathic approach from a mental health clinician; receive an expert biopsychosocial assessment with a written emergency care plan; have family/carer involvement, and are followed up and linked to appropriate next care. One aspect of the follow-up and link to next care is the recommendation that 'where clinically appropriate, patients discharged from the ED following a presentation with self-harm, including those seen out of hours, should be offered a telephone call within 24 hours from a Specialist Nurse (Registered Psychiatric Nurse) to offer support and discuss the care plan further' (HSE 2016c).

Among patients who have been discharged from hospital following self-harm, the risks of repeated acts of self-harm and suicide among all ages is highest immediately following discharge (Geulayov et al 2018). Brief contact interventions such as post-discharge telephone calls have been shown to offer social support, improve suicide prevention literacy and assist in learning alternative behaviours (Milner et al 2016).

National NCPSH data for 2019 for all patients who were assessed following self-harm or with suicidal ideation found that only 39.5% of those who were assessed received a follow-up phone call. Of CNS-assessed patients, 51.4% received a follow-up phone call and of NCHD-assessed patients the percentage was 27.7% (HSE 2020, Delivering Specialist Mental Health Services). While this gives an overall percentage, it does not give any breakdown on what presentations were more likely to receive a follow-up phone call, or on the outcome of the phone calls. Also, large variations between hospitals are shown in the national statistics, with the percentage receiving a follow-up phone call ranging from 2% to 90%.

A more in-depth audit of follow-up phone calls was conducted to identify and analyse the factors contributing to such national variation. The results of this audit will further inform practice and data collection.

Method

A Clinical Nurse Specialist in each service was asked to complete an Audit of 10 consecutive presentations to the ED following self-harm or with suicidal ideation. This audit identified the number receiving a follow-up phone call, the reason why a phone call was not given, the timeframe within which the phone call was made; whether the patient had self-harmed or had suicidal ideation; whether the patient was assessed by a CNS or an NCHD, and if contact was made with the patient. The audit also identified the time the person presented, whether alcohol of substance misuse was a factor, and the lethality of the suicidal attempt.

Results

Results were obtained for 17 out of 24 services. The mean rate of follow-up phone calls for the 7 services that did not complete the audit, as shown by the national NCPSH data in 2020, was no less than the mean for all the hospitals. There was a slightly higher rate, but the numbers are too small to indicate any significant difference (Table 1).

Table 1 Rates of follow-up phone calls for hospitals (NCPSH data 2020)

Services	Mean rate of follow-up phone calls
7 services that did not complete the audit	45.1%
All hospitals in 2019	39.5%

Table 2 Results of audit of follow-up phone calls from 17 hospitals Text in top-right cell unreadable

No. of hosp.	No. of phone calls made	Reason for no phone call	Timeframe for call	No. of calls for patient who self-harmed	No. of calls for patient with suicidal ideation only	No. of calls for CNS assessed patient	No. of calls for NCHD assessed patients	No of calls for which contact was made	% of all w required a c receiving a f up phone ca
1	4	1a) 5 e)	4 in 24 hrs.	3 of 8 (37%)	1 of 2 (50%)	2 of 6 (33 %)	2 of 6 (33 %)	2 of 4	22%
2	2	3 b)	1 in 24 hrs. 1 in 72 hrs.	1 of 6 (17%)	1 on 4 (25%)	2 of 3 (66%)	0 of 7	1 of 2	14%
3	7	1a) 2 e)	5 in 24 2 In 72	4 of 7 (57%)	3 of 3 (100%)	4 of 6 (67%)	3 of 3 (100%)	7 of 7	78%
4	5	3 a) 1b)	3 in 24 2 in 72	5 of 8 (62%)	1 of 2 (50%)	3 of 3 (100%)	2 of 2 (100%)	2 of 5 (40%)	40%
5	3	1a) 5b) 1e)	2 in 24 1 in 72	2 of 7 (29%)	1 of 3 (33%)	3 of 4	0 of 0	3 of 3	75%
6	5	5 a)	5 in 24	3 of 7 (43%)	2 of 3 (66%)	2 of 2	3 of 3	5 of 5	100%
7	7	2 b) 1 e)	7 in 24	4 of 6 (66%)	3 of 4 (75%)	7 of 9	1 of 1	3 of 7	37.5%
8	8	1a) 1 b)	8 in 24	3 of 5	5 of 5	5 of 5	3 of 3	8 of 8	100%
9	7	3 a)	7 in 24	4 of 5	3 of 5	5 of 5	2 of 2	6 of 7	(86%)
10	10	0	10 in 24	6 of 6	4 of 4	7 of 7	3 of 3	7 of 10	(70%)
1 1	9	1a)	8 in 24 1 in 72	6 of 7	3 of 3	9 of 9	0	8 of 9	(90%)
12	8	2 a)	8 in 24	2 of 2	6 of 8	7 of 7	1 of 1	8 of 8	(100%)
13	6	1a) 1b) 2e)	6 in 25	5 in 7	1 in 3	6 of 8	0	6 of 6	(75%)
14	2	3a) 2 b) 3e)	1 in 24 1 in 72	1 of 3	1 of 7	2 of 4	0 of 1	2 of 2	(40%)
15	9	1e)	8 in 24 1 in 72	4 of 5	5 of 5	9 of 9	0	9 of 9	(100%)
166	2	3 a)	2 in 72	2 of 4	0 of 6	2 of 2	0 of 1	2 of 2	(66%)
		4 b) 1 e)							
177	7	2a) 1 e)	4 in 24 2 in 72 1 in aweek	1 of 2	6 of 8	7 of 8	0	7 of 7	(87.5%)

Key to column 3. Reason for no phone call: a) Admitted to approved centre; b) Phoned by CMHT team; c) Medical records not available; d) CNS on leave; e) Other.

Of the 17 hospitals that completed the audit only one hospital delivered a follow-up phone call in each of the 10 presentations audited. When the presentations who did not require a follow-up phone call (e.g. the person was admitted to an approved centre or received contact from a home-based treatment team or a community mental health team) were removed, 4 services delivered phone calls to 100% of people who required them, and the range was from 14% to 100%, with 12 services delivering a follow-up phone call in 66% or more cases, with a mean of 86%. 52 presentations overall were either admitted to an approved centre, or the person was contacted by a CMHT the following day. This left 118 presentations from a total of 170 where a follow-up phone call was required. 101 phone calls were delivered, giving an overall percentage mean of 86%. Two hospitals found only half of the calls made contacted the patient, resulting in a 22% and 14% rate for giving a call when it was required. For 2 hospitals this rate was between 35% and 40%, for 1 it was 66%, and for the 11 remaining it was over 70% (Table 2).

Table 3 Patient age and follow-up call

Patient Age Range	F/u call YES	F/u call N	Admitted	Total	Contact not made with the patient
16-yr	41 (84%)	5	4	50	3
25-34 yr	21 (87.5)	3	6	40	1
35-44 yr	28 (85%)	5	4	37	5
45-54 yr	23 (79%)	4	3	30	2
55-yr	15 (100%)		2	17	
65-74 yr	2 (100%)			2	
75+			3	3	
Unknown			1	1	

These results show that, while numbers are lower, those over 55 yrs. were more likely to receive a call. It was noted in a number of centres that up to 4 calls could be made to a person. In others, one call was made and no comment was given as to why another call was not made.

Table 3 Alcohol a factor and follow-up call

Alcohol a Factor	F/u call YES	F/u Call NO	Admitted	Total	Contact not made with patient
Yes	69 (85%)	1 1	7 (8%)		12
No	5 5 (90%)	6	18 (36%)		2
Unknown	1		2		

It was noted in a number of services that people were called up to 5 or 6 times and still contact was not made.

Table 4 Suicidal act/suicidal ideation

SA or SI	F/u call YES	F/u call NO	Admitted	Total	Contact not made
Suicidal Act	73	8	14		9
Suicidal Ideation	47	8	9		3
Unknown		1	1		

There were a higher number of presentations for suicidal acts compared with suicidal ideation. There was almost no difference between the two groups on the numbers where contact was made.

Table 5 Severity of suicidal act/lethality

Severity	F/u call YES	F/u call NO	Admitted	Total	Contact not made
Low	63	10	2		5
Moderate	37	6	8		5
Severe	7	1	8		2
N/A	13	9	6		

While those with more severe attempts have a lower number of contacts made, it was noted that, in some cases of moderate or severe lethality, no contact was made despite 4, 5 or 6 phone calls being made.

Of the 17 people for whom a follow-up call was appropriate and it did not occur, 12 were out of hours and assessed by an NCHD, and 5 were assessed by a CNS.

Discussion

This audit showed a marked variation in the use of the follow-up calls across services in Ireland, but the rates were higher and the mean percentage of 86% is much higher than the NCPSH data rate of 39.5%. Also, 13 of the 17 hospitals had a rate of over 50%, with 11 having a rate of over 70%. This discrepancy can be explained by the reasons for not offering a phone call. Another mental health team, such as a home-based or a community team, contacted a large number within 24 hours, and yet in the national statistics this group would have been recorded as not receiving a phone call. This has identified a need to collect data in the national statistics on numbers receiving a call within 24 hours, to include those who are contacted by another mental health team.

A number of people were not contactable, despite the CNS making a number of calls. Age, alcohol use or severity of suicidal behaviour were not factors as to whether the person was contactable or not. This has demonstrated that no standard has been identified in the NCPSH for how many attempts at follow-up phone call should be made. Following discussion with the Implementation Advisory Group of the NCPSH, it has been agreed that best practice would be to call each person on at least two occasions on at least 2 days, and if the person still cannot be contacted their GP and the next appropriate care is informed. This remains a clinical decision. It identifies a minimum standard and it is then a clinical decision if more attempts are warranted.

As is seen with the NCPSH national data, those assessed by a CNS had a higher rate of follow-up phone calls.

Conclusion

This audit has shown a high rate of compliance with the requirement under the NCPSH to provide a follow-up phone call for each person who presents to the ED following self-harm or with suicidal ideation. It has found that an apparent low compliance with national standards, seen from NCPSH data, reflects the fact there is no place in the NCPSH to submit data on phone calls delivered by other mental health teams. There is a greater rate of follow-up calls for those assessed by a CNS compared with those assessed by an NCHD. Based on this audit, the NCPSH has introduced a change on how data on follow-up phone calls are collected. Also, CNSs are now advised to use clinical judgement to determine how often to attempt to make contact with a patient, but at a minimum they should attempt at least on two occasions on two different days. Training to ensure that NCHDs are aware of the need to provide the CNS with information on assessments they complete continues. This should increase the numbers of NCHD-assessed patients receiving a follow-up phone call.