Suicide Prevention in Montana

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NAMI Montana & Suicide Prevention

- Key stakeholder in Montana’s suicide prevention efforts.
- Key stakeholder in the Commander John Scott Hannon Veterans Mental Health Care Improvement Act
- Helped pass prior state suicide prevention legislation, including key model language.
- Led suicide prevention effort of the Creating Options for Veterans Expedited Recovery (COVER) Commission
- Helped found the Montana Conference on Suicide Prevention and worked with national experts through that.
- Helped developed the Montana Crisis Action School Toolkit on Suicide
Montana: Consistently One of the Highest Rated States

- Consistent with other rural states in the Rocky Mountain region (including Alaska).
- Number of High Prevalence Groups
  - Native American
  - Veterans
  - Gun owners
  - Older white males
- Population moving in are at risk of suicide.
- Mental health access
- Other geographic reasons?
Main Question
That We Do Not Expect to Change

How do you do suicide prevention in a high gun ownership state with a variety of at-risk populations?
Why?

Simplified Diathesis Stress Model

- Disrupted Circuits
- Biological Susceptibility
- Functioning Circuits
- Environmental Factors
Research-Proven

Community-Desired
Areas For Intervention

- Stressful Life Event
  - A, C2, D
- Mood or Other Psychiatric Disorder
  - A, C2
- Acute Intoxication
  - B

Suicidal Ideation

- Decision-Making
  - C2
- Hopelessness and/or Pessimism
  - A, C1-2
- Social Cognition and Lack of Treatment Engagement
  - D1-2
- Learning and Memory
  - C2, 3, 6

Suicidal Act

PREVENTION INTERVENTIONS
(Effective methods in boldface)

A. Awareness and Education
   Education for general practitioners
   Educating youths
   Training for gatekeepers
B. Screening for Individuals at High Risk
C. Treatment
   1. Pharmacotherapy
   2. Psychotherapy (individual [e.g., CBT] and group therapies)
   3. Brain stimulation
   4. Collaborative care
   5. School-based interventions
   6. Internet-based interventions
D. Follow-Up Care for Suicide Attempts
   1. Contact intervention following a suicide attempt/crisis
   2. Active outreach
E. Means Restriction

Screening for High-Risk Individuals

Access to Lethal Means
SAMHSA has used the National Registry of Evidence-based Programs and Practices (NREPP) since 1997. For the majority of its existence, NREPP vetted practices and programs submitted by outside developers – resulting in a skewed presentation of evidence-based interventions, which did not address the spectrum of needs of those living with serious mental illness and substance use disorders. These needs include screening, evaluation, diagnosis, treatment, psychotherapies, psychosocial supports and recovery services in the community.

The program as currently configured often produces few to no results, when such common search terms as “medication-assisted treatment” or illnesses such as “schizophrenia” are entered. There is a complete lack of a linkage between all of the EBPs that are necessary to provide effective care and treatment to those living with mental and substance use disorders, as well.


Constraints:

Lack of investment in suicide prevention research

Especially in Native American suicide prevention research
Example: