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Journal of Substance Abuse & Alcoholism

Mini Review

Alcohol Relapse as a Suicide-Risk Signal: Preparing Nurses for Integrated Assessment Through Immersive Simulation

Cody Bruce* and Elizabeth Wells-Beede

College of Nursing, University of North Texas Health, USA

***Corresponding author**

Cody Bruce, College of Nursing, University of North Texas Health, 3500 Camp Bowie Blvd. Fort Worth, TX 76107, USA, Tel: 817-735-5880

Submitted: 10 August 2026

Accepted: 29 October 2026

Published: 30 October 2026

ISSN: 2373-9363

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Keywords

- Alcohol use disorder; Relapse; Suicide risk; Nursing education; Virtual reality; Simulation

Abstract

Alcohol use disorder (AUD), depressive illness, and suicide risk frequently intersect in clinical practice, yet health professions education may address alcohol screening and suicide assessment as separate competencies. This separation can leave learners insufficiently prepared for patients whose alcohol relapse, worsening depression, and suicidal thinking emerge together. This perspective argues that alcohol relapse should be taught as a dynamic safety signal that prompts integrated assessment rather than as a secondary diagnosis to be documented after the immediate psychiatric evaluation. A previously developed immersive virtual reality simulation for prelicensure psychiatric-mental health nursing is used as an educational exemplar. In the case, a patient with major depressive disorder and alcohol dependency presents after a binge following six months of sobriety and reports suicidal ideation with a plan. The simulation requires learners to establish therapeutic rapport, explore alcohol use and relapse context, conduct structured suicide-risk assessment, prioritize safety, and identify referral needs. Current evidence supports this integrated approach: AUD is associated with substantially elevated suicide mortality, while brief alcohol screening and intervention remain recommended components of routine clinical care. Simulation can provide a psychologically safe setting in which nursing students practice asking direct questions about both alcohol use and suicide, respond without stigma, and connect screening findings to immediate safety planning and longer-term treatment. The educational goal should move beyond learner confidence toward observable performance in integrated AUD and suicide-risk assessment.

INTRODUCTION

Alcohol use disorder remains a common and consequential health condition in the United States. In 2025, an estimated 25.7 million people aged 12 years and older met criteria for past-year AUD [1]. Alcohol-related harm extends well beyond the physiologic consequences of heavy drinking. AUD commonly intersects with mood disorders, social disruption, treatment nonadherence, impulsivity, and suicide risk. A 2024 systematic review and meta-analysis encompassing more than 37 million participants found that, in longitudinal studies, AUD was associated with more than twice the odds of suicide mortality in both males and females [2]. These findings reinforce a practical implication for nurses: when significant alcohol problems and depressive or suicidal symptoms coexist, assessment cannot be compartmentalized.

This has direct implications for nursing education. Alcohol screening is often taught through substance-use content, while suicide assessment is taught within psychiatric-mental health content. In clinical practice, however, patients do not present according to curricular boundaries. A patient may arrive with depression, a recent alcohol relapse, interpersonal loss, medication concerns, and suicidal thoughts simultaneously. The nurse must recognize how these factors interact, determine which findings signal immediate danger, communicate without judgment, and connect the patient with appropriate care.

This perspective proposes that alcohol relapse be taught as a dynamic suicide-risk signal that requires integrated assessment. An immersive virtual reality (VR) simulation previously developed for prelicensure psychiatric-mental health nursing provides an exemplar of how this integration can be operationalized. The purpose here is not to report a new dataset, but to translate an established educational innovation into specific recommendations for preparing nurses to identify and respond to the convergence of AUD, relapse, depression, and suicide risk.

Why Alcohol Relapse Belongs in Suicide-Risk Education

Relapse is clinically important for reasons that extend beyond whether a patient has resumed drinking. It may

indicate worsening stress, erosion of coping strategies, disengagement from treatment or recovery supports, and increased exposure to the disinhibiting effects of alcohol. The National Institute on Alcohol Abuse and Alcoholism notes that alcohol can worsen depression over time and may contribute to suicide risk through mechanisms that include impaired judgment and impulsivity [3]. For a patient with established depressive illness or suicidal thinking, a recent return to alcohol use should therefore alter the nurse's level of concern.

The educational challenge is to prevent learners from treating relapse as an isolated checkbox. Asking, "Have you been drinking again?" is not sufficient. Learners should be prepared to explore when use resumed, the amount and pattern of drinking, what precipitated the relapse, the patient's last use, possible withdrawal risk, use of other substances or sedating medications, changes in adherence to psychiatric treatment, and whether suicidal thoughts intensified before, during, or after drinking. The nurse must then connect those findings to an immediate safety assessment.

This approach is consistent with broader screening expectations. The U.S. Preventive Services Task Force recommends screening adults for unhealthy alcohol use and providing brief behavioral counseling interventions to those engaged in risky or hazardous drinking [4]. Screening, Brief Intervention, and Referral to Treatment (SBIRT) similarly links identification of substance use severity with a brief intervention and referral when a higher level of care is indicated [5]. When suicidality is present, however, the sequence must become more urgent. Screening for alcohol use is no longer only preventive; it becomes part of determining immediate psychiatric safety.

5A Simulation Exemplar: Alcohol Relapse, Depression, and Suicidal Ideation

The VR case used in the psychiatric-mental health nursing course was intentionally designed around clinical overlap. The simulated patient has a six-year history of major depressive disorder, a history of alcohol dependency, and a recent binge after approximately six months of sobriety. The relapse follows an emotionally significant interpersonal trigger. During the encounter, the patient discloses suicidal ideation with a plan to run into traffic.

The original VR innovation was implemented with 84 prelicensure nursing students and was associated with favorable learner evaluation, faculty-observed improvement in therapeutic communication and client assessment, mastery of structured suicide-risk assessment elements, and efficiencies in feedback and faculty grading [6]. The case is especially relevant to AUD education because alcohol use is not inserted as a secondary background detail. It changes how the patient must be assessed.

The learner must first establish enough therapeutic rapport for the patient to disclose sensitive information. The student then has to recognize the recent binge as clinically meaningful, explore the relationship between the relapse and worsening mood, ask directly about suicidal thoughts, and complete a structured suicide-risk assessment using the Columbia-Suicide Severity Rating Scale approach. Direct questioning must include suicidal thoughts, plan, intent, access to means or opportunity, prior suicidal behavior, and protective factors [7]. At the same time, the learner must avoid language that shames the patient for returning to alcohol use. The encounter requires the student to integrate substance-use assessment, psychiatric assessment, therapeutic communication, and safety prioritization rather than perform them as disconnected tasks.

Five Educational Priorities for Integrated AUD and Suicide-Risk Training

First, simulation scenarios should require learners to treat alcohol relapse as a change in clinical status. Faculty can design cues that force the student to decide whether a relapse represents a routine follow-up issue or a possible escalation in risk. The key educational question is not simply whether the learner identifies alcohol use, but whether the learner interprets what the change means for safety.

Second, alcohol screening and suicide screening should be paired when the clinical picture warrants it. The 2024 meta-analysis by Lange and colleagues concluded that AUD is associated with elevated suicide mortality and specifically emphasized the importance of screening for alcohol use among people presenting with depression or suicidal ideation, and screening for depression or suicidal ideation among people with AUD [2]. Simulation can make this reciprocal screening pattern habitual. A learner who identifies heavy drinking should think about mood and suicide risk. A learner who identifies suicidality should think about alcohol and other substances.

Third, learners should be evaluated on the language they use. Substance-use stigma can alter the quality of assessment and the willingness of patients to disclose information. Students should practice neutral, person-centered phrasing, normalize screening, ask permission when appropriate, and respond to relapse with clinical

curiosity rather than disappointment. Therapeutic communication is not a soft skill added after the "real" assessment. It is the mechanism that makes accurate assessment possible.

Fourth, learners should practice matching the intervention to the level of risk. SBIRT is valuable for identifying unhealthy alcohol use and initiating behavior change, and simulation-based SBIRT training has demonstrated improvements in nursing students' knowledge, confidence, competence, and readiness [8,9]. Yet brief intervention alone is not an adequate response to a patient with imminent suicide risk. Students must learn to distinguish between patients appropriate for brief counseling and outpatient referral and those requiring immediate safety measures, continuous observation, emergency psychiatric evaluation, or a higher level of care. The educational design should make escalation decisions visible and assessable.

Fifth, evaluation should emphasize observable behavior rather than confidence alone. Students may report feeling more comfortable discussing alcohol or suicide without consistently performing a complete assessment. Competency-based simulation should therefore score behaviors such as asking directly about suicide, clarifying the timing and pattern of alcohol use, identifying acute and chronic risk factors, recognizing withdrawal or medication interaction concerns, prioritizing safety, and communicating an appropriate referral or escalation plan. Recorded standardized-patient encounters can add an additional layer by allowing learners to review their own language, body posture, missed cues, and clinical decisions. This moves simulation evaluation from "Did the learner like the experience?" to "Can the learner perform the integrated assessment safely?"

Implications for Nursing Education and Clinical Practice

Integrating AUD and suicide-risk education has value beyond psychiatric-mental health courses. Nurses encounter unhealthy alcohol use in primary care, emergency departments, medical-surgical settings, trauma care, obstetrics, community health, and older-adult care. A patient may not identify alcohol as the reason for seeking care, and clinicians may miss the opportunity to connect drinking patterns with depression, injury risk, medication interactions, or suicide.

Simulation provides a controlled environment for practicing conversations that many learners initially find uncomfortable. Recent nursing education studies support the use of simulation for SBIRT skill development. Adamshick and Payton used an SBIRT simulation with 79 nursing students to teach substance-use assessment [8]. Yeh and colleagues reported significant gains in SBIRT-related knowledge following VR simulation among 380 participants, with outcomes assessed immediately and again at three months [9]. These findings, together with the earlier psychiatric-mental health VR work [6], suggest that immersive and simulation-based approaches can help learners move from knowing screening tools to using them in realistic interactions.

The next step is deliberate integration. AUD simulation should not end once the learner calculates a screening score, and suicide simulation should not omit substance-use context. Scenarios should require learners to synthesize both. Faculty can strengthen this approach by mirroring cases across a semester, first providing formative VR practice and later requiring performance with a live standardized patient. Such a design allows educators to assess whether learners transfer integrated screening, communication, and safety behaviors into a more complex interpersonal encounter.

LIMITATIONS AND RECOMMENDATIONS

The educational exemplar described here does not establish that VR exposure causes later competency or improves patient outcomes. The original VR implementation included favorable learner and faculty outcomes, but the present article does not analyze new learner-level data. Future studies should prospectively examine whether integrated AUD-suicide simulation improves performance on standardized-patient assessments, clinical evaluations, or practice-based outcomes. Studies should also evaluate whether learners maintain skills over time and whether integrated scenarios reduce stigmatizing communication.

Future simulation research should distinguish among unhealthy alcohol use, established AUD, acute intoxication, relapse after abstinence, and withdrawal risk. These presentations require different clinical responses. Researchers should also examine whether learners appropriately escalate care when alcohol use co-occurs with active suicidal intent, rather than relying on brief intervention strategies that are appropriate only for lower-acuity presentations.

CONCLUSION

Alcohol relapse can be more than a substance-use event. In a patient with depression, acute stress, or suicidal thinking, it may be an important signal that the clinical picture has changed. Nursing education should prepare learners to recognize that change and respond with integrated assessment.

Immersive simulation offers a practical method for teaching this integration. A well-designed case can require students to explore alcohol use, identify relapse context, ask direct questions about suicide, communicate without stigma, prioritize safety, and connect the patient with appropriate treatment. The educational standard should be observable performance, not confidence alone. Preparing nurses to see the intersection of AUD and suicide risk may improve the quality of screening, strengthen early recognition of danger, and support safer transitions to treatment.

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