

A biopsychosocial approach to suicide: Exploring the effectiveness of behavioral health programs in rural healthcare settings

by

Paige Kean

B.S., The University of Alabama, 2018

M.S., Saint Louis University, 2022

AN ABSTRACT OF A DISSERTATION

submitted in partial fulfillment of the requirements for the degree

DOCTOR OF PHILOSOPHY

Department of Health and Human Sciences

College of Applied Human Sciences

KANSAS STATE UNIVERSITY

Manhattan, Kansas

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Abstract

The phenomenon of suicide is not an isolated experience for one or a few demographics, but rather a public health concern that is applicable to anyone. Prevention and intervention for suicide has been an ongoing need in our country because, in addition to deaths by suicide, it is also important to consider those who sought help for thoughts of suicide. In rural settings, healthcare providers are limited in the amount of resources they can provide in addition to there are already being low amount of healthcare providers to begin with. Accordingly, the purpose of this study is to use the stress-diathesis model of suicidal behavior in conjunction with the biopsychosocial model of patient care to explore what is working well in behavioral health departments for suicide intervention. The method of analysis chosen for this study was a hybrid approach that incorporated both the deductive priori methodology and research questions and a data-driven inductive analysis. The nature of this study best aligns with purposive sampling. Participants must meet inclusion criteria and will complete 90-minute, semi-structured interviews. The current study emphasized the importance of clinicians' voices on their experiences both when providing care for suicide and while working in rural and frontier healthcare settings; Specifically, our study revealed the need for follow-up care for the clinical providers themselves, how a sociocultural lens on suicide may positively impact patient outcomes, why normalizing suicide and patient free will is beneficial, and risk assessment is part of treatment planning because anyone can experience suicidality. We hope that findings can have transferability and importance for further research in the field to continue advancements in suicide prevention and intervention.

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1. Introduction

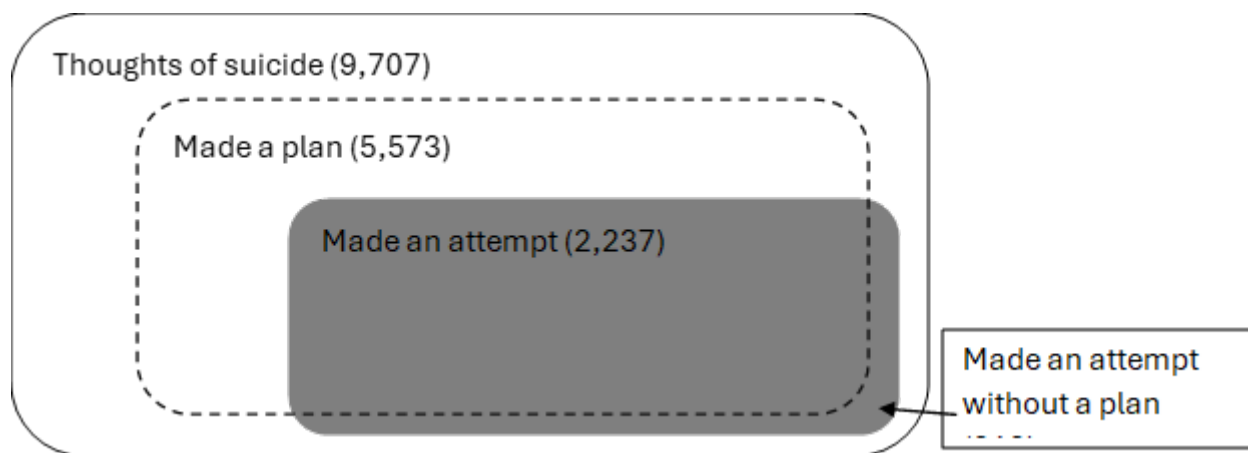
National statistics show that death by suicide consistently ranks among the top 10-15 leading causes of death in the past decade among various age groups (CDC, 2024). The phenomenon of suicide is not an isolated experience for one or a few demographics, but rather a public health concern that is applicable to anyone. Accordingly, it is no surprise that prevention and intervention for suicide has been an ongoing need in our country, even the world. Although studies have shown promising results for suicide intervention for certain groups, such as LGBT communities (Green et al., 2022), geriatric populations (Okolie et al., 2017), and ethnically diverse groups (Meza & Bath, 2021), these interventions are too specific for replicability and increasing the scope of practice.

Fortunately, there are clear signs that foundational components of the healthcare system have the potential to impede the trajectory of nationwide suicide rates by improving policies and practices for intervention when risk factors for suicide are present. As reported in 2014, up to 80% of individuals who died by suicide in the United States accessed healthcare in the year prior to their death and nearly half within 30 days of their death (Ahmedani et al., 2014; Labouliere et al., 2018). Similarly, the Zero Suicide Institute (2024) reported that the risk of a suicide attempt is highest within the first 30 days after discharge from emergency units. Integrating the biopsychosocial model, which examines biological, sociological, and psychological factors of health (Adler, 2009), with the stress-diathesis model of suicidality, which incorporates predisposed individual factors and situational stressors contributing to suicidal behavior (Van Heeringen, 2012), provides a comprehensive framework of the factors contributing to suicidality in patients that can be used to enhance the effectiveness of policies and procedures in clinical

settings where suicidal patients frequently interact with mental health practitioners as part of an integrated or collaborative care team.

For example, in a recent report from the Office of Disease Prevention and Health Promotion (2021), there were 148.2 emergency department visits for nonfatal intentional self-harm injuries per 100,000 individuals, which has held almost constant since 2017. Nonfatal intentional self-harm is often referred to as non-suicidal self-injury (NSSI) and is typically associated with some form of distress (i.e. emotional and/or psychological) and is a risk factor for active suicidal ideations (Klonsky et al., 2014). While it may seem pragmatic for these [NSSI] individuals to seek care and receive services at an emergency department, it is rather alarming that the quantity of visits has held constant for almost a decade. Further, according to the Kansas Suicide Prevention Plan over 17,000 Kansas actively sought out help for suicide attempts or ideations from emergency departments in 2018. Figure 1.1 depicts the breakdown of Kansas student-reported suicide thoughts, plans, and attempts (Kansas Department for Aging and Disability Services, 2021).

Figure 1.1. Kansas Student-Reported Suicide Thoughts, Plans, and Attempts (2019)



These statistics highlight a major concern for providers in healthcare settings, but also for the healthcare system as it fails to mitigate continuous suicidal ideations and behaviors. Additionally, rural populations are at greater risk for suicidality (Pettrone & Curtin, 2020), making Kansas's 37 frontier counties (less than 6 persons per square mile) and 33 rural counties (6-19 persons per square mile) an important context to understand (Kansas Department of Health and Environment Classifications, 2023). To try and make care accessible to persons in need across the state, catchment areas assign hospitals to specific areas of service (Zusman, 1969). Currently, there are 26 catchment areas in Kansas and 5 established crisis stabilization centers (Association of Community Mental Health Centers of Kansas, 2025). Unfortunately, as indicated by the stars in Figure 1.2., some of the catchment locations are hours from the farthest county in their catchment area.

Figure 1.2. Kansas County Groups and Catchment Locations (2010)



Therefore, limited resources and the shortage of mental healthcare professionals (Morales et al., 2020) are not sufficient to meet the needs of individuals and families living in rural areas, nor are the brick-and-mortar locations serving their intended potential. Possibly because of this incongruence, the highest suicide rates are found in counties that can be classified as Frontier (Kansas Department for Aging and Disability Services, 2021). Accordingly, the purpose of this study is to use the stress-diathesis model of suicidal behavior in conjunction with the biopsychosocial model of patient care to explore suicide prevention challenges and successes in rural and frontier behavioral health departments to improve policies and procedures for patients at risk for suicide.

The Biopsychosocial Model and the Stress-Diathesis Model of Suicidal Behavior

The conceptualization of “health” is continuously evolving as science advances, new methodologies come to fruition, and patient care adapts to be more effective. In-patient care settings with mental health professionals largely apply a biopsychosocial model to treatment (Adler, 2009) which includes biological, sociological, and psychological factors. Biological factors refer to those that stimulate a brain response on a chemical level, such as medical/recreational drugs and genetics. Sociological factors include contextual factors, such as social networks and school/work environments. Psychological factors refer to self-awareness, coping strategies, and personality trait characteristics which can be determined by the environment in which one was raised and genetics (Brezo et al., 2006). Personality trait characteristics then influence the individual’s cognitions and behavioral response. The most recent version of this model (Wade, 2015) is person-centered and focuses on the individual's context. Implementing a biopsychosocial model necessitates collaboration and information sharing among professionals

from various fields. Although its original uptake was underutilized, the person-centered, holistic approach is increasingly popular in the healthcare community (Wade & Halligan, 2017).

Some newer adaptations of this model also include a spiritual element to better capture the ultimate meaning, purpose, and significance of self, and can include religiosity (Saad et al., 2017; Puchalski et al., 2014). The version that includes the spiritual element has predominantly been used in end-of-life care and those with chronic conditions (Sulmasy, 2002; Taylor et al., 2013). There is still much room for continued studies to increase evidentiary support for including this element in the model.

Aligned with the components of the biopsychosocial model and based on sociobiology (De Catanzaro, 1980), the Stress-Diathesis Model of Suicidal Behavior provides a greater understanding of suicidal behavior, specifically by incorporating adverse childhood experiences and neurological factors. This model posits that each time a suicidal mode gets activated, it becomes more accessible in the memory and, therefore, requires less triggering to become activated again (Van Heeringen, 2012). While patients may not understand the significant impacts of stress on individual diatheses, healthcare professionals can work more proactively and effectively when they are able to care to patients because they are aware of what diatheses the patient may be predisposed to. This theory also complements the already widely used Social Determinants of Health (SDOH) framework. SDOH are risk and protective factors for suicide and suicide-related behaviors (Kansas Department of Health and Environment, 2025), such as access to healthcare, financial stress, social isolation, historical trauma, discrimination, and much more. Integration of these models provides a framework for improved full patient care because it allows healthcare providers to take into account patient and family history surrounding suicide

risks in addition to the current symptoms. The culmination of these factors encourages a proactive lens that may help improve policies and practices for more preventative measures.

Missed Opportunities for Suicide Prevention

While a biopsychosocial approach to care attempts to ensure full-patient care, the “diagnose and fix” approach may still dominate the healthcare field (Vögele, 2022). The “diagnose and fix” approach can be understood by quickly assessing the present symptoms (diagnose) and prescribing a medication or immediate remedy (fix). The “diagnose and fix” approach has served well in many medical settings, such as hospitals and primary care offices, because it is quick, allows practitioners to see numerous patients in a day, requires proper professional training, and provides immediate results (Vögele, 2022). When it comes to suicide prevention, this focused diagnose and fix approach is myopic in nature; it is designed to facilitate more immediate results; thus, its intentional nearsightedness and time constraints may not allow for a proper assessment of the patient, hindering the possibility of ensuring long-term fixes (de Groot et al., 2011; Schiff, 2008).

Say, for example, a patient comes in complaining of a painful growth that recently appeared. The physician does a quick physical exam and examines the growth itself. Being 90-95% certain this growth is a simple calcium build-up, it is recommended to administer a steroid shot to relieve some of the discomfort and a few lifestyle adjustments that are helpful in getting rid of calcium build-ups. The physician also recommends some additional testing to be certain it isn’t something more dangerous, but the patient opts for just the steroid shot.

Alternatively, when we apply the integrated biopsychosocial stress-diathesis model here, we would assess whether the patient has a family history of certain cancers (biological), if the

patient has the knowledge to know what questions to be asking the physician related to their care (psychological), what support the patient has to facilitate advance planning for additional care (social), or the amounts of stress in the patient's lifestyle and social context (diathesis-stress); thus, they would have no reason to screen for possible social isolation and thoughts of suicide (diathesis-stress). In this vignette, it is neither the patient nor physicians' fault that full biopsychosocial patient care was not prioritized, but rather the limitations of healthcare system policies.

Systemic Policies Guiding Care

Objectively, healthcare is heavily influenced by politics. The government designs the policies that provide the financing, delivery, and regulation of healthcare across the country (Marmor & Wendt, 2012). While universal healthcare is at the forefront for many advocacy groups (Kuehne et al., 2022), the US is far from seeing this come to fruition. In a literature review, Marmor and Wendt (2012) compared if the focus of healthcare [from a political perspective] is more on the healthcare policy (i.e., the analysis of decision-making in healthcare and institutional structures) or the healthcare system (i.e., how they function, what they produce, patient experience). Their findings highlight that healthcare systems are themselves an outcome of healthcare policy, meaning there is a reciprocal impact in which both need to learn from the other. This reciprocal process can be harnessed to improve suicide prevention in rural settings. By identifying successful suicide prevention strategies in rural behavioral health programs, we can also pinpoint what does not work in these areas to advocate for more functional policies and expanded resources.

Funding is necessary for the development, renovation, and expansion of healthcare facilities to address capacity barriers to suicide prevention. According to Morton (2003), most rural hospitals were built through the Hill-Burton Act passed back in 1946, which provided federal grants and loans for developing healthcare facilities. However, it was not necessarily equitably distributed to account for how nonmetropolitan counties with less than 10,000 people consistently experience higher age-adjusted mortality rates (Morton, 2003). Further, funding for mental health services in Kansas is a newer concept because it has historically not been prioritized in general healthcare. Funding is necessary for the development of new facilities and renovations and expansions of already existing facilities to address barriers to suicide prevention. Current national healthcare funding of mental health services in Kansas is detailed by the Kansas Legislative Research Department (2021) as follows:

Crisis stabilization services are generally funded through lottery vending machine revenue. However, given this relatively new source of revenue, several of the crisis stabilization centers receive individual funds for their operations. These include centers in Wichita, Topeka, and Salina. RSI in Kansas City receives its own established fund ...

This quote highlights that funding for mental health services in Kansas is a newer concept because it has historically not been prioritized in general healthcare. This quote demonstrates that revenue allocated for crisis stabilization centers is predominantly directed to Kansas's urban and semi-urban counties.

Barriers to Suicide Prevention Service Delivery in Rural Healthcare Settings

Suicide rates in rural areas are generally higher than those in urban areas (Suicide Prevention Resource Center, 2020) due to many factors, including an increased distance from

homes to medical facilities, a shortage of healthcare and mental health providers, limited funding to update healthcare equipment and facilities, increased access to lethal means (e.g., firearms), and increased isolation from social systems (Gordon et al., 2020). For example, Graves and colleagues (2020) classified 9,500 mental health facilities by level of suicide prevention services (e.g., suicide screenings, treatment for suicidal thoughts, and referrals for follow-up care) and found that although 64% of all US counties had at least one mental health facility for young people, only about 30% of highly rural areas had mental health facilities, and rural facilities are less likely than those in more populated areas to even offer specific suicide prevention services. It is a major concern that just because healthcare services are available, they may not include mental health services, which may or may not have specific suicide prevention services. The incongruence of residents in rural communities being at an increased risk for suicide and being severely underserved by health, mental health, and suicide prevention services is alarming.

Many mental health and other healthcare providers, regardless of the setting, require a reason for screening for suicide (Ryan & Oquendo, 2020). Following that, they do the risk assessment/safety plan, referral process, and follow-up care procedures (O'Rourke et al., 2018). While this seems standard and straightforward, there are intricacies that create problems for healthcare providers. In an interview with the Lead Trainer for the Kansas Certified Peer Specialist Training program (October 18, 2024), it was revealed that there is hesitation to administer a risk assessment when there is lack of resources available for care and follow-up care. Rural settings do not have the luxury of in-patient care facilities or transportation services to get patients to necessary care. Additionally, follow-up care may not be available for certain families, due to working parents that cannot take time off work or are unable to make the drive

again for a follow-up appointment. All this to say, it is almost sometimes easier for the patient and provider to not even administer the assessment to begin with because there are not a lot of options that follow.

Additionally, even when risk for suicide is established, implementing plans designed to reduce risk in people's lives may be more challenging in rural settings. For example, residents of rural areas are far more likely to have a gun in the house (58% of households) than residents of suburban (41% of households) or urban (29% of households) due to a higher prevalence of hunting animals for food (Parker et al., 2017). In a report from 2022, over 300 Kansas died by suicide by firearm, over 100 Kansas died by suicide by suffocation or hanging, over 50 Kansans died by suicide by poisoning or overdoses, and over 20 Kansas died by suicide by other mechanisms (KDHE, 2025). Thus, it is important to understand the functions guns may have in the lives of rural residents and discuss ways to balance safety with the needs met by gun ownership and access in rural settings.

Suicide Prevention Training in Rural Healthcare Settings

Rural health settings face unique challenges when it comes to the training and development of their staff. Because these settings are largely underfunded, they have limited ability to send their staff to additional training programs (Daniels & Walter, 2002). Similarly, when they are hiring new staff members, they may be seeking individuals with advanced training to expand the scope of the practice, but may have challenges finding these individuals, getting these individuals to relocate to rural areas, and retaining them (Lehmann et al., 2008)

Further, in congruence with what Strasser (2016) found, generally training and development programs are designed for universal administration, meaning they may be intended

for patients who have more resources available and settings that have the means to implement the interventions than is true for many rural healthcare contexts. Some advancements are being explored, such as online free trainings (i.e. Zero Suicide Initiative) and online, publicly accessible toolkits (i.e. Rural Suicide Prevention Toolkit), but there is little evidence of effectiveness due to them being more recent advances. Another option being explored in rural healthcare settings is year-long internships, which show benefits in skill development for potential future employees and increase workforce capacity (Dos Santos, 2019). Though these results are promising, they may create an additional challenge for suicide prevention due to having unlicensed and inexperienced providers working with high-risk cases.

Current Study

The current qualitative study utilizes a hybrid inductive and deductive (Fereday & Muir-Cochrane, 2006; Schutz, 1967) phenomenological approach and practitioner design (Ravitch & Carl, 2021) in the hopes of understanding the phenomenon of suicide prevention in rural integrative healthcare settings. Past research has not fully explored the challenges of suicide intervention programs in rural and frontier settings from the clinician's perspective, nor has it provided insight on how to improve these settings to decrease suicide rates as intended. Given that mental health providers on treatment teams in integrative healthcare settings are often trained to apply systemic thought to patient care, they serve a crucial role in suicide prevention (Mendenhall & Berge, 2010). Specifically, the current study will seek to understand mental health clinicians' experiences when providing care for suicide while working in rural and frontier healthcare settings to compile direct, realistic strategies for improving care for suicidal clients.

The biopsychosocial and stress-diathesis models of suicidal behavior deductively guided the development of interview questions to elicit the lived experiences of mental health practitioners engaging with patients experiencing suicidality in integrative healthcare settings in four areas: clinician factors (the professionals themselves), patient factors, environmental factors, and systemic factors. The biopsychosocial model guides the clinician and systemic factor questions from a collaboration perspective and the diathesis-stress theory guides the patient and environment questions about patient voice and environmental factors. Then, using an inductive approach, the data were coded to uncover emerging patterns, themes, and concepts. The following research questions guided the study:

RQ 1: How do mental health providers experience the impact of environmental factors in a rural setting on their ability to provide suicide care to patients?

RQ 2: What are mental health providers' lived experiences regarding the inclusion of patients in their own treatment plans?

RQ 3: What are the mental health providers' lived experiences with implementing policies and practices for suicide prevention in rural healthcare settings?

RQ 4: How do mental health providers perceive and describe their contributions to patient care treatment teams for high-risk patients?

2.

Methods

Participants and Procedures

Participants were recruited through announcements in online professional networks (e.g., Certified Community Behavioral Health Clinics, the Kansas Mental Health Therapists Facebook Group) and emails sent to various organizations across Kansas that offer healthcare and mental health services (e.g., crisis stabilization units, outpatient care centers, mental health offices). Participants were included in the study if they were currently working towards or actively held a degree/licensure in a mental health field and worked in a rural or frontier county in Kansas as a mental health provider in an integrative healthcare setting where they engaged with patients experiencing suicidality. To enroll in the study, participants completed a short online screening survey followed by informed consent for those who met the inclusion criteria. Participants were then contacted to schedule a Zoom interview based on the availability they listed in the screening survey. Snowball sampling was also used to recruit additional participants through recommendations by current participants.

To protect confidentiality in talking about workplace experiences, participants were not required to have their real or full name on the screen, could choose a pseudonym in the screening survey, and could keep their camera turned off for the entirety of the interview. To ensure participation in the study is fair and equitable to the participant's time and opportunity cost, participants will receive a condensed version of study findings that may be applied to improve policy and practices in their own work settings and/or community. The final sample consisted of six participants. All of the participants racially identified as White/Caucasian. The ages of the participants ranged from 20 to 61 years old ($M = 45$); 86% of the participants were female, 14%

were male, 50% worked in rural areas, and 50% worked in frontier areas. The participants had a variety of mental health degrees and licenses with various levels of training on suicide prevention.

Data Collection

Phenomenological qualitative research aims to understand a phenomenon through people's lived experiences, specifically focusing on the perceptions, feelings, and meanings attached to their experiences (Santiago et al., 2020). Schutz (1967) developed a methodology for studying social action that includes both inductive and deductive methods. Schutz (1967) proposed that understanding a social phenomenology must begin with consistency, subjective interpretation, and adequacy. Essentially, conceptual frameworks and methods follow the logic and are recognizable and understood. Beginning with a deductive approach allows for in-depth planning to most effectively understand the phenomenon in which will be studied. Theoretical rigor, in this case the biopsychosocial and stress-diathesis models, provides sound reasoning for the choice of methods in which to study the phenomenon (Higgs, 2001; Rice & Ezzy, 1999). This approach also demonstrates transparency and replicability by clearly showing how the researcher formulated the overarching purpose and research questions for the study (Fereday & Muir-Cochrane, 2006). Subjective interpretation and adequacy then demonstrate the inductive approach of a hybrid methodology. An inductive approach following subjective interpretation ensures that the researchers preserve the voice of the individual's described subjective experience and acknowledge the context in which the phenomenon was studied (Fereday & Muir-Cochrane, 2006). Additionally, adequacy (Schutz, 1967) speaks to the credibility of the research. The

purpose is to capture the lived experiences of the individual and to adequately do this is to learn from the data itself. Deductive reasoning allows themes to naturally emerge from the data itself.

Semi-structured in-depth interviews are the recommended approach for understanding the lived experiences of mental health and other healthcare professionals and exploring a complex phenomenon where the participants' perspectives are crucial (Adams & van Manen, 2017).

Semi-structured interview questions are typically open-ended questions that encourage detailed answers to truly grasp the individual's perspective/experience (Adams, 2015). These types of questions do not prompt answer options, which minimizes the chances that the interviewer will influence the answer and often leads to secondary and tertiary questions to expand on the lived experience, which aligns with core principles of phenomenological approaches (Santiago et al., 2020).

Interview Questions

The biopsychosocial model and stress-diathesis model of suicidal behavior guided the development of interview questions that focused on four main aspects of experience: clinician factors (the professionals themselves), patient factors, environmental factors, and systemic factors. The full interview can be found in Appendix 1.

Clinician factors.

This category of interview questions reflected the use of a biopsychosocial model to understand how clinicians perceived and described their contributions to patient care for high-risk individuals. Questions related to their training and experience, thoughts about their role in suicide prevention, and feelings about policies/protocols at their workplace.

Patient factors.

This category of interview questions reflected the diathesis component of the stress-diathesis model and the biopsychosocial model's psycho-social sections to assess mental health providers' lived experiences regarding the inclusion of patients in their own treatment. Questions related to clinicians' experiences establishing trust with patients and collecting background information.

Environmental factors.

This category of interview questions reflected the stress component of the stress-diathesis model and the biopsychosocial model's social sections to assess mental health providers' lived experiences regarding the environmental factors that contribute to suicide care. Questions related to their experience working in rural areas, client environmental risk factors, and community outreach.

Systemic factors.

This category of interview questions reflected the stress component of the stress-diathesis model and use of the biopsychosocial model to assess mental health providers' lived experiences regarding implementing policies and practices within their organization. Questions related to their experience with policy implementation, support from the organization, and workplace culture.

Data Analysis

Qualitative research requires a balance of knowledge and understanding demonstrated through rigor and reliability (Roberts et al., 2019). The present study is designed as an interpretative phenomenological analysis (IPA) to identify a phenomenon through how it is

perceived by the people in the situation or setting (Ravitch & Carl, 2021). Qualitative research involves interpretation of the ways people view and make meaning of their experiences in the world (Ravitch & Carl, 2021). The researcher's methodology encourages the ability to be interpretive and structured in order to take a more inductive approach while also acknowledging the researcher's input in shaping the study (Ravitch & Carl, 2021). The IPA approach will elicit both the individual's subjective experience and objective experiences of commonalities representing themes (Alase, 2017).

Conducting a pilot study is a recommended pre-step to enhance qualitative work's methodological rigor and effectiveness (Shakir & ur Rahman, 2022). Specifically, I conducted a pilot interview with an individual who has first-hand experience working in the target context to ensure the interview questions were clear, effectively focused on certain topics, and would elicit experiential responses. The interview guide was refined following the pilot study before the primary study began to increase the credibility and trustworthiness of the data (Shakir & ur Rahman, 2022).

Trustworthiness

Because identifying themes from interviews involves researchers assigning meaning to data (Ravitch & Carl, 2021), personal experiences, theoretical frameworks, and individual biases may potentially influence the coding process. Therefore, the primary investigator began an open coding process with the involvement of three additional coders. To ensure the study emulates the participants' lived experiences rather than the researchers' assumptions, the research team used reflective journaling throughout the study to track any emotions, thoughts, commentary notes, modifications, and changes that came to mind (Thorpe, 2004). This allowed all edits to be clearly

documented throughout the study's lifetime and increased transparency in the analysis process through reflection of biases, personal influence, and personal experiences (Vicary et al., 2017).

To increase the extent to which coders made similar decisions when coding interviews (i.e., reliability; MacPhail et al., 2016), the coding team jointly clarified the study purpose to guide data gathering and preparation, developed a comprehensive codebook, conducted independent coding, compared coding results, and reconciled coding differences through in-depth discussion (Cole, 2024; Stuart et al., 2002).

Positionally of the Coding Team

The lead researcher, a Marriage and Family Therapist, utilizes a cognitive-behavioral orientation and biopsychosocial framework to work with clients experiencing suicidality, has clinical experience in integrative care settings, and has advocated for increased national funding for mental health services. The second coding team member is a 1st year Masters student in a Couple and Family Therapy Program who uses Acceptance and Commitment Therapy (ACT), has an interest in working with schools to improve relational health curriculum and mental health services, and has minimal clinical experience working with suicidal and crisis clients; The third coding team member was a 1st year Masters student in a Couple and Family Therapy program who uses Acceptance and Commitment Therapy (ACT), is interested in specializing in working with clients who experience suicidality, and has behavioral health experience working with adolescents in an inpatient eating disorder facility. The 4th coding team member is an undergraduate student at Kansas State University studying psychology and addictions counseling with clinical and non-clinical experience working with suicidal and crisis clients through community crisis services.

Coding Process

Steps to increase reliability were utilized throughout the coding process to improve agreement between the participant's actual experiences and the researcher's interpretations (Ortlipp, 2008). First, before data were gathered, research team members met to align their understanding of the purpose of the study and the research goals and to receive common training on qualitative methods (Ortlipp, 2008). As the PI then conducted interviews, the Zoom transcriptions were checked for accuracy against the audio recordings by the other three coding team members. The coding team removed names or any identifying information from the transcripts to ensure participants' anonymity, and all recordings and transcriptions were stored on password-protected computers only accessible to members of the coding team. Consistent with an IPA approach, the four coding team members then precoded the data from the transcriptions using LiGRE. Precoding allows researchers to become familiar and engaged with the data before formally coding the data (Ravitch & Carl, 2021). LiGRE is an online software program that allows research teams to perform in-depth qualitative data analysis. Using LiGRE, the research team collectively identified precoding themes and codes that consistently came up in the 1-2 interviews each coding team member transcribed. Precoding allows researchers to become familiar and engaged with the data before formally coding the data (Ravitch & Carl, 2021). The researchers used both open coding, which broadly assigns codes based on participants' responses to a question (Delve, 2024), and structural coding (Delve, 2024), which categorizes sections of your text according to a specific structure, or in this case, research question.

These precodes were then used to collaboratively develop an initial codebook which ensures codes are understood collectively. LiGRE allows each code to be represented by a

unique color so that the researchers were able to highlight different codes throughout the transcripts and themes emerged in clusters or subordinately. Codes from the initial codebook were modified, added, or deleted based on what was being represented in the data. The final codebook was collaboratively established after each research team member coded two full interviews. Codes from the initial codebook were modified, added, or deleted based on what was being represented in the data. To develop a comprehensive codebook, the coding team focused on ensuring the codes were developed both deductively through the identified theories and previous research and inductively being heavily informed by the respondents' voices [dialogic engagement] (Paulus et al., 2008). In the formal coding phase, each interview was coded by two coding team members. Independent coding allows for various perspectives in the coding process (Paulus et al., 2008) and all coders engaged in ongoing reflective journaling throughout coding to acknowledge any personal assumptions, biases, and/or experiences that may have influenced the coding process (Ortlipp, 2008). Then, coding pairs then met to compare coding results to ensure codes were consistent and reliable with the master codebook. Reconciliation provided an opportunity for coders to discuss differences in coding and establish inter-coding agreement. The primary coder decided the final code when agreement amongst primary coders wasn't reached.

3. Results

The participants shared their experiences working as mental health providers in rural integrative care settings for patients experiencing suicidality. Using the biopsychosocial model of patient care for clinician and systemic factors and the diathesis-stress theory of suicidal behavior for patient and environmental factors, the responses were organized into four categories in congruence with the research questions covering clinician, patient, environmental, and systemic factors. Within each category, several thematic clusters emerged. Results for each research question are reported by the most used theme to the least used theme and code frequency is represented by ‘some’ meaning less than 2 participants shared this experience, ‘several’ meaning 3 or 4 participants expressed this, and ‘majority’ meaning 5 or 6 participants mentioned this experience. All participants’ interviews represented all the codes, however the frequency of each code varied.

Clinician Factors

Clinician factors focus on the mental health providers’ perceptions of their contributions to patient care treatment teams for patients at high risk for suicide. From the analysis of clinician factors, three themes emerged: Scope of practice, inability to provide additional support, and innovative collaboration.

Scope of Practice

This theme consisted of three codes: perceived responsibility and accountability, increased clinical experience, and mandated trainings. Our findings revealed that a majority of participants felt a level of responsibility and accountability attributed to them by other healthcare

professionals. For example, one participant explained the expectations others have of them when treating clients who express suicidal ideation:

I see this a lot with our emergency rooms where they'll call for consultation and they'll say, '[An expert], we need somebody to be able to tell whether they're lying.' I can't tell that. I can just tell you that I've asked this question 50 times today, and here's how I'm going to document the answer.

A majority of participants also indicated that in addition to a perceived responsibility that they need to “have all the answers”, they are expected by other members of the treatment team to make the decisions about patient care: “So people are looking for an adultier adult. They're looking for another expert somebody who speaks suicide.”. Participants’ experience of liability responsibility was supported by mandated trainings that outlined the legal responsibilities of mandated reporting. One participant discussed how being a mandated reporter shifted their team members’ perceptions of their responsibility:

And that collaboration can feel very bad on my side because it feels like really, they're trying to shift liability. ... They want someone else to put their name on the paper and say this person isn't going to go kill themselves.

Another participant described the benefits of mandated trainings in regard to providing care within their scope of practice:

So since coming to this organization I work at currently, they make us do regular trainings to make sure that we understand kind of the populations we're working with, the different resources that are available, and then making sure that we're in compliance with

the different types of training that we're supposed to be doing and types of therapy that we're doing.

Inability to Provide Additional Support

Another perception of clinicians' contribution to patient care was experiencing an inability to provide additional support. Participants reported experiences where they felt unable to provide support due to: 1) time constraints and 2) unfamiliarity with the community and resources. These time constraints limited providers' ability to collaborate effectively and provide the support to the client the clinician wanted to provide. As one participant stated, "So that is kind of a barrier that I've been noticing as well is like trying to coordinate so that we can all meet". Additionally, some participants described working in rural communities as requiring knowledge of the community itself. Several participants expressed being unfamiliar with the community and its resources limits a provider's ability to provide the support they wanted to. One participant said, "... sometimes, just literally yesterday, I was trying to figure out what exact services are offered for like youth community care". Another participant mentioned, "... it's kind of nerve-wracking at times because you're kind of like, you know, I'm not from the town. I don't really know everyone here".

Innovative Collaboration

Mental health providers described their contributions to treatment teams and patient care as needing to be creative in their efforts to collaborate through their use of: 1) telehealth/phone services and 2) personal relationships.

Several participants described a better ability to contribute to care for high-risk individuals and treatment teams because of their access to telehealth and phone services. For

example, one participant explained how telehealth allowed them to provide services to a client who didn't feel safe enough to come in person, "Like the one client I was telling you about who like, it took so long before she felt safe enough. She is a Zoom only person, and she's made such great strides even though it's only virtual". These virtual options have also increased access to care across rural areas where distance is a barrier. For example, one participant stated:

Zoom has been huge for the rural and frontier types of towns that would have to drive many, many, many miles. It allows us access to those individuals that we didn't necessarily have and they might not have accessed any services without that type of an option.

Additionally, many participants described their experiences utilizing personal relationships within the community to contribute to care for patients at risk for suicide. For example, one participant mentioned how they needed to be "...very persistent about kind of attending meetings and ... making those connections with people and identifying what programs there are and just reaching out to people. That really helped a lot with people understanding that I'm not a threat." Further, some participants described how they had initial negative expectations about collaborating with police officers, but have combatted their own bias through connection:

I am on law enforcement's speed dial, I think. And that has been tremendous. I will say I came into the field with a little bit of bias of thinking we were always going to butt heads and that has not been the case.

Patient Factors

Patient factors focus on the mental health providers' experiences of including the patient in treatment plans. Two themes emerged from the analysis of patient factors: treatment transparency and patient involvement.

Treatment Transparency

Mental health providers described their experiences regarding the inclusion of patients in their own treatment plans as needing to: 1) find useful resources for the specific needs of the individual patients and 2) be transparent about crisis intervention. Our findings revealed that a majority of participants experienced needing to find useful resources for the specific needs of individual patients, and one participant explained how sometimes that required getting creative:

I will sometimes, if we're needing to get very creative about how we serve a person, I may go into their complete medical record and just look for opportunities for collaboration. What haven't we tried? What Doctor do they really go to see? I need to call them. ... But then we have a bunch of folks who are really better trained to address those social determinants of health, any pressing social needs to serve the rest of the person.

Further, a few participants noted that seeking the input of the patient directly helped ensure the resources were useful and implemented in an effective way. One participant explained, "So when we're able to get together and stop any triangulation we create paths for people to use the appropriate resource at the appropriate time. I've seen patient care really improve".

A majority of participants mentioned the importance of addressing patient concerns surrounding involuntary commitments and wellness checks when they needed to implement

policies due to risk of suicide. One participant provided an example of what they may say to explain the process of a wellness check to a patient: “Our plan B is we're going to just call in a wellness check because we're concerned about you. And you'll have somebody showing up at your door from law enforcement just to check on you.” Several participants further explained how this transparency builds trust with the patient and trust allows for more openness from the patient. For example, one participant clarified:

And I think that transparency is key. The thing is, like you mentioned at the beginning, we talk about suicide all the time. The things that we talk about are foreign to others. So being transparent about what the process looks like, understanding that it's a difficult process, but being able to walk someone through it and let somebody know what we think is going to happen and potential pitfalls along the way. It lets them make informed decisions about their own care.

Patient Involvement

Mental health providers described the need for patient involvement in their own treatment plans as: 1) crisis intervention considering sociocultural factors and 2) the importance of matching pace with the client. A majority of participants described crisis intervention with attention to sociocultural factors as important when including patients in their own treatment. One participant described this as, “So many things add up to a person's risk for suicide or how a person is feeling on any given day, because suicidal ideations can fluctuate, and individual cultures and context are necessary for appropriate care.” Another participant explained crisis intervention that attends to sociocultural factors as:

Yes, we got the background history from the individual but sometimes seeing, you know, what their living situation is or what their job situation, or whatever, by actually seeing that and bringing that back to the table for the team is huge and it makes us, you know, everybody, you know, it helps everybody understand why the person is in this situation that they're in.

The potential benefits of crisis intervention considering sociocultural factors are, as described by one participant, “I don't think of my interventions with people who are in crisis as highly clinical. I just, I want them to feel seen and heard. And usually if they feel heard, they can get out what they need to feel safe right now”.

Our findings revealed that a majority of participants also experienced a need to match the pace of care with the patient's level of readiness and abilities. Participants described experiences like, “But again, we're meeting a person where they are and putting our trust in them”, and “I try to kind of match the energy that my client's giving”.

Environmental factors

Environmental factors focused on the mental health providers' experiences providing suicide care in rural-specific settings. From the analysis of environmental factors, three themes emerged: communal attitudes and beliefs, familiarity with the community, and rural location nuances.

Communal Attitudes and Beliefs

Communal attitudes and beliefs consisted of three codes: 1) the need to normalize conversations of suicide for people in the community not involved in healthcare, 2) community members not feeling like the clinical setting is a safe space, and 3) the need for more community

engagement. A majority of participants reported experiencing challenges providing care in rural communities due to a lack of awareness around suicide and suicide prevention by those not involved in healthcare (teachers, law enforcement, lawyers, etc.). One participant stated, “I think there's such a lack of resources for understanding suicidality crisis in rural areas. And maybe not a lack of personal understanding, but collective understanding”. Similarly, participants discussed how the lack of conversations surrounding concerns of suicide contributes to stigmas about mental health and preconceived ideas about mental health providers. One participant noted, “... so that's something we've been really working with the town on to kind of change that viewpoint that a lot of individuals have with us”.

Relatedly, a majority of participants described the experience of community members not feeling like the clinical setting is a safe place. One participant described trying to increase safety by improving the ambiance of the clinic: “I feel like the vibe of the office is really important. That I want it to be as comfortable as possible without trying too hard”. When asked to describe main challenges that they experienced when it comes to suicide care, one participant answered, “I think the big one I've experienced, at least in the town, is the idea that the clients don't trust the emergency room and the police as much. Being scared to ask for help”. Another participant talked about how it is a major challenge to provide care or access individuals who could benefit from services if people are scared of the people they can seek help from:

[We] still have kind of some of those individuals who are still very angry and hostile and ... But it's one of those things where I think a lot of people are coming around and understanding that we want to help...

Finally, most participants described a need for more community engagement about suicide in rural settings to improve services. Specifically, one participant explains how community feedback could help improve the care delivery system:

So, I feel like if they were more willing to actually engage with the townspeople and kind of create that trust, that it would open up the ability to look at what type of procedures need to be adjusted and how do we implement that within the town as well?

Most participants described how community engagement may also help other professionals be more prepared for suicide care. One participant mentioned, “Medical professionals, at least, our hospitals, they don't see this as much. They see accidents and they see illness, but suicide is something that they are completely unfamiliar with and uncomfortable with”.

Familiarity with the Community

The theme of familiarity with the community consisted of three codes: 1) insufficient referral sources/locations, 2) exposure to the town, and 3) the rural location provides accessibility. A majority of participants experienced rural and frontier communities as being under-resourced and somewhat isolated from necessary resources. One participant mentioned, “You know the individuals might be 50, 100 miles from the nearest mental health provider”, and another mentioned, “It can sometimes be a 12-hour process for somebody that needs that help right now”. Participants also pointed out that not only is distance a factor of insufficient locations, but the challenge of specialty providers in these rural locations. For example, one participant explained:

Yeah, and that's a huge area of need in our area in our rural area is access to psychologists and neurologists. To refer somebody to a neurologist, whether it's a child or for an adult, you're looking at six months to even get an appointment. So, um, that you know, that's a that's a huge piece of it.

Participants also revealed experiencing a need for more exposure to the community in which they work. One participant shared, “Um... It feels a little isolated. Like, I know these things exist, but I don't actually know most of these people.” Another participant discussed their efforts to gain exposure in the community, “So just getting really involved in the town so that they also understand who I am because it's a very tight-knit community”.

On the contrary, several participants experienced rural locations as providing unique accessibility to patients. One participant described efforts to increase ease of access to telehealth: “then we also offer, for those who don't have access to internet, we have satellite locations. So, they can go to a satellite and use the Zoom at that satellite location to talk to me”. Another participant explained how they bring the care to patients using mobile units:

Across all of our counties, the mobile crisis team is who you're going to go to if you need extra supports for a client, or even just if someone's not one of our clients, we still provide those crisis services through the mobile crisis team.

Rural Communities Folkway

Mental health providers experience the environmental factors as needing to be mindful of rural communities' folkway, which takes into account 1) patient rurality and 2) rural-specific conflicts of interest. Our findings revealed that several participants experienced the impact of patient rurality, specifically the awareness that in addition to the clinic being in a rural

community, the patients themselves live in rural communities. When discussing patient rurality interfering with suicide care, one participant noted, “Like the rural and the weather is super disruptive...”. Other participants mentioned rural cultural factors that increase suicide risk, such as, “Rural America has a lot of hunting so there's a lot of access to firearms in this area”. Another participant noted a need for crisis intervention to encompass these patient environmental factors:

But really, I do think right now, what I'm listening for are a lot of social factors. That's what we're seeing lead to a great deal of suicidality, at least here in my area. Yes, we have people with mental health concerns who struggle on an ongoing basis, but more often, I hear ... ‘I'm going to be homeless and I can't sleep on the street again tonight’, ‘I don't know how to get diapers for my kid and you know what? I'd just rather not be here than struggle through this again’.

Most participants described experiencing rural-specific conflicts of interest. This can be an issue in personal lives, as one participant described, “The dual relationship is problematic. Whereas, I know one of our other clinicians literally like... the clients can see into their home. Like they live on a corner, and clients will see into their home”. Another environmental dual relationship concern is the boundary between being a clinician and a person. One participant described, “And there's always the possibility of running into somebody, so I never totally feel turned off because I could always run into a client”, and another said, “So for example, one of the biggest barriers in rural Kansas is dual relationships”.

Systemic factors

Systemic factors focus on the mental health providers’ experiences with implementing policies and practices for suicide prevention in rural healthcare settings. From the analysis of

systemic factors, three themes emerged: 1) systemic security, 2) policy-related challenges, and 3) insufficient resource options.

Systemic Security

This theme consisted of three codes that influence systemic security: 1) internal support/collaboration, 2) using follow-up care in congruence with policy, and 3) screening tools. Our findings revealed that a majority of participants experienced helpful internal collaboration when implementing policies for suicide prevention. For example, one participant elaborated:

... you know part of protocol is if somebody on the overnight thing, if they call in, they're going to the phone will directly go to the organization that we contract with. And then they send us a report every morning. And then whoever is the open access or our clinical director, somebody reaches out to that individual just to check on them.

Additional benefits of collaborative care described by participants included, they received "...various viewpoints on the situation" and were "...able to process those more difficult cases with a supervisor, with my colleagues". In addition to policy encouraging collaboration, another participant mentioned how internal support strengthens their ability to practice effectively: "I think that my supervisor, my director has been extremely supportive in like helping advocate for a lot of the barriers that I've been experiencing within the town. So I do feel a lot of support with that".

A majority of participants also experienced a sense of security from using follow-up care in accordance with policy. One participant, referencing proactive screening because of policy, stated, "And then if my clients do have a history of having either suicide attempts or thoughts to harm themselves, every session I always do those check-ins with them". Participants noted that

when policy is developed well and implemented correctly, there is a noticeable improvement in patient care. For example, one participant shared, “I think that our organization has done a very good job of infusing the policies and procedures that are by the letter necessary with the way that we serve people”. Alternatively, another participant described the challenge of having to abide by policy, even when it does not prioritize the patient: “And ensuring that one person has their eyes on that follow-up can be difficult when we're doing this collaborative care”.

A majority of participants shared their experiences regarding the use of screening tools for patients at risk for suicide. While screening tools have evidentiary support for effectiveness, participants explained that how we utilize risk assessments doesn't always complement patient care, such as prioritizing assessment over listening to the client:

What we do, I think, is shut down good conversation by stopping at risk assessment and moving for hospitalization. The times where I'm most frustrated are when people have had only two minutes of conversation and asked me for a state-level screen.

Additionally, other participants noted how screening scores are used to limit access to certain services that may be helpful to particular clients and prevent worsening symptoms:

So even if I have a clinical opinion that a client would benefit from having a case manager to help them address certain barriers in public that they're experiencing, if the client is not scoring a certain score on the DLA 20, they would not qualify for those services and I'm not allowed to refer them to those services, even if my clinical judgment is that they would benefit from it.

Policy Related Challenges

The theme of policy-related challenges includes two codes: 1) different policies across organizations and 2) accessibility to policy implementers. A majority of participants described experiencing challenges with different policies across different organizations which impacted their ability to provide suicide care. For example, one participant stated how state-level policies may not make sense with the policies designed to fit a rural context: "... and that's at the state level. Sometimes they throw some stuff out there that's... they're not looking at that rural and frontier piece as to how this is going to get delivered". Another participant explained the extra work that goes into navigating conflicting policies to best serve clients in a rural context:

And so when it comes to working with those individuals, and kind of the organizations, some of their policies don't align with our policies. So, then it does kind of creates some conflict and then we kind of have to figure out how to make everything align. And so that's kind of a barrier that we're still experiencing, but we've been working a lot with those different organizations and meet to try to figure out what are appropriate steps so that everyone's policies are still met and the person's still getting the appropriate care they need.

A majority of participants described experiencing a lack of accessibility to the policy implementers themselves because many rural locations are branches of organizations based in other areas or operate as a referral site for medical organizations. For example, one participant said, "I do feel like kind of a lot of the smaller locations are neglected when it comes to the connection with the actual organization". Another participant elaborated on the challenge experienced when these different parts of an organization do not communicate well, "So

sometimes I feel like sometimes it would be more effective if communication was better between departments”. Another participant explained how communication from rural locations may not make it to the policymakers of the larger organization so the policy guiding care remains stagnant:

I think this is really common, you know the client is experiencing this type of situation or kind of has a conflict with this, and then when I bring it to higher up's attention, it's kind of just like brushed off and not addressed. And then the client's still continuing to experience it and it's like... In that type of situation, it's kind of frustrating because I want to help the client, and I've already addressed it with the higher-ups, but nothing's being done to help the client.

Insufficient Resource Options

Participants described two main areas where resource options were insufficient: 1) lack of training policies and practices and 2) lack of providers available. Several participants experienced a lack of training policies and practices for suicide-related care in addition to a lack of administrators ensuring that the clinicians know what the policies are and how to effectively implement them. For example, one participant said:

But I think the biggest thing that we've had to tackle is staff feelings of competency. So we can put all of these procedures and policies into place, but they're not going to be followed unless people feel like they are able to adequately assess and then refer somebody for suicide care.

Additionally, participants reported experiencing an implicit assumption by administrators that mental health providers have the skills and knowledge already established for effective

suicide care. One participant stated, “I personally would have liked more emphasis on what to do when we see that suicidality”. Another participant discussed the lack of assessing staff readiness for their role:

And I know that when I came into my first clinical role it was almost assumed that I knew how to do these things. That wasn't something that the role trained on either. So there was no checks and balances between if we didn't get this in education, we'd get it role-specific or if we didn't get it for our job, at least we knew how to do it clinically. There was a huge gap that I think still exists.

A majority of participants also described an experience with the lack of providers available and the shortage of providers ultimately resulting in extremely high caseloads. One participant said, “... we're spread so thin”, another participant expressed the need of, “Having more people ... More people. We need more people,” and a third participant shared, “You know, there's only so many people to go around”. Another participant elaborated further on the challenges contributing to the lack of providers:

And it's just attracting individuals, whether it be at the clinical level or at bachelor's or even the associate, you know or even the clinic care, that kind of level is frustrating ... the studies I've seen is that there literally is not going to be enough people graduating in any of the mental health type fields to provide the needs that are out there. That's kind of scary, too, to be honest.

4.

Discussion

The voices and experiences of mental health clinicians are an invaluable part of understanding how to improve behavioral health services for suicide prevention and intervention services in rural Kansas. A biopsychosocial approach emphasizes holistic care, and mental health providers are the necessary component to facilitating conversations with patients in order to understand what they [patients] need. Our findings revealed both strengths of behavioral health policies and practices already in place at certain organizations, as well as growth areas for more effective suicide care options. (1) Environmental factors impact mental health providers' abilities to provide care because there are communal attitudes and beliefs about mental health needs and rural folkways that require a period of learning and becoming familiar with the community to be effective. (2) Participants' experiences revealed that the inclusion of patients in their own treatment is not only beneficial but necessary for improving patient outcomes. (3) Systemic policies and practices provide a sense of security for mental health providers and can also benefit from additional elements and more structured implementation. (4) Treatment teams and collaboration, when used correctly, allow for creativity and innovation, but need equality amongst professionals within their scope of practice. Because the aim of this study is to elicit recommendations for improved policy and clinical practice for integrative suicide care in rural communities, we discuss recommended improvements in each section independently.

Clinician Factors

Mental health providers in this study experienced challenges in providing care to patients at risk for suicide in rural areas at the personal and professional levels. Our findings suggest several advantages of mental health providers' contributions to treatment teams for high-risk

patients, like fostering creative collaboration, expanding clinical expertise, and passion for this type of work. It is important to note that the interviews revealed some ambiguity to the terminology depending on the setting of practice: treatment team, collaboration, integrative care, interdisciplinary team, and care team can all be used to represent a group of healthcare professionals working in congruence with a biopsychosocial model to provide whole patient care. Treatment teams are intended to incorporate different professional perspectives in order to best serve the patient (Holley & Pasch, 2020). In many instances, treatment teams are utilized effectively and allow every professional to highlight concerns contributing to the patient's risk for suicide (Holley & Pasch, 2020), essentially letting everyone capitalize from their "own lane", as one participant mentioned in their interview. Additionally, participants in this study experienced increased confidence in their ability to provide competent suicide care from mandated trainings and being a mandated reporter. While they expressed that there may not always be a clear sense of direction for suicide safety planning in the moment, they felt confident in knowing the first steps in risk assessment and intervention. To expand this confidence in working with suicidal patients, as one participant acknowledged, implementing more training programs, such as Zero Suicide (Zero Suicide Institute, 2024) can facilitate those changes. Zero Suicide offers a variety of training options depending on the specific areas training is needed in, such as leadership, engagement, policy improvement, and other topics (Zero Suicide Institute, 2024). There are additional evidence-based practice for suicide care, such as what is detailed in the Kansas Suicide Prevention Plan (Kansas Department for Aging and Disability Services, 2021). The importance of utilizing evidence-based best practices, especially for suicide, is that we are implementing strategies that have shown to work.

Alternatively, congruent with literature on insufficient resources in rural healthcare settings (Maganty et al., 2023; Weinhold & Gurtner, 2014), mental health providers in our study discussed instances where they wanted to do more but simply could not. Our findings revealed that clinicians felt they must comply with time constraints due to a variety of factors. They described the limited supply of providers available paired with the high demand of people experiencing suicidality poses an economical problem. Although the mental health providers in the study wanted to dedicate time to clients, high caseloads and limited availability makes it impossible. This also limits the amount of time for all members of the treatment team, including the patient, to schedule time to collaboratively develop treatment plans.

One recommendation to this, in line with the use of mandated trainings, is mandatory meetings as part of working hours, rather than in addition to high caseloads. As mentioned, the quick treatment process (de Groot et al., 2011; Schiff, 2008; Vögele, 2022) does not always lead to long term outcomes, therefore not providing justification for carrying higher caseloads. Manageable caseloads per clinician potentially increases the quality of care provided and ensures time in clinician's schedule to meet for effective collaboration with other healthcare professionals. While we [mental health providers] aim to work our way out of a job, mental health will continue to be a in high demand for the foreseeable future, meaning there will be a waitlist. Foreshadowing later parts of this discussion, there are areas to capitalize on reaching more isolated individuals in rural Kansas, but for the 80% of individuals who could die by suicide in the United States within a year of accessing healthcare (Ahmedani et al., 2014; Labouliere et al., 2018) we need to confidently provide the level of care that patient needs in that moment.

Patient Factors

We used the psycho-social elements of the biopsychosocial model and the stress element of the diathesis-stress theory to better incorporate patient factors. The importance of patients being involved in their own treatment plans is to consider factors we [healthcare professionals] may otherwise not be privy to. This begins with translating certain verbiage into layman's terms (Allen et al., 2023) in congruence with the client's social-cultural location. To facilitate conversations complementary to the client's social-cultural location, providers have to be aware of what that location is. Specifically, taking treatment a step further than collecting patient background information and using a diagnostic assessment, but also incorporating the patient's voice and level of understanding. Similarly to the before mentioned vignette, when we apply the integrated biopsychosocial stress-diathesis model, we invite patient voice as opposed to just prescribing the treatment (Vögele, 2022).

Another element of integrating sociocultural factors is recognizing power differentials that may be present between the clinician and the patient. Intentionally inviting the patient's voice is a small way to bridge the power gap between providers and patients (Beagan et al., 2022). Patients with established trust in their clinician and/or treatment team are able to honestly describe what resources are available to them and what barriers they face. Our findings suggest that trust may also create a reciprocal relationship where clinicians have trust in their clients to voice their concerns and follow through on safety plans/treatment. A sociocultural consideration is recognizing that patients may not contribute enough to their treatment if they feel powerless to their care provider/s. To mitigate these challenges, it is recommended that mental health providers more readily use interpersonal skills and joining abilities (Wampold, 2015). It is more

than being friendly and asking the right questions, but recognizing the specific needs of the individual patient and inviting them to be a collaborator in their own care.

An arguable element of trust is transparency. Every participant of this study described an experience that required transparency; most commonly mentioned was the use of transparency for crisis intervention. Our results revealed that clinic policies, mandated reporting, and screening tools indicate that a certain level of crisis requires more immediate intervention (i.e. police transportation, crisis stabilization units, wellness checks, and hospitalization). Objectively, immediate intervention sounds like prioritizing care, however what has appeared to actually be doing is creating feelings of fear and hesitation in the patients and even sometimes the clinician themselves.

It is not to say that immediate intervention should be eliminated, rather it is recommended this process be slowed down, as to match the pace of the client's level of readiness and abilities and the clinician's level of experience. Slowing down this intervention process allows the clinicians to be upfront and honest with the client, establishing a sense of alliance (Wampold, 2015). Transparency allows clinicians to practice in congruence with their legal obligations and walking the patient through the subsequential steps of this process. Further, slowing this process down allows for a marriage of screening tools and clinical judgement, versus the screening tool score dictating the line of treatment. Screening tools are incredibly effective in helping assess risk for suicide (Thom et al., 2020). There are advancements being made with the capabilities of screening tools, such as the more culturally competent assessment of suicide being the Cultural Assessment of Risk for Suicide (CARS) (Chu et al., 2013), but they still cannot always account for the fluctuation in patient risk. Use of clinical judgement not only

accounts for assessing the patient's current state by using the established relationship, but also explores what resources are a better fit for and accessible to the patient. It explores patient rurality and community folkway for safety plan purposes of support systems and removing potential weapons.

Systemic Factors

Another interesting finding that was revealed was stress factors for the clinicians themselves. Many of the participants described needing more internal support, specifically support for the demands of the profession. Mental health providers are trained in self-care and stress reduction practices (Rudaz et al., 2017); however, they are not immune to the effects of humanness. This job can often require huge caseloads, long hours, mental/emotional drainage, and worry that persists even after hours because of risks for suicide. It is recommended that organizations be more proactive in meeting the needs of the clinicians through improved policy and the use of supervisors. Policies focus on follow-up care for the patient, but do not have space for follow-up care for the clinician who had to use the policy. Integrating the stress factor in the diathesis-stress theory and the economic problem stated earlier, we can cautiously anticipate losing even more of the mental health providers because of the high mental demands of this profession (Rudaz et al., 2017). In other words, we are already limited in the amount of mental health providers and if we are not careful in supporting the stress of the ones that we do have, we face the threat of them leaving this profession. It is recommended that organizations implement policies around follow-up for the clinical provider. This could include required debriefs with a supervisor after a crisis intervention (Harder et al., 2020), increased conversations on unique experiences, such as losing a patient to suicide (Gutin, 2019), or even recommending the clinical

seek their own mental health services independently. Debriefing can positively affect the clinicians after these experiences by providing more psychological support and guidance (Harder et al., 2020). Similarly, when clinicians receive support from their supervisors following the loss of a patient, they are able to retrospectively identify benefits of the experience (Gutin, 2019).

Mandated training for suicide, in addition to increasing confidence for clinicians, can also provide benefits on a systemic level. As mentioned by one participant, routine mandated training may serve as checks and balances for clinical experience. There can sometimes be a well-intended assumption that licensed professionals have the necessary training for the job, however this may not always be the case. To ensure clinicians at organization are trained in suicide care and on the specific policies of the organization, it is recommended to require routine trainings. Mandated training on suicide keeps organization up-to-date on the current evidence-based care most effective in suicide prevention (Mann et al., 2021). Routine training on policies ensure that clinicians are clear on how to implement the policies to that organization specifically, regardless of their experiences and training prior. These adjustments may also serve as a needs assessment in which organizations can see where training is lacking or what areas of concern are present.

Communication barriers between mental health providers and their superiors create challenges in clinicians' abilities to provide care. Specifically, challenges arise when attempting to communicate changes that could be helpful and general reachability of the policy implementors themselves. Not to minimize the important work that policymakers are consumed by, but rather to highlight the imperative need for increased accessibility. Change cannot happen if we work against one another; Mimicking the act of integration we see in effective patient care,

mental health providers and policy makers must work together to improve patient care, as opposed to separate entities.

Collaborative care can sometimes involve the use of professionals outside of the healthcare realm (Reuland, Schwarzfeld, & Draper, 2009; Wiedermann et al., 2023), such as teachers and law enforcement. Interestingly, the results revealed that collaborating with other professionals can spark feelings of nerves and apprehension. Whether these feelings emerge from personal biases about police officers, or previous experiences, it is important to acknowledge they are present so that we can find ways to lessen these feelings and work towards effective collaboration. One recommendation is understanding differences in policies across various organizations. If we are able to identify differences in policies, we may be able to better capitalize on our own role in patient care. Cross-disciplinary collaboration is most effective when professionals are able to understand and learn from each others' perspective (Pennington, 2008). When roles and legal obligations are clearly defined for each professional, it may be easier to reduce biases and increase comfort.

Environmental Factors

Transversely, mental health providers experience other professionals holding biases about mental health as well. While the awareness of stigmas surrounding mental health is evident, there is little to no research on the biases formed toward mental health providers. Mental health providers sometimes experience injustices from the general public and other professionals, such as projected doubts about their professional capabilities and misplaced blame for negative patient outcomes. These biases create a challenge for mental health providers to develop personal relationships within the community because others are unsure about the services mental health

providers are able to provide. It is recommended to increase personal relationships within the community to reduce mental health stigma. Social engagement improves stigma-related knowledge and attitudes about mental health (Thornicroft et al., 2016). Community engagement can normalize the language about suicide and the common occurrence of suicidal thoughts both for the community and other professionals that will come across these issues (which is basically everyone). Community engagement could be events like community speakers about suicide and/or suicide care, providing training opportunities to those who may not work directly in the healthcare realm, but still engage with people who could experience suicidality. These opportunities could provide space to integrate local knowledge and lived experiences across various age groups (Grattidge et al., 2025). Social engagement also allows for reducing the stigma of experiencing suicidality (Niederkrötenhaler et al., 2014). Yes, suicide is objectively a scary topic, and it's okay to talk about it. In fact, talking about suicide more openly and comfortably, brings more awareness to its relevance. These conversations may also demystify communal attitudes and beliefs about mental health and mental health providers. If there is less stigma around having suicidal thoughts and seeking professional care, individuals may be more likely to find resources when experiencing suicidal thoughts.

Strengths and Limitations

As with any research study, there are several limitations. This study's participation fell within the recommended number of participants for a phenomenological study, however, all of the participants identified as racially white and five were female. Phenomenological studies require detailed perspectives from a specific environment, and while the experiences of the included participants were rich in detail, perspectives from other genders, races, and ages would

expand our understanding of this phenomenon. The methodology of this study also reinforced suspected barriers to care, namely time constraints. This study required up to 90-minute interviews; With mental health providers having busy schedules, 90 minutes can interfere with other work demands. This interference may have a potential impact on the contributions provided from participants, such as challenges in recruitment, not obtaining the experiences of the most time-stressed individuals, and not collecting as rich responses for each question. Additionally, the coding process is based on interpretation of participants' experiences. Although reliability was accounted for to the best of the research team's ability, there cannot be a guarantee of no biases being present.

Another limitation is the level of recommendations able to be made to improve practices and policies. Monetary funding plays a huge role in improving suicide prevention and intervention. Many recommendations for improved policies and practices, such as ways to expand community outreach, increase suicide training opportunities for mental health providers, increase number of mental health providers available, and increase rural office locations, and entirely dependent on the ability to acquire monetary funds. Therefore, resulting in condensed, more attainable recommendations.

The current study serves as a stepping-stone to future research opportunities. The current study categorized four factors that contribute to suicide care in rural healthcare settings: patient, clinician, environment, and systemic. Each other these categories could benefit from being studied independently, as opposed to group all of four of them into one study. Replication of this study with other lived experiences may also provide necessary insights. For example, having participants that are other medical professionals that aren't the mental health providers, have

important lived experiences, or using patients that experience receiving care for suicidality in integrative care settings.

Conclusion

The aim of this study was to better understand mental health providers' experiences for collaborative suicide care in rural parts of Kansas. The results of the current study do not contradict previous research, but rather exemplify already established areas of concern about mental health services for suicide care and serve as a valuable contribution to understanding suicide prevention and intervention in rural Kansas. Elements of our findings are in line with other studies (Hirsch & Cukrowicz, 2014; Prazak et al., 2025; Varia et al., 2014), which can argue for reliability in our study, and also expand insights about how suicide care is provided across clinician, patient, environment, and systemic levels. The importance of mental health providers' lived experiences is that we gain a keen understanding of the actual intricate processes of suicide care. Specifically, our study revealed the need for follow-up care for the clinical providers themselves, how a sociocultural lens on suicide may positively impact patient outcomes, why normalizing suicide and patient free will is beneficial, and risk assessment is part of treatment planning because anyone can experience suicidality. We hope that findings can have transferability and importance for further research in the field to continue advancements in suicide prevention and intervention.

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A.

Interview Guide

Introduction PK: “Hello. I first want to thank you again for taking the time to participate in this study. My name is Paige, and I am the doctoral student conducting this study to better understand facilitators and barriers to the implementation of suicide intervention programs, policies, and practices in rural integrative healthcare settings. This interview will last about 90 minutes, and I will let you know when the recording has begun. As a reminder, this interview will explore your experiences providing care to patients at risk for suicide while working in rural healthcare settings. The goal is to be able to provide recommendations for improved clinical practices and policies. Please confirm the pseudonym on your screen is correct or you may change it at this time. Also, if you would prefer to have your camera off, you may turn it off at this time. Just as a reminder, if you are uncomfortable with any of the questions, you may skip the questions and/or end the interview at any time.

-Based on all of this information, do you consent to participate in this interview? [obtain verbal consent]

-Great, thank you! We will start the recording now if you are ready. [**Start Zoom Recording**].”

Interview Questions:

Block 1: “I want to start out by asking you about your current role and the organization your work at”

1. Without saying the name of your organization, can you describe the type of services provided?

2. What is your role within this organization

Block 2: “Now I will be asking you about your experiences in training for the type of work you provide and the settings in which you work.”

1. Based on your current clinical position, how has your degree, licensure, and/or training prepared you for working with suicidal clients?

1. How do you feel when working with these clients?

2. How have your experiences allowed you to feel competent in working in rural/frontier parts of Kansas?

3. In which circumstances do you interact with different kinds of professionals outside of the mental health field?

1. What is your experience collaborating with other health professionals?

2. How do you feel before/during/after these interactions?

Block 3: Next, I want to ask you a bit about your experiences with the organization’s policies and collaboration with other healthcare professionals.

1. Can you describe your experience implementing your organization’s procedures for risk of suicide?

1. How do you feel about these procedures?

2. How do you feel about the amount of time you are able to spend with the patient themselves?

3. How do you feel about the length of time allotted with the treatment team to be able to collaborate effectively?

1. What changes to this structure would you recommend?
2. Have you experienced power differentials when working with these other professionals?
 1. Can you describe one of those experiences?
4. Based on your experiences with treatment teams, does collaborative care feel effective in treating the whole patient? Why or why not?
 1. Where do you see strengths and growth area for the procedural aspects when it comes to collaborative care?
5. What has been your experience with collaborative care specific to rural areas?

Block 4: In the next set of questions, I will ask you about your experiences in establishing patient-clinician relationships.

1. How do you, personally, go about establishing an alliance with your patient?
2. Do you feel you are able to effectively establish trust with your patient?
3. What is your role in collecting patient background information?
 1. In your experience, does this feel effective to elicit important information from the patient?
4. In your experience, what client factors alert you to include screening for thoughts of self-harm and/or suicidality?
 1. How do you feel about assessment and safety planning for rural parts of Kansas?
5. What kinds of concerns have you had when assessing high-risk individuals?

1. What did you find helpful in addressing those concerns?
6. What is your experience with care/follow-up care for high-risk cases?
 1. How do you feel about this?

Block 5: In the final set of questions, I will ask you about overall experiences within your work environment.

1. As a mental health professional, what feels most important when building trust with your patients?
2. What has your experience with workplace culture been?
3. Have you experienced community outreach for suicide prevention purposes?
 1. How do you feel about virtual/phone care provided given the limited resources in rural and frontier communities?
4. What are the main challenges you experience when it comes to suicide care?
 1. How do you feel about support from your organization when it comes to this type of work?
 2. What has been your experience is mistakes are made when it comes to suicide prevention or intervention?
5. Do you have any other experiences to speak to that I have not already provided space for?