Q&A – LVF Suicide Prevention Conference – 11.2.22

Substance Use - Dave Fialko

Q: If these people are not in treatment how do we know that the people who commited suicide are using substances?

- Answer: The main source for this data / information is state reporting from the coroner's office. Anytime there is an out of the ordinary death, toxicology is in involved to investigate. Annual coroners' reports are filed yearly to track trends in cause of death. Here is a link which shows how this info is used. https://www.cdc.gov/mmwr/preview/mmwrhtml/mm5546a1.htm

Q: Does the statistic regarding marijuana include the use of medical marijuana for anxiety and depression?

- Really good question! Thank you for asking! No, this data set only included individuals who met the diagnostic criteria for either the past classification of "substance use disorder" with the main drug of choice being marijuana or the current classification of "cannabis use disorder". No data from individual who were part of a medical marijuana program were used.

Q: Where are the studies for benzodiazepines related to suicide? Marijuanaaa may calm people dawn when they are depressed or suicidal.

- Thank you for asking this! Great question! With around 60 million benzo scripts written a year, this is a relevant question! However, due to time constraints, I was mainly focusing on the top two misused "recreational" substances, so I was hesitant to include data sets on prescribed drugs even though we all know these are diverted for recreational abuse. Most data sets that I have found show that there is a direct association associated with increased suicide risk for individuals who misuse benzos. Here is a study that can shed some light on the correlation: https://pubmed.ncbi.nlm.nih.gov/28257172/

Q: With delays of introduction to alcohol/marijuana do factors such as race, and class play a role in formations of SUDs?

- Unfortunately, yes it can, even with delayed introduction of substances, gender, race, socioeconomic factors all can have influence on outcomes when looking at categorical variables regarding who will be susceptible to forming an SUD. This is why I really like the ecological model for identifying protective factors that can help reduce negative outcomes related to SUD formation. A main part of prevention is providing all individuals with resources that can focus on holistic support.

Q: Are Warmlines better than Hotlines for Suicide Prevention?

- I can't answer this with an opinion, but I can simply explain the differences:
    - Warmlines tend to help reduce hospitalization by providing individuals with support by volunteers who staff the phone lines who often have life experience. If needed the warmline will call emergency services to respond to the caller.
    - Hotlines tend to be reserved for emergency situations (eminent harm) and are staffed by trained emergency responders who follow strict protocol.

People of Color - Victor Armstrong

Q: How do we apply these tenets in cases of individuals with invisible minorities?

- The core concept remains the same. It is not about necessarily speaking "To" a minoritized identity. It is about speaking to an individual and allowing them to tell you who they are rather than relying on stereotype and perceptions. Treating another based on their inherent worth and valuing that individual's story and unique identity is a universally transferable concept. If we attempt to speak "to" an identified group, we can become paralyzed once again by our own perceptions of that group.

Q: Just wondering if like others he had a website or email address with additional information and resources.

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https://www.soulshopmovement.org/

- The Black Swan Diaries, Resources. Use this link to access some Black-specific mental health tools
- Black Emotional and Mental Health Collective, Black Virtual Therapist Directory. Seek a therapist or counselor you can speak with in a private online setting
- Suicide Prevention Resource Center, Blacks, and African Americans. Learn more about how to address suicidal tendencies in the Black community.
- The Everygirl, Online Mental Health Resources for Black Women. Check out additional services and treatment options for Black women
- Black Girls Smile, Resources & More. Check out this resource list, focused specifically on Black girls.
- Mental Health America, Black and African American Communities and Mental Health. Take a closer look at mental health disparities in Black and African American communities.
- The Trevor Project, "Supporting Black LGBTQ Youth Mental Health." Learn more about supporting mental health among black LGBTQ youth.

LGBTQ+ - Dave Yovino & Michael Gill

Q: Are there things that a therapist would do to support a person who is experiencing gender dysphoria or are trans that a Certified Peer Specialist might not?

- There are certainly going to be differences in exploring these matters as a peer specialist or as a therapist, but providing affirming services and unconditional positive regard should be present in both cases. Any parties working with trans or gender diverse individuals should seek out training in what affirming care is and seek to provide such services always. I am not too familiar with the scope of practice related to being a certified peer specialist, so I can't speak to what the specifics may be, but approaching individuals with care and concern from an affirming and trauma informed perspective is always a critical piece of the puzzle and can be done regardless of scope of practice or relationship to the individual.

Q: What considerations should providers make in their documentation/progress notes for minors exploring name/pronouns but may not be out to their parents yet who would have access to requesting their file?

- Firstly, let's specify minors under the age of consent to mental health services. Whenever I work with an individual age 14 or older I have them sign their own consent to treat and paperwork to

avoid this difficulty as then confidentiality belongs to them, and not the parent. I will often have them sign a release for parents which allows me to engage with them, but limits their access. Nonmaleficence (do no harm) is always a priority. It is important to consider the safety and well being of the client when creating and providing documentation. There are ways to keep records that are not considered part of a clinical chart, and even with access to records there are ways to limit what is provided particularly regarding notes. I would not personally place anything in a clinical chart or documentation that I would not want read aloud in a courtroom or that would potentially harm the client. This is also an opportunity to provide transparency to your client and discuss that with them, allowing them to decide for themselves. That being said, what specific information that is said in session that you include in your clinical record is up to you, and at times could be phrased such as "individual attended session, explored identity". These are just my thoughts and perspectives (not legal advice, of course).

Q: Do you offer LGBTQIA+ trainings to other agencies (101 and more advanced behavioral health clinicians on how to work with individuals)?

- Dave and I would both be more than happy to provide additional or more in depth trainings related to working with LGBTQIA+ individuals. We can tailor trainings as needed, from 101 to more advanced topics.