Nursing Advocacy For Women Veterans And Suicide

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Introduction

Women are one of the fastest-growing groups within the U.S. veteran population, and nursing advocacy must recognize both their military service and the diversity of their post-service lives. Women veterans are not a single clinical category. They differ by age, race, ethnicity, sexual orientation, gender identity, branch, era, combat exposure, family role, disability, rural or urban location, and connection to the Department of Veterans Affairs. Some experience posttraumatic stress, depression, chronic pain, traumatic brain injury, substance-use problems, intimate-partner violence, military sexual trauma, housing instability, or difficulty moving from military to civilian systems; many do not. Suicide prevention should therefore avoid assuming that every woman veteran is traumatized while also recognizing that women veterans have a higher suicide risk than non-veteran women. The VA's 2025 National Veteran Suicide Prevention Annual Report, released in 2026 with data through 2023, found that the suicide rate among women veterans rose from 13.7 to 13.9 per 100,000 between 2022 and 2023 (U.S. Department of Veterans Affairs, *2025 National Veteran Suicide Prevention Annual Report*). Nursing advocacy is most effective when it identifies military history, asks directly and safely about suicide, connects patients with timely care, addresses lethal means and social conditions, and follows the person after referral rather than treating a screening question as the end of responsibility.

Why Women Veterans May Be Missed

Women veterans are often not recognized as veterans in civilian healthcare because clinicians and staff may unconsciously imagine a veteran as male. A patient may also avoid disclosing service because she did not deploy, does not regard her role as combat, had a negative military experience, or has repeatedly been mistaken for a spouse rather than the service member. Asking every adult patient a neutral question such as "Have you ever served in the military?" can reveal eligibility, exposures, and resources without stereotyping. The answer should lead to relevant follow-up, including service era, current VA connection, occupational or environmental exposures, injuries, transition challenges, and whether the patient wants help navigating benefits. Identification is especially important because VA reported that 61 percent of veterans who died by suicide in 2023 had not received VA healthcare in the final year of life (U.S. Department of Veterans Affairs, *2025 National Veteran Suicide Prevention Annual Report*). Civilian nurses, emergency departments, community clinics, universities, maternal-health services, and workplaces therefore form part of the

prevention system. A warm handoff to a VA contact or community provider is more useful than simply giving a telephone number.

Risk, Protective Factors, and Individual Assessment

Suicide is not caused by one diagnosis or experience. Risk may increase through previous attempts, current suicidal thoughts, depression, PTSD, substance use, chronic pain, sleep disturbance, recent loss, legal or financial problems, homelessness, social isolation, relationship violence, and access to highly lethal methods. For women veterans, military sexual trauma and intimate-partner violence require particular awareness, but they should never be presumed. VA defines military sexual trauma as sexual assault or threatening sexual harassment experienced during military service and offers related care without requiring that the event was officially reported or that the veteran has a disability rating (U.S. Department of Veterans Affairs, “Military Sexual Trauma: Effects and Veteran Resources”). Protective factors can include supportive relationships, meaningful work, stable housing, parenting or caregiving connections, spiritual or cultural community, effective treatment, coping skills, and reasons for living. Nurses should ask directly about suicidal thoughts, intent, planning, past behavior, and access to lethal means. Asking does not create suicidal behavior. A positive screen requires a comprehensive evaluation and collaborative response proportionate to risk, not automatic punishment or loss of control (Conard et al.).

Trauma-Informed and Gender-Responsive Nursing Care

Trauma-informed care emphasizes safety, choice, collaboration, trust, and empowerment. A nurse explains why sensitive questions are being asked, requests permission where possible, protects privacy, and avoids unnecessary repetition of traumatic details. The patient should be offered options about clinician gender, support people, examination sequence, and communication when feasible. Care must also address reproductive and general health rather than treating mental health as separate from the body. Pregnancy, infertility, menopause, sexual health, chronic pain, medication effects, sleep, and caregiving can interact with distress and treatment. Gender-responsive care does not mean reinforcing stereotypes about women as emotional or vulnerable. It means recognizing service experiences and barriers that may differ while providing the same seriousness, dignity, and evidence-based assessment given to every veteran. Nurses should also be prepared to care for transgender and gender-diverse veterans and to respond to racism, harassment, or prior institutional betrayal that affects trust (U.S. Department of Veterans Affairs, “Suicide Prevention—Women Veterans Health Care”; Conard et al.).

Suicide Screening, Safety Planning, and Lethal Means

VA reported record screening performance in March 2026: 88 percent of veterans who received VA care in the previous year completed annual suicide-risk screening, and 96 percent of those identified at risk completed a comprehensive follow-up evaluation and support plan within twenty-four hours (U.S. Department of Veterans Affairs, *2025 National Veteran Suicide Prevention Annual Report*). These system measures demonstrate the value of structured processes, but quality depends on the conversation and follow-through. Safety planning is a collaborative, written process identifying warning signs, internal coping strategies, people and places that provide distraction, supportive contacts, professional resources, and steps to make the environment safer. Lethal-means safety is essential because suicidal crises can be brief and the likelihood of death varies greatly by method. Nurses can discuss temporary off-site firearm storage, locked storage, separating ammunition, medication limits, or involving a trusted person without framing the patient as dangerous. The approach should be respectful, practical, and tailored to the household. When imminent risk is present, emergency action is necessary; when risk is not immediate, overly coercive responses can discourage future disclosure. Documentation and communication across transitions are critical (Conard et al.).

Advocacy beyond the Clinic

Clinical treatment cannot compensate for every social condition associated with suicide risk. Nursing advocacy includes connection to housing, employment, disability benefits, childcare, transportation, legal assistance, pain care, substance-use treatment, peer support, and protection from violence. Transition from military service can disrupt identity, routine, income, healthcare, and community. Women may also face the assumption that their service was less significant, which can make veteran organizations or clinics feel unwelcoming. Nurses can advocate for visible inclusion, women's-health contacts, private and accessible facilities, flexible appointments, telehealth where appropriate, and integration between VA and civilian records. Outreach should include rural areas, colleges, shelters, reproductive-health settings, and community organizations. Policy advocacy is also necessary when insurance gaps, staff shortages, fragmented referrals, or lack of culturally competent care prevent access. Success should be measured through connection and continuity, not the number of pamphlets distributed (Conard et al.).

Comparing Advocacy in Different Resource

Settings

The original essay compares women-veteran advocacy with mental-health advocacy in Sierra Leone. The contexts are different, but several principles transfer. Advocacy succeeds when the problem is framed in language that communities understand, affected people participate in leadership, stakeholders coordinate, and resources support more than awareness. Barriers such as stigma, limited funding, workforce shortages, and low government priority can occur in wealthy and low-income settings, although their scale and institutional forms differ (Hann et al.). A student campaign about mental health can be useful, but it should not replace the title's focus on women veterans or imply that workshops allow people to "cater to issues on their own." Education should teach recognition and help-seeking while creating real referral capacity. Confidentiality has limits when imminent safety is at risk, so campaigns must explain what remains private and what requires emergency action. Policymakers should fund evidence-based services, crisis response, peer programs, and evaluation rather than relying on inspirational messaging.

Ethical Communication and Crisis Resources

Suicide should be discussed with accuracy, hope, and care. Reports should avoid sensational detail, single-cause explanations, or language suggesting inevitability. Nurses should never promise complete secrecy before assessing risk, but they can explain how information will be used and involve the patient in decisions. Family or friends can be powerful supports when the veteran agrees or when emergency law permits necessary disclosure. Follow-up after emergency care, hospitalization, or a missed appointment can reduce dangerous gaps. In the United States, veterans in crisis and people concerned about them can call 988 and press 1, text 838255, or use the confidential Veterans Crisis Line chat. Enrollment in VA healthcare is not required to contact the line. Emergency departments and 911 remain appropriate for immediate danger. Publishing these resources is valuable, but advocacy must also build relationships so that reaching out feels possible before a crisis becomes overwhelming (U.S. Department of Veterans Affairs, "Suicide Prevention—Women Veterans Health Care").

Nurses need support as well. Repeated exposure to trauma and suicide risk can produce moral distress, fear, or defensive practice. Training, supervision, manageable workloads, postvention after a death, and clear consultation pathways help clinicians remain compassionate and accurate. Organizations should review adverse events without blaming one worker for system failures and should learn from veterans and families. Evaluation can examine screening completion, time to assessment, successful referrals, follow-up contacts, treatment engagement, housing stability, patient experience, and inequities across groups. The purpose is continuous improvement rather than proving that one campaign has solved suicide.

Conclusion

Nursing advocacy for women veterans requires recognition, direct assessment, trauma-informed relationships, and action across clinical and social systems. Women veterans face higher suicide risk than non-veteran women, yet risk differs greatly among individuals and should never be inferred from gender or service alone. Nurses in VA and civilian settings should ask about military service, assess suicidal thoughts directly, respond to military sexual trauma and other violence without assumptions, create collaborative safety plans, discuss lethal-means safety, and ensure warm referrals and follow-up. Advocacy also includes housing, employment, pain treatment, reproductive and general healthcare, peer connection, and policies that make services accessible. The latest VA data show both progress and continuing urgency: veteran suicides declined overall in 2023, while the rate among women veterans increased slightly and most veterans who died had not recently used VA care (U.S. Department of Veterans Affairs, *2025 National Veteran Suicide Prevention Annual Report*). Prevention therefore belongs to every healthcare setting. The central message is not that women veterans are permanently damaged; it is that respectful identification, timely evidence-based care, and sustained connection can protect life and support recovery.

References

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