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Perspective

Clinical pathways for suicidality in emergency settings: a public health priority

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Abstract. Rates of self-harm in Australia are increasing and constitute a concerning public health issue. Although there are standard treatment pathways for physical complaints, such as headache, abdominal pain and chest pain, in Emergency Medicine, there is no national pathway for self-harm or other psychiatric conditions that present to the emergency department. Herein we outline the difference between clinical practice guidelines and clinical pathways, discuss pathways we have identified on self-harm in Australia and overseas and discuss their applicability to the Australian context and the next steps forward in addressing this public health issue.

Additional keyword: emergency department.

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Suicidality, clinical practice guidelines and clinical pathways

Although suicide is a comparatively rare event, suicidality (self-harm behaviours and suicidal ideation) is relatively common in the community and an important part of the work of emergency departments (EDs) and acute mental health services.

Over their lifetimes, 2.1 million Australians aged 16–85 years experience serious thoughts about taking their own life; over 600 000 make a suicide plan and over 500 000 attempt suicide.[1] Hospitalisation rates for intentional self-harm have increased in Australia to 27 112 presentations in 2011–12 and suicide is the commonest cause of death in Australians aged 18-44 years.[2]

Although most people presenting with suicidality are acutely emotionally distressed, depressed and/or in crisis, they are a very heterogeneous group. This is evidenced by the wide variety of risk factors identified for suicidality, including anxiety and depressive disorders, substance abuse,[3,4] history of sexual abuse,[5] body image or weight control issues,[6,7] psychiatric problems or social isolation,[7,8] and poor family communication or family breakdown.[3,9] This diversity creates challenges in providing appropriate clinical management and has led experts to highlight the need to understand the patient's predicament[10] rather than focusing on psychiatric diagnosis in assessment and management.

There are local and UK clinical practice guidelines (CPGs) available for self-harm.[11,12] CPGs are defined as 'systematically developed statements that assist clinicians and patients in making decisions about appropriate treatment for specific conditions'.[12] They should provide current evidence-based recommendations that set clinical standards and assist patients to make informed decisions.[12] The National Institute for Heath and Care Excellence (NICE) guidelines[12,13] have been particularly influential in this regard. CPGs are usually thick documents with recommendations intended as general guidance, but their usefulness is limited by factors such as whether they are easily accessible and translatable into local contexts, lack of research evidence on effectiveness and low-quality implementation methodology.[12]

The term 'clinical practice guideline' is often used interchangeably with 'clinical pathway', despite their differences. Although CPGs are predicated on high-level principles requiring translation into local clinical use, clinical pathways 'integrate medical treatment protocols, nursing care plans and activities of allied healthcare professionals into a single care plan, which clearly defines the expected progress and outcomes of a patient through the hospital system'.[14] The term 'clinical pathway' has been in the literature since the 1980s.[15,16]

Where CPGs are broader in scope, more detailed and seek to include all patient population groups, effective clinical pathways

should capture 60–80% of the target population because they are designed for 'usual' patients.[14] Pathways are focused on the clinical side, or 'coalface', of medicine and the best ones are driven by practicing clinicians.[14] The advantages of clinical pathways include reduced delays, lower length of stay and less variation in treatment.[14,17,18]

What clinical pathways are available?

We reviewed the literature to identify clinical pathways for self-harm and to determine what they covered, as well as their potential for use in an Australian context. Kinsman *et al*.[15] had undertaken a systematic literature review and we used their criteria (noted in Table 1) to assess the seven pathways we identified. Of the seven pathways we identified (Table 1), six included a flow diagram to facilitate interpretation and expedite use, something that increases the usefulness of the pathways for busy clinicians.

Most of the pathways[19–23] were developed and implemented within the UK for young people in local health areas as a response to the NICE guidelines.[12,13] The single Australian pathway[18] was more broadly based and the only one evaluated empirically. The nurse-led pathway is for all attenders and aims to expedite the course of suicidal people through ED[24]. Locally in New South Wales (NSW), Project Air is intended only for people with personality disorders,[25] and the Green Card Clinic at St Vincent's Hospital[26] provides pathways for suicidal people that go beyond the ED and could dovetail with ED-focused pathways. Between them, these pathways provide elements to inform models for clinical pathways that local services could develop across all age bands.

We note the finding that people presenting with suicidality often have poor lifestyle habits and increased future morbidity not only from suicide and accidents, but also from many common medical conditions.[27,28] This, coupled with the increasing number of suicidality presentations in a heterogeneous group of patients and the need to encourage community-based approaches for follow-up instead of using the ED for repeat crisis presentations, highlights the importance of implementing clinical pathways for local settings as important issues in health service and public health domains.

Where to next?

There are several steps in developing a clinical pathway for suicidality: (1) moving the conversation from 'what is a clinical pathway?' to 'why is a pathway needed for suicidality'?; (2) bringing together relevant stakeholder groups at a local health service or district level; (3) appraising available models and the relevant CPGs; and (4) evaluating the implementation of candidate pathways for outcomes such as the number of people for whom it is relevant, the effect at different time points and decreases in the number of repeat presentations to the ED and attempted suicide rates.

There are well-established pathways used in EDs in NSW for physical health problems such as chest pain, headache, abdominal pain and head injury. There is a recently revised state-wide reference guide for psychiatric presentations,[29] alongside a new policy statement on care of people who may be suicidal.[30] However, both deal with these issues in a very general way. The nearest either gets to a pathway is a rudimentary flowchart in the former, the 'Framework for Suicide Risk Assessment and Management for NSW Health Staff', itself republished from a 2004 guideline for managing suicidality in EDs.[31] Addressing the discrepancy between how physical and mental health presentations (including suicidality) are approached is a good starting point. The updated Australian CPG[11] will be available in late 2016 and provide added opportunity for this to happen. We also recommend extending suicidality pathways beyond the confines of the ED to anticipate longer-term solutions for people presenting in crisis and to decrease the reliance on the ED for those with repeated suicidality and crisis presentations.

Table 1. Clinical pathways identified in the literature and assessed against the criteria of Kinsman *et al.*[15]

The first five pathways[25–29] were developed by British National Health Service (NHS) Trusts as a result of local clinical practice guidelines. The criteria of Kinsman *et al.*[15] are as follows: 1, multidisciplinary; 2, guidelines translated for local structures; 3, steps developed in a plan, pathway or algorithm; 4, time frames or criteria-based progression; and 5, standardised care for a specific population. ED, emergency department

Pathway	Criterion					Meets pathway criteria?	Comments
	1	2	3	4	5		
Children's Trust Self-harm Care Pathway[25,A]	✖	✖	✖		✖	✖	Designed for young people in the local area, stops at the ED but gives context and some post-discharge resources
Derby City Self-harm Protocol[26,A]	✖	✖	✖	✖	✖	✖	Designed for young people in the local area, stops at the ED but gives context and some post-discharge resources
Lancashire Self-harm Care Pathway[27]	✖	✖	✖		✖	✖	Comprehensive resource: care pathway is more about process than addressing issues for different groups among people expressing suicidality
Northumberland Self-harm Care Pathway[28,A]	✖	✖	✖		✖	✖	Designed for young people in the local area, stops at the ED but gives some post-discharge resources
Shropshire Integrated Care Pathway for self-harm[29,A]	✖	✖	✖		✖	✖	Designed for young people in the local area, stops at the ED but gives some post-discharge resources
Nurse-led pathway[30]	✖	✖	✖	✖	✖	✖	Description of care pathway to provide a 'fast track' through the ED
Hunter Area model for management of self-poisoning[18]	✖		✖	✖	✖	✖	Care pathway covers all age groups but is only for self-poisoning, not other forms of deliberate self-harm or suicidality more generally

[A]Pathways specifically for children and young people.

We propose that treating suicidality as a public health issue will promote appropriate prevention and management strategies inside and outside hospital and clinical settings.[32]

Competing interests

None declared.

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