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Suicide and the creation of evidence-based guidelines: the ACEP perspective

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The American College of Emergency Physicians, as well as most emergency physicians, recognize that suicide is a national epidemic [1]. Suicide is the 10th leading cause of death for all ages combined [1], and from 1999 to 2016, suicide rates rose by 28% nationally [2]. Most patients have seen a physician prior to their suicide [3,4], and many of these patients have seen this physician in the emergency department (ED) [5-7]. In fact, "mental disorders" was the 9th leading diagnosis made in emergency department patients in 2015 [8].

In virtually every other medical condition, emergency physicians either treat or refer to specialists. Often, this is not possible for suicidal patients, as there are few psychiatrists and even fewer psychiatric beds available to accept them. Over time, due to lack of the availability of specialists in many areas including orthopedics, plastic surgery, and anesthesia, emergency physicians have often increased their scope of practice. Our hypothesis was the expanded scope of practice could be true for patients with "suicidal ideation." A 2016 ACEP survey, for instance, found that more than 90% of emergency physicians indicated that they board psychiatric patients every week, with more than 55% boarding such patients daily [9]. The majority of these patients do not receive treatment in the ED, but are simply warehoused in emergency departments until a bed becomes available. This strategy of warehousing patients with "suicidal ideation" takes up valuable emergency department resources and often results in suboptimal care for those patients. The purpose of creating the ICAR^{2}E guideline was to create an actionable evidence-based guideline to improve screening and treatment of suicidality, and expediting disposition when it is appropriate to do so.

There have been advances in evaluation, treatment and disposition, but these advances have not been translated to emergency department clinical practice. In 2018, ACEP decided that the time had come to survey the evidence pertaining to patients with suicidal behavior who present to the ED. The result, as you can read for yourself in the accompanying manuscript, is the ICAR^{2}E tool [10].

Even before ICAR^{2}E, there were of course other guidelines from suicide prevention organizations which attempted to provide similar guidance to emergency physicians [11-15]. Two guidelines are particularly worthy of note: The 2015 Suicide Prevention Resource Center (or SPRC) "A consensus guide for emergency departments" [14] and the 2018 "Recommended Standard Care for People With Suicide Risk" from the National Action Alliance For Suicide Prevention (or Action Alliance) [15]. Consequently, with the publication of ICAR^{2}E, it may be worth asking what this particular tool adds to the literature. In other words, why did ACEP feel the need to create this guideline, what did ICAR^{2}E get right, and what might this tell us about how future guidelines ought to be created?

To answer that question, it may be worth asking what guidelines are really for. In other words, what should a guideline do for emergency physicians and how can guideline creators help make them even more useful?

We believe that, although guidelines have many purposes, there are three fundamental tasks for a clinical guideline: provide education, clarify medico-legal issues, and describe the evidence for each recommendation in a way that allows physicians to understand which recommendations have support from higher-quality evidence and which do not. We examine each of these in turn.

1. Education

Almost all medical specialties universally offer guidelines on specific topics for the purpose of education, i.e., in order to narrow the difference between the scientific literature and what clinicians actually do [16]. Hundreds of such clinical guidelines were stored on the website of the government-funded National Guideline Clearing House before it was shut down in 2018.

However, in order to provide appropriate education, it is important to generate consensus about what appropriate physician behavior should be. The Institute of Medicine (IOM) recognized the importance of diversity in the composition of writing groups in their 2015 report calling for the standardization and improvement of clinical practice guidelines [17]. By this criterion, the SPRC guideline is well-constructed, since it included a diverse panel of 60 experts on suicide prevention (although a majority of this group were neither emergency physicians nor nurses). The National Action Alliance, on the other hand, included only 8 contributors and 2 staff. Out of the 8 contributors, only 2 were physicians: 1 healthcare consultant and 1 psychiatrist. Additionally, the IOM recommended that patient stakeholders be included in the

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process. Although the SPRC guideline meets this test, the Action Alliance report does not.

2. Medico-legal issues

It is crucial to address physician fears of lawsuits in order to change medical practice. The term "standard of care" is sometimes difficult to define but the ICAR^{2}E guideline audaciously moves to advance psychiatric care in the ED and appropriately expand the scope of practice of emergency physicians. Decision-making in medical settings is complex, all the more so because particular clinical trials taken as "standard of care" may not apply to a particular patient in a particular bed at a particular time. In order to decide whether the evidence does apply, physicians must understand the benefit or harms of a particular intervention. This means that guidelines should include all trials, not just a selected list. In other words, is the writing group aware of all existing evidence and has the presence of lack thereof been appropriately communicated to the reader?

By this criterion, both the SPRC and Action Alliance guidelines are lacking. Neither guideline was constructed after a systematic review of the existing evidence, although it should be acknowledged that both efforts included nationwide experts who were presumably aware of the evidence base for each recommendation. The SPRC guide offers an algorithm for screening of the suicidal patient which has not been studied in the emergency department, may not be applicable to every ED, and may have a large number of false positives [18]. In terms of defining standard care, neither writing group included a large number of emergency providers. Out of 60 experts, for instance, the SPRC roster lists only 15 emergency physicians or emergency nurses (approximately 25% of the panel), although most of the remaining members of the panel had some sort of practice affiliation with the ED. However, the Action Alliance "Recommended Standard Care" included only two physicians and no emergency providers, and it is unclear whether the other contributors were selected for their expertise in emergency settings.

Although the authors of the Action Alliance report were careful to avoid the term "standard of care," the existence of a document created largely by non-EM providers about appropriate treatment of ED patients raises concerns that such reports might one day be used against emergency providers in court. In addition to the lack of ED providers, this is troubling for a number of reasons. In this guideline, contributors did not disclose how their participation was funded, although the document itself acknowledges multiple sources of federal funding. The guideline also does not disclose whether contributors had conflicts of interest, or whether or not the guideline used a methodologist to rate the quality of the included evidence. Furthermore, the report recommends several screening instruments which have not yet been evaluated in the ED. All of these points were explicitly mentioned in the ICAR^{2}E tool, although of course emergency physicians should be mindful that no tool affords full legal protection.

3. Evidence base for recommendations

The ICAR^{2}E tool, like all ACEP guidelines, provides a rating for each recommendation. This allows providers to quickly ascertain the evidence base for a particular recommendation, which then allows providers to make an informed decision about whether it is better to evaluate, treat, and discharge than to admit and board a particular patient in the ED. Neither the SPRC guide nor the Action Alliance provides levels of evidence or levels of agreement among experts for each recommendation.

4. Our hope

ACEP of course is hopeful that the ICAR^{2}E tool will do more than provide interesting reading to emergency physicians. First and foremost, we wish to improve the quality of guidelines which are being written by non-emergency providers for ED physicians. Creators of guidelines would do well to follow the advice of the Institute of Medicine, especially as it pertains to a complete and systematic review of the evidence.

Beyond encouraging the researchers to do better, however, ACEP hopes that the ICAR^{2}E guideline will have other beneficial effects. Hopefully, this guideline will awaken both the public and the policymakers to the need to allocate more resources to follow-up and research in emergency psychiatric care. We hope that this discussion will elevate compassion and decrease the stigma of mental illness. Mental health is often a treatable disease, and providers should be as nonjudgmental about these diagnoses as with ankle sprains, fractures, or heart attacks. Additionally, we hope that ICAR^{2}E will evolve and revolutionize the evaluation, treatment, and disposition of patients with suicidal ideation. The results will ideally improve patient care, increase patient satisfaction, advance emergency psychiatric care, and decrease bias against some of the most vulnerable patients in our emergency department. Perhaps one day, all of our treatment of psychiatric patients will be truly evidence-based, and all psychiatric patients will view the emergency department as a place of hope and compassion — the same as trauma patients, cardiac patients, and those that have nowhere else to turn.

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