Veterans Ages 18–34 May Require More Intensive Clinical Assessment to Prevent Suicide

From Science to Practice

Using Research to Promote Safety and Prevent Suicide

Issue

Of the four defined Veteran age cohorts (ages 18–34, 35–54, 55–74, and 75 and over) the 18–34 age cohort went from having the third-highest rate of suicide in 2005 to having the highest rate in 2016.[1] Clinicians can help Veterans by promoting lethal means safety, building resilience, and enhancing protective factors.

Key Findings

Substance Use

- Male and female Veterans in the 18–25 age cohort had the highest substance use rates among all age groups, and Veterans ages 26–34 had higher rates of substance use than those in older cohorts. Substance use rates were elevated among younger Veterans in comparison with rates among civilian counterparts for the categories heavy episodic drinking and daily cigarette use, but not in the categories of illicit drug use and misuse of prescription drugs.[2]
- The prevalence of alcohol dependence was lower among Veteran suicide decedents ages 18–34 than among Veteran suicide decedents ages 35–64. However, evidence of acute alcohol use (blood alcohol content at or above 0.08) was present in roughly one-third of decedents ages 18–34, compared with less than 10 percent of Veterans age 65 or older.[3]

Lethal Means

- The VA Office of Mental Health and Suicide Prevention found that 69.4 percent of Veterans who died by suicide died by firearm injury, 15.0 percent by suffocation, 10.6 percent by poisoning, and 5.1 percent by other means.[1]
- Veterans in the 18–29 age cohort had the lowest prevalence of firearm ownership of any age cohort, with 26.5 percent of respondents to the 2015 National Firearm Survey in that age range identifying themselves as gun owners, and an additional 1.1 percent reporting that they live with a gun owner.[4]

Relationships

- The stressors experienced prior to suicide among Veterans varied by age group. Nearly half of Veterans ages 18–34 had experienced relationship problems immediately before suicide.[3]
- The proportion of women who screened positive for intimate partner violence (IPV) was highest for patients under age 35 (10.5 percent), decreasing to a low of 3.6 percent for patients age 65 and older.[5]

Combat Experience and PTSD

- Combat Veterans ages 18–29 were more likely than older combat Veterans to screen positive for lifetime and current posttraumatic stress disorder (PTSD), suicidal ideation, and migraine headaches.[6]
- Iraq and Afghanistan Veterans with a median age of 28 who had proxies for greater combat exposure (such as having been junior enlisted or having been in the Army) were at greater risk than Veterans without those characteristics of having an alcohol use disorder or substance use disorder diagnosis.[7]

Separation

- Average ages at discharge varied between 33.2 for misconduct discharges and 38.5 for routine discharges. The odds ratio for nearly all diagnostic outcomes was higher for Veterans discharged for disqualification or misconduct than for routinely discharged Veterans.[8]
- In a sample of over 3.9 million Operation Enduring Freedom/Operation Iraqi Freedom service members, the rate of suicide for those who served less than one year prior to separation was double that of those who completed four or more years.[9]

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Implications

Research suggests that substance use,[10,11] access to lethal means,[12] limited time in service,[9] and having received a diagnosis of PTSD[13] are linked with increased risk for suicide. In addition, suicidal ideation rates in the 18–34 age cohort were highest among those with perceived unmet mental health care needs, severe psychological distress, and anxiety diagnoses.[14]

Ways You Can Help

- Implement evidence-based assessments for Veterans ages 18–34, and offer access to treatment options for substance use as necessary.[2]
- Although means safety strategies have been shown to reduce suicide rates,[15] researchers suggested that interventions aiming to promote lethal means safety may be most effective, because only 6 percent of Veterans surveyed believed that access to firearms increased suicide risk.[16]
- Because some women may be reluctant to disclose experiences of IPV in clinical settings, providing information about care related to IPV should be done as a part of routine care.[5]
- The prevalence of PTSD and other mental health concerns in this population suggests that age- and condition-sensitive screening is an important aspect of care,[6] especially in addressing perceptions of unmet mental health care needs.[14]

There is no single cause of suicide. It is often the result of a complex interaction of risk and protective factors at the individual, interpersonal, community, and societal levels. To prevent Veteran suicide, we must maximize protective factors and minimize risk factors at all of these levels.

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