The Rehabilitation Professional, 31(3), pp. 7–16

Suicide Risk and Prevention Among U.S. Military Veterans: A Topical Review

William A. Ramsey[1] and Patricia D. Russell[2]

[1]South Texas Veterans Health Care System,
[2]Rocky Mountain VA Mental Illness Research, Education, and Clinical Center

Veterans are a group at increased risk for death by suicide. Veteran suicide is a complex multidetermined behavior, and preventing suicide among Veterans requires community collaboration and partnership to grow awareness, reduce stigma, and increase access to suicide prevention resources. This article discusses current theories of suicide including Joiner's (2005) Interpersonal Theory of Suicide and Klonsky & May's (2015) Three-Step Theory of Suicide as these theories relate to Veterans at risk for suicide. Discussion of the impacts of combat stress, traumatic brain injuries (TBI), military sexual trauma, and adverse childhood experiences (ACEs) are highlighted. Details of current clinical approaches that have been incorporated by the Veterans Health Administration (VHA) to reduce Veteran suicides are shared, including the Suicide Risk Identification Strategy (RISK ID), Cognitive Behavioral Therapy for Suicide Prevention (CBT-SP), engagement with Suicide Prevention Coordinators, Recovery Engagement and Coordination for Health–Veterans Enhanced Treatment (REACH VET), and the Veterans Crisis Line (VCL). Recommendations for Veteran suicide prevention strategies using a multipronged public health approach that combines both clinically-based and community-focused strategies are provided.

Keywords: Veterans, suicide risk, suicide prevention, combat stress, trauma

Suicide Risk and Prevention Among U.S. Military Veterans: A Topical Review

Suicide is the second leading cause of death among U.S. military Veterans under the age of 45 (U.S. Department of Veterans Affairs [VA], 2022). In 2020, an average of 16.8 Veterans completed suicides per day with 6,146 Veteran suicides reported that year. Notably, the majority (60.3%) of Veterans who died by suicide did not have an encounter with the Veterans Health Administration (VHA) in the past year. Among VHA users who completed suicide in the past year, 58% were diagnosed with a mental health or substance use disorder. Firearm use was the most lethal method of suicide, involved in 71% of completed suicide among Veterans. In 2018, the VA identified suicide prevention among Veterans as a national priority (VA, 2018). In this review, the authors will aim to provide a framework for understanding suicide, describe Veteran-focused determinants of suicide, and discuss a public health approach to decrease suicide among Veterans.

Why People Die by Suicide

Two leading theories of suicide have been essential in shaping our understanding of suicide's causes, correlates, and key preventative factors—the Interpersonal Theory of Suicide (Joiner, 2005; Van Orden et al., 2010) and the Three Step Theory of Suicide (Klonsky & May, 2015; Klonsky et al., 2021). The Interpersonal Theory of Suicide asserts that suicide occurs in the presence of three central constructs: thwarted belongingness, perceived burdensomeness, and acquired capability for suicide. Thwarted belongingness emphasizes one's fundamental need to belong, which when unmet, drives a desire for suicide. Two dimensions of thwarted belongingness include loneliness and the absence of reciprocally caring relationships (Van Orden et al., 2010, p. 10). Perceived burdensomeness is purported to be driven largely by family conflict, unemployment, and physical illness. Habituation to painful and/or fear-inducing experiences can lead to increased pain tolerance and decreased fear of death, both of which increase one's acquired capability for suicide (p. 15). In summary, the Interpersonal Theory of Suicide involves three conditions that, when present simultaneously, are sufficient, but not necessary, to result in suicide.

The Three-Step Theory of Suicide (Klonsky & May, 2015; Klonsky et al., 2021) exists within the "ideation-to-action" framework, which emphasizes two distinct processes: the development of suicidal ideation and the progression from suicidal ideation to suicide attempt. The Three-Step Theory of Suicide postulates the desire for suicide is initially spurred by a combination of pain and hopelessness, where pain is broadly defined to include psychological pain associated with diverse circumstances (e.g., relationship disruptions, job loss, medical conditions, and social rejection). The second step involves the process whereby pain exceeds or overwhelms one's sense of connectedness to friends, family, occupation, and sense of purpose, intensifying one's feelings of hopelessness and desire to die. The third step relates to the process whereby desire for suicide progresses to suicide attempt. Additionally, Klonsky and colleagues (2015, 2021) emphasize the role of both dispositional capability for suicide (i.e., temperament, personality, and genetics) and practical capability for suicide (i.e., knowledge of and access to lethal means) as they relate to suicide capability. In summary, the Three-Step Theory of Suicide identifies conditions under which suicidal thoughts and actions may occur with particular importance given to pain, hopelessness, connectedness, and capability for suicide.

Public Health Approach to Address Suicide Among Veterans

Carroll and colleagues (2020) advocated for the position of a national public health strategy to address suicide among Veterans that involves a population approach, primary prevention, commitment to science, and multidisciplinary strategies. Since not all Veterans are connected with VHA, the national strategy encourages collaboration within the systems Veterans engage—communities of faith, family systems, institutions of higher education, law enforcement, media and entertainment, Veteran Service Organizations, public-private partnerships, healthcare organizations, as well as federal, state, and local governments (VA, 2018). This public health approach to suicide among Veterans combines both clinically-based and community-focused interventions. Specific initiatives congruent with this approach will be described further below. The interested reader is encouraged to consult the *National Strategy for Preventing Veteran Suicide 2018–2028* (VA, 2018) for further information.

Determinants of Suicide Among Veterans

Suicide is a multidetermined behavior that requires an understanding of the complex interaction of factors that increase risk, such as, economic loss, housing instability, food insecurity, substance use, relationship issues, health issues, and others. Transition out of the military is a particularly vulnerable time for suicide among Veterans (Ravindran et al., 2020). In 2019, the suicide rate among Veterans who separated from the military in the preceding 12 months was 47.8 per 100,000 with the highest rates observed among those who served in the U.S. Army and Marine Corps (VA, 2019). Furthermore, Veterans who are male, younger, and served a shorter time are at increased risk for suicide (Ravindran et al., 2020).

Combat stress involves exposure to combat and may include potentially life-threatening scenarios, such as combat patrol, being surrounded by the enemy, being under enemy fire, nearly being killed or wounded in combat, or witnessing others' wounding or death. Interestingly, results from a recent study that included a nationally representative sample of Veterans revealed small positive associations between overall combat exposure and suicide-related outcomes (Nichter et al., 2020), which was consistent with previous meta-analytic findings (Bryan et al., 2015). Notably, Nichter and colleagues identified combat experiences that involved direct exposure to death, killing, or grave injury demonstrated particularly strong associations with suicide-related outcomes. That is, even after adjusting for sociodemographic characteristics and lifetime trauma exposure, exposure to the death or wounding of fellow service members was associated with the greatest odds for both suicidal ideation and suicide attempts among Veterans.

Traumatic brain injury (TBI) has been described as a signature injury for Veterans returning from Iraq and Afghanistan with recent estimates from the U.S. Department of Defense (2023) totaling more than 463,000 TBIs since 2000. These TBIs are categorized as mild (82%), followed by moderate (11%), and severe (1%). Hostetter and colleagues (2019) assessed for the association between TBI and suicide risk among a large sample of Veterans and found that after controlling for psychiatric conditions, chronic conditions, age, and gender—Veterans diagnosed with a TBI were 2.19 times as likely to die by suicide compared with Veterans without a TBI. More specifically, results revealed a 1.62 times greater likelihood of death by suicide for mild TBIs as compared with no TBI, and a 2.45 times greater likelihood of death by suicide for moderate and severe TBIs as compared with no TBI.

Adverse childhood experiences (ACEs) can include a range of experiences—such as, physical abuse, sexual abuse, emotional neglect, or domestic violence—which are associated with both physical and behavioral health problems across the lifespan. Blosnich and colleagues (2021) assessed a large, nationally representative sample of civilians and Veterans, which revealed male Veterans reported a greater average frequency of ACEs than nonveteran males, 2.7 vs. 2.3, respectively. This pattern was similar among female Veterans and nonfemale Veterans, 3.1 vs. 2.4, respectively. Furthermore, 11.1% of Veteran men indicated exposure to 6 or more ACEs, which was found to increase the likelihood of a suicide attempt at age 18 or older by 420%. Interestingly, although 14.9% of female Veterans reported exposure to 6 or more ACEs, the strongest correlate among female Veterans was suicidal ideation or attempt prior to the age of 18, which increased the likelihood of a suicide attempt at age 18 or older by 537%. Overall, research suggests that Veterans are more likely to report exposure to ACEs as compared with their civilian counterparts, which confers increased risk for suicide.

Holiday and colleagues (2022) examined interaction effects between childhood sexual abuse and military sexual trauma as they pertain to suicide risk. It was observed that when perpetrated in the context of previously supportive and trusting relationships, these forms of abuse and trauma were particularly pernicious. Such betrayal limited the capacity to trust and was associated with increased symptom severity, risk of suicidal ideation, suicide attempts, and suicide completion (Holiday et al., 2022).

According to meta-analytic findings, access to lethal means increases likelihood of death by suicide by 388% among Veterans (Schafer et al., 2022); however, lethality among methods is highly variable. Cai and colleagues (2022) conducted a systemic review of lethal methods and found an estimated 89.7% lethality rate in cases involving firearms, making this the most lethal method. Hanging/suffocation (84.6%), drowning (80.4%), gas poisoning (56.6%), and jumping (46.7%) were associated with high rates of lethality, whereas drug/liquid poisoning (8.0%) and cutting (4%) demonstrated comparatively low rates of lethality. The strongest risk factors associated with death by suicide among Veterans, following access to lethal means, included mania/bipolar/psychosis (OR = 3.63), substance/alcohol use disorders (OR = 3.63), and prior self-injurious thoughts and behaviors (OR = 7.48). Similar risk factors were associated with suicide attempts among Veterans with additional financial and legal problems (OR = 6.90) as well as interpersonal difficulties (OR = 3.65). Furthermore, meta-analytic findings suggest age functions as a moderating risk factor among Veterans (Schafer et al., 2022). More specifically, Schafer and colleagues found that depressive symptoms, alcohol use disorder, and

substance use disorders were particularly strong predictors of suicide-related outcomes among younger Veterans; however, these correlations were attenuated as Veterans advanced in age.

Nichter and colleagues (2022) recently reported upon the completion of a seven-year longitudinal investigation that assessed a national sample of Veterans, finding the strongest risk factors for attempted suicide included higher levels of loneliness, lower levels of adaptive psychosocial traits (e.g., dispositional gratitude), thoughts of self-harm, and exposure to trauma post-baseline. Furthermore, the researchers found an additive effect among Veterans with co-occurring risk factors, such that the identification of 0 (2.0%), 1 (5.3%), 2 (13.5%), 3 (30.4%), or 4 (55.0%) of these factors was associated with their respective predicted probabilities of suicide attempt. Elbogen and colleagues (2020) reported upon data from a national longitudinal investigation that described the protective role of psychosocial factors, such as, employment, money for basic needs, self-care, housing stability, social support, spirituality, resilience, and self-determination. These findings are congruent with recent cross-sectional findings that describe factors associated with remission of self-injurious thoughts and behaviors in Veterans with a history of suicide attempts (Herzog et al., 2022). That is, Herzog and colleagues identified purpose in life, dispositional gratitude, and conscientiousness as particularly important protective factors, accounting for over 40% of the variance in suicide-related outcomes.

The rate of suicide among rural Veterans is a notable concern, exacerbated by the COVID-19 pandemic, the role of stigma (Kline et al., 2022; Monteith et al., 2020a), and limited access to healthcare resources in rural areas (Gujral et al., 2022). Gujral and colleagues (2022) found that the VA's video-enabled tablets distributed during COVID-19 were associated with approximately 158 fewer emergency department visits, 24 fewer suicide-related emergency department visits, and 168 fewer suicide behavior reports within a 10-month period. Using 2019-2020 data from the National Health and Resilience in Veterans Study (n = 4,069), Kline and associates (2022) found that history of attempted suicide was associated with greater likelihood of behavioral health engagement. Notably, though embarrassment related to treatment-seeking was associated with highly reduced odds of behavioral health service utilization, stigma appeared to account for relatively little variance associated with behavioral health use. Monteith and colleagues (2020a) conducted a qualitative investigation into stigma as a barrier to the implementation of a community-based suicide prevention program for rural Veterans and identified a lack of community awareness regarding Veteran suicide and lack of knowledge concerning relevant resources. Emergent themes included lack of discussion of suicide, rarely reading or hearing of Veteran suicide via local media outlets, concerns for privacy, as well as fear and avoidance of suicide-related discussion. These rural study participants tended to view suicide as more stigmatized as compared with other behavioral health conditions such as depression.

Suicide Prevention

Clinically-Based Strategies

The clinically-based strategies described below are consistent with recommendations provided within the *National Strategy for Preventing Veteran Suicide 2018-2028* (VA, 2018) and encompass a range of strategies such as same day access to mental health and primary care services as well as universal screening for Veterans. The VHA Office of Mental Health and Suicide Prevention established an interdisciplinary group of experts to develop an evidence-based approach to identify suicide risk among VHA patients across inpatient and outpatient settings, which led to the development of Suicide Risk Identification Strategy (RISK ID)—a three-stage screening and evaluation process (VA, 2018.) RISK ID involves a primary screen using item nine of the Patient Health Questionnaire 9 (Kroenke et al., 2002), followed by a secondary screen using the Columbia Suicide Severity Rating Scale (Katz et al., 2020), and as indicated, a comprehensive suicide risk evaluation (Lakso, 2019).

An assessment of over 5,000,000 patient encounters across settings within the VHA revealed Veterans were more likely to report suicidal ideation when assessed within emergency department and urgent care centers as compared with Veterans assessed within ambulatory care settings (Bahraini et

al., 2020). Furthermore, Veterans assessed within emergency department and urgent care centers were more likely to report suicidal ideation with plan and intent. The increased acuity of suicide risk among Veterans in acute care settings underscores the importance of safety planning in the emergency department, which has been associated with 45% fewer suicidal behaviors and has been found to double the odds of having a Veteran attend at least one outpatient behavioral health appointment post hospital discharge (Stanley et al., 2018).

Safety planning is a brief intervention that takes an estimated 20 to 45 minutes to complete (Stanley & Brown, 2012). It involves the identification of individualized specific signs that precipitate a suicidal crisis as well as identification of internal coping strategies, social strategies for distraction and support, social contacts followed by professional and agency contacts that can aid in resolving suicidal crises. A key component of safety planning involves means restriction (e.g., safe storage of firearms, medications, and related) that employs a collaborative, problem-solving approach to safeguard against potential roadblocks to using these strategies.

Cognitive Behavioral Therapy for Suicide Prevention (CBT-SP) is an evidence-based treatment that is typically delivered over the course of 10–12 outpatient sessions (Bryan, 2019). It targets the patient's capability for emotion regulation, cognitive flexibility, and relapse prevention. CBT-SP has been supported across two separate randomized clinical trials, demonstrating superior outcomes as compared to treatment as usual (Bryan, 2019; D'Anci et al., 2019). That is, patients who received CBT-SP were 50–60% less likely to attempt suicide over a two-year period posttreatment when compared to individuals that received treatment as usual.

Fulfilling a key role as part of VA's public health model, Suicide Prevention Coordinators serve as subject matter experts for suicide-related prevention, intervention, postvention, education, training, outreach, and awareness (VA, 2018). Suicide Prevention Coordinators advocate for enhanced treatment among Veterans identified to be at high risk for suicide and accurately document suicidal behaviors using a variety of tracking and reporting tools. Suicide Prevention Coordinators are responsible for identifying, case managing, and supporting Veterans at risk for suicide within VHA and coordinating strategies to increase the awareness and adoption of best practices for suicide prevention within the broader community.

The Veterans Crisis Line (VCL) is available 24/7/365 via phone (Dial 988 and Press 1), text (838255), or chat (VeteransCrisisLine.net/Chat). Since its inception in 2007, the VCL has engaged Veterans in over 6.4 million calls, 269,000 texts, and 772,000 chats with more than 248,000 dispatches of emergency services and more than 1.2 million referrals to VA Suicide Prevention Coordinators (VA, 2023). Britton and colleagues (2022) assessed the effectiveness of the VCL in reducing distress, suicidal ideation, and suicidal urgency in a subset of VCL calls (n = 563). The researchers found support for the reduction of distress (OR = 5.03), suicidal ideation (OR = 4.92), and suicidal urgency (11.01) as assessed at the beginning of the call compared to the end of the call; however, these results should be interpreted with caution given the limited sample size. Moreover, Hannemann and colleagues (2020) found that the risk of suicide among 158,927 VHA patients was elevated 1-month, 3-months, 6-months, and 12-months following contact with the VCL. The suicide rate in this cohort was 797/100,000 in the first month and 298/100,000 through 12 months following a VCL call, which is contrasted with the suicide rate among VHA users in 2020 at 31.7/100,000 (VA, 2022a).

Recovery Engagement and Coordination for Health–Veterans Enhanced Treatment (REACH VET) utilizes a suicide mortality risk prediction algorithm capable of identifying Veterans at the top 0.1% of risk for death by suicide (McCarthy et al., 2021). The algorithm was developed by the VA and National Institute of Mental Health scientists and was nationally implemented across the VHA in 2017. Veterans identified for REACH VET demonstrate a 30-fold increase in suicide risk as compared to the overall VHA Veteran population. McCarthy and colleagues assessed the impact of REACH VET as it relates to improved treatment engagement and quality of care as well as reduced acute care needs and suicide-related behaviors in a sample of 173,313 Veterans. REACH VET identification was associated with increased completed outpatient appointments; fewer missed appointments and psychiatric hospitalizations; greater initiation of suicide safety plans; and fewer suicide attempts within 6

months. Although there was no evidence of a reduction in death by suicide associated with REACH VET, the authors noted that power analyses suggest a sample of more than 430,000 would be required to detect a 10% reduction in 6-month suicide mortality.

Community-Focused Strategies

Since passage of the Mission Act, an increasing number of Veterans receive part or all of their physical and behavioral health care in non-VA healthcare and community organizations (Library of Congress, 2018). As of January 17, 2023, the Compact Act further expanded access to suicide related healthcare across VA and non-VA healthcare for eligible Veterans including inpatient or crisis residential care for up to 30 days and outpatient care for up to 90 days at no cost. Veterans do not need to be enrolled in the VHA to use this benefit (VA, 2023). The expansion of healthcare outside of VA settings, coupled with the 60% of Veterans who die by suicide not having had a recent VHA visit for care, underscores the importance of a public health approach to Veteran suicide prevention that reaches Veterans within their communities (VA, 2022a; VA, 2022b).

The community-based initiatives described below are consistent with recommendations provided within the *National Strategy for Preventing Veteran Suicide 2018-2028* (VA, 2018). VHA implemented a media initiative in 2021 that involved a series of public service announcements to educate the public regarding lethal means safety and suicide prevention (https://www.va.gov/reach/lethal-means/). The campaign described tips for secure storage of medications, firearms, and methods of accessing support for Veterans and their families. The Governor's Challenge (Carroll et al., 2020) was established in 2019 to provide communities with technical support including site visits, state-level policy making, and virtual consultation meetings to increase an organization's evidence-based outreach strategies in serving Veterans at risk for suicide. Staff Sergeant Parker Fox Suicide Prevention Grant Programs was established with the aim of reducing suicide among Veterans and their family members by offering grants up to $750,000 to community organizations (VA, 2022c). Together With Veterans (Monteith et al., 2020b) targeted rural Veterans via coalition building with community organizations to increase access to lethal means safety, suicide prevention gatekeeper training, crises services, peer support, and training primary care physicians to identify Veterans at-risk for suicide. This work is supported by Community Engagement and Partnership Coordinators who intervene by facilitating the building of local coalitions to implement Veteran-specific suicide prevention strategies and community partnerships.

DeBeer and colleagues (2020) piloted the Patient Safety Center of Inquiry—Suicide Prevention Collaborative, a learning cooperative which aids Veteran-serving community organizations in implementing Veteran specific suicide prevention strategies. The program focused on three primary aims: (1) create an organizational structure between the VHA and local, academic, public, nonprofit, and private entities to improve Veterans' access to quality care in a timely manner, (2) establish a learning collaborative among community organizations to share and facilitate the implementation of the evidence-based and best practice suicide prevention strategies utilized in VHA, and (3) pilot a Veteran suicide prevention intensive case management intervention for mental health needs to Veterans at-risk for suicide regardless of VHA eligibility. The Patient Safety Center of Inquiry-Suicide Prevention Collaborative aims to develop practical solutions to decrease the rising suicide rate among veterans receiving care outside of VHA.

Conclusion

Veterans are a group at increased risk for death by suicide. Our understanding of suicide's causes, correlates, and key preventative factors has been substantially increased across the past two decades. Veteran specific risk factors, such as, exposure to combat, military sexual trauma, TBI, and others were reviewed. Although Veteran suicide is a complex multidetermined behavior, it can be prevented using a multipronged public health approach that combines both clinically-based and community-focused strategies. Clinically-based strategies being implemented to decrease death by suicide include initiatives ranging from universal screening protocols to machine learning based algorithms to iden-

tity Veterans at high risk for suicide. Suicide prevention is everyone's business. Preventing suicide among Veterans requires community collaboration and partnership to grow awareness, reduce stigma, and increase access to suicide prevention resources.

References

Bahraini, N., Brenner, L. A., Barry, C., Hostetter, T., Keusch, J., Post, E. P., Kessler, C., Smith, C., & Matarazzo, B. B. (2020). Assessment of rates of suicide risk screening and prevalence of positive screening results among us veterans after implementation of the veterans affairs suicide risk identification strategy. *JAMA Network Open, 3*(10), e2022531-e2022531. https://doi.org/10.1001/jamanetworkopen.2020.22531

Blosnich, J. R., Garfin, D. R., Maguen, S., Vogt, D., Dichter, M. E., Hoffmire, C. A., Bernhard P. A., & Schneiderman, A. (2021). Differences in childhood adversity, suicidal ideation, and suicide attempt among veterans and nonveterans. *American Psychologist, 76*(2), 284. https://doi.org/10.1037/amp0000755

Britton, P. C., Karras, E., Stecker, T., Klein, J., Crasta, D., Brenner, L. A., & Pigeon, W. R. (2022). Veterans Crisis Line c outcomes: Distress, suicidal ideation, and suicidal urgency. *American Journal of Preventive Medicine, 62*(5), 745-751. https://doi.org/10.1016/j.amepre.2021.11.013

Bryan, C. J. (2019). Cognitive behavioral therapy for suicide prevention (CBT-SP): Implications for meeting standard of care expectations with suicidal patients. *Behavioral Sciences & the Law, 37*(3), 247-258.

Bryan, C. J., Griffith, J. E., Pace, B. T., Hinkson, K., Bryan, A. O., Clemans, T. A., & Imel, Z. E. (2015). Combat exposure and risk for suicidal thoughts and behaviors among military personnel and veterans: A systematic review and meta-analysis. *Suicide and Life-Threatening Behavior, 45*(5), 633-649.

Cai, Z., Junus, A., Chang, Q., & Yip, P. S. F. (2022). The lethality of suicide methods: A systematic review and meta-analysis. *Journal of Affective Disorders, 300*, 121-129. https://doi.org/10.1016/j.jad.2021.12.054

Carroll, D., Kearney, L. K., & Miller, M. A. (2020). Addressing suicide in the Veteran population: Engaging a public health approach. *Frontiers in Psychiatry, 11, 1-5.* https://doi.org/10.3389/fpsyt.2020.569069

D'Anci, K. E., Uhl, S., Giradi, G., & Martin, C. (2019). Treatments for the prevention and management of suicide: A systematic review. *Annals of Internal Medicine, 171*(5), 334-342.

DeBeer, B., Baack, S., Bongiovanni, K., Borah, E., Bryan, C., Bryant, K., Cassidy, R., Clafferty, S., Franciosi, G., Heise, J., & Hoffmire, C. (2020). The Veterans Affairs Patient Safety Center of Inquiry—Suicide Prevention Collaborative: Creating novel approaches to suicide prevention among Veterans receiving community services. *Federal Practitioner, 37*(11), 512-521.

U.S. Department of Defense, Veterans Brain Injury Center. (2023). 2000-2022 Q3 DOD Worldwide Numbers for TBI. https://health.mil/Military-Health-Topics/Centers-of-Excellence/Traumatic-Brain-Injury-Center-of-Excellence/DOD-TBI-Worldwide-Numbers

Elbogen, E. B., Molloy, K., Wagner, H. R., Kimbrel, N. A., Beckham, J. C., Van Male, L., Leinbach J., & Bradford, D. W. (2020). Psychosocial protective factors and suicidal ideation: Results from a national longitudinal study of veterans. *Journal of Affective Disorders, 260*, 703-709. https://doi.org/10.1016/j.jad.2019.09.062

Gujral, K., Van Campen, J., Jacobs, J., Kimerling, R., Blonigen, D., & Zulman, D. M. (2022). Mental health service use, suicide behavior, and emergency department visits among rural US Veterans who received video-enabled tablets during the COVID-19 Pandemic. *JAMA Network Open, 5*(4), e226250-e226250. https://doi.org/10.1001/jamanetworkopen.2022.6250

Hannemann, C. M., Katz, I. R., McCarthy, M. E., Hughes, G. J., McKeon, R., & McCarthy, J. F. (2021). Suicide mortality and related behavior following calls to the Veterans Crisis Line by Veterans Health Administration patients. *Suicide and Life-Threatening Behavior, 51*(3), 596-605.

Herzog, S., Nichter, B., Hill, M. L., Norman, S. B., & Pietrzak, R. H. (2022). Factors associated with remission of suicidal thoughts and behaviors in U.S. military veterans with a history of suicide attempt. *Journal of Psychiatric Research, 149*, 62-67. https://doi.org/10.1016/j.jpsychires.2022.02.021

Holliday, R., Nichter, B., Holder, N., Hill, M. L., Monteith, L. L., Norman, S. B., & Pietrzak, R. H. (2022). Childhood sexual abuse and military sexual trauma interact to increase suicide risk: Results from a nationally representative veteran sample. *Journal of Interpersonal Violence,* 08862605221120909.

Hostetter, T. A., Hoffmire, C. A., Forster, J. E., Adams, R. S., Stearns-Yoder, K. A., & Brenner, L. A. (2019). Suicide and traumatic brain injury among individuals seeking veterans health administration services between fiscal years 2006 and 2015. *The Journal of Head Trauma Rehabilitation, 34*(5) E1-E9. https://doi.org/10.1097/HTR.0000000000000489

Joiner, T. E. (2005). *Why people die by suicide*. Harvard University Press.

Katz, I., Barry, C. N., Cooper, S. A., Kasprow, W. J., & Hoff, R. A. (2020). Use of the Columbia-suicide severity rating scale (C-SSRS) in a large sample of Veterans receiving mental health services in the Veterans Health Administration. *Suicide and Life-Threatening Behavior, 50*(1), 111-121. https://doi.org/10.1111/sltb.12584

Kline, A. C., Panza, K. E., Nichter, B., Tsai, J., Harpaz-Rotem, I., Norman, S. B., & Pietrzak, R. H. (2022). Mental health care use among US military veterans: Results from the 2019–2020 national health and resilience in veterans study. *Psychiatric Services, 73*(6), 628-635.

Klonsky, E. D., & May, A. M. (2015). The three-step theory (3ST): A new theory of suicide rooted in the "ideation-to-action" framework. *International Journal of Cognitive Therapy, 8*(2), 114-129.

Klonsky, E. D., Pachkowski, M. C., Shahnaz, A., & May, A. M. (2021). The three-step theory of suicide: Description, evidence, and some useful points of clarification. *Preventive Medicine, 152*, 106549. https://doi.org/10.1016/j.ypmed.2021.106549

Lakso, W. (2019). *VA sets standards in suicide risk assessment, offers support to community providers.* https://blogs.va.gov/VAntage/55281/va-sets-standards-in-suicide-risk-assessment-offers-support-to-community-providers

McCarthy, J. F., Cooper, S. A., Dent, K. R., Eagan, A. E., Matarazzo, B. B., Hannemann, C. M., Reger, M.A., Landes, S.J., Trafton, J. A., Schoenbaum, M., & Katz, I. R. (2021). Evaluation of the recovery engagement and coordination for health–veterans enhanced treatment suicide risk modeling clinical program in the veterans health administration. *JAMA Network Open, 4*(10), e2129900-e2129900. https://doi.org/10.1001/jamanetworkopen.2021.29900

Monteith, L. L., Smith, N. B., Holliday, R., Holliman, B. A. D., LoFaro, C. T., & Mohatt, N. V. (2020a). "We're afraid to say suicide": Stigma as a barrier to implementing a community-based suicide prevention program for rural veterans. *The Journal of Nervous and Mental disease, 208*(5), 371-376. https://doi.org/10.1097/NMD.0000000000001139

Monteith, L. L., Wendleton, L., Bahraini, N. H., Matarazzo, B. B., Brimner, G., & Mohatt, N. V. (2020b). Together with veterans: VA national strategy alignment and lessons learned from community-based suicide prevention for rural veterans. *Suicide and Life-Threatening Behavior, 50*(3), 588-600. https://doi.org/10.1111/sltb.12613

Nichter, B., Hill, M., Norman, S., Haller, M., & Pietrzak, R. H. (2020a). Impact of specific combat experiences on suicidal ideation and suicide attempt in U.S. military veterans: Results from the national health and resilience in veterans study. *Journal of Psychiatric Research, 130,* 231-239. https://doi.org/10.1016/j.jpsychires.2020.07.041

Nichter, B., Hill, M., Norman, S., Haller, M., & Pietrzak, R. H. (2020b). Mental health treatment utilization among U.S. military veterans with suicidal ideation: Results from the national health and resilience in veterans study. *Journal of Psychiatric Research, 130*, 61-67. https://doi.org/10.1016/j.jpsychires.2020.07.004

Nichter, B., Stein, M. B., Norman, S. B., Hill, M. L., Straus, E., Haller, M., & Pietrzak, R. H. (2021). Prevalence, correlates, and treatment of suicidal behavior in US military veterans: Results from the 2019–2020 national health and resilience in veterans study. *The Journal of Clinical Psychiatry, 82*(5), 35870.

Ravindran, C., Morley, S. W., Stephens, B. M., Stanley, I. H., & Reger, M. A. (2020). Association of Suicide risk with transition to civilian life among US military service members. *JAMA Network Open, 3*(9), e2016261. https://doi.org/10.1001/jamanetworkopen.2020.16261

Schafer, K. M., Duffy, M., Kennedy, G., Stentz, L., Leon, J., Herrerias, G., Fulcher, S., & Joiner, T. E. (2022). Suicidal ideation, suicide attempts, and suicide death among Veterans and service members: A comprehensive meta-analysis of risk factors. *Military Psychology, 34*(2), 129-146. https://doi.org/10.1080/08995605.2021.1976544

Stanley, B., & Brown, G. K. (2012). Safety Planning Intervention: A Brief intervention to mitigate suicide risk. *Cognitive and Behavioral Practice, 19*(2), 256-264. https://doi.org/10.1016/j.cbpra.2011.01.001

Stanley, B., Brown, G. K., Brenner, L. A., Galfalvy, H. C., Currier, G. W., Knox, K. L., Chaudhury, S. R., Bush, A. L., & Green, K. L. (2018). Comparison of the safety planning intervention with follow-up vs usual care of suicidal patients treated in the emergency department. *JAMA Psychiatry, 75(*9), 894-900. https://doi.org/10.1001/jamapsychiatry.2018.1776

U.S. Department of Veterans Affairs. (2023). *Veterans crisis line.* https://www.veteranscrisisline.net/about/about-us/

U.S. Department of Veterans Affairs. (2018). *National strategy for preventing veteran suicide 2018-2028.* https://www.mentalhealth.va.gov/suicide_prevention/docs/Office-of-Mental-Health-and-Suicide-Prevention-National-Strategy-for-Preventing-Veterans-Suicide.pdf

U.S. Department of Veterans Affairs. (2019). VA/DoD clinical practice guideline for the assessment and management of patients at risk for suicide. https://www.healthquality.va.gov/guidelines/MH/srb/VADoDSuicideRiskFullCPGFinal5088212019.pdf

U.S. Department of Veterans Affairs. (2022a). *2022 National Veteran Suicide Prevention Annual Report.* https://www.mentalhealth.va.gov/suicide_prevention/data.asp

U.S. Department of Veterans Affairs. (2022b). Suicide Prevention Program Guidebook. https://www.mentalhealth.va.gov/docs/VA-Office-of-Mental-Health-and-Suicide-Prevention-Guidebook-June-2018-FINAL-508.pdf

U.S. Department of Veteran Affairs (2022c). *Staff Sergeant Parker Gordon Fox Suicide Prevention Grants.* https://www.mentalhealth.va.gov/ssgfox-grants/#:~:text=The%20Staff%20Sergeant%20Parker%20Gordon,to%20VA%20and%20community%20resources

U.S. Department of Veterans Affairs (2023). *Starting Jan. 17, Veterans in suicidal crisis can go to any VA or non-VA health care facility for free emergency health care.* Office of Public and Intergovernmental Affairs. https://www.va.gov/opa/pressrel/pressrelease.cfm?id=5852

Van Orden, K. A., Witte, T. K., Cukrowicz, K. C., Braithwaite, S. R., Selby, E. A., & Joiner Jr, T. E. (2010). The interpersonal theory of suicide. *Psychological Review, 117*(2), 575-600. https://doi.org/10.1037/a0018697

Author Notes

The authors have no known conflict of interest to disclose.

William A. Ramsey, PhD received his Doctor of Philosophy in Counseling Psychology from the University of Memphis, and he received his Master of Science degree in Rehabilitation Counseling from the University of Texas-Pan American. Dr. Ramsey is a trained scientist-practitioner and currently serves as a suicide prevention psychologist for South Texas Veterans Health Care System.

Patricia D. Russell, PhD earned her Doctor of Philosophy in Military Health Psychology from The University of Texas at San Antonio. She earned her Master of Arts in Clinical Psychology from Sam Houston State University. Dr. Russell is a health science specialist, and currently works at the Rocky Mountain Veterans Affairs Medical Center's Mental Illness, Research, Education, and Clinical Center for Suicide Prevention in Denver, Colorado.

Correspondence concerning this article should be addressed to William A. Ramsey, at:
william.ramsey.phd@gmail.com