Lessons Learned

SUICIDE RISK ASSESSMENT AND INTERVENTION

in Military and Veteran Populations

Cohen Veterans Network

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Executive Summary

INTRODUCTION & BACKGROUND:

Despite substantial efforts in suicide prevention research and practice, military and veteran communities continue to experience disproportionately high suicide rates. Early screening for suicide risk is critical in these populations, yet it relies heavily on subjective clinical judgments. This report summarizes key findings from a research study conducted within Cohen Veterans Network (CVN) to better understand clinical decision-making in suicide risk assessment and intervention for veterans, active-duty service members, and military family members. The report includes implications for suicide prevention policy, practice, and research.

KEY FINDINGS:

1 Standardized Risk Assessment Measures Complement Clinical Judgment:

Clinicians valued the benefits of standardized risk assessment measures in improving client care, mitigating risk, and facilitating preliminary interventions, in combination with fostering collaborative conversations with clients.

2 Continuous and Collaborative Risk Assessment is Essential:

Clinicians emphasized continuous risk assessment throughout the course of care to facilitate adaptations to treatment plans and responses to crisis situations. Collaboration among care team members is essential to address both social determinants of health and co-morbid medical concerns, as well as to improve overall client well-being and safety.

3 Need for Clinician Transparency to Establish Trust and Therapeutic Alliance:

Working with military and veteran clients requires clinicians to acknowledge stigma related to suicidal thoughts. Transparent discussions about the limits of confidentiality and firearm safety are crucial to establish client buy-in and build rapport.

4 Collaborative Postvention Processes are Critical Supports for Clinicians:

Supervisor support is crucial for clinician confidence and resilience, especially in the wake of adverse events. Collaborative postvention processes, including case reviews, played a vital role in helping participating clinicians process such events.

5 Opportunities to Refine Existing Models:

Variations exist in how clinicians determine appropriate care plans for clients with different levels of risk and interpretations of the model may impact risk stratification decisions.

RECOMMENDATIONS/ IMPLICATIONS:

Implementation of **Measurement-Based Care** (MBC)

MBC, including use of standardized risk assessment measures, may confer an advantage over treatment as usual in terms of suicide risk assessment and management. MBC offers advantages in terms of care quality and risk mitigation that are valued by clinicians who implement these procedures.

Facilitate **Collaboration & Connection** within Care Teams & with Clients

Encourage clinicians to engage with case management services as needed to address social determinants of health. Encourage open communication with military/veteran clients by addressing fears and stigma around sharing suicidal thoughts and behaviors during therapy.

Best Practices for Providing **Telehealth**

Further research is warranted to determine best practices for telehealth with high-risk clients. Ongoing education and training for clinicians can help bridge the research-to-practice gap in providing telehealth care to clients at elevated risk.

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INTRODUCTION & BACKGROUND

Despite sustained efforts in suicide prevention research and practice, military and veteran suicides continue at rates that far exceed those of non-military populations. Early screening for suicide risk in health care systems is a crucial aspect of suicide prevention (Stanley et al., 2019) as stratification of suicide risk is foundational to risk management (Wortzel et al., 2014) and is linked to increased access to care for veterans (Bahraini et al., 2022). However, despite the use of standardized, validated screening measures, stratification of suicide risk levels still relies significantly on subjective clinical judgements (Airey & Iqbal, 2022; Petrik et al., 2015) and varies substantially between clinicians (Regehr et al., 2022). Continued research is vital to understand how clinicians make risk stratification decisions and how risk stratification impacts decisions regarding care and intervention.

This report presents lessons learned from our research study into clinical decision making in suicide risk assessment and intervention in a mild to moderate risk outpatient mental health setting and addresses implications for clinical suicide risk management policy, practice, and research.

Research was conducted within Cohen Veterans Network (CVN), a not-for-profit organization providing mental health care to post-9/11 veterans, active-duty service members, and their families at 24 outpatient clinics across the US. CVN has developed a robust suicide prevention ecosystem and is committed to suicide prevention at all levels. CVN embraces a public health approach to suicide prevention that includes a communications strategy to increase awareness and reduce population risk, evidence-based assessment and treatment, emphasizing gold standard, empirically validated protocols for those at clinically elevated risk, and continuous screening and clinical assessment for all clients receiving care.

For those at clinically elevated risk, CVN Clinics offer personalized, evidence-based mental health care along with access to comprehensive case management support and referrals to address suicide risk and other stresses, including unemployment, finances, housing, and legal issues. The clinics are equipped and trained to respond in the event of a client in crisis, ensuring they are assessed and connected to the appropriate level of care. CVN clinics provide a full range of services and activities from prevention, early intervention, emergency evaluation, to evidence-based treatments all designed to save lives. Mandated elements of CVNs suicide prevention ecosystem include screening all new clients via the Columbia Suicide Severity Rating Scale (C-SSRS) and for those assessed at clinically elevated risk, weekly C-SSRS screening and completion of the Stanley-Brown Safety Plan (Stanley et al., 2008).

PROJECT OVERVIEW

This project examined clinical decision-making during suicide risk assessment, with a specific focus on treating clients who are veterans, active-duty service members, and military family members. Six vignettes were designed to represent varying levels of acute and chronic risk based on the Rocky Mountain MIRECC Suicide Risk Stratification Tables and were validated by internal and external subject matter experts including clinicians and researchers at CVN, the University of Texas Health Science Center at San Antonio, and the Department of Veterans Affairs. Forty-two CVN clinicians completed a survey in which they were asked to stratify acute and chronic risk, select an appropriate disposition, and provide feedback on the factors that influenced their decisions for four randomly assigned vignettes. Seventeen of these clinicians then participated in a 60-minute follow-up interview related to their survey responses and approaches to suicide risk assessment and risk management more broadly. Additionally, interview participants were asked about their personal experiences and challenges completing suicide risk assessment and variations they observed when working with diverse clients or in a variety of care settings.

Descriptive statistics were used to examine the distributions of responses for each vignette and to evaluate the association between assessed risk and disposition. Directed content analysis (Hsieh & Shannon, 2005) of open-text responses provided insight into common factors influencing risk and disposition decisions. Thematic exploration via rapid analysis (Hamilton, 2013) illuminated themes relating to the conceptualization, operationalization, and practice of suicide risk assessment and management among participating clinicians.

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LESSONS LEARNED

The following summarizes key findings and lessons learned from this mixed methods study incorporating both survey and interview data. These findings have potential implications for suicide risk assessment and management in outpatient settings and for suicide prevention policy and research.

IMPLICATIONS FOR **POLICY AND PRACTICE**

1 **Measurement-based care** complements clinical judgement in suicide risk assessment and intervention when implemented appropriately

Measurement-based care (MBC) is widely supported as a method to improve clinical outcomes and is considered a gold-standard in mental health care (Boswell et al., 2023; Linkh et al., 2023), however, implementation remains limited in the behavioral health field (Lewis et al., 2019). Mixed clinician perspectives on MBC may be one barrier to implementation, as clinicians acknowledge the benefits to client care but maintain some apprehension about the impacts of MBC on the therapeutic alliance and additional documentation burdens (Cuperfain et al., 2021; de Beurs et al., 2011).

Measurement-based care is a core tenet of the CVN model and a critical element of our suicide prevention ecosystem. Measurement-based care policies are well defined at the network level and all CVN clinicians receive training in its implementation (Cohen Veterans Network, n.d.). This study revealed widespread clinician support for the use of MBC in suicide risk assessment and intervention among participants due to the perceived benefits in client care, legal risk mitigation for the clinicians, and facilitation during interventions for suicidality. Benefits in these three categories are summarized below.

Improving Client Care

Clinicians reported several ways that MBC improved client care, including its assistance with ensuring comprehensive evaluations, tracking changes through the duration of care, and adapting session goals to a client's current needs. One of the most commonly highlighted benefits by participating clinicians was the importance of using multiple standardized measures as appropriate based on client presentation. The PHQ-9 and C-SSRS were routinely used in suicide risk assessment, with the PCL-5 and GAD-7 implemented for indications of trauma or anxiety. Clinicians reported that many clients would not endorse suicidal ideation or behavior on suicide screeners but would endorse these thoughts and behaviors on other symptom measures. Clinicians credit variations in the phrasing of questions related to suicidality for these differences in endorsement. Some clients may resonate with a particular phrasing or focus of a question, while others waited to endorse suicidal thoughts and behaviors until they had established rapport with their clinician. Clinicians stressed that these measures were most effective when used in conjunction with clinical interviewing and observation and the importance of maintaining a connection with the client while completing standardized measures.

Legal Risk Mitigation

Participating clinicians endorsed standardized measures as important tools for legal risk mitigation. These measures supported clinician organization during clinical interviewing and prevented any missed questions, particularly during crisis situations. Standardized measures also facilitated clinical documentation and communication with other members of the client care team. These benefits of standardized measures were reported to improve clinician confidence in risk and disposition decisions.

LESSONS LEARNED

Measurement-Based Care as Intervention

Interventions for suicidality start with standard measurement tools during the risk assessment process, these may include the C-SSRS, PHQ-9, PCL-5, and GAD-7 depending on patient presentation. Intake assessments addressing suicidality introduce the topic early in care to normalize discussions of suicide and to build rapport and client buy-in. Standardized measures that assess for suicidal thoughts and behaviors are also important conversation starters that can provide insights into the context around these symptoms. These conversations were used to collaboratively explore a client's history and emotional responses to their suicidal thoughts. Clinicians frequently reported using these discussions as opportunities to reinforce a client's strengths and protective factors and to pivot into safety planning for clients at elevated risk. Client-clinician interactions during the review of the standardized measures formed the basis for a variety of individualized therapeutic approaches and interventions that were adaptable throughout the course of care.

RECOMMENDATION

Implementation of measurement-based care may confer an advantage over treatment as usual in terms of suicide risk assessment and management, especially when used in combination with clinical interviewing. MBC may offer advantages in terms of both care quality and legal risk mitigation based on capturing a range of objective, self-reported client responses to support risk stratification and disposition decisions. MBC may also constitute an effective preliminary intervention for suicidality when used as a part of collaborative treatment planning to build rapport and trust and establish safety/risk assessment as a norm early in the therapeutic relationship.

2 Suicide risk assessment and management is **continuous and collaborative**

Risk assessment is a continuous process throughout the course of care as risk is not static (Bryan et al., 2020). Therefore, risk assessment and management should inform the therapeutic process in terms of changes in the treatment plan or goals and recommendations to change session frequency or level of care. Clinicians reported that continuous and collaborative assessment of risk facilitated proactive decision making which reduces disruptions and allows for warm handoffs during emergent referrals due to crisis or decompensation. Clinicians noted the importance and value of completing a Stanley-Brown Safety Plan (Stanley et al., 2008) as well as the additional benefit of reviewing/rehearsing these plans with their clients. Additionally, clinicians emphasized the importance of planning for client safety after the course of treatment, either due to client discharge or referral to continued care.

Additionally, effective and consistent risk management throughout the course of care benefits from a collaborative approach with a wider, multidisciplinary care team each contributing their own expertise and insights (see Table 1). Participating clinicians endorsed this approach for providing comprehensive care for the client as well as support for the treating clinician. A notable opportunity for the enhancement of care teams is

the addition of case management. Some clinicians identified the importance of social determinants of health in relation to the mental health of their clients. These clinicians noted that engagement with case management services was significantly beneficial for these clients. Encouraging clinicians to remain cognizant of and utilize these services as needed has the potential to both reduce client risk and improve quality of life.

Table 1. Contributions to Risk Assessment and Management in a Multidisciplinary Collaborative Care Team

CARE TEAM	ROLE
Clinician	Direct assessments and therapy using clinical judgement and measurement-based care
Client	Collaborate in their own treatment goals and interventions
Family/Friends (with permission)	Provide support outside of sessions, notice warning signs, collaborate in lethal means safety
Supervisor/Peers	Consultation to provide additional perspectives on clinical decisions, risk assessments, and disposition options
Case Management	Assist in locating additional resources, including alternative or higher-level care, biopsychosocial supports, and factors impacting social determinants of health
Medical Providers/ Psychiatrists	Consult on co-morbid medical concerns, manage/adjust medication, advise on lethal mean safety surrounding prescription medications

RECOMMENDATION

Facilitate collaboration and connection within care team through clinic procedures and clinician trainings.

3 **Clinician transparency** is a critical element in building therapeutic alliance with active-duty and veteran clients.

CVN clinicians noted higher degrees of guardedness when discussing suicide and assessing risk with active-duty and veteran clients. Participating clinicians perceived this guardedness as being related to ongoing stigma surrounding suicide in military and veteran culture, fears of being perceived as weak by other service members and veterans, fears about impacts to their careers or mission-readiness, and most prominently, fears about a loss of rights through involuntary hospitalizations and/or loss of firearms.

Clinicians reported addressing these concerns through direct and transparent discussions about the limits of confidentiality early during the assessment process and repeating relevant information frequently throughout the course of treatment. They stressed their commitment to client autonomy but also emphasized that safety is paramount, assuring clients that if safety was felt to be compromised, they would be engaged in planning and apprised of options before any decisions were made regarding emergency care.

LESSONS LEARNED

Similarly, direct and transparent discussions about firearm safety were felt to help build buy-in with clients. Clinicians reassured clients that their goal is not to permanently remove guns, but rather to enhance safety during a difficult period or crisis. Clinicians worked with clients to negotiate safety measures that are acceptable to the client. These may include having a friend or battle buddy hold firearms temporarily, giving another family member the key to the safe, or storing firearms disassembled in different locked locations, all of which help to reduce risk by increasing time between thought and action.

RECOMMENDATION

Incorporate direct and transparent discussions about the limits of confidentiality to encourage open communication by addressing fears and stigma around sharing suicidal thoughts and behaviors during therapy. Recognize and acknowledge the client's perspective on their firearms while providing education. When warranted, problem solve around means safety in a non-judgmental and collaborative manner. These discussions are especially important in combating ingrained fears present within the military and veteran communities.

4 **Supervisor support** during risk assessment along with strong, collaborative postvention processes in the wake of adverse events bolster clinician confidence and resilience

Supervisor support was widely endorsed as a critical element in clinician confidence and well-being in relation to managing client suicidality. Consultation with supervisors was mentioned throughout both survey responses and interviews in a wide variety of contexts, including risk assessment, referrals to more appropriate care, and management of clinical biases. Supervisor support was particularly important in the wake of a client suicide attempt or death. Postvention case reviews and debriefings with supervisors were positively viewed by participating clinicians and credited with helping clinicians process an adverse event, bolstering their confidence, and improving their resilience.

RECOMMENDATION

Promote collaborative and supportive relationships between supervisors and clinicians at a clinic and administrative level and conduct independent, non-punitive, protected case reviews following adverse events to identify areas of needed support and process improvement.

LESSONS LEARNED

IMPLICATIONS FOR **RESEARCH**

1 Getting from Risk to Disposition: Understanding Clinician Strategies

Findings from the clinical stratification of vignettes showed a tendency towards recommending higher levels of care as the assessed level of acute risk increased. However, even within assessed acute risk levels, differences persisted in the level of recommended care. Participating clinicians appeared to take two different approaches to determining an appropriate disposition. Some clinicians selected the most restrictive disposition and listed factors that would justify a less restrictive level of care. Others selected the least restrictive disposition and listed factors that would require a more elevated level of care. While each strategy has merits, we do not currently know how clinicians decide which strategy to use and the implications of using each approach.

More research is needed to determine how frequently each strategy is used, the benefits and limitations of each approach, as well as their implications for the consistency and accuracy of risk stratification determinations.

2 Opportunities for Model Development

The chronic/acute model of suicide risk (Wortzel et al., 2014) has gained widespread popularity across the mental health field. This model offers a number of benefits including avoiding a unidimensional assessment of risk, advancing understandings of the role of historical factors in current risk, and encouraging clinicians to separately assess temporality and severity. At the same time, the results of this project indicated the need for additional research on several aspects of the model. For example, clinicians varied in their understanding of the timeframe that should be considered "acute". While this timeframe could refer to the most recent minutes or hours of the client's life, it was also being considered by some clinicians to be within the last 30 days to the last several months depending on the intensity of the ideation or behaviors. It is not clear how these varying timeframes may impact risk assessment, stratification, or treatment, and research should focus on helping clarify how the timeframe used during assessment impacts these aspects of clinical decision making.

3 Bridging the Gap: Enhancing Clinicians' Understanding of Suicide Intent

Future research should aim to bridge the gap between clinicians' conceptualizations of intent and its practical application in suicide risk assessment. Despite participating clinicians almost universally endorsing the significance of intent, they rarely experienced verbal affirmations of intent in these mild to moderate outpatient settings. It is essential to explore how clinicians weigh denial or ambiguous statements related to intent against other observed or reported indicators, i.e., preparatory behaviors or engagement in safety planning to infer or formulate a client's level of intent. Investigating how these factors interact and influence risk and disposition determinations, especially when clients verbally deny intent, could lead to more precise assessment models.

To advance the field, future studies should explore the specific client statements that inform intent assessment, such as the choice of suicide method, the level of detail in the plan, and access to various means. Additionally, examining the role of clinical judgment in assessing a client's engagement in therapy or safety planning, ability to maintain safety, desire to die, ability to deny intent, and impulsivity can provide a more comprehensive understanding of intent assessment.

LESSONS LEARNED

4 Best Practices for Providing Telehealth to High-Risk Clients

Telehealth is a well-validated method for providing mental health services, including for veterans (Shelton et al., 2020). However, the COVID-19 pandemic dramatically changed the landscape in which telehealth services were offered both at CVN and throughout the country, including a substantial increase in the volume of high-risk clients receiving telehealth services.

Participating clinicians had varying levels of experience with providing telehealth services, particularly for high-risk clients. Many reported reservations with telehealth for high-risk clients at the beginning of the pandemic-related transition. However, we found that participants who regularly saw high-risk clients via telehealth reported increased comfort with the treatment modality and readily shared their perspectives on the benefits of telehealth and minor practice adaptations intended to mitigate any perceived challenges or limitations.

Given the widespread adoption of telehealth in conjunction with the apparent impact of clinicians' levels of professional experience in refining safety procedures and clinical adaptations, additional research into clinician perspectives on best practices for telehealth with high-risk populations as well as training clinicians to provide telehealth care successfully and confidently for such clients is warranted.

CONCLUSIONS AND NEXT STEPS

The goals of the current effort included developing an improved understanding of the processes used by clinicians to stratify suicide risk among clients in an outpatient mental health network, the factors they consider and prioritize, and the relationship between their risk stratification decisions and case dispositions. Participants were licensed clinicians self-selected for participation in a vignette scoring survey and semi-structured interviews.

This mixed methods study is limited in two ways. First, it elucidates risk stratification approaches within a small sample of clinicians in a network serving military members, veterans, and their family members. Another potential limitation is the relatively low rates of elevated suicide risk across the network with rates of 5.5% and 2.0% for moderate and high risk, respectively (Lancaster & Linkh, 2023) which may impact both decision making and risk perception across the network.

This study also has a number of notable strengths. First, it contributes to the limited literature on clinician decision making in suicide risk stratification. Second, it includes a professionally diverse group of clinicians including Licensed Professional Counselors, Licensed Clinical Social Workers, Licensed Marital and Family Therapists, and Licensed Clinical Psychologists, reflecting the professional diversity of clinicians across mental health settings. Third, participating clinicians reported a wealth of experience with 55% of the clinicians who completed the survey having 5+ years of clinical experience and 14% greater than 10 years. Finally, the use of mixed methods afforded an opportunity to further explore issues identified in the quantitative component through the semi-structured interviews and qualitative data analysis allowing for triangulation across data types to enhance understanding of and confidence in the key findings.

Broadly speaking, these lessons highlight the collaborative nature of suicide risk assessment and management. Clinicians are not on their own during this process. Concerted training to and use of measurement-based care and standardized measures, in combination with clinical interviewing, support clinicians in risk assessment and management in mild to moderate risk outpatient mental health settings. Beyond the use of assessment tools, clinicians reported extensive benefits to multidisciplinary, collaborative care teams for improving client care. Additionally, they referenced the benefits from cooperative relationships with supervisors and supportive postvention processes to bolster clinician confidence and well-being. Well-supported clinicians report improved confidence and enhanced ability to provide high-level client care. Finally, opportunities to foster collaborative suicide prevention ecosystems exist at administrative and clinic levels through policy and procedure development, well-designed clinician training, and strong mentoring relationships.

In terms of next steps, while published studies on clinician decision making in suicide risk assessment and management are limited, there is a glaring gap in terms of published studies related to clients' experiences with and perception of suicide risk and safety interventions. Addressing this gap, particularly with regard to specific practices or elements that patients found most or least relevant to and beneficial for their coping, safety, and recovery, should be a near term imperative for the field. **The addition of systematically derived client feedback on these critical processes will inform continued advancements in clinical suicide risk assessment and management which are sorely needed in light of the increasing risk across both clinical and non-clinical populations in the US.**

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