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Suicide Prevention in Montana

NAMI Montana

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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?

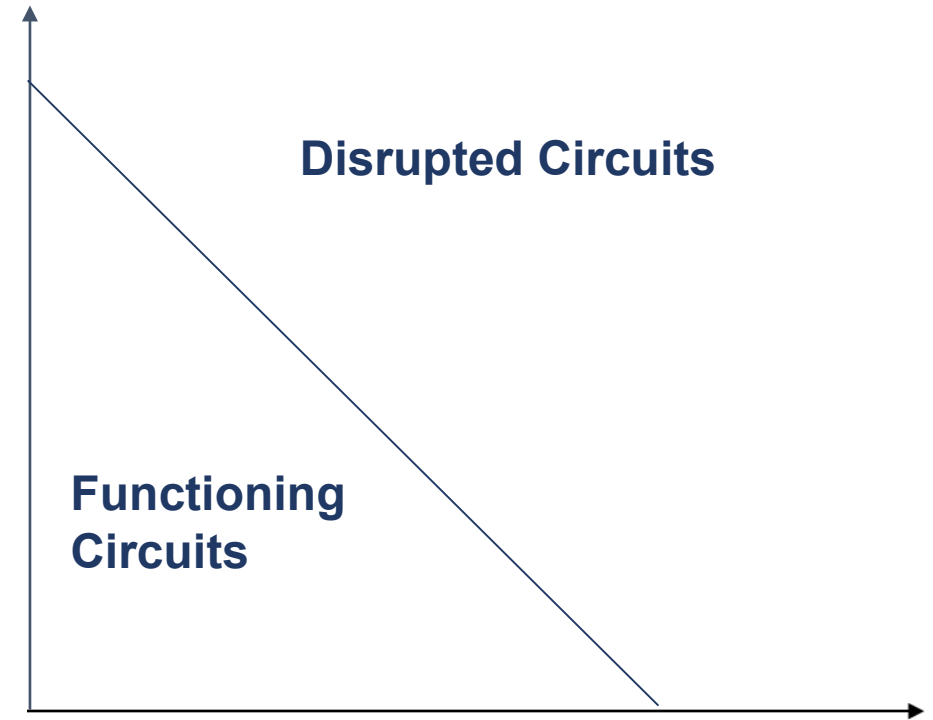
Main Question
That We Do
Not Expect to
Change

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

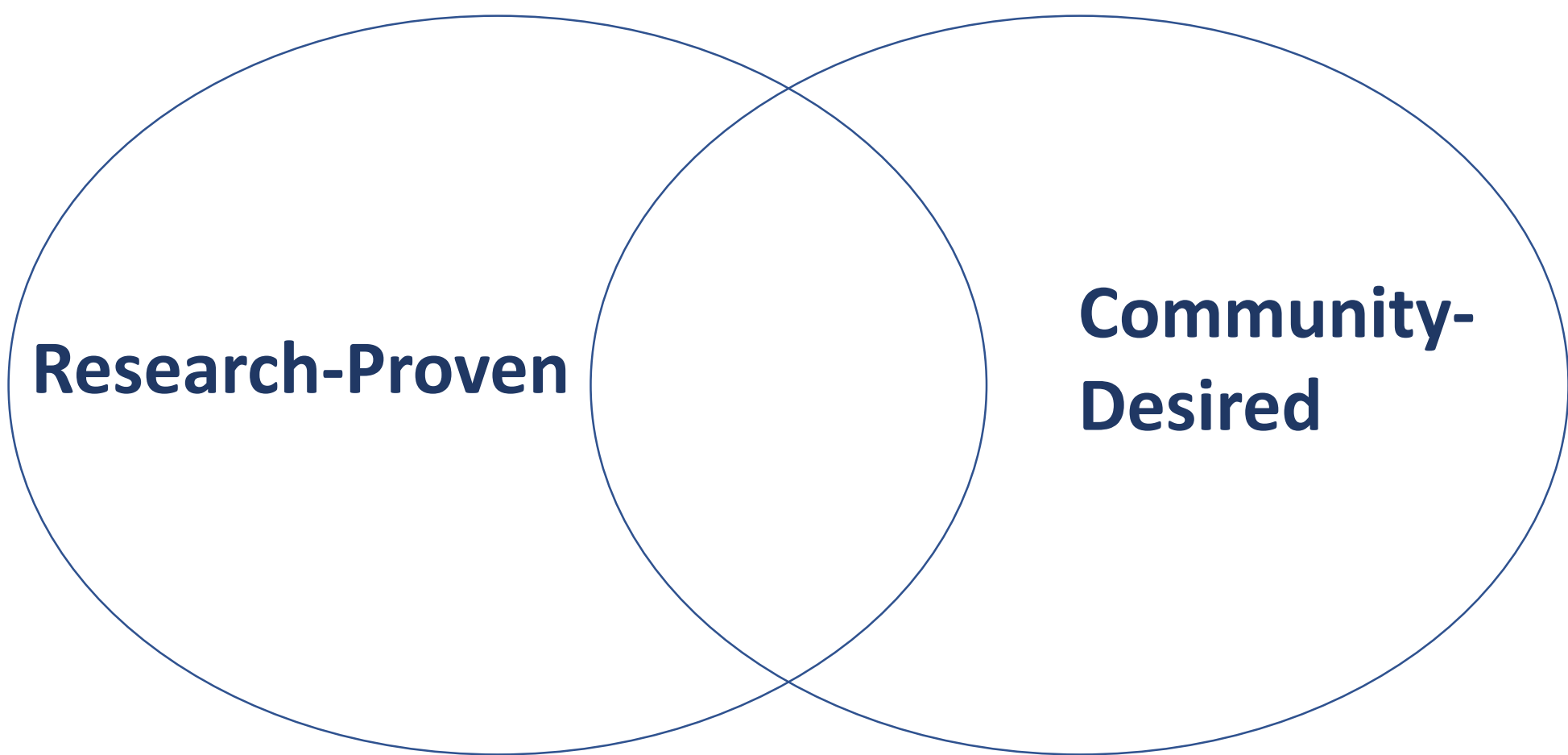
Why?

Simplified Diathesis Stress Model

**Biological
Susceptibility**



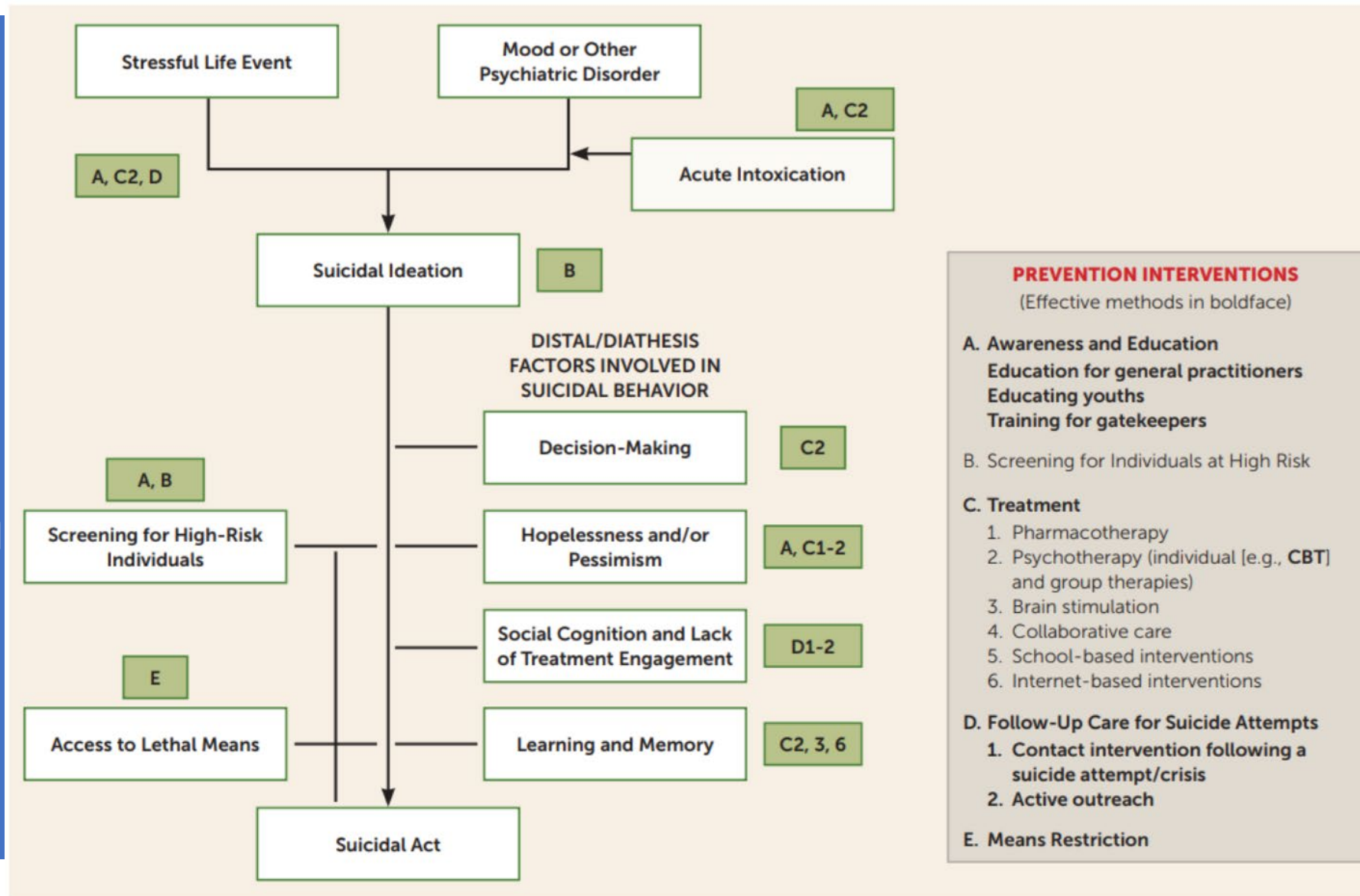
Environmental Factors



Research-Proven

**Community-
Desired**

Areas For Intervention



Can't rely on SAMHSA for Evidence Determinations

Dr. Elinore F. McCance-Katz, MD, PhD. – Assistant Secretary of Health and Human Services for Mental Health and Substance Use

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.

<https://www.samhsa.gov/newsroom/press-announcements/201801110330>

Examples:
Systematic
Reviews
and
Peer-Reviewed
Articles

Mann, J. J., Michel, C. A., & Auerbach, R. P. (2021). Improving Suicide Prevention Through Evidence-Based Strategies: A Systematic Review. *The American journal of psychiatry*, 178(7), 611–624. <https://doi.org/10.1176/appi.ajp.2020.20060864>

Nelson, H. D., Denneson, L. M., Low, A. R., Bauer, B. W., O'Neil, M., Kansagara, D., & Teo, A. R. (2017). Suicide Risk Assessment and Prevention: A Systematic Review Focusing on Veterans. *Psychiatric services (Washington, D.C.)*, 68(10), 1003–1015. <https://doi.org/10.1176/appi.ps.201600384>

Kaess, M., Schnyder, N., Michel, C., Brunner, R., Carli, V., Sarchiapone, M., Hoven, C. W., Wasserman, C., Apter, A., Balazs, J., Bobes, J., Cosman, D., Haring, C., Kahn, J. P., Keeley, H., Keresztesy, A., Podlogar, T., Postuvan, V., Varnik, A., Resch, F., ... Wasserman, D. (2022). Twelve-month service use, suicidality and mental health problems of European adolescents after a school-based screening for current suicidality. *European child & adolescent psychiatry*, 31(2), 229–238. <https://doi.org/10.1007/s00787-020-01681-7>

Constraints:

Lack of investment in
suicide prevention
research

Especially in Native
American suicide
prevention research

Example:

YAM in Montana

