

Psychiatric Emergency – Suicide Prevention and Intervention Strategies: Focus on Asian Americans

Henry Chung, M.D. , Clinical Associate Professor of Psychiatry and
Associate Vice President, Student Health, New York University



Background:

Suicide is the 4th leading cause of death in the United States for those between 18 – 65 years of age; when one accounts for the number of suicide attempts that goes unreported, it is clear that this is major public health problem. Most of those that attempt or complete suicide have a psychiatric disorder that is treatable; most often clinical depression. A sobering fact that often goes unreported is that from 30- 60% of suicide victims have often had a nonpsychiatric physician visit in the prior 3 months. The opportunity for successful intervention at the general or nonpsychiatric specialist level is significant but underutilized.

Focus:

Mental health concerns among Asian Americans are often unreported, unaddressed, and remains a significant health disparity for this group in the U.S. National data supports the following conclusions about suicide: 1) like the US population, Asian males have significantly higher rates of suicide than Asian females 2) Asian females in the ages of 15-24 and over 65 complete suicide at higher rates than other racial groups in the same groups 3) among elderly males and females seeking primary care services with clinical depression, Asian Americans have the highest rates of both death ideation (passive wishes of not living) and suicide ideation (plans or intent to commit suicide) of 40% and 20% respectively 4) In national surveys of college students, Asian students report higher levels of depressive symptoms and suicide ideation than other racial groups with possibly 10% seriously thinking of it in past academic year 5) there is a thought that US born females between ages 15-34 may be at higher risk for suicide ideation and suicide attempt than those who are non US born.

General Risk Factors for Suicide:

- Mental disorders and substance use disorders
- Hopelessness, impulsiveness
- Major physical illness or poor perceived health
- Previous attempts or family history of suicide or attempts
- Significant financial/social/family stress
- Access to lethal means
- Recent local cluster of suicides

Detection and Intervention:

The United States Preventive Services Task Force recommends screening for depression in routine medical care at least yearly using a patient self report instrument. Frequently the PHQ9 is utilized in medical settings because of its validity, reliability, and brevity. It can be obtained at <http://www.depression-primarycare.org/clinicians/toolkits/>. The instrument queries for the presence and frequency of all the symptoms of major depression according to DSM criteria and has a specific question about thoughts of death and self harm. It is frequently used as a depression severity instrument which can help with treatment planning, follow up and management. Scores of 10 or more generally have an 88% sensitivity and specificity for the diagnosis of depression. Because this is a patient self report instrument; clinical confirmation by a health professional is required to rule out other medical or psychiatric diagnoses that could account for the symptoms. If PHQ9 scores are greater than 10, further investigation is warranted. If the suicide item is endorsed, then further questioning is warranted even if scores are less than 10.

Assessing suicide risk:

- Ask about past history of attempts or attempts in the family
- Ask about intensity and frequency of the suicide thoughts; if occurring on any kind of regular basis, especially if intensity is moderate to high, consider treatment if there is a diagnosable disorder, ie treat depression and monitor for reduction of depression and thoughts of self harm
- Warning signs for crisis referral include: 1) having plans and intent to go through with suicide 2) recent attempt made 3) having lethal means 4) significant alcohol or substance abuse

Treating for depression in medical care:

- When suicide risk is present, consider involving family/friends
- Ask for consultation from a mental health professional
- If using antidepressants, monitor for response and side effects at least once a month, preferably twice a month for 2-3 months after starting medication

Resources:

Macarthur Foundation Depression in Primary Care Toolkit
American Foundation of Suicide Prevention Toolkits
Asian LIFENET : number 1-800-LIFENET; Chinese 1-877-990-8585