Personal and Professional Knowledge of and Experience With Suicide and Suicide Prevention Among Stakeholders in Clinical and Community Practice

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Community-dwelling veterans at risk for suicide may be in contact with a variety of providers in agency-based settings that offer health and human services. The study aim is to describe the perspective of agency-based clinical and community providers who may come into contact with veterans in need of suicide prevention services and to examine the nature of their personal and professional relationships to individuals at risk for suicide among this sample.

This study reports on qualitative data from a sample of Veterans' Affairs (VA) and community providers serving veterans and military families in one Midwestern state (N = 70). Providers completed a survey assessing exposure to suicide, including contact with and relationship to someone suicidal, and

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organizational characteristics of the providers' employing agencies. Semi-structured interview questions probed for the nature of how they would react with suicidal individuals. Most providers (94%) had some prior contact with someone who was suicidal, and nearly three quarters (77%) knew someone who had died by suicide. Providers reported powerful emotional responses of sadness and remorse to suicidal experiences. While these providers interact with veterans and military families as part of their jobs, they may have their own history of being exposed to suicide, both professionally and personally.

KEYWORDS *suicide, United States Department of Veterans Affairs, health personnel, health service, veterans, prevention, qualitative research*

Community-dwelling veterans at risk for suicide may encounter a variety of professionals, including but not limited to those in the mental health, substance abuse, employment, and veteran-focused service sectors such as benefits. These providers can act as a gateway to necessary health and psychosocial services by assessing for unmet needs and making referrals to other resources and community agencies to meet those needs. According to the Gateway Provider Model (Stiffman, Pescosolido, & Cabassa, 2004), a variety of individual- and system- level factors influence this provider decision making. With such an important role in linking suicidal veterans to necessary crisis services, it is important to understand providers' background, motivations, and experiences with suicide and suicide prevention.

BACKGROUND

Suicide is the 10th leading cause of death among adults in the United States, with more than 34,000 deaths each year (WISQARS, 2013). In 2010, the prevalence rate for adults 18 and over was 15.92 per 100,000, which is higher than the age-adjusted national suicide rate of 12.02 deaths per 100,00 across all age groups (WISQARS, 2013). Research has demonstrated a higher rate of suicide in western states and those states with more rural areas. One mid-western state with high rates of suicide and few urban counties is Missouri. Missouri was ranked 17th in the nation with a suicide rate of 14.1 per 100,000, much higher when compared to the U.S. national rate of 12.0 per 100,000 (McIntosh & Drapeau, 2012). In any state, suicide is an important public health issue that affects all those that knew the individual who died by suicide, and their surviving family members, friends, colleagues, and associates.

According to the 2012 Suicide Data Report, suicide among veterans, specifically among the high-risk subgroups of women veterans and aging Vietnam Era veterans, has been deemed targets for more increased intervention and provider outreach by the Department of Veterans Affairs (VA) (Kemp & Bossarte, 2012). A specific policy mandate of assessing suicide risk in mental health and non-mental health settings is mentioned in this report, as well as in the recent release of the National Strategy for Suicide Prevention (NSSP) (HHS, 2012). The providers working in these settings are the “front lines” of services provided to veterans and military families, and as such they serve a role as “gatekeepers” for at-risk veterans (Matthieu, Cross, Batres, Flora & Knox, 2008; Matthieu, Chen, Schohn, Lantinga, & Knox, 2009). Their perspectives are critically important in understanding how to tailor interventions aimed at increasing rates of referral for necessary, life-saving, crisis intervention services. Prior knowledge about suicide and current resources to facilitate suicide prevention and intervention are important contributing factors that may impact a providers’ referral decision making.

Knowledge of and previous experience with suicide may impact a provider in both professional and personal ways. Professional exposure may include knowledge of the death by suicide or a suicide attempt by a client, co-worker, or colleague with whom they interact at work or as part of their job role. Typical initial reactions after learning about a suicide can include shock and grief, yet over time, these life-changing experiences tend to provide some positive means of coping that influence clinicians to engage in activities such as suicide prevention workshops or seminars (Cotton, Drake, Whitaker, & Potter, 1983). While initial reactions to suicide in this professional context are typically negative, this may become more positive once a provider enters the recovery phase. In this phase, individuals are motivated to share knowledge about how to respond in similar at-risk-for-suicide situations in the future (Bartels, 1987).

Although these and other studies have explored the impact of suicide within a provider–patient context, there is little literature to suggest the impact of suicide on clinical providers outside of the typical mental health field. These community providers, who primarily offer employment or benefits assistance, may nonetheless encounter suicidal clients. These experiences can explicitly and implicitly impact these clinical and community providers’ ability to be a necessary link in the chain to services for suicidal veterans. Thus, the aim of this article is to describe the perspective of agency-based clinical and community providers who may come into contact with veterans in need of suicide prevention services and to examine the nature of their personal and professional relationships to individuals at risk for suicide among this sample.

METHODS

Study Design

These data were collected as part of a larger study eliciting stakeholder perspectives on the organization- and provider-level barriers to veterans accessing suicide prevention services in their local communities. This article reports on the qualitative data from a sample of VA and community providers serving veterans and military families in one Midwestern state ($N = 70$). Ethical approval was obtained prior to data collection from the local VA and the academic affiliates' institutional review boards (IRB) and informed consent was obtained from each participant. The ascertainment and description of the sample and data collection procedures for this study has been described previously (Matthieu, Gardiner, Ziegemeier, & Buxton, 2014), therefore a brief overview will be provided here.

Ascertainment of the Sample

Considering the need to obtain data from providers serving rural-living veterans, as well as to maintain representativeness of population dispersion, we chose both an urban and rural segment of a Midwestern state (e.g., Missouri) as our sampling areas. We limited our sampling frame to agencies within the state given (1) our focus on returning veterans, (2) the number of programs and services for veteran and military service members offered by the public sector, and (3) the high density of private agencies in each region.

For this study, the sample comprised 70 providers. The goal was to recruit at least 6 different VA and community based providers from the 10 different service sectors (i.e., mental health, substance abuse, aging, homeless, employment, justice, education, military, benefits, policy) we identified ($n = 60$). In addition, the study oversampled providers ($n = 10$) from the aging sector to increase the focus on life transitions encountered as part of aging and on male veterans over 50 years of age due to their increased risk for suicide (Kemp & Bossarte, 2012).

Sample Characteristics

The sample included adults aged 18 and older who were employed in the public or private sector providing health, psychosocial, employment, benefits, or other social services within agencies that may serve veterans in Missouri. The exclusion criteria were individuals who were not employed in an agency or who did not have sufficient experience with veterans to provide a perspective on the topic of suicide prevention services.

Data Collection Procedures

After attaining informed consent, all interviews were administered individually in person by the qualitative interviewer, a cultural anthropologist with extensive experience conducting interviews on mental health topics and with adult social service providers. The interviewer trained all staff who participated as members of the coding team on qualitative data analysis procedures. Surveys were emailed to participants in advance of the interview with additional copies brought to the interview by the interviewer. All surveys were collected by the interviewer. The total survey response rate was 99% ($n = 69$).

Measures

Four of the five sections of the suicide and suicide prevention self-report survey instrument have been utilized in previous research (Matthieu et al., 2008, 2009). These sections include: (1) Organizational assessment, (2) Provider demographics, (3) Individual-level factors, (4) Exposure to suicide, and (5) Awareness of suicide prevention resources. The *organizational assessment* items, developed for use in this study, asked about the type of organization, annual budget, number of clinical/medical and all employees, annual number of clients served, age range of clientele, type of services provided, and if services were military- or veteran-focused. *Demographic* data on the provider's age, gender, race, ethnicity, education, job role, and years of clinical experience were collected. *Individual-level factors* data included an assessment of the participant's lifetime history of general and clinical interviewing experience and trainings attended that related to suicide and crisis. *Exposure to suicide* included a series of questions related to lifetime exposure to suicide, such as previous contact with potentially suicidal individuals, suicide attempters, and suicide decedents. *Awareness of suicide prevention resources* was assessed with a series of questions about knowledge of departmental-, local-, state-, and national-level suicide prevention activities.

Data collected for the interview focused on three main topics from the providers' perspective: (1) Veterans' overall need for mental health and suicide prevention services, (2) the referral process to attain these services, and (3) the barriers encountered in accessing mental health services, particularly when veterans are at heightened risk for suicide. The interviews were coded for any mention of suicide to capture providers' experiences with suicide, either professionally or personally.

Data Analysis

For this study, we report on a subset of interview data that was subjected to content analysis (Krippendorff, 2013; Schreier, 2012). Digital audio recordings

of all 70 interviews were professionally transcribed and analyzed using the computer-assisted qualitative data analysis software Atlas.ti, version 7. Interrater reliability was assessed using the *Coding Analysis Toolkit* (CAT), a free service of the Qualitative Data Analysis Program, and during coding consensus meetings, achieving an acceptable level (.70) of reliability for the codes reported in this study.

Using a framework approach (Pope, Ziebland, & Mays, 2000), qualitative methods were used to analyze the textual data attained from individual providers, our unit of analysis (Miles, Huberman, & Saldaña, 2014). The qualitative interviewer and the Principal Investigator (PI) led the 5-member team in developing a plan to follow the framework approach, from familiarization to theme identification to indexing using a two-tiered coding strategy (e.g., top-level and sub-level codes). In order to familiarize the team with the data, a sample of transcripts deemed rich in detail by the interviewer was selected and given to team members to read for identification of key ideas and recurring themes, which were then discussed and categorized. Using these themes as a guide, the PI and interviewer developed an indexing system with an initial list of top-level codes, which were then presented to the coding team with detailed instructions on how best to apply them. A coding protocol was also produced to establish norms for the parameters of coded text, specificity of coding, double-coding, and other procedures. The team coded identical transcripts and the CAT software was utilized to run comparative statistics estimating team consensus in applying codes. Based on whether the results met the acceptable reliability criterion of .70 or higher, the team would then meet to discuss differences and negotiate possible new codes or expansion of existing code applications. This discussion and consensus process was repeated until coding consistency at the acceptability level or higher was achieved. Sub-level codebook development followed a similar trajectory to that of the top level codebook, but with a three-person coding team. For this article, specific codes pertaining to specific mention of suicide, to capture providers' experiences with suicide, either professionally or personally, were applied to all transcripts by means of a key word search and from these results, illustrative quotes were purposively selected and presented.

RESULTS

Sample characteristics are shown in Table 1. In general, the sample comprised well-educated, Caucasian, social workers with a fairly even distribution of males and females. About one third were veterans themselves, and nearly a quarter currently work for the VA. Nearly three quarters had a master's degree or higher education level (73.1%, $n = 51$), and almost 90% had attended a previous suicide prevention training ($n = 62$).

TABLE 1 Demographics and Organizational Characteristics of Stakeholders ($N = 70$)

	<i>n</i>	%
Provider characteristics		
Mean Age = 46.4 ($SD = 9.5$)	65	Range = 27–65
Gender	69	
Male	37	53.6
Female	32	46.4
Race	68	
Caucasian	60	87.0
African American	6	10.1
Native American	1	1.4
Ethnicity	67	
Hispanic/Latino	7	10.4
Education	69	
Master's degree or above	51	73.9
Bachelor's degree or below	18	26.1
Degree	49	
Social Worker	30	61.2
Counselor	8	16.3
Psychologist	3	6.1
Chemical Dependency Counselor	2	4.1
Nurse	1	2.0
Previous History of Suicide Prevention Training	69	
Yes, provider has had suicide prevention training	62	89.9
Veteran Status	70	
Yes, providers own history of service in U.S. Armed Forces	21	30.0
Job Role	63	
Administrator	39	61.9
Clinician	24	38.1
VA Provider	70	
Yes, provider is a VA employee	17	24.3
Organizational Characteristics		
Type of Organization	69	
Not-for-profit agency	25	36.2
For-profit agency	3	4.3
Governmental agency	32	46.4
College/University	6	8.7
Public/private hospital	2	2.9
Other	1	1.4
Budget	56	
Under \$1 million	28	50.0
Over \$1 million	28	50.0
Total number of employees	67	
Less than 100	38	56.7
100 or more	29	43.3
Total number of clinical/medical staff	65	
Less than 25	41	63.1
25 or more	24	36.9

(Continued)

TABLE 1 (Continued)

	<i>n</i>	%
Number of clients	65	
Less than 1,000	22	33.8
1,000 or more	43	66.2
Age range of clients	69	
Birth to 17 years	22	31.4
18–24 years	58	89.2
25–64 years	64	91.4
65 years and older	54	77.7
Provides veteran-focused services	67	
Yes	50	74.6
Provides services to rural areas	70	
Yes	30	42.9

Organizationally, most of the participants represented medium-sized, government, and non-profit organizations. The organizations provided services across the lifespan, from birth to the elderly, although the majority focused their services on middle-aged clients aged 25–64 (91.4%, $n = 64$). Many also provided veteran-focused services (74.6%, $n = 50$), although those were not necessarily specific to mental health.

As noted in Table 2, nearly everyone in the sample had some sort of contact with someone who was suicidal at some point; only 6.1% reported having no contact with someone who was suicidal. Given that some relationships tend to be more personal in nature, the sample reported that they knew more family (35.9%, $n = 23$) than friends, neighbors, or acquaintances. Conversely, for professional relationships, the majority of respondents reported knowing mostly patients (81.3%, $n = 52$) who were suicidal, but also noted co-workers, students, veterans, and others as well. About half (46.3%) of the sample had a personal contact with someone who was suicidal, and nearly all (89.1%) had a professional contact with someone who was suicidal.

Of those who had some contact with someone suicidal, nearly all participants in the sample made an intervention (96.9%, $n = 62$). Referrals were the most common type of intervention, mostly within the professional networks. Of these personal and professional relationships, the majority referred “patients” (76.9%, $n = 50$), followed by “Veterans” (55.4%, $n = 36$). Nearly three quarters of the sample (76.8%) knew someone who died by suicide, with the type of relationship highest for “friends” (45.5%, $n = 25$) among personal contacts, and “patients” (43.6%, $n = 24$) highest for professionals. Of those who knew someone who had died by suicide, 11.3% knew more than 11 people. About one fifth of the sample (20.8%) knew only one person who died by suicide.

TABLE 2 Nature of Relationship to Individuals at Risk for Suicide ($N = 70$)

Variable	<i>n</i>	%
Ever had contact with someone suicidal?	69	
No	4	5.8
Yes, only one person	4	5.8
Yes, 2–4 people	18	26.1
Yes, 4 or more people	43	62.3
Relationship to person contacted	64	
Family	23	35.9
Friend	18	28.1
Co-worker	12	18.8
Patient	52	81.3
Neighbor	3	4.3
Acquaintance	7	10.9
Student	1	1.6
Veteran	28	43.8
Other	6	9.4
Talked to them about their concerns	65	
Yes	64	98.5
Asked them about if they were thinking of killing themselves	65	
No	3	4.6
Yes, indirectly	6	9.2
Yes, directly	56	86.2
Intervened on them	64	
No	0	0
Yes, indirectly	2	3.1
Yes, directly	62	96.9
Ever made a referral for someone suicidal	64	
No	1	1.6
Yes, indirectly	3	4.7
Yes, directly	60	93.8
How many people have you referred?	65	
0 people	1	1.5
1 person	10	15.4
2–4 people	13	20.0
5–10 people	10	15.4
11 or more people	31	47.7
Relationship to person referred	65	
Family	15	23.1
Friend	11	16.9
Co-worker	7	10.8
Patient	50	76.9
Neighbor	5	7.7
Acquaintance	6	9.2
Student	4	6.2
Veteran	36	55.4
Other	8	12.3
Know someone who has attempted suicide ($n = 69$)	69	
Yes	58	84.1
How many people have you known who attempted suicide?	57	
1 person	8	14.0
2–4 people	17	29.8
5–10 people	12	21.1
11 or more people	20	35.1

(Continued)

TABLE 2 (Continued)

Variable	<i>n</i>	%
Relationship to person who attempted suicide	59	
Family	21	35.6
Friend	19	32.2
Co-worker	15	25.4
Patient	34	57.6
Neighbor	4	6.8
Acquaintance	12	20.3
Student	4	6.8
Veteran	20	33.9
Other	8	13.6
Know someone who has died by suicide	69	
Yes	53	76.8
How many people have you known who died by suicide?	55	
1 person	13	23.6
2–4 people	26	47.3
5–10 people	10	18.2
11 or more people	6	10.9
Relationship to person who died by suicide	55	
Family	14	25.5
Friend	25	45.5
Co-worker	11	20.0
Patient	24	43.6
Neighbor	7	12.7
Acquaintance	19	34.5
Student	5	9.1
Veteran	12	21.8
Other	5	9.1

Interview Data

EMOTIONAL RESPONSES OF SADNESS AND REMORSE TO SUICIDAL EXPERIENCES

Although the situations varied considerably by provider, the re-telling of experiences with suicidal individuals included an element of sadness, with some visibly shaken as they related their stories while others remained composed. One provider spoke of services “not being offered” to a veteran who was a repeat service user with an alcohol addiction, who was clean for a period of time, but relapsed and subsequently committed suicide in the preceding few months. This participant lamented his/her absence and still carried some guilt related to the sad outcome:

Oh, I cried for days and weeks because he did that, because he was so devastated. He was. When he'd call me he'd say, 'I know . . . '—he would just be talkin' and he was managin' the food pantry down there . . . he'd say, '____, I'm so happy. I know I sound like a little kid, but I'm just so happy.' This is . . . I still pray about him. I mean, I still do. It breaks my heart. It breaks my heart. Oh my God, it breaks my heart. . . . I struggled with it, I was just devastated when I heard.

When asked what the VA could do better in regards to suicide prevention or how the VA could make front line providers' jobs more efficient, this participant stated that there is always a need for more suicide prevention and intervention services beyond the current offerings. However, he/she would really like to see training programs for "certain line staff" to assist them in managing suicidal clients by "not shifting, not just 'poo-poo-ing away' somebody's behavior or whatever and (instead), normalizing the conversation. We talk about it. Let's talk about it. Let's not shove it under the rug and think it's gonna go away."

POWERFUL EMOTIONAL RESPONSES

The most emotional response came from another participant during the course of the interview. At one point, the participant suddenly remembered a personal experience with suicide and realized that the person they were thinking of had been a veteran, a connection they had not made previously. The interviewer paused the audio recording and allowed several moments for the individual to regain composure.

JOB-RELATED INTERACTION WITH SUICIDAL CLIENTS

Another participant experienced the suicide of a close friend in the wake of two suicides occurring at work. He/she spoke directly about the actions taken at the agency in response to the client suicide:

Now the year before, I had two cases really close around each other . . . right after that, I had suicide prevention hotline numbers posted throughout the building, so they're on all the walls and all the cubicles and all that stuff. (*Interviewer:* You did that?) Yeah, we . . . 'cause after that first one, we got a little better prepared.

Finally, one clinician with prior exposure and experience with suicide worked together with the VA to avert a fatal outcome for a veteran client. This participant relates how his/her organization collaborated with the VA and used suicide prevention materials to engage a veteran in self-monitoring his/her suicidal episodes:

When we look at the suicide thing, I've seen it work in action. I had a bipolar client who had very severe psychotic episodes, not very terribly medication compliant. We worked with him almost religiously, but I would say about every three months, there would be kind of this rapid de-compensation, usually followed by voices in the head, he would drink alcohol, the voices would tell him to kill himself. He was here a year and a half and probably went on suicide watch over at the VA three times,

four times. That was probably one of the more difficult cases. He always called the number . . . we have the great big poster up there, it takes the courage of a warrior—that's upstairs, in our main living area and we use a lot of the magnets and materials to kind of give out that the VA provides for that kind of thing. (*Interviewer*: The hotline, yeah.) Right, so we try to be really good about keeping that stuff kind of open and accessible.

DISCUSSION

The aim of this study was to describe the perspective of agency-based clinical and community providers who may come into contact with veterans in need of suicide prevention services and to examine the nature of their personal and professional relationships to individuals at risk for suicide among this sample. Findings reveal that this population tends to have a high degree of experience with suicide, both personally and professionally. Compared to previous literature, Matthieu et al. (2009) found that 94.3% ($n = 71$) of VA employees had contact with suicidal individuals, which is consistent with the sample in the current study. This finding may be due to the way in which the current sample was selected, targeting community and clinical providers, particularly those within the VA who worked specifically in mental health or who were suicide prevention coordinators. While this may explain why many of those experiences with someone suicidal were through professional networks rather than personal ones, this cannot fully account for the large proportion of our sample with previous experience with suicide.

This article adds to the literature by providing a rich description of provider experiences with suicide and provides a larger context in which to understand these experiences. Providers with prior experience with suicidal individuals responded to questions about that experience with sadness, guilt, and occasionally remorse. These responses, ranging from facial expressions, tonal modulations, to tears and physical expressions of grief, are indicative of the emotional resonance attached to death by suicide. Whether the experience occurred through professional or personal networks, the experience with suicide was described as an emotionally impactful event for the provider.

Limitations

The data collected for this study was primarily focused on understanding the barriers to accessing suicide prevention services for community and VA providers and was not necessarily specific to better understanding providers' experience with or exposure to suicide, professionally or personally. Thus, interviews did not specifically address or probe for thoughts and/or reactions to exposure to suicide. Future studies may consider including specific interview questions on suicide exposure to obtain greater insight into this topic.

A final limitation of this study is that the language used to discuss exposure to suicide seems to be varied in both the literature and in practice. When talking about exposure to suicide there are important distinctions between distant and closer personal relationships and the type of suicidal behavior (threatened, attempts, or death) that introduce complexity that is not reflected in our current vocabulary.

Implications

Those who are motivated to work within the field of mental health, both within the VA and in the community, may have more experience with suicide than is typically encountered across the general population. This experience can serve as a motivator for learning more about how to connect clients, in particular veterans, with available crisis intervention and referral services. However, to maximize the motivating potential of these experiences, agencies interested in connecting providers to those available services, such as the VA, must devise training strategies and policies and procedures that take these experiences into account.

CONCLUSION

This article provides a more detailed picture of the experience that a sample of providers has had with suicide, personally and professionally. In addition to reporting a high proportion of experience with suicide, these providers exhibit strong feelings of sadness and remorse when discussing their experience with suicide, reinforcing the power that prior suicidal experience has on service providers. Ongoing awareness and training regarding suicide prevention can assist provider decision making in linking suicidal veterans to necessary crisis services.

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REFERENCES

- Bartels, S.J. (1987). The aftermath of suicide on the psychiatric inpatient unit. *General Hospital. Psychiatry*, 9(3), 189–197.
- Cotton, P.G., Drake, R.E., Whitaker, A., & Potter, J. (1983). Dealing with suicide on a psychiatric inpatient unit. *Hospital & Community Psychiatry*, 34(1), 55–59.
- Kemp, J., & Bossarte, R. (2012). *Suicide data report, 2012*. Washington DC: U.S. Department of Veterans Affairs, Mental Health Services, Suicide Prevention Program.
- Krippendorff, K. (2013). *Content analysis: An introduction to its methodology* (3rd ed.). Thousand Oaks, CA: SAGE Publications.
- Matthieu, M.M., Chen, Y., Schohn, M., Lantinga, L.J., & Knox, K.L. (2009). Education preferences and outcomes from suicide prevention training in the Veterans Health Administration: One-year follow-up with healthcare employees in upstate New York. *Military Medicine*, 174(11), 123–1131.
- Matthieu, M.M., Cross, W., Batres, A.R., Flora, C.M., & Knox, K.L. (2008). Evaluation of gatekeeper training for suicide prevention in veterans. *Archives of Suicide Research*, 12(2), 148–154.
- Matthieu, M.M., Gardiner, G., Ziegemeier, E., & Buxton, M. (2014). Recruitment by service sector: Identifying community stakeholders to help stakeholder perspectives on improving access to suicide prevention services for veterans. *Military Medicine*, 179(4), 388–395.
- McIntosh, J.L., & Drapeau, C.W. (2012). U.S.A. suicide 2010: Official final data. Washington, DC: American Association of Suicidology. Retrieved from <http://www.suicidology.org>
- Miles, M.B., Huberman, A.M., & Saldaña, J. (2014). *Qualitative data analysis: A methods sourcebook*. Thousand Oaks, CA: SAGE Publications.
- Pope, C., Ziebland, S., & Mays, N. (2000). Qualitative research in health care: Analysing qualitative data. *British Medical Journal*, 320(7227), 114–116.
- Schreier, M. (2012). *Qualitative content analysis in practice*. Thousand Oaks, CA: SAGE Publications.
- Stiffman, A.R., Pescosolido, B., & Cabassa, L.J. (2004). Building a model to understand youth service access: The gateway provider model. *Mental Health Services Research*, 6(4), 189–198.
- U.S. Department of Health and Human Services (HHS) Office of the Surgeon General and National Action Alliance for Suicide Prevention. (2012). National strategy for suicide prevention (NSSP): Goals and objectives for action. Retrieved from <http://www.surgeongeneral.gov/library/reports/national-strategy-suicide-prevention/full-report.pdf>
- WISQARS. (2013). *Injury mortality reports, 1999–2010*. Web-based Injury Statistics Query and Reporting System (WISQARS). Retrieved from http://webappa.cdc.gov/sasweb/ncipc/mortrate10_sy.html