Assessing Suicidality: Experiences of Healthcare Professionals and Developing a Professional Consensus for People with Post-Stroke Aphasia

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Abstract

Background: Healthcare professionals have a duty of care to detect and assess suicidality, which is recognised to be a global health problem. However, relatively little is known about their subjective experience of suicide risk assessment. In certain situations, such as when stroke affects communication in post-stroke aphasia, the risk of suicide may be increased but there is uncertainty about how to approach risk screening and assessment. Professionals often feel underconfident, undertrained and unsupported to address communication needs, leaving stroke survivors with aphasia at risk of being missed by routine assessment.

Method: A systematic review and meta-synthesis were completed to understand the experiences of healthcare professionals completing suicide risk assessment. A Delphi study was undertaken to develop a professional consensus on the most useful methods to detect and assess suicide risk in stroke survivors with aphasia.

Results: Thirteen reports of 12 studies were reviewed and synthesised. Four themes emerged; 1) Assessing Suicide Risk is a Challenging Experience, 2) Relying on Experience and Intuition to Guide Assessment, 3) Navigating the Gaps Between Guidance and Practice and 4) Systemic Factors Influence Approaches to Assessment. Twenty experienced stroke professionals completed a three-round Delphi study, reaching a strong consensus on many aspects of detecting and assessing suicide risk in stroke survivors with aphasia. On some issues, consensus could not be reached, such as the use of specific standardised mood measures in this context.

Conclusions: Assessing suicidality is a challenging experience, with healthcare professionals reporting reliance on intuition, and barriers to risk assessment, reinforcing a need for further research and clinical resource dedicated to supporting those conducting suicide risk assessment. This portfolio presents the first professional consensus on detection and assessment of suicide risk in stroke survivors with aphasia, advocating a multi-faceted approach integrating joint professional working, supported interview techniques, and family involvement.

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On a personal note, I am deeply grateful to my partner and parents for their love and belief in me. I have been fortunate to receive this support through all phases of my life, and I would not be where I am today without you.

Lastly, I would like to dedicate this work to the memory of those who have been lost to suicide. This project is driven by a continued commitment to developing better professional support for those experiencing distress or crisis.

Chapter 1 – General Introduction

Introducing Stroke, Aphasia and Suicidality, Models of Suicidal Behaviour and Risk Assessment and Healthcare Approaches

Word Count: 4197

General Introduction

> "There is but one truly serious philosophical problem, and that is suicide. Judging whether life is or is not worth living amounts to answering the fundamental question of philosophy." (Camus, 1955, p. 3)

Suicide has remained a central topic of moral, ethical and philosophical debate for centuries. Whilst early scholars often condemned the act from a theological standpoint and twentieth century essayists observed it through an existential, absurdist and nihilistic lens, modern researchers have sought to analyse suicide through frameworks of understanding and, ultimately, structured approaches of prevention. Within the United Kingdom, it is common for healthcare professionals to make symbolic declarations of their commitment to ethical care, such as recitation of modified forms of the Hippocratic Oath for medical doctors. Allied health professionals are governed by similar ethical and regulatory codes. The core of these ethical codes is an overarching responsibility to act in the best interest of those accessing medical care, yet this can become uniquely challenging when an individual presents with suicidal ideation. Consistent professional guidance and training in suicide prevention is limited in many services (Fedorowicz et al, 2023), and this problem is magnified when a person at risk of suicide has additional needs, such as a communication disorder (Carroll et al, 2024; Schlesinger et al, 2024).

Suicide and Understanding Suicidal Behaviour

Suicide is defined as the act of intentionally ending one's own life. Definitions often refer to specific factors associated with suicidality or suicidal behaviours, including suicidal ideation (thoughts about ending one's life), suicidal planning (thoughts about specific methods), and suicide attempts, which involve self-injurious acts driven by at least some degree of intent to die (Nock et al., 2008; Goodfellow et al., 2019; Sarkhel et al., 2023).

Suicide presents a significant global health challenge, highlighting the importance of attempts to understand suicide risk. The World Health Organisation (WHO; 2025) estimates that approximately 727,000 individuals die annually from suicide, ranking suicide as the third leading cause of death worldwide among individuals aged 15–29. The reasons for suicidality are complex and multi-faceted. In the nineteenth century, seminal works highlighted an

association between social determinants and the prevalence of suicide (Durkheim, 1897). Social determinants are defined as factors that negatively affect economic stability, educational access, healthcare access, the living environment, and community context (Kirkbride et al., 2024). Reframing suicide as a social issue challenged historical medicalised models that were prominent in the 1800's, which viewed suicide as a sign of mental illness (Griesinger, 1867). Contemporary perspectives now recognise the interplay between individual psychological vulnerabilities and broader sociological drivers (National Health Service [NHS] England, 2025; Pirkis et al., 2024). It is now recognised that cultural approaches to suicide are often shaped by theological and political ideologies. These influences can lead to stigma and limit the resources allocated to suicide prevention, ultimately marginalising at-risk individuals and restricting their access to life-saving interventions (Stack, 2021).

The psychological understanding of suicide has transformed over the centuries. Durkheim (1897) provided what is viewed as the first systematic study of suicide. His model describes four types of suicide based on social integration and moral regulation. Egoistic suicide involves low social integration and detachment, while Altruistic suicide stems from excessive integration where the individual sacrifices for the group. Anomic suicide occurs during periods of low societal regulation or rapid change, causing feelings of aimlessness, whereas Fatalistic suicide results from excessive regulation and oppression, leading to a sense of being trapped without hope. However, the usefulness of these categories has been critiqued, as they were not only difficult to test empirically, but also added little to explain the reasons why individuals were driven to these types of suicide (O'Connor and Sheehy, 2001).

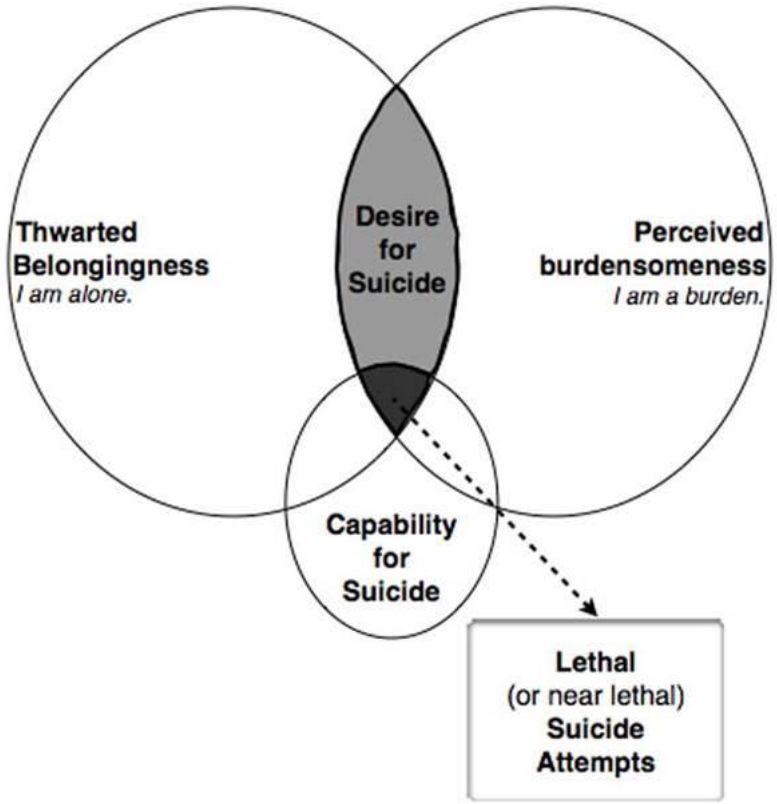
The twentieth century saw an increased focus on the psychological mechanisms underlying suicidal behaviour. Early psychodynamic perspectives, such as those proposed by Freud (1957), suggested that suicide was an act of self-directed aggression resulting from an unconscious response to a lost loved object. Later, the Hopelessness Theory of Depression proposed feelings of hopelessness as the key factor present before suicidal ideation, suggesting that a perceived inability to change one's depressive state leads to a state of hopelessness depression (Abramson et al., 1989; Beck et al., 1979; Seligman, 1972). Within this framework, a negative inferential style serves as a key vulnerability. Where individuals

attribute negative events to internal, stable, and global causes, facilitating the transition from ideation to intent (Abramson et al, 1989). The concept of Psychache, or unbearable psychological pain, was also proposed as the primary driver of suicidal behaviour, with depression and hopelessness understood as secondary factors (Shneidman, 1993). Shneidman argued that suicide is driven by a perception of pain that the individual finds intolerable, where the cessation of consciousness is viewed as the only remedy. Escape Theory described a similar desperation to avert psychological pain, and escape from self-awareness or the perception of personal inadequacy (Baumeister, 1990). It is suggested that suicidal behaviour can be triggered by a causal chain where life events fall short of elevated expectations, leading to an internal attribution of fault that makes awareness of self an intolerable state. This process results in cognitive deconstruction, characterised by inflexible and concrete thinking styles used to avert self-awareness. This state leads to disinhibition and irrationality where suicide is perceived as a drastic yet reasonable method of escaping the self and the world. A common critique is that many of these theories were limited by their linearity, oversimplification, and lack of predictive validity, which led them to be descriptive considerations rather than providing practical applications for suicide prevention efforts (Klonsky et al., 2018).

Contemporary models sought to refine and operationalise theories of suicidality. The Interpersonal Theory of Suicide (ITS; Joiner, 2005; Van Orden et al., 2010) proposes that suicidal desire arises from a combination of perceived burdensomeness ("I am a burden") and thwarted belongingness ("I am alone"). According to this model, suicidal behaviour occurs only when these factors converge with an acquired capability for suicide, developed through habituation to pain and fear via past self-harm or other experiences (see Figure 1).

Figure 1

Assumptions of the Interpersonal Theory of Suicide



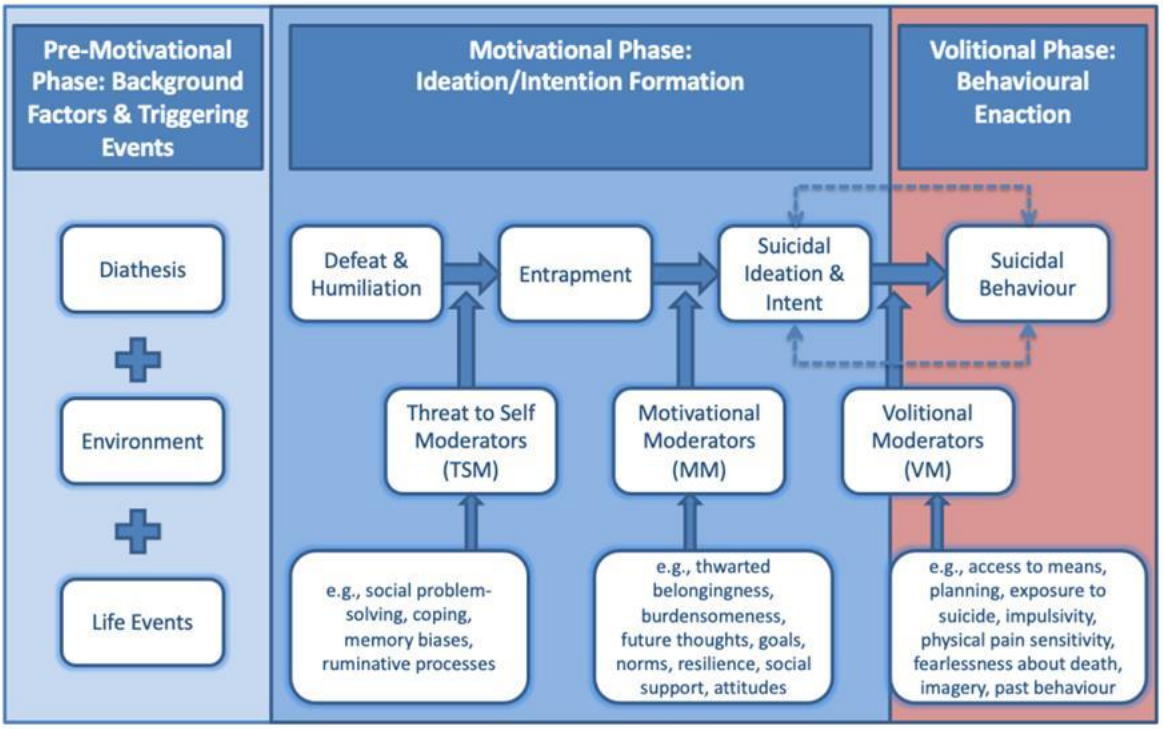
Note. *From Why People Die by Suicide (p. 46), by T. E. Joiner, 2005, Harvard University Press. Copyright 2005 by the President and Fellows of Harvard College.*

The ITS offered the first ideation-to-action framework, postulating processes leading an individual to suicide following periods of suicidal ideation. This contrasted with previous theoretical accounts which focussed on the level of distress felt by an individual showing suicidal behaviours (Abramson et al., 1989; Shneidman,1993 & Baumeister, 1990).

The Integrated Motivational-Volitional (IMV) model (O'Connor et al., 2011; O'Connor & Kirtley, 2018) built upon the notion of capability for suicide, by differentiating factors that lead to ideation (Ideation/Intention Formation) from those leading to suicidal behaviours (Behavioural Enaction) (see Figure 2).

Figure 2

The Integrated Motivational-Volitional Model of Suicidal Behaviour



Note. From "The Integrated Motivational–Volitional Model of Suicidal Behaviour" (p. 3), by R. C. O'Connor and O. J. Kirtley, 2018, *Philosophical Transactions of the Royal Society B: Biological Sciences*, 373(1754). Copyright 2018 by The Royal Society.

The IMV model conceptualises suicide as a process with three distinct phases. The pre-motivational phase provides the biopsychosocial context through background factors and life stressors, while the motivational phase describes how feelings of defeat and entrapment lead to the development of suicidal ideation. Finally, the volitional phase identifies specific factors such as impulsivity, access to means, and acquired capability that govern the transition from ideation to action. A significant strength of this model is its focus on moderators, such as resilience, social support, and coping strategies, which serve as targets for therapy to reduce risk (Torino et al., 2026). The model has been found to accurately predict associations between defeat, entrapment, and suicidal ideation (Souza et al., 2024).

Other ideation-to-action models include the Fluid Vulnerability Theory (FVT; Rudd, 2006), which serves as an extension of the cognitive behavioural framework for formulating suicidal states. FVT is unique in its consideration of a broad spectrum of suicidogenic beliefs that change over time, suggesting that suicide risk can be dynamic and fluctuate rather than remaining static. Similarly, the Three Step Theory (3ST; Klonsky and May, 2015) offers a parsimonious view of suicide ideation and attempts through four interconnected factors: pain, hopelessness, connectedness, and suicide capability. Although there are differences between the IMV, 3ST, and FVT, many of the components of these theories complement one another by focussing not only on the internal state and presence of ideation, but also on what motivates a movement into suicidal behaviours. However, there is currently limited research on their ability to predict completed suicide. Furthermore, most research testing these theories has occurred in predominantly white, wealthy, and Western populations (Klonsky et al., 2018; Torino et al., 2026).

Recently, research has explored the application of the IMV to the increased suicidality found in people with Attention Deficit Hyperactivity Disorder (Cleare & O'Connor, 2026). This research has identified how specific traits such as impulsivity act as volitional moderators that bridge the gap between thinking and acting on suicidal ideation. As our understanding of suicidality evolves, adapting theoretical accounts to incorporate experiences of diverse groups will provide an important area for future research and clinical practise.

Suicide Risk Detection and Assessment in Healthcare Settings

Suicide prevention is a global healthcare priority (WHO, 2014). A fundamental component of suicide prevention is the detection and assessment of suicide risk, which informs the selection of appropriate interventions for managing suicidality. Relevant clinical procedures are generally divided into suicide detection (or screening) and suicide assessment. Suicide risk detection focuses on rapid identification of individuals with suicidal ideation, intent or plans. An example of a risk detection question is the use of the ninth item of the Patient Health Questionnaire-9 (PHQ-9), which asks patients how often they have been bothered by "thoughts that you would be better off dead or of hurting yourself in some way" (Kroenke et al., 2001). In contrast, suicide risk assessment provides a

comprehensive evaluation of suicidality to enable formulation of factors influencing suicide risk and development of an individualised intervention plan (Horowitz et al., 2023). Structured approaches to assessment typically involve an evaluation of historical factors, alongside direct inquiry regarding the presence, frequency, and intensity of suicidal ideation, specific plans, and access to the means of harm (Hughes et al., 2023).

In the UK, the NHS has recommended important changes to suicide risk detection and assessment procedures (NHS England, 2025). Historically, risk assessment required professionals to stratify risk using categorical labels, such as high, medium, or low, based on the perceived likelihood of a suicidal act. However, risk stratification labels have been found to be poor predictors of individual behaviour and may lead to a false sense of security, or the denial of care (Fedorowicz et al., 2023; NICE, 2022). Consequently, current UK guidelines recommend development of collaborative, person-centred risk formulations rather than risk stratification, encouraging a greater focus on person-centred understanding and the collaborative development of a safety plan (NHS England, 2025).

Many healthcare professionals have a responsibility to screen for and assess suicide risk. Despite this, research suggests that practitioners often remain reluctant to initiate these discussions with patients (Ford et al., 2021). This hesitancy is frequently attributed to a lack of clinical confidence and an intervention anxiety, described by some as a fear of "opening a can of worms" (Fedorowicz et al., 2023; Hawton et al., 2022). A particularly pervasive barrier is described by Bajaj et al (2008) as the “myth of induction”, or the unfounded concern that asking about suicide may inadvertently increase risk by planting the thought of self-harm in a patient’s mind. However, robust meta-analytic evidence has demonstrated that direct risk questioning does not induce suicidal ideation and may instead reduce a patient’s immediate distress (Dazzi et al., 2014). It has been highlighted that avoiding assessment procedures due to clinician discomfort can lead to missed opportunities for therapeutic engagement and safety planning (NHS England, 2025).

The potential for missed opportunities in suicide prevention is already present in risk screening among practitioners working with stroke survivors with aphasia (Carroll et al., 2024; Schlesinger et al., 2024). The most recent NHS guidance offers limited practical guidance for clinicians tasked with undertaking suicide risk detection and assessment procedures with people who have complex communication needs (NHS England, 2025).

While a lack of specific guidance and training has already been identified as a significant barrier to suicide assessment in general healthcare, these issues are likely exacerbated when clinicians are faced with the additional linguistic and cognitive complexities in post-stroke aphasia (Hawton et al., 2022). Without tailored protocols, people with communication difficulties may be inadvertently excluded from suicide prevention pathways.

Stroke and Aphasia

The World Health Organisation (2025) defines a stroke as a "medical emergency that occurs when blood flow to the brain is interrupted, either due to a blockage or bleeding" (Overview Section). This disruption prevents brain tissue from receiving necessary oxygen, leading to cellular damage. There are two main types of strokes: ischemic stroke is caused by a blood clot in a blood vessel, and haemorrhagic stroke which is caused by an intracerebral haemorrhage from the rupture of a blood vessel leading to bleeding in the brain.

Globally, it is estimated there are over 100 million people living after stroke, and 6.5 to 6.6 million stroke-related deaths per year (Feigin et al., 2024). Stroke is the second leading cause of death, and the third leading cause of disability worldwide (Chen et al., 2025). In the United Kingdom, stroke is the leading cause of disability affecting approximately 1.3 to 1.4 million or two-thirds of survivors (Stroke Association, 2025).

Many factors affect the extent to which stroke causes disability, including lesion location and extent. Recent data from the Sentinel Stroke National Audit Programme (SSNAP, 2025) indicate that 64% of 92,414 stroke survivors reported difficulty performing daily activities, 62% faced persistent mobility challenges, and 47% experienced anxiety or depression following their stroke.

Several types of communication disability are relatively common after stroke. These include dysarthria, where speech intelligibility is affected; aphasia, where language is affected; and apraxia, where there are difficulties initiating speech due to motor planning deficits (Mitchell et al., 2021). Aphasia is often categorised into two types: receptive aphasia, where the individual has difficulties receiving communicated information, and expressive aphasia, where the individual has difficulty expressing communication (Stroke Association, 2021). Individuals can also experience global aphasia, where deficits in both receptive and expressive domains are present. It is estimated that approximately 30% of stroke survivors

have a form of aphasia within the acute stroke population and estimates increase to 34% in rehabilitation settings and reduce to 2 to 12% at one-year post stroke (Baker et al., 2020; Flowers et al., 2016).

As communication is a central factor in human connection and daily life, aphasia often negatively impacts stroke survivors wellbeing. Individuals who experience communication difficulties post-stroke are at an increased risk of social isolation and reduced quality of life (Hilari, 2011; Kurup et al, 2024). Though reviews of inpatient data indicate that dysarthria, or combined dysarthria and aphasia, are more prevalent immediately post-stroke, language difficulties caused by aphasia are associated with more chronic disability (Ali et al., 2015; Mitchell et al., 2021). In addition, stroke survivors with aphasia often experience emotional distress and poor mental health outcomes (Kristo & Mowll, 2021). People with post-stroke aphasia report lower quality of life across multiple domains including psychological., physical and environmental functioning when compared to survivors without aphasia (Filipska-Blejder, 2023). Greater severity of aphasia can further exacerbate the impact on quality-of-life domains, as well as on employment status, social isolation and reduced physical mobility (Kurup et al., 2024; Konishi et al., 2025).

Rehabilitation interventions are essential for stroke survivors with aphasia. The National Institute for Health and Care Excellence (NICE, 2023) updated its guidance to emphasise person-centred care and increased therapy intensity, recommending that survivors receive at least three hours of multidisciplinary therapy per day. Specific protocols include screening for communication difficulties within 72 hours and tailored speech and language therapy within a multidisciplinary framework. Without such targeted support, survivors face poorer functional recovery, increased risk of social isolation and further reduction in quality-of-life domains (He et al., 2025). Engagement in these programmes can be further complicated by other difficulties associated with stroke, such as reduced motivation and poor self-regulation, mood disorders, and other acquired disabilities (Brady et al., 2022; Menahemi-Falkov et al., 2025). Systemic challenges including chronic staffing shortages and fragmented transitions from hospital to community care mean that many survivors are unable to access the consistent support required for recovery. Data from the SSNAP (2025) indicates that only 14% of patients nationally receive the target of 45 minutes

of speech and language therapy for five days a week, while access to specialist stroke units has decreased to 74% of patients.

Despite research on psychological aspects of stroke being recognised as a top priority by survivors, carers, and clinicians alike (James Lind Alliance, 2021), access to long-term psychological and functional rehabilitation remains inadequate. Stroke survivors face many obstacles during their recovery journey. For those with aphasia, these barriers to support can often feel insurmountable, worsening outcomes and impacting recovery (Baker et al., 2020).

Post-Stroke Depression and Aphasia

Post-stroke depression (PSD) is a common consequence of stroke, with recent estimates suggesting that approximately 27% of survivors exhibit depressive symptoms at any given interval following a stroke (Lui et al., 2023). While clinical recognition of the association between stroke and mood disturbances dates back over a century, systematic research did not begin in earnest until the 1970s (Robinson & Jorge, 2016).

A challenge for clinicians lies in differentiating PSD from similar post-stroke phenomena, such as apathy, cognitive impairment, or the emotional distress resulting from communication barriers (Tampi & George, 2021). To meet diagnostic criteria for PSD, individuals must present with a persistent period of depressed mood, or loss of pleasure/interest in activities (American Psychiatric Association [APA], 2013). Symptoms must be a direct consequence of the stroke, not explained by another mental disorder and must cause significant distress or impairments (social, occupational or in other areas of functioning). There are several biological factors implicated in the development of PSD, including the location and volume of the brain lesion, significant neurochemical alterations, and an increased presence of pro-inflammatory cytokines (Robinson & Jorge, 2016). These processes, alongside acute neurotoxicity, are thought to impair serotonergic neurotransmission and transport, creating a biological vulnerability to depressive symptoms following a stroke (Lui et al., 2023; Tampi & George, 2021).

Social and psychological factors are significant contributors to the aetiology of post-stroke depression (PSD). Stroke survivors frequently experience a profound loss of physical function, reduced social interaction, and shifts in familial roles, all of which can foster

pessimism regarding future recovery (Zhou et al., 2024). PSD is associated with an increased risk of chronic functional impairment, diminished quality of life, and higher mortality rates, with effects persisting for up to 10 years post-stroke (Lui et al., 2025). Stroke survivors with aphasia face a significantly elevated risk of PSD, with evidence suggesting they are 7.4 times more likely to develop symptoms than those without language impairments (Zanella et al., 2023). However, prevalence rates may be under-estimated due to a lack of research on this population and a shortage of assessment tools adapted for communication disorders (Laures-Gore et al., 2020). While some research explores demographic variables such as age and education, Zanella et al. (2023) found no significant correlation between these factors and PSD, instead suggesting that the type and severity of aphasia are primary risk indicators.

Systematic reviews indicate that pharmacological therapy is effective in reducing depressive symptoms compared to placebo (Roberts et al., 2015) and preventing PSD (Zhou et al., 2020). However, Zhou et al. (2020) found that when used to prevent PSD, improvements in mood with selective serotonin reuptake inhibitors (SSRIs) do not translate to improvements in functional independence. It has been recommended that to adopt a holistic approach, integrating medical treatments with therapeutic interventions, such Cognitive Behavioural Therapy (CBT) or Psychological Care and Social Support Groups (NICE, 2023). There has been growing evidence supporting the usefulness of these interventions in supporting psychological and functional recovery following PSD (Wijeratne et al., 2022). However, access to formal mood assessment and psychological support remains inconsistent across many healthcare settings, and for those with a communication disorder it is reported to be an even greater challenge (Baker et al., 2018).

Psychological intervention is a key strategy for managing symptoms of PSD in survivors with aphasia (Baker et al., 2021). The primary healthcare professionals responsible for these interventions are typically speech and language therapists (SLTs) and clinical psychologists. Research indicates that SLTs frequently report feeling inexperienced and underskilled in delivering psychological treatments (Northcott et al., 2018). Conversely, clinical psychologists report feeling less competent when tasked with adapting standard interventions to suit the complex communication needs of individuals with aphasia (Baker et al, 2020). These factors, alongside limited access to adapted assessment and mood measures, mean that stroke survivors with aphasia and depression are at risk of being

overlooked by clinical services. This increases the risks associated with chronic mood disturbance, including suicidality.

Post-Stroke Suicidality and Aphasia

Stroke survivors are at increased risk of suicide, with a recent review suggesting that suicide risk is increased by 73% following stroke, compared to the general population (Vyas et al., 2020). This review also found that risk was greatest immediately following the stroke and particularly elevated for younger survivors, those with major depression, and individuals with lower socioeconomic status or greater physical disability. PSD is known to be associated with increased risk of suicidal ideation and attempts (Eriksson et al, 2015), but increasingly research suggests that having a stroke itself is an important predictor of increased suicide risk (Vyas et al., 2025). There is a small, growing body of research on the association between post-stroke suicidality and aphasia. Costanza et al (2021) proposed a vicious cycle regarding suicide risk in those with aphasia, suggesting that impaired language can worsen mood difficulties, which in turn exacerbates language impairment. This feedback loop creates a vulnerable state in which suicidality can develop.

The Theory of Planned Behaviour (TPB) (Ajzen, 1991) has been applied to understanding and predicting the intention of healthcare professionals to conduct post-stroke screening (Gillespie et al., 2020; Hart & Morris, 2008). The theory suggests that an individual's intention to perform a specific behaviour is determined by three key factors: attitudes (their evaluation of the behaviour), subjective norms (perceived social pressure from colleagues or institutions), and perceived behavioural control (the perceived ease or difficulty of performing the task). Evidence suggests that TPB can be useful in predicting staff behaviour in healthcare settings (Godin et al, 2008). Schlesinger et al (2024) found that healthcare professionals have significantly lower intention to screen for post-stroke suicidality than for PSD. Notably, TPB variables were found to account for a significant proportion of the variance in staff intentions to screen stroke survivors with aphasia for depression with normative beliefs a significant predictor of screening intention. Carroll (2024) used a randomised online vignette experiment to test if increasing a normative belief that screening for suicidality is an expectation of stroke professionals, could increase the intention of SLTs to complete suicide risk screening in stroke survivors with aphasia

compared to a control condition and found that screening intent was increased in a UK-based sample of SLTs.

In addition to research highlighting the role of screening intentions and normative beliefs, several other barriers to screening depression and suicidality in people with post-stroke aphasia have been identified. Carroll (2024) also found that lack of access to training, and lower confidence were identified by SLTs as factors influencing screening. Olsson and Schilling (2025) focussing on risk assessment for people with aphasia, identified that differing perspectives on professional role responsibility, alongside clinical uncertainty acted as barriers to the completion of comprehensive suicide risk assessments. There are also few validated measures designed for mood screening in stroke survivors with aphasia. Schlesinger's (2021) systematic review highlighted the pervasive exclusion of stroke survivors with aphasia in psychometric literature. Importantly, even the validated measures available for people with post-stroke aphasia, often lack specific items relating to suicidality or rely exclusively on verbal communication to probe these themes (Hackett et al., 2010), thereby excluding those with the most severe communication impairments.

Current Thesis

This thesis portfolio aimed to develop an understanding of the experiences of healthcare professionals assessing suicide risk and to support them in doing so in the context of communication disorder. It focuses on the subjective experience of the process of completing suicide risk assessment and the development of the first professional consensus to support healthcare professionals in the detection and assessment of suicidality in the context of post-stroke aphasia. Chapter Two provides a systematic review and meta-synthesis of qualitative research on the experience of suicide risk detection and assessment. Chapter Three reports a Delphi study of experienced stroke professionals which developed a professional consensus on the most effective ways to detect and assess suicide risk in stroke survivors with aphasia. By exploring professional experience and consensus, the portfolio sought to bridge the gap between understanding ethical and professional duties and the practical complexities of suicide risk assessment.

Chapter 2 – Systematic Review

Healthcare Professionals' Experiences of Suicide Risk Assessment: A Qualitative Systematic Review and Meta-Synthesis

Kellsey E. McCann*, Dr. Catherine Ford, & Professor Niall Broomfield

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Formatted for submission to the Journal of Clinical Psychology & Psychotherapy

See Appendix A for formatting guidelines for authors

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Abstract

Objectives: Suicide is a global health concern. Healthcare professionals are expected to assess suicide risk routinely, but systemic and personal factors could make this challenging. Few reviews have explored the lived experiences of professionals delivering suicide risk assessment, with little understood about their perceptions and feelings or how these influence the process. This review aimed to understand the subjective experiences of healthcare professionals conducting suicide risk assessments, exploring their perceptions of what impacts these processes.

Methods: Four databases (MEDLINE, Scopus, APA PsycArticles and CINAHL) were searched for the terms, “Suicide”, “Suicide Risk Assessment”, “Healthcare Professionals” and “Experiences”. Qualitative studies were included, where participants were healthcare professionals who shared their experiences of suicide risk assessment in healthcare settings. Quantitative mixed-methods, non-staff samples, and articles prior to 2015 were excluded. Thematic synthesis of the papers was used to analyse findings. Papers were coded based on resonance, relevance and rigour to identify core, central and peripheral papers.

Results: 405 articles were screened for eligibility. Qualitative data were extracted from 13 reports of 12 included studies and synthesised. Four themes emerged from the data: Assessing Suicide Risk is a Challenging Experience, Relying on Experience and Intuition to Guide Assessment, Navigating the Gaps Between Guidance and Practice and Systemic Factors Influence Approaches to Assessment

Conclusion: The themes that emerged highlight that suicide risk assessment is viewed as challenging, with professionals regularly relying on clinical intuition and peer support to navigate vague guidelines and systemic barriers. Recommendations for further research and training are discussed.

Key Practitioner Message:

- Increased access to formal suicide risk screening and assessment training
- Clearer guidance, increased supervision and greater institutional support are required to support Healthcare Professionals.
- Future research should aim to capture diverse experiences of wider suicide prevention efforts across the world to support practical suicide risk assessment implementation.

Keywords: Suicide, Suicide Risk Assessment, Suicide Risk Screening, Health Care Professionals, Experiences

Introduction

Suicide is a prevalent international health problem. In 2021, an estimated 727,000 people died from suicide globally, according to the World Health Organisation (WHO, 2021). Suicide is the third leading cause of death in individuals aged 15 to 29; the majority (73%) of suicide deaths occur in lower to middle income countries (LMICs), representing most of the global population (80%) (WHO, 2021).

Acknowledging that approaches to suicide varied globally, the WHO developed the Comprehensive Mental Health Action Plan 2013–2023 (2013). This was adopted by all 194 member states and established suicide prevention as a global priority. The subsequent publication, "Preventing Suicide: A Global Imperative" (WHO, 2014), provided guidance on managing suicidal behaviours, specifically recommending reduced access to lethal means, responsible media reporting, and improved early detection of high-risk individuals. However, implementing a universal strategy proved challenging, as cultural practices, resource allocation, and legal barriers often hindered progress (Fleischmann et al., 2016). This is particularly the case in countries where entrenched suicide stigma and criminality pose significant obstacles to establishing suicide prevention as a healthcare priority (Jidong et al., 2025; Menon et al., 2024).

Global approaches to suicide prevention and management still vary markedly. In the UK, increasing rates of suicide following the Covid-19 pandemic and record high demands on mental health services led to a governmental discussion paper and call for evidence on mental health and wellbeing (Department of Health and Social Care [DHSC], 2022). Subsequently, the UK government published the Suicide Prevention Strategy for England (DHSC, 2023) and best practice guidance, Staying Safe from Suicide (NHS England, 2025), to support professionals to assess risk of suicide. This guidance defines Suicide Risk Assessment

(SRA) as a process where information is gathered about suicide risk, with risk questions used to detect the presence of suicidal ideation, intentions, plans and history to understand the nature of the individual's risk and inform intervention. There is an increasing expectation on healthcare professionals (HCPs) to complete SRA (Airey & Iqbal, 2020). A scoping review of SRA methods in healthcare settings found, however, that there is a highly variable approach to assessment, with limited access to training, a lack of clarity across different settings and low confidence impacting the quality of risk assessment for suicide (Fedorowicz et al., 2023).

Research regarding clinician's experiences of suicide assessment has predominantly focussed upon the impact of losing a patient to suicide. Several studies have detailed the profound emotional and professional repercussions that can arise (Sandford et al., 2021; Wyder et a, 2020). These can include feelings of lost confidence, guilt, shame and blame (Morales-Silva, 2025; Saini et al, 2024). Similar feelings are also reported when HCP's work closely with patients engaging in suicidal behaviours (Huggett et al, 2024; Malik et al, 2022).

There is less known about the personal factors that influence approaches to working with suicidal individuals. Boukouvalas et al. (2020) reviewed studies exploring the knowledge, attitudes and confidence of professionals supporting individuals at risk of suicidal behaviours. They found that these relationships are complex, particularly when professionals hold strong religious, cultural, and political beliefs, which can lead to moralistic or stigmatising approaches to care. Factors such as training, education, role, country of practice, and prior experience were found to be interrelated; increased education and experience predicted a more empathic approach to working with suicidal individuals in HCPs.

There has been limited qualitative research on the experiences of healthcare professionals completing SRA. An earlier review sought to understand nurses' experiences of

caring for those with suicidal behaviours (Clua-Garcia et al., 2021). The findings described the impact of suicidal behaviour on perceptions of patients, and staff resilience. The importance of adequate planning to manage suicide risk, and a shared understanding that risk management should extend beyond hospital care were highlighted. Though SRA was considered, there was limited focus on experiences of carrying out this assessment. This review is an isolated example of research on the subjective experiences of HCP's conducting SRA, highlighting a gap within current research (Hechinger & Fringer, 2021; MacGarry et al., 2022).

To date, existing reviews have examined the influence of HCP attitudes, training and experience on responses to SRA and working with suicidal individuals and the impact of suicide deaths on HCPs, but there have been no reviews examining HCP experiences of SRA or the impact of factors such as staff anxiety or systemic pressures during SRA and whether these affect the approach and delivery of SRA. The current review and meta-synthesis focussed on moving towards an understanding of the subjective experiences of HCPs conducting suicide assessments and how these shape approaches to SRA. We aimed to develop a greater understanding of the experiences of HCPs completing SRA across different healthcare contexts, and specifically to address the questions:

1. What are the experiences of healthcare professionals completing suicide risk assessment processes in healthcare settings?
2. What factors do healthcare professionals perceive impact the delivery of these interventions?

Method

This systematic review was completed following the Preferred Reporting Items for Systematic Review and Meta-Analyses (PRISMA) guidelines (Page et al., 2021). It was prospectively registered on the International Register of Prospective Systematic Reviews (PROSPERO) (registration number: CRD420251001809). The research team was comprised of the Lead Researcher, a 33-year-old white female Trainee Clinical Psychologist, who has worked within mental healthcare settings for a decade. The first and second supervisors are experienced Clinical Psychologists and researchers (CF & NB). The review team were comprised of two trainee clinical psychologists (PP and IM), undertaking doctoral level training in research methods as part of clinical training.

Design

The methodology for this review was guided by the critical realist approach to thematic synthesis (Thomas & Harden, 2008) due to our focus on subjective experiences of SRA within the context of healthcare structures. This approach has been successfully adopted by other reviews of qualitative research on the subjective experiences of HCPs (see Ali et al., 2025; Mostafa et al., 2025 & Lee et al., 2025). The approach supports researchers to move beyond surface-level descriptions of phenomena to uncover underlying structures and processes that drive them (Fryer, 2022).

Date Source and Search Strategy

A predetermined search string developed in consultation with a specialist librarian was to search for the terms: suicide, healthcare professional and experience, and synonyms of these (see Appendix B). Four electronic databases (CINAHL, Scopus, MEDLINE and PsychArticles) were searched on 31st December 2025 for studies published between January

2015 to December 2025. Additional research was identified by hand-searching the reference lists of included studies.

Eligibility Criteria

Studies were included if they used qualitative data collection methods and analysis, recruited healthcare professionals working in clinical settings, focussed on subjective experiences of suicide risk screening and assessment; and had full text available in English or could be translated to English. Only studies from the last 10 years were included to focus on contemporary clinical experiences. This threshold aligns with the implementation of the World Health Organization's report, *"Preventing Suicide: A Global Imperative"* (WHO, 2014). As this document established international guidance for managing suicide risk, literature published prior to this threshold was excluded to avoid capturing outdated practices that do not reflect current clinical procedures.

Studies were excluded if they used quantitative or mixed methods, or focused on the perspectives of patients, carers, or individuals bereaved by suicide. To mitigate contextual noise, research was also excluded if it focused primarily on service-specific interventions, training programmes, policy implementation, or specific clinical subgroups (e.g., youth or dual-diagnosis populations), rather than the core experience of conducting Suicide Risk Assessment (SRA). Mixed-methods studies were excluded as they typically lack epistemological alignment with the review's qualitative objectives. Furthermore, mixed method studies can lack* the depth and richness of purely qualitative accounts, meaning they failed to generate new codes or insights beyond the point of coding saturation during analysis (Atkins et al, 2012; Noyes et al., 2025).

Study Screening and Selection

Search results were exported to Endnote. Titles and abstracts were screened to identify studies that focussed upon the experiences of HCPs providing SRA. Study inclusion and exclusion criteria were consulted and studies that used qualitative methods to explore HCP's experience of SRA were retained for full text review. Studies that did not focus on the risk assessment process or focussed only on training/service policy or did not use qualitative methods were removed. The number of studies excluded according to these criteria was recorded. Using Rayyan AI, a second reviewer (PP) independent from the research team, reviewed a random sample of 20% of studies included in the final synthesis, to confirm inclusion criteria were met. Disagreements were discussed and resolved.

Quality Assessment

Recognising the limitations of relying solely on stratified scoring of qualitative research, Whiffin et al. (2021) proposed the use of a combined appraisal of the relevance, resonance and rigour of research included in systematic reviews and meta-syntheses of qualitative research. In this combined appraisal they evaluated relevance based on review questions and participants, resonance on depth of content and scope of findings and rigour on methodological soundness.

The current review adopts a similar combined quality appraisal approach. Methodological rigour of included studies was assessed using the Critical Appraisal Skills Programme (CASP) qualitative research checklist, consisting of 10 items evaluating research aims, methodology, design, recruitment, and data collection. The checklist also examines the reflexivity of the researchers, ethical considerations, rigor of data analysis, and overall contribution of the findings to the existing literature (CASP, 2024). For this review, Butler et al.'s (2016) updated guidance for CASP scoring, which categorises methodology as low quality, (>7.5/10), moderate (7.5-9/10), or strong (9 or 10) according to CASP score, was

used. Articles received one point for each criterion satisfied, zero for each criterion not satisfied and half a point if it was unclear if a criterion were satisfied. Each of the included studies was then classified as Core, Central, or Peripheral to the current review using the Whiffin et al. (2021) criteria (see Table 1). To ensure methodological rigour and minimise subjective bias, 100% of included studies were independently appraised by the lead research (KM) and an independent second reviewer (IM) using the CASP checklist and Whiffin et al (2021) criteria. Any discrepancies in quality ratings were resolved through discussion until a consensus was reached. No papers were excluded from the analysis based on these criteria.

Table 1

Classification of Studies as Core, Central, or Peripheral Table

Category	Description
Core	**Relevance** – Research question explicitly aligned to the review question **Resonance** – Findings are rich, complex and evocative and make a meaningful and insightful contribution to advancing the evidence base **Rigour** – Methodologically congruent and appropriately applies qualitative methods
Central	As above but may fail to meet one or more of the criteria in its fullest sense.
Peripheral	**Relevance** – Research findings relevant but research question not completely aligned to the meta-synthesis question **Resonance** – Findings superficial., thin or expected, do not advance the evidence base in a meaningful way **Rigour** – There may be questions about the methodological congruence of the study and if methods were appropriately applied

Note. From "Whiffin, C. J., Gracey, F., & Ellis-Hill, C. (2021). The experience of families following traumatic brain injury in adult populations: A meta-synthesis of narrative structures. International journal of nursing studies, 123, 104043. https://doi.org/10.1016/j.ijnurstu.2021.104043"

Data Extraction

Qualitative data were extracted from the Results sections of included studies by the first author (KM). Data were systematically categorised into two distinct levels: first-order constructs, which are direct participant quotations capturing their original voices and lived experiences, and second-order constructs, which represent the research group interpretations, statements, and themes. This approach ensures that final themes are grounded in the experiences of the participants, whilst also benefitting from researcher insights (Britten et al., 2002, Thomas & Harden, 2008). Key study characteristics, including aims, participant demographics, design/sampling, findings, and outcome of quality assessment were extracted and summarised in Table 3

Analysis

The meta-synthesis was conducted using the three-stage approach to thematic synthesis developed by Thomas and Harden (2008), adapted to provide a transparent and systematic process for synthesizing qualitative data from diverse studies.

Stages One and Two: Coding Data and Developing Descriptive Themes

Following appraisal of study quality and relevance, relevant text (the results section of each study) were extracted. The initial analytical process involved the first author reading study findings multiple times. A reflexive process was undertaken by completing a diary alongside the coding process. The data from papers categorised as ‘core’ was coded first, followed by data from papers coded ‘central’ and then ‘peripheral’. Semantic and latent codes were identified and applied line-by-line to each of the text using NVivo software. The initial coding of data from core papers supported the development of a thematic codebook. As this analysis progressed, fewer new codes emerged. Whiffin et al. (2021) suggest that adopting this process allows for saturation of the coding within higher quality papers, which are of greater relevance to the research question.

Following this process, 176 inductive and deductive initial codes were identified, which included direct participant quotes and author interpretations. They were then systematically grouped into thematic clusters based on shared meaning and content, which formed descriptive themes summarising groups of related findings across multiple studies whilst remaining close to the data. The content of the reflexive diary and themes were discussed with the research team in supervision (CF & NB); additional interpretations of themes were explored. Examples of the initial codes, grouping, quotes and themes can be seen in Appendix C.

Stage Three: Generating Analytic Themes

In the final, interpretive stage, descriptive themes were examined in relation to the review questions, by a process of iteration and reflection that moved beyond original study findings to develop analytical themes, novel constructs and interpretations to provide new insights related to the review questions.

Rigour

Methodological rigour was maintained through application of several frameworks. The ENTREQ checklist (Tong et al., 2012) guided the reporting process (see Appendix D), while Lincoln and Guba's (1985) criteria were considered to address credibility, dependability, transferability, and confirmability. Credibility was enhanced through reflexive journaling and iterative supervisory discussions (Barrett et al., 2020). Procedural rigour and dependability were ensured by maintaining a transparent, replicable approach, including publication of a PROSPERO protocol, clearly defined CASP appraisal (See Appendix E) and search strategies. To facilitate transferability, a maximum variation sampling approach was adopted alongside descriptions of geographical and cultural contexts (Munthe-Kaas et al., 2020). Finally, confirmability was established via a digital audit trail of search and inclusion

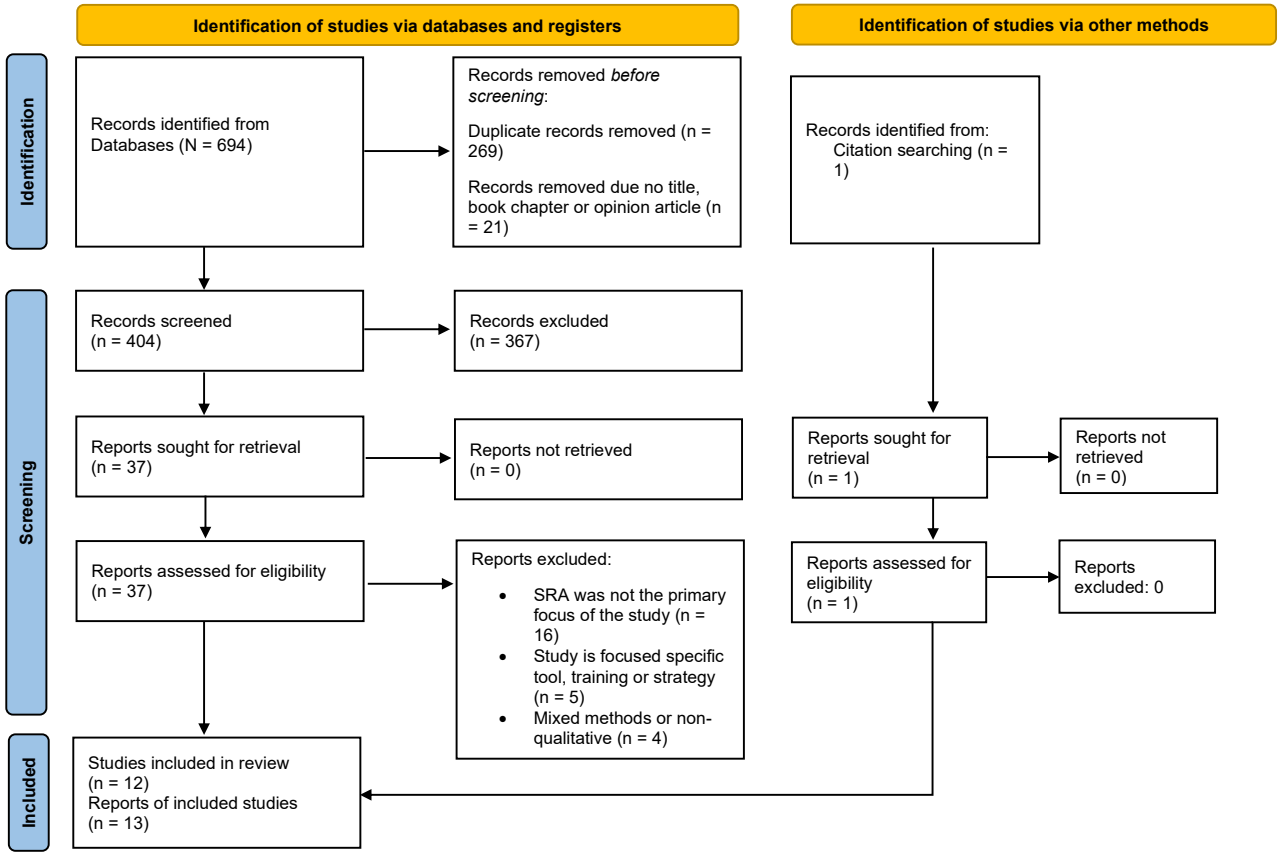
decisions, external data grounding, and the inclusion of direct quotes, evidence tables, and raw codes (Ahmed, 2024).

Results

Final electronic searches using four databases found 695 results from 2015 to 31st December 2025, with the Scopus database yielding 362, PsychArticles yielding 8 and the CINHAL and Medline databases yielding 108 and 216 results, respectively. Hand searching and reviewing relevant literature recommendations identified one further study. After removing duplicates and texts with no title etc. 405 studies were retained (see Figure 1) and screened by the lead researcher.

Figure 1

Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) Flow Diagram (2020)



Source: Page MJ, et al. BMJ 2021;372:n71. doi: 10.1136/bmj.n71.

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A random sample of 20% of papers at both title and abstract (N= 80) were screened by an independent reviewer (PP). The percentage agreement with the first author was 95%. Disagreements between the lead researcher and the independent reviewer were resolved by consensus and consulting and referencing the eligibility criteria.

Thirteen reports of 12 studies were included in the meta-synthesis. Studies were published between 2015 and 2025 (Table 2). The studies were conducted in Sweden (k = 6), the United States of America (k = 3), the United Kingdom, Uganda, China and Spain (k = 1 each). The data collection methods used were content analysis (k = 6), thematic analysis (k = 5) and interpretive phenomenology (k = 1). Across studies, 320 participants were involved. The samples recruited were predominantly composed of nursing staff (n = 184), but there was also representation of medical doctors (n = 101), mental health professionals (n = 19), allied health and other professionals (n = 16). Studies ranged in their reporting of demographic information: 12 papers reported gender with 82 males and 222 women represented across studies, Roy et al. (2016) did not report gender. All papers reported age (21 - 69 years) and years of experience (1 - 30 years).

Considering relevance, resonance and rigour (using the CASP), five papers were classified as core, five as central and three as peripheral.

Table 2

Study Characteristics, CASP Score and Relevance to Synthesis

Study ID and Country	Aims	Samples Size and Characteristics	Setting and Context	Recruitment and Data Collection Techniques	Data Analysis Method	Key Findings	CASP Checklist Score	Relevance to Synthesis
Derblom et al. (2021) Sweden	To explore nurses' experiences of assessing suicide risk in psychiatric inpatient care.	10 Registered nurses and mental health nurses.	3 different inpatient/open care units (two psychiatric, one substance misuse) in Sweden	Convenience sampling. A cross-sectional qualitative semi-structured interview design	Content Analysis	Four main themes, 11 sub-themes: Creating a caring alliance: Knowing about the patient Trusting one's intuition Taking responsibility: Managing a challenging task, being afraid of making the wrong decision, bringing work worries home. Collaborating with colleagues: Feeling alone in decision-making, Seeking support from colleagues. Lacking knowledge and training	8.5	Core

Du et al. (2025) China	To explore the process and needs of emergency pre-examination and triage nurses in assessing patient suicide risk.	14 Registered Nurses	Emergency departments within two urban hospitals in a city in China	Convenience sampling. A cross-sectional qualitative semi-structured interview design	Descriptive Phenomenology	Three themes and nine sub-themes, including identifying suicide risk characteristics of patients (suicide and self-injurious behaviours, psychological and mental state, medical history and life experience), barriers in assessing suicide risk of patients (suicide stigmatization, uncertainty of responsibility, and occupational psychological stress of nurses), and suicide risk management needs (concise and effective suicide risk assessment process, knowledge and skills training on suicide prevention, and organizational support).	7	Peripheral
Jansson & Granehei	To describe nurses' experiences of assessing	12 participants, 8 Registered Nurses and 4 Enrolled Nurses	Outpatient services across three	Purposeful sampling. Cross-sectional	Content Analysis	One theme and four sub-themes - Feeling anguish due to lack of control: Uncertainty,	9	Core

m (2018) Sweden	suicide risk in specialised mental health outpatient care in rural areas		rural areas of Sweden	qualitative semi-structured interview design		Loneliness, Ethical issues, Organisational challenges		
Munoz-Sanchez et al. (2018) Spain	To analyse the views and experiences healthcare professionals who complete suicide risk management, and identify key factors in suicide prevention	56 Healthcare professionals, Primary care physicians (N = 12), Emergency physicians (N = 14), Psychologists (N = 17), Psychiatrists (N = 13)	Healthcare centres across Spain	Purposeful sample. Cross-sectional qualitative design using focus groups to gather data	Content Analysis	The four groups of professionals agreed that interventions in at-risk behaviours are first in importance, then prevention, then increasing time to assess and finally increased interprofessional communication.	8	Peripheral
Petrik et al. (2015) USA	To provide an investigation of Emergency department professionals perspectives on factors that facilitate or hinder effective suicide risk assessment.	92 Participants from two hospitals, Registered Nurses (N= 64), Emergency Medicine Residents or Fellows (N = 9), Attending Physicians (N =	Two Community based hospitals Emergency departments in a suburban area of Midwest USA	Maximum variation sampling, cross sectional design using open ended surveys to gather data	Thematic analysis	Six themes: Time, Privacy, Professional collaboration and consultation, Integration of standardised screening protocols, Patient engagement and participation, Provider	8	Central

		9), Social Workers (N = 4), Physician Assistants (N = 6)				communication approaches		
Roy et al. (2016) USA	To explore the real-world experience and perceptions of emergency medicine (EM) physicians involved in suicide risk assessment and management	16 Emergency Medicine physicians, Attending (N = 10) and Resident (N = 6)	A Teaching hospital emergency department in an urban area of the USA	Convenience sample. A cross-sectional qualitative design using focus groups to gather data	Thematic Analysis	Eight themes from 1,293 coded passages: Participants discussed how they deal with the challenges of assessing suicide risk, Limits of suicide screenings, resource scarcity and the value of experience and client rapport.	7.5	Central
Rukundo et al. (2022) Uganda	To explore the knowledge, attitudes and experiences of primary healthcare workers in assessing and managing suicidality	18 Healthcare professionals, Medical Doctors (N = 5), Clinical Officers (N = 2), Midwives (N = 2) and General Nurses (N = 9)	2 different hospitals and 12 healthcare centres across 5 districts of Uganda	Purposeful sampling. A cross-sectional qualitative semi-structured interview design	Content Analysis	Four themes: Knowledge and attitudes of primary healthcare workers in the assessment and management of suicidality, Experiences in the assessment and management of suicidality, challenges faced by primary healthcare workers	8.5	Peripheral

						while assessing and managing suicidality, and Recommendations for improving assessment and management of suicidality in PHC.		
Waern et al. (2016) Sweden	To investigate psychiatrists' personal experiences in clinical interactions involving the assessment of suicidal patients	15 Psychiatrists	Various backgrounds within psychiatry in mental health, emergency services and forensic.	Purposeful sampling. Cross-sectional qualitative semi-inductive interview design	Thematic Analysis	Three main themes: Understanding the patient in a precarious situation, Understanding one's own reactions, and Understanding how the doctor-patient relationship impacted on risk assessment and management decisions. Subthemes included: Emotional contact and Credibility issues.	9	Core
Wolf et al. (2018) USA	To explore the process by which emergency nurses assess and manage patients with suicidal ideation.	41 Nurses, who had different roles in emergency departments including staff nurse, manager, clinical specialist etc.	Settings included multiple different emergency departments across the USA, including	Convenience sampling, data collected using open ended questions in a survey and focus groups	Thematic analysis	Findings were examined using nursing process theory, they included that suicidality assessment occurs not by asking a single question but also with the assessment of patient behaviours and	8	Central

			General, Adult-only and Paediatric			presentation (appearance, hygiene, etc). When emergency nurses suspected occult suicidality, additional actions (finding private space, keeping patients safe, and passing on information), took priority.		
Wärdig et al. (2022a) & Wärdig et al. (2022b) Sweden	The study used two reports to explore nurse's experiences of suicide risk assessment in telephone counselling in primary health care(a) and suicide prevention work in primary health care.(b)	15 Registered and District Nurses	Nine primary healthcare centres in two different regions of Sweden	Purposeful and Convenience sampling. A cross-sectional qualitative semi-structured interview design	Content Analysis	First report: two themes and six subthemes – A challenging task; Challenging assessment, Holding the patient's life in their hands, In need of mor education. Organisational Unclearness – Lack of guidelines, Lack of time, In need of collaboration. Second report: three main themes and eight subthemes- Reasons for suicide risk assessments:	8.5/8	Central/ Central

						When patients seek help for mental illness, The intuition says something is not right Challenges in suicide risk: assessment It takes time Assessing without seeing Need for support Flexibility through suicide risk assessments: Communication skills To refer correctly Support and knowledge to lead.		
Wärdig et al. (2024) Sweden	See above.	Nine Nursing staff including Registered Nurses (N = 3) and Assistant Nurses (N = 6)	Psychiatric inpatient and outpatient services, including emergency departments in Sweden	Convenience sampling. A cross-sectional qualitative semi-structured interview design	Content Analysis	Three categories with subthemes: How - The instruments and the clinical assessment need to interact harmoniously, with experience, patient knowledge, and intuition as tools, Determining the patient's honesty. Why - the sharing of feelings, some	8.5	Core

						scepticism and a valuable support, assessing to protect oneself. When – lack of knowledge or inadequate protocols, as routine or with gut feeling		
Xanthopoulou et al. (2025) United Kingdom	To explore how Mental Health professionals in Emergency depts. experience and approach the assessment of suicide risk for patients.	22 Mental Health practitioners from various healthcare roles: Mental Health Nurse (n = 6), F1 Doctor (n= 5), Senior mental health professional (n = 3), Consultant Psychiatrist (n = 2), F2 Doctor (n = 2), Occupational Therapist (n = 2), Social Worker (n = 2)	One emergency departments liaison psychiatry team in England	No detail available on sampling, part of a mixed methods study across two papers, this paper focusses on qualitative interviews only	Thematic Analysis	Four themes: the complexity of assessing suicide risk and lack of confidence in some patients/ accounts, the dynamic nature of risk, the impact/barrier of a structured assessment form, and institutional pressures and lack of resources.	7.5	Central

Meta-Synthesis Outcomes

Four themes emerged following analysis of the data:

1) Assessing Suicide Risk is a Challenging Experience

2) Relying on Experience and Intuition to Guide Assessment

3) Navigating the Gaps Between Guidance and Practice

4) Systemic Factors Influence Approaches to Assessment

Theme 1: Assessing Suicide Risk is a Challenging Experience

Healthcare professionals described completing SRA as a highly challenging personal and professional experience. Across studies, they shared thoughts about the difficulty, uncertainty, anxiety, fear, loneliness and threat perceived when completing assessments as part of their role. One nurse participant shared that "I become like I have mentioned, always fearful, not fearful for the assessment but afraid of making the wrong decision…" (Derblom et al., 2021, p. 779).

Many of the participants also shared concerns about the weight of responsibility when making decisions based on their assessment, construing the process as a heavy task which impacted their emotions negatively at times (Wärdig et al., 2022b).

Part of the challenge lay in the consistent presence of uncertainty and the fear of making an incorrect decision. One psychiatrist described it as, "There is something that bites and digs at my soul, … a catastrophe is going to happen" (Waern et al., 2016, p. 5), illustrating the emotive impact of disclosures of suicidality to healthcare professionals. Many others spoke about the intense emotions provoked by risk assessment. One quotation from a nurse which illustrates this is, "It gets harder to handle other situations because you are so focussed on whether this assessment was right or not" (Derblom et al., 2021, p. 779), noting again the deep feeling of responsibility and a fear of making the wrong decision that was

often "taken home". This is evident in the accounts of nurses describing their thoughts in the evening following an assessment: “Help! Do I have responsibility for another person’s life here now?” (Wärdig et al., 2022a, p. 906) and “Oh my god, what have I done now, how did it go,” (Derblom et al., 2021, p. 779). Some professionals shared that uncertainty could prompt them to use more restrictive approaches to care, such as involuntary admission. One psychiatrist reflected, “It was this uncertainty... that was what prompted me to admit him involuntarily... Unfortunately, this is not the first time that I caused this type of situation” (Waern et al., 2016, p. 6). This suggests that defensive practice can become a pattern of behaviour adopted when healthcare professionals struggle to manage the uncertainty of SRA.

Another challenge was a pervasive sense of doubt regarding the veracity of patients' reported risk. This was particularly prominent among those in decision-making roles, such as psychiatrists and senior nurses. Participants often feared that patients had hidden motivations (Waern et al., 2016) or secondary benefits for the assessment, such as receiving medication or hospital admission (Petrik et al., 2015; Roy et al., 2016). An example of this can be seen in this quotation:

> Patients trying to manipulate the system. Some patients do appear to be a risk but they purposely say something so that they can be either admitted (i.e. homeless on a cold night) or at least further evaluated. (Petrik et al., 2015, p. 25)

This concern was magnified when encountering patients with diagnoses such as borderline personality disorder or substance misuse disorder. Distrust of the motivations of patients with these diagnoses could lead to underestimation of risk, as noted by an

emergency department doctor: “If I hadn’t known the [Personality Disorder] history then I would’ve placed more confidence in what they were saying than I end up doing” (Xanthopolou et al., 2025, p. 47). Similar challenges were shared regarding patients who were considered emotionally dulled or blunted (Waern et al., 2016), or where the physical “injury doesn’t match what they’re telling you” (Wolf et al., 2018, p. 494). These mismatches in presentation created a professional and moral dilemma for professionals trying to assess risk.

Further challenges included professionals feeling undertrained or lacking the specific knowledge held by specialised colleagues. An emergency physician commented, “I don’t think I have the right training in psychiatry to assess many psychiatric patients” (Muñoz-Sánchez et al., 2018, p. 7). Although onward referral was a role responsibility, some shared that this was often motivated by an emotional response to the assessment process, rather than clinical necessity. When access to specialists was limited, it acted as a deterrent to thorough risk assessment. This is illustrated by the observation that, “sometimes staff doesn’t care to ask if a patient is suicidal. They don’t want to deal with the work involved in getting someone care” (Petrik et al., 2015, p. 583), suggesting a level of avoidance when managing the burden of SRA.

Theme 2: Relying on Experience and Intuition to Guide Assessment

This theme examines how professionals frequently used clinical intuition and accumulated experience to navigate SRA. Experience was seen across the participants as one of the key facilitators of effective assessment; “practice, practice and more practice” (Waern et al., 2016, p. 4) was described by a psychiatrist as the mechanism by which they were able to combine clinical training and experience to help attain the true representation of the patient’s risk (Waern et al., 2016). Similarly, nurse participants described greater self-reliance

and confidence in asking risk questions as their experience increased, noting that less experienced professionals found this aspect of the role particularly awkward or frightening. HCPs shared that this tentativeness could lead to lower-quality assessment, as illustrated by one nurse:

> I find one of the other challenges is new-to-triage nurses don't have the expertise to know what cues and what questions to ask or what about body language or how the patients are withdrawn or eye contact, you know, very quiet voice, soft spoken, evasive (Wolf et al., 2016, p. 496).

There was a sense that this experience could not be taught and that SRA was not only a form of verbal communication but also a process of learning to interpret the "whole person" through a combination of clinical knowledge and intuition. One participant described the importance of observing a patient's body language when assessing their risk

> …eighty percent is in the body language, I don't know if this is true, but there are subtle ways of saying things, ways of being, ways of looking at one another. (Waern et al, 2016, p. 4)

Intuition, or developing a gut feeling about the nature of suicide risk was a widely shared experience among healthcare professionals (Derblom et al., 2021; Wolf et al., 2016; Wärdig et al., 2022a; 2024). This was described in different ways, including developing a "vague feeling of discomfort" (Jansson & Graneheim, 2018, p. 557), unease (Roy et al., 2016), and "an ineffable sense that something is not right, a lump in the stomach, an

undefined feeling of unease or unpleasant 'butterflies'" (Derblom et al., 2021, p. 778). Developing this intuition was linked to the repeated experience of completing suicide assessments and was viewed by HCPs as being as valuable as formal training:

> …Absolutely, if I have a gut feeling that something is wrong and there is a potential risk for suicide, it is crucial to follow that instinct. In such cases, it is important to assess the situation as potentially risky and signal this concern to colleagues or other appropriate healthcare professionals (Wärdig et al., 2024, p. 5).

Part of developing intuitive approaches involved HCPs focussing on getting to know patients and accessing their history to support assessment. Although intuition was suggested to be a formative part of most professionals' risk assessments, several quotations highlighted the limitations of relying on intuition alone. Some participants expressed concerns that relying on a gut feeling may be perceived as unprofessional (Wolf et al., 2016), while others emphasised the importance of balancing intuition with structured tools. This suggests that participants experienced a professional tension between the use of skills crafted from experience and the objective, formal tools often encouraged by training and policy. Given the reported dearth of access to training and guidance reported by participants across studies, this is arguably an understandable and adaptive way to support risk assessment.

Theme 3: Navigating the Gaps Between Guidance and Practice

This theme focusses on the adaptive strategies used by HCPs to navigate discrepancies between official guidance and professional practice. Mirroring the challenges of accessing suicide-specific training, many participants found guidance regarding SRA to be

vague or difficult to access. One nurse shared that they had not encountered comprehensive guidelines for SRA's (Derblom et al., 2021), this was echoed by others who described a series of vague or unclear routines (Jansson & Graneheim, 2018; Wärdig et al., 2022b). This could result in risk assessments being used sporadically or randomly, without a structured written protocol. When guidance was clear, HCPs reported feeling more secure in their assessments, as evidenced by the following quotation: "Our anxiety would be alleviated if we got support and guidance when we encountered difficulties and reported to the head nurse and director." (Du et al., 2025, p. 1006)

However, this was often not the case; such support was frequently viewed as a privilege reserved only for those who had received specialist suicide training. HCPs described various ways of navigating these guidance gaps, often seeking informal support from peers. Accessing the expertise of colleagues to ask questions and reflect on assessments was found to alleviate anxiety among some psychiatrists, whilst also helping nurses feel more secure in their decision-making (Wolf et al., 2016).

Most HCPs agreed that assessments were better when staff felt supported; conversely, limited support was believed to result in poorer risk assessments. This is reflected in observations that on occasions where there was limited help available, nurses shared that they would struggle to focus on other tasks due to concerns about patient safety (Wärdig et al., 2022b). Such findings indicate a heightened level of inconsistency in how colleagues respond to SRA, suggesting that the quality of care may be impacted by individual team dynamics rather than standardised protocols.

The use of risk assessment tools was identified as another method of supporting the process. These tools offered a structured approach that was seen as particularly helpful for less experienced staff members. One nurse described her experience:

> If we consider the suicide continuum, which forms the foundation of what we use, I can see why it might be perceived as somewhat for dummies. It is straightforward, so someone who is new can simply follow the steps. Therefore, it serves as a clear instrument when provided with proper instructions. (Wärdig et al., 2024, p. 6)

However, an over-reliance on these tools was criticised as treating SRA as a checklist or tick-box exercise (Waern et al., 2016; Wolf et al., 2018; Wärdig et al., 2024; Xanthopoulou et al., 2025) which was a practice often condemned by practitioners across professions. Many suggested that risk tools were only useful for assessing risk when combined with clinical skill and experience:

> No, I have to supplement it with my experience, absolutely. I can't just rely on the instrument. Absolutely not, never. Never actually. Because you have to have a deeper communication (Wärdig et al., 2024, p. 4)

Because an over-reliance on structured tools was perceived as unacceptable, some practitioners even admitted to going against guidance to avoid using them:

> For a while I tried to be good... to note in the patient's record how many [risk factors] were present, but I think I have lost it a bit... I have no sense that rating scales aid my clinical assessment (Waern et al., 2016, p. 4)

Theme 4: Systemic Factors Influence Approaches to Assessment

This theme reflects HCPs' perspectives of systemic barriers to SRA. There was a shared acknowledgement that factors such as time, setting, modality, and resource allocation all impacted approaches to SRA. "Time, time, time, there is never enough time" (Petrik et al., 2015, p. 583) claimed one nurse; most professionals agreed, noting that the time allocated to complete a risk assessment was often described as being too short, sometimes only a few minutes, depending on the setting and competing priorities. This time pressure could lead to the abrupt delivery of risk questions, which felt jarring to professionals. A physician provided an example of this apologetic approach to questioning: "Say, I'm sorry I have to ask this, I know it's crazy, but have you had any thoughts of hurting yourself?" (Roy et al., 2017, p. 374)", suggesting that the quality of interaction is frequently impaired by these constraints.

HCPs suggested that having additional time to assess or screen allowed them to develop and build rapport (Petrik et al., 2015) and complete observations of a patient's physical state, both of which supported an accurate assessment of risk. Seeing fewer patients in a day was viewed as a factor that facilitates longer, better-quality assessments; however, this was difficult for HCPs to achieve across most settings. In the following quotation, a nurse describes the impact of allotting more time to a patient during a busy shift:

> It is not many minutes you have and then you sit there and feel that it has taken a quarter of an hour and I'm behind, in the schedule. Then it's hard not to get stressed (Wärdig et al., 2022b, p. 4)

Similar concerns could influence practitioners to avoid asking risk questions or documenting risk accurately to negate the perceived time burden of managing the outcome of a high-risk assessment (Roy et al., 2017). This presented a further ethical dilemma: whilst there was a shared understanding that risk could be missed, those at risk of suicidal ideation could also be seen as adding to time pressures, as seen in this quote from an emergency department physician: "We're drowning … We're stretched thin on resources and time. We just don't have the time to sit with each patient and try to elicit as good of a history as we should. "(Roy et al, 2017, p. 375)

Experiencing ethical challenges due to organisational constraints was mentioned by many professionals. Lack of access to resources was perceived as a barrier to completing suicide risk procedures, one participant said:

> One of the challenges we face is a scarcity of resources… we are few qualified health workers who can manage such clients. So, when the one who is well versed with such clients is not around you find that it is a hassle (Rukundo et al., 2022, p. 7)

Another highlighted "there are too many physically sick people to spend a good amount of time correctly assessing people with mental health issues" (Petrik et al., 2015, p. 583). This indicates that SRA is perceived as a resource intensive process that places demand on even experienced HCPs. These pressures can lead to a dilemma regarding how to prioritise SRA alongside other aspects of healthcare.

The appropriateness of the context and setting was also seen to add to these demands. Regarding the physical setting, there was often uncertainty as to whether HCPs could access the required privacy to complete an assessment that encouraged patients to

feel comfortable enough to disclose suicide risk. This is illustrated in the following quote: "The location of our triage room… It is within hearing distance of the EMS room as well as the admitting desk" (Petrik et al., 2015, p. 583). Conversely, some professionals detailed the risks of visiting patients in the community; as one nurse noted, "I didn't know the building, what was happening in other rooms, or who else was there … and what could I do if something unexpected happened" (Jansson & Graneheim, 2018, p. 558). For some, the modality of assessment presented its own barrier; a nurse detailed her concerns with telephone-based risk assessment:

> It is body language. We communicate so much with our body language. We can see attitudes, facial expressions and other expressions. And then there is much greater security as staff if you meet the patient face to face than if you only talk over the phone in these situations (Wärdig et al., 2022b, p. 4)

Taken together, the HCPs agreed that most settings require significant organisational improvement to support the successful implementation of routine SRA protocols.

Discussion

This systematic review and meta-synthesis explored the experiences of health care professionals completing SRAs across healthcare settings. Four themes were identified during analysis: Assessing Suicide Risk is a Challenging Experience, Relying on Experience and Intuition to Guide Assessment, Navigating the Gaps Between Guidance and Practice and Systemic Factors Influence Approaches to Assessment

A significant theme was that SRA was experienced as a profoundly challenging personal and professional endeavour, characterised by intense anxiety, fear, and a pervasive sense of threat. A primary driver of this distress is the heavy weight of responsibility (Wärdig et al., 2022a), where clinicians feel personally accountable for a patient's life. This emotional burden was exacerbated by persistent clinical uncertainty, which could lead to defensive practice and ruminative thoughts, extending into the clinician's personal life. Similarly, Huggett et al. (2024) observed a culture of blame within mental health services can drive professionals towards restrictive or defensive approaches to mitigate the risk of litigation or professional criticism following a suicide.

Another challenge was that HCPs had to frequently navigate complex moral dilemmas when confronted with perceived discrepancies between a patient's self-report and their clinical presentation. These dilemmas often stemmed from the interplay of limited knowledge, less confidence, and pre-existing personal stigma, which can reduce through prolonged clinical exposure and targeted training (Boukouvalas et al., 2020). Participants also shared that these dilemmas could lead to feelings of anxiety and avoidance of SRA. Research shows that professional avoidance during SRA can manifest through the use of leading questions or double negatives that inadvertently dissuade disclosure and facilitate a change in subject (McCabe et al., 2017; Roush et al., 2018). Given that clinical anxiety and discomfort can impede the in-depth exploration of suicidal ideation (Hawton et al., 2022), increasing direct professional contact with suicidal patients, alongside enhanced specialist training and robust clinical supervision may support breaking the cycle of avoidance and ensuring earlier risk detection.

To mitigate the challenges of formal assessment and gaps in training, HCPs frequently used accumulated experience and clinical intuition. The data suggest that this often

manifests as a gut feeling or intuitive response, which has been explored clinically through dual processing theory, described as a system one cognitive process in diagnostic reasoning (Croskerry et al, 2009; Norman et al, 2024). These processes are typically unconscious, rapid, and based on minimal information, contrasting with the logical and analytical, system two processes which are slower and grounded in knowledge. Notably, system one reasoning can be error-prone if used in isolation (Norman et al., 2024). While this intuitive approach was highly valued by participants, it also generated professional tension between these adaptive intuitive skills and the objective formal protocols mandated by service policy. Ultimately, the reliance on intuition was perceived as a necessary, though informal strategy for navigating the complexities of SRA in the absence of institutional support or specialised training. It has been recommended that greater access to specialised training, focussed on how to assess the risk of suicide in a holistic way using real life scenarios, could support HCPs to develop their knowledge and confidence (Fedorowicz et al., 2023). Such training could balance the perceived reliance on intuition by providing a foundation of strong knowledge to support slower clinical reasoning processes during SRA.

Further themes focussed on how HCPs navigate the complexities of clinical practice. The extent to which institutional risk protocols and structured assessment tools were perceived as helpful varied between participants. This is supported by evidence that suggests the multifactorial nature of suicidal behaviour cannot not be captured effectively by risk assessment tools alone. Instead, it is recommended that combined approaches be undertaken alongside clinical interviews (Lotito & Cook, 2015; Runeson et al., 2017). Participants also suggested that the effectiveness of SRA frequently depended on strong team dynamics and the availability of peer consultation, alongside clinical interviews and the use of risk tools.

The final theme explored the perceived obstacles that impaired SRA. Demanding schedules often necessitated brief interactions with patients, creating the sense of a time burden (Roy et al., 2017) that inadvertently led some practitioners to prioritise workload management over thorough SRA. A similar theme was echoed by Fedorowicz et al. (2023), who interviewed psychiatrists and found that time restrictions were viewed as a predominant barrier to conducting risk assessments. This is particularly evident within the NHS, where primary care appointments with a General Practitioners typically last only ten minutes. Additionally, environmental factors, such as a lack of privacy in certain clinical areas or the limitations of remote assessments, hindered the development of the rapport necessary for patients to disclose sensitive information. These systemic limitations consistently posed an ethical challenge, as the need for comprehensive risk evaluation was frequently constrained by the physical and organisational realities of healthcare settings.

Limitations

Several limitations should be acknowledged. Firstly, there was a limited number of published papers available focussing on HCP experiences of delivering SRA. Only a few of the primary research papers featured research questions that fully aligned with the overarching aims of this review. This was reflected in the allocation of lower relevance scores during the quality appraisal of the literature (Whiffin et al., 2021), as some data provided in more peripheral papers were determined not to be relevant to the review objectives. Four of the papers were categorised as core, meaning they had high relevance and resonance with the research questions and strong methodological rigour. These represented less than a third of included reports, which may have impacted the overall richness of the findings in relation to the review aims. Critical appraisal of rigour was considered using the CASP quality checklist and most studies were found to lack reference to research-participant reflexivity and ethical

considerations regarding study methodology. This has been identified as a significant methodological limitation across qualitative research (Braun and Clarke, 2013) but is particularly critical in suicide research where the failure to report on situational ethical challenges may overlook the complex power dynamics and emotional safety of the participants (Mishara & Weisstub, 2024).

Secondly, in line with the findings of a review by Boukouvalas et al. (2020), the combined participants consisted predominantly of nursing staff. Future research would benefit from insights from other allied health professionals, who may now hold greater responsibility for SRA under updated clinical guidelines (NHS England, 2025). Furthermore, it is recognised that most included studies included are situated within Western healthcare settings, with only two (Du et al., 2025; Rukundo et al., 2022) representing non-Western perspectives on SRA. Both studies were assessed as peripheral in relevance due to a limited focus on professionals' rich experiences of completing SRA. This, combined with the high number of studies originating from a single country (Sweden), may limit the international generalisability of the findings. A further review and meta-synthesis may be beneficial in the future as research develops in response to the evolving international landscape of suicide prevention.

Future Research

Further qualitative research on the experience of conducting suicide assessments across varied professions, settings, and countries would continue to develop our understanding of clinicians' perceptions of assessment and how this may change over time. Further research on professional understanding of the barriers and facilitators of suicide screening and assessment, would be helpful and particularly how facilitators help to navigate barriers and support professionals to complete assessments in difficult clinical

environments, such as emergency departments. Finally, there should be a greater research focus on developing specialised suicide training and evaluating its impact on professional engagement with patients expressing suicide risk, as well as how it may affect their approaches to suicide risk assessment.

Conclusions

This systematic review and meta-synthesis provide the first qualitative exploration of healthcare professionals' experiences of completing SRA. Four themes emerged from the current systematic review and meta-synthesis of healthcare professional's experience of suicide risk screening and assessment: Screening and Assessing Suicide Risk is a Challenging Experience, Relying on Experience and Intuition to Guide Screening/Assessment, Navigating the Gaps Between Guidance and Practice and Systemic Factors Influence Approaches to Screening/Assessment. These themes illustrate that suicide risk assessment is perceived as a profound challenge, with professionals frequently relying on clinical intuition and peer support to navigate vague service guidelines and systemic barriers. Our findings highlight a need for enhanced training, clearer guidance, increased supervision and greater institutional support. Future research should aim to capture more diverse experiences of wider multidisciplinary team members involved in suicide prevention efforts across the world.

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Chapter 3 – Bridging Chapter

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Bridging Chapter

The systematic review in Chapter Two investigated how healthcare professionals experience suicide risk assessment across diverse clinical settings. Themes revealed that assessments are perceived as inherently challenging and often exacerbated by systemic barriers. While professionals navigate these hurdles using clinical intuition, experience, and peer support, a lack of clear guidance and role ambiguity can lead to avoidance of suicide risk detection and assessment. Consistent with existing literature, such uncertainty and anxiety can lead clinicians to avoid difficult conversations, a tendency that intensifies when cases are complex or protocols are vague (Fedorowicz et al., 2023; Hawton et al., 2022).

Recent research identifies disparity in psychological support for stroke survivors with aphasia. Schlesinger et al. (2023) found that while healthcare professionals frequently report high intention to screen people with post-stroke aphasia for PSD, their intention to screen for suicidality is significantly lower. Qualitative findings highlighted that clinicians perceived that they lacked competence and specialised tools, which presented as a primary barrier to suicide screening. Participants identified a need for training in aphasia-accessible screening methods and supported communication strategies to ensure that patients with communication impairments were not systematically excluded from these interventions.

Building on these findings, Carroll (2024) completed a Theory of Planned Behaviour experimental vignette study to examine the factors influencing screening intentions among Speech and Language Therapists (SLTs). Identifying that the reasons for not screening for suicidality in stroke survivors with aphasia is complex, and rooted in issues of competence, confidence, as well as role expectations. This research indicated that normative beliefs impact a clinician's intention to screen. When these normative expectations are unclear and combined with the difficulty of using standard suicide risk assessments that rely heavily on complex verbal communication, SLTs were more likely to feel unconfident and anxious. This lack of confidence often results in professional avoidance, where the perceived communication barrier serves as a deterrent to performing necessary risk assessments.

To address training and guidance gaps in support for healthcare professionals conducting suicide screening and assessment with people with post-stroke aphasia, the research study reported in Chapter Four sought to establish a professional consensus on the

most useful methods for detecting and assessing suicide risk in this group. By mitigating the uncertainties inherent in communication barriers, the study aimed to start to develop a standardised protocol providing the practical guidance currently missing from the field and offering a foundation for future research on suicide risk assessment in people with post-stroke aphasia.

Chapter 4 – Empirical Paper

A Professional Consensus on Suicidality Assessment in Aphasia: A Delphi Study (SAADS)

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See Appendix F for formatting guidelines for authors

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Abstract

Background: Stroke is associated with increased risk of suicidality, but communication impairment and lack of validated assessment tools complicate assessment of suicidality in stroke survivors with aphasia.

Aims: This study aimed to establish a professional consensus on the most useful methods for suicide risk detection and assessment in post-stroke aphasia.

Method: Thirty-one experienced stroke professionals were recruited to a three-round Delphi study, of whom 23 and 20 were retained to Round Two and Three respectively. Data were analysed using a mixed-methods approach, combining content analysis for Round One to inform the development of the subsequent round, and descriptive statistics to refine consensus across subsequent rounds.

Results: Round One identified key themes, including the use of specific standardised mood measures and varied approaches to assessment. Rounds two and three reached strong consensus on the usefulness and delivery of many methods, including involving wider family and healthcare systems, as well as using adapted approaches to communication. However, consensus was not achieved for several mood measures and verbal approaches for receptive symptoms, including using direct risk questions. Data on participant confidence and method accessibility provided additional clinical context.

Conclusion: Participants reached a strong consensus on effective approaches for detecting and assessing suicide risk in stroke survivors with aphasia. These findings provide the first professional consensus focussed on how to detect and assess risk of suicide in stroke survivors with aphasia. We also highlight practical recommendations and address limitations

to help professionals develop the specialised skills necessary for this critical area of post-stroke care.

Keywords: Post-Stroke Aphasia, Stroke, Suicidality, Suicide assessment, Delphi Method

Introduction

Stroke is a leading cause of complex disability, impacting physical and sensory functioning, social participation and mood (Prust et al., 2024). In the United Kingdom, two-thirds of survivors develop disability due to stroke (Stroke Association, 2025). Communication impairments are common, with an estimated third of survivors developing aphasia and half developing dysarthria (Mitchell et al., 2020; Stroke Association, 2025). Emotional difficulties are also common. An estimated third of stroke survivors develop depression (Hackett et al., 2014; Liu et al., 2024), a prevalence higher than found in the general population. This is negatively associated with quality of life (Lui et al., 2025) and can be associated with suicidality, reflecting the strong association between mood disorders and suicide (Angst et al., 1999).

Stroke is associated with increased risk of suicidality. A meta-analysis of 23 studies with over 2 million stroke survivors found that the overall risk of suicide is 73% higher when compared to those without a history of stroke (Vyas et al., 2021). Between 10–15% of stroke survivors experience suicidal ideation, and post stroke depression (PSD) is a significant predictor of this risk (Bartoli et al., 2017; Chen et al., 2021). Suicide risk is even more pronounced for individuals with post stroke aphasia, who experience higher rates of PSD and comorbid symptoms like anxiety and fatigue compared to those without aphasia (Kao & Chan, 2024). It has been hypothesized that language impairment can exacerbate psychiatric symptoms, which can then further impair language function, becoming a vicious cycle where the risk of suicidal ideation and behaviour can increase (Costanza et al., 2021).

In the UK, clinical guidelines for the detection, assessment, and management of suicide risk have undergone substantial revisions, yet the process remains highly complex (Fedorowicz et al., 2023). While historical approaches recommended suicide prediction tools and risk stratification (Department of Health & Social Care, 2009), the effectiveness of these methods has been questioned. Recent research reveals that most individuals who died by suicide were in contact with mental health services and had been rated as low or no risk during their final consultation (The National Confidential Inquiry into Suicide and Safety in Mental Health, 2024). Consequently, the Staying Safe from Suicide (SSFS) guidance was produced to prioritise risk formulation over a reliance on risk

stratification or quantitative assessment tools (National Health Service [NHS], England, 2025a).

Reviews of suicide risk assessment in healthcare settings indicate that professionals still rely heavily on standardised tools (Fedorowicz et al., 2023), despite a reported lack of consistency, personalisation and adequate training across professional, patient and carer samples (Graney et al., 2024). Although the SSFS guidance recommends shifting away from this by encouraging open questions and inclusive communication, there remains limited guidance on how to directly question suicidal intent in those who cannot understand verbal or written language. Whilst National Institute for Health and Care Excellence (NICE) guidelines for depression (2022) and stroke (2023) state that professionals must screen for and assess suicide risk, there is currently a lack of practical clinical guidance on how to fulfil these requirements to meet the diverse needs of stroke survivors. This poses a significant risk of exclusion for people with communication disorders such as aphasia. The issue is particularly pertinent as Hackett and colleagues (2010) found that depression screening tools which do not ask directly about suicidal ideation often miss important negative cognitions indicative of suicidal intent in stroke survivors.

Research on screening for depression and suicidality in stroke survivors with aphasia remains limited. Schlesinger (2021) conducted a systematic review of the most prevalent mood assessment tools used with stroke survivors to screen for depression, where aphasia was not explicitly excluded. The findings revealed that 21 different mood measures were commonly utilised across 70 studies, yet only the Depression Intensity Scale Circles (Turner-Stokes et al., 2005) was validated for use with aphasia. This indicated that most mood measures were not regularly tested or validated with survivors with aphasia, increasing the risk that individuals experiencing these symptoms may be missed during screening.

Despite recognition of the elevated suicide risk after stroke, Schlesinger et al. (2024) found that staff intention to screen for depression in people with post-stroke aphasia was predicted by subjective norms, and that staff reported much lower intention to screen for suicidality than depression. These findings were interpreted using the Theory of Planned Behaviour (TPB) (Ajzen, 1991), and it was recommended that creating the explicit normative belief that screening is a professional expectation could increase screening intention. Consistent with this, Carroll et al. (2024) provided preliminary evidence that intention to

screen post-stroke suicidality in people with aphasia can be increased by strengthening normative beliefs. Speech and language therapists (SLTs) from the UK showed significantly higher intention to screen people with post-stroke aphasia for suicidality when clear professional expectations were provided in contrast to a matched control condition. Qualitative enquiry revealed, however, that SLTs perceived low confidence, fears of incompetence, and lack of training as barriers to screening for suicidality. These findings are consistent with a survey of 981 stroke professionals by Olsson and Schalling (2025), which found that only 13% viewed suicide assessment as their clinical responsibility, with most reporting aphasia and lack of competence and guidance as significant barriers to completing this duty. These challenges are further compounded by a lack of clear professional consensus or formal guidance, which remains a primary obstacle to the routine detection and assessment of suicidality in people with post-stroke aphasia.

The Delphi methodology has been applied successfully to developing professional consensus in stroke, for example in the establishment of core outcome sets and clinical competencies (Baker et al., 2024; Wallace et al., 2019). Development of a professional consensus on the detection and assessment of suicide risk in stroke survivors with aphasia would support stroke professionals in completing these duties in the context of communication disorder. For the purposes of this study, suicide risk *detection* relates to clinicians identifying the presence of factors indicating suicidality such as thoughts of suicidal ideation or hopelessness, it can be brief and flags risks for more intensive investigation. *Assessment* referred to the comprehensive clinical evaluation to understand the nature of that risk and the factors that influence it. Risk detection (or screening) and assessment are regularly separated in research concerning the management of suicidality (Horowitz et al., 2023; Powsner et al., 2023). Thus, a distinction between these constructs was operationalised in this study, due to the different clinical approaches recognised for each task.. The current study applied the Delphi method to this issue because it is recommended as a robust technique for addressing complex clinical areas where empirical evidence is scarce or a gold standard is absent (Hobden et al., 2024). We aimed to develop the first professional consensus on the most useful methods for detecting and assessing suicidality in people with post-stroke aphasia, using the Delphi methodology.

Methods

Design

An adapted e-Delphi study design was employed to achieve a reliable consensus. This method is a structured group communication technique that systematically gathers opinions through multiple iterative rounds of anonymised online questionnaires (Graham and Milne, 2003). This method was selected because in going beyond the currently known (Iqbal & Pipon-Young, 2009), it can support the synthesis of scientific knowledge and professional experience into informed judgments, to support the development of effective decision-making in clinical settings (Nasa et al., 2021). It has been applied previously to generate consensus between healthcare professionals working in stroke (Graham and Milne, 2003; Nasa et al., 2021). It is recommended that a threshold of consensus is set prospectively before starting Delphi rounds. Consensus thresholds vary though commonly they range between 70% and 80% participant agreement per item. The threshold of consensus for this study was set at 75%; this is a recommended methodological criterion for reporting Delphi studies, demonstrating a high level of consensus between participants (Diamond et al., 2014).

Ethical Approval

Ethical approval (Appendix G) was received from the University of East Anglia (UEA) Faculty of Medicine and Health Sciences Research Ethics Committee [Approval number – ETH2526-0698]. Before accessing the study, participants were required to read an electronic participant information sheet (Appendix H) and complete an online consent form. The questionnaire required the use of a unique identifier to maintain anonymity of participants throughout the rounds. Participants were presented with an electronic debrief sheet (Appendix I) following completion of the study rounds. General Data Protection Regulation and UEA policy were followed when storing participant data.

Participants

Participants were recruited internationally through professional networks and social media. Inclusion and exclusion criteria were checked during recruitment via email. Potential participants provided details regarding their qualifications and professional background.

Inclusion Criteria

To be eligible to join the expert panel, participants were required to hold a current professional clinical membership (such as the Health and Care Professional Council, Royal College of Speech and Language Therapy, or an international equivalent), while regularly working with stroke survivors with aphasia and performing, or expecting to perform, suicide risk assessments as part of their clinical role; alternatively, they could qualify by demonstrating significant expertise through published research specifically concerning the principles of suicide risk identification in post-stroke aphasia.

Exclusion Criteria

Individuals were excluded from participation if their career focused predominantly on research with limited or no practical clinical experience, or if they did not hold a recognised professional clinical qualification.

It is recommended that recruiting between 20 and 30 participants is sufficient to support reliability between Delphi rounds (de Villiers et al. 2005). Thirty-seven participants initially agreed to participate in the study during the recruitment period of April to May 2025. Recruiting an initial panel of over 30 participants was a strategic decision to attempt to mitigate the impact of well-documented high attrition rates often associated with the Delphi method (Gargon et al., 2019; Vogel et al., 2019,).

Participants were recruited via advertisement posts on social media (LinkedIn and Bluesky), emailed advertisements to professional networks (e.g., British Aphasia Society, British Psychological Society Division of Neuropsychology and the Organisation for Psychological Research into Stroke), and posters in NHS staff areas, such as neurorehabilitation and psychiatric liaison services. Additionally, leading stroke researchers and healthcare professionals were identified through a targeted literature search and invited via publicly available email addresses. Eligibility was confirmed against inclusion criteria prior to enrolment, and panellist demographics across rounds are summarised in Table 1.

Table 1

Panellist Demographic Characteristics across each round of the Delphi Study

Demographic	Round One (N = 31)	Round Two (N = 23)	Round Three (N = 20)
Age			
18 – 29	4	3	3
30 – 39	5	4	4
40 – 49	11	7	6
50 – 59	9	7	5
60 +	2	2	2
Gender			
Male	3	3	3
Female	26	18	15
Non-binary	1	1	1
Prefer Not to Say	1	1	1
Sexuality			
Heterosexual	25	18	16
Bisexual	2	2	2
Homosexual	1	1	1
Pansexual	1	1	-
Prefer Not to Say	2	1	1
Ethnicity			
White (eg. English, Scottish, Welsh, Irish, Traveller, European etc.)	25	18	17
Asian (eg. Indian, Pakistani, Bangladeshi, Chinese etc.)	2	2	2
Other White, New Zealander	1	1	1
Mixed or Multiple	2	1	-
Prefer Not to Say	1	1	-
Professional Role			
Speech and Language Therapist	17	14	14
Psychologist (Clinical., Health etc.)	6	3	3
Neuropsychologist	4	3	2
Professional Research or Professor	2	1	1
Nurse or Nurse Specialist	1	1	1
Occupational Therapist	1	1	-

Highest Level of Education			
Bachelor's Degree	11	9	8
Master's Degree	7	6	6
Doctorate or Professional Doctorate	12	7	5
Post-Graduate Certificate	1	1	1
Duration of Experience (Years)			
2 – 5	5	4	4
6 – 10	7	6	5
11 – 15	2	-	-
16 – 20	5	4	2
21 – 25	7	6	6
30 – 35	5	3	3
Location			
United Kingdom	22	15	12
Europe	7	6	6
Australia (Pacific Nations)	2	2	2

The study aimed to retain 70% of participants between rounds as this threshold is recommended to maintain validity of responses across rounds (Muhl et al., 2023; Nasa et al., 2020). In the first round 31 participants completed the questionnaire, in the second 23 (74%) were retained and in the final round 20 (64.5% from Round One, 86.96% from Round Two) finished all rounds of the study.

Measures

In line with Delphi methodology, the first round used open-ended questions to generate ideas on the subject, as research on the topic is limited. Panellists were asked to detail the methods they would use or suggest to detect and assess suicidality risk in stroke survivors with aphasia (See Appendix J)., with an additional open-text question concerning further factors to consider during detection and assessment. Demographic data, including age, gender, years of experience, and professional role, were also collected at this stage.

Round One findings were analysed using manifest content analysis (Graneheim & Lundham, 2004), and informed the second-round questionnaire, where panellists rated

items on usefulness, accessibility, and confidence (See Appendix K for example). A 4-point Likert scale (Strongly Agree, Slight Agree, Slightly Disagree, Strongly Disagree) was employed to prevent neutral responses and force a clear consensus decision (Chuenjitwongsa et al., 2017; Vogel et al., 2019). An open text question also asked participants to comment on what influenced their confidence rating.

The third and final round analysed Round Two results using a simplified 2-point scale (Agree/Disagree). A binary approach is recommended for concluding rounds to clarify the final strength of consensus and solidify the inclusion of specific items (Diamond et al., 2014). Participants re-rated the usefulness of methods while viewing the Round Two group percentages. In line with established practice, items were removed if a significant number of participants reported a lack of experience with a specific tool, ensuring the final consensus was based on reliable, expert experience (Hsu & Sandford, 2007).

Procedure

The application of the Delphi method varies across studies; however, consistent characteristics include use of a multiple round format and iterative rounds, that are directly informed by panellist feedback. In developing this study, guidance was followed from a variety of sources to adapt the method for online delivery (Graham & Milne, 2003; Iqbal & Pipon-Young, 2009). The study ran from May 2025 to December 2025. Prior to development of the first round, Patient and Public Involvement (PPI) was considered. As our focus related to professional consensus, consultation was sought from other professionals to inform questionnaire development, inclusivity, safety of materials, and debrief provision. Three researchers and lecturers with expertise in aphasia, ethics, and equality and diversity were consulted.

In the first round, all participants were sent an online questionnaire via Microsoft Forms. The round was open for four weeks, with one reminder email sent to mitigate participant dropout (Hall et al., 2018). Following completion, answers were reviewed using manifest content analysis (Graneheim & Lundham, 2004) to identify and count explicit, surface level content. A preliminary codebook was developed based on prevalent emergent themes for detection and assessment methods. To establish inter-rater reliability and

minimise researcher bias, an independent rater reviewed and applied this codebook to the data.

Following the analysis and review, the second round was developed. Those who completed the first round received the questionnaire four weeks later via email (See Appendix L). This round remained open for nine weeks, with three reminder emails sent (Hall et al., 2018). Participants confirmed prior round completion, as guidance recommends that only initial participants are eligible for follow up rounds (Chuenjitwongsa, 2017). Round durations varied due to factors such as annual leave. Descriptive methods were used to characterise results, which were provided to participants via email upon completion (McMillan et al., 2016). Participants were asked to reconsider their ratings using this feedback in the next round. This process continued into the third and final round, which opened five weeks later for six weeks. Participants were sent the link again via email (See Appendix M). This was structured using the same feedback and reminder process from the previous round. Participants accessed a debrief at the end of the third round and provided an email for an Amazon voucher. An update email was sent shortly after the final consensus and confirming study completion (See Appendix N).

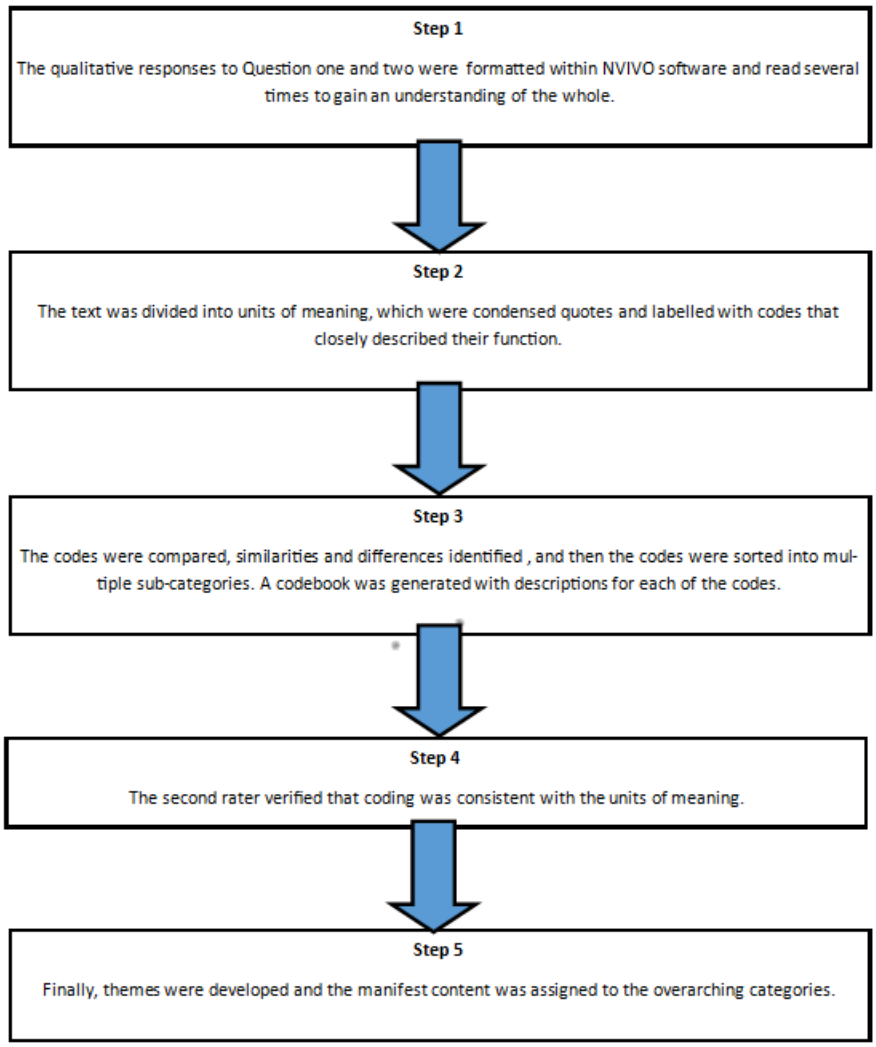
Analysis

Content Analysis

Manifest Content Analysis was used following guidance from multiple sources (Graneheim & Lundman, 2004; Nicmanis, 2024; Schreier, 2012;). The initial round involved gathering qualitative data from experts through open-ended questions. Content analysis was subsequently employed to code, categorise, and synthesise these diverse opinions into a structured set of items for subsequent rating (see Figure 1).

Figure 1

Manifest Content Analysis Process for Round One Data



A codebook was generated (see Appendix O for an example). Following second rater review of the codebook, comparison of the coding results revealed a high degree of agreement between the two raters, with 83% of the coded responses matching. This strong level of consensus demonstrates the clarity and objectivity of the coding scheme and ensures high inter-rater reliability for the analysis presented in this report. Discrepancies were reviewed and resolved through discussion to reach consensus before proceeding with the final analysis.

Descriptive Statistics

In Rounds Two and Three, percentage agreement was recorded to identify whether consensus was reached. The distribution of expert ratings per item (e.g., percentage of agreement/disagreement) was calculated. For Round 2, descriptive statistics of the median and interquartile range (IQR), were used to evaluate the central tendency and dispersion of

participant responses. The median was utilised to identify the typical level of agreement on a four-point scale (1: Strongly disagree; 2: Slightly disagree; 3: Slightly agree; 4: Strongly agree), while the IQR provided a measure of consensus or variance among the experts, with a lower IQR <1 (on a 5 -point scale) presenting a stronger consensus (Ab Latif et al., 2016). These statistics were not continued in analysis Round Three, due to the transition to a binary response format. An item was considered to have a reached consensus if the percentage agreement was 75% or above.

Results

Generation of Methods Useful for Detection or Assessment of Suicide Risk (Round One)

Tables 2 and 3 summarise the methods for the detection or assessment of suicide risk in people with post-stroke aphasia, which were generated by panellists in the initial round of the Delphi study and used to generate the next round of the study. Analysis revealed five broad, recurring themes that represent the most prevalent topics within the data: Detection Methods, Assessment Methods, Adapted Approaches to Assessment, Synthesizing Information through Formulation and Mood Measures. These themes were developed based on the frequency with which corresponding concepts were mentioned and were used to generate the main areas of potential consensus regarding methods of suicide risk detection and assessment represented in the second and third round questionnaires.

Table 2

Useful Methods for Detecting Suicide Risk in People with Post Stroke Aphasia, Generated in Delphi Round One

Method	**Frequency (N = 31)**
Supported conversation/Total communication	14
Standardised Self-reported Visual Mood Measures	14
Discussion with Next of Kin (NOK), Family or Carers	14

Observations	12
Discussion with Healthcare Professionals (HCPS)/Multiple Disciplinary Teams (MDT)/professionals	9
Direct Risk Assessment Questions – Suicidality	8
Review Medical History	8
Standardised Self-reported Verbal Mood Measures	8
Joint working with other HCP's to interview	5
Observer-Rated Mood/Behaviour Measures	5
Unstructured informal conversation with individual	5
Standardised Clinical Interview (structured, semi-structured, verbal questions)	3

Table 3

Useful Methods for Assessing Suicide Risk in People with Post Stroke Aphasia, Generated in Delphi Round One

Method Code	**Frequency**
Adapted approaches to Risk Assessment Questions (Total Communication, visual aids, communication aids)	18
Risk Assessment Questions	12
Discussion with HCPs/MDT/professionals	10

Standardised Self-reported Verbal Mood Measures	10
Joint working with other HCP's to interview	7
Discussion with Next of Kin, Family or Carers	6
Observations	5
Review Medical History	5
Observer-Rated Mood/Behaviour Measures	3
Clinical Interview (structured, semi-structured, verbal questions)	2
Risk Formulation	2

Consensus (Delphi Rounds Two and Three)

Table 4 presents the degree of consensus on the perceived usefulness of mood measures for detecting suicide risk in stroke survivors with aphasia across Round Two and Three of the Delphi study. The SADQ-H achieved the strongest consensus, rated highly for usefulness in both expressive and receptive aphasia detection across all rounds. The VAMS reached the pre-defined consensus threshold in Round Three for both conditions. While the VASES and the BASDEC also surpassed the consensus threshold in Round Three, these results should be interpreted cautiously due to potential attrition bias following the dropout of three panellists between rounds, also the changes in panellists reporting no experience with these measures. The PHQ-9 reached consensus for usefulness in expressive aphasia in Round Three but remained below threshold for receptive aphasia, with disagreement >75%. The DISCS failed to reach the consensus threshold for usefulness across aphasia types and rounds. Of the five measures that excluded from the second round due to <50% panellist experience, the BOA/Carer reached consensus for expressive aphasia, but the Carer version did not reach consensus for receptive symptoms. Due to limited data points and exclusion

of the measures from the final analysis phase, caution is advised when interpreting the reliability of the initial consensus ratings for these items.

Table 4

Consensus on Usefulness of Mood Measures for Suicide Risk Detection in People with Expressive or Receptive Aphasia

Mood Measures	Delphi Round Two (N = 23) Percentage Agreement (n) Median Rating /(IQR)		Delphi Round Three (N = 20) Percentage Agreement (n)	
	Expressive	Receptive	Expressive	Receptive
Measures Recommended by Professional Consensus (≥ 75% agreement) for Detecting Suicide Risk in People with Post-Stroke Aphasia				
- Stroke Aphasic Depression Questionnaire Hospital Version (SADQ-H) (Lincoln et al., 2000)	80 (12)* Mdn = 3(1) *(NE = 8)*	80 (12)* Mdn = 3(0) *(NE = 8)*	100 (13)* (NE = 7)	100 (13)* (NE = 7)
- Visual Analogue Self-Esteem Scale (VASES) (Brumfitt & Sheeran, 1999)	69.3 (9) Mdn = 3(1.25) *(NE = 10)*	61.5 (8) Mdn = 3(1.25) *(NE = 10)*	88.9 (8)* (NE = 11)	88.9 (8)* (NE = 11)
- Visual Analogue Mood Scales (VAMS) (Stern et al., 2007)	75 (9) Mdn = 3(1) *(NE = 11)*	61.5 (8) Mdn = 3(1) *(NE = 10)*	91.7 (11)* (NE= 8)	83.3 (10)* (NE = 8)
- Brief Assessment Schedule Depression Cards (BASDEC) (Adshead et al., 1992)	92.3 (12)* Mdn = 3.5(1) *(NE = 10)*	53.85 (7) Mdn = 2.5(1.25) *(NE = 10)*	88.9 (8)* (NE = 11)	77.7 (7)* (NE = 11)
- Depression Intensity Scale Circle (DISCS)	50 (8) Mdn = 2(1) (NE = 7)	46.7 (7) Mdn = 2(1.5) (NE = 8)	69.23 (9) (NE = 7)	69.23 (9) (NE = 7)

(Turner-Stokes et al., 2005)				
- Patient Health Questionairre-9 (PHQ-9) (Kroenke et al., 2001)	64.7 (11) Mdn = 3(2) (NE = 6)	23.53 (4) Mdn = 1(1) (NE = 6)	75 (12) (NE = 4)	20 (4) NE = 4)
Generated in Round One but Not Included in Delphi Round Three Due to Lack of Experience Reported by Panellists (< 50% of panellists reported no experience of these measures)				
- Antecedent, Behaviour Consequence Charts (ABC Charts) (Bijou et al., 1968)	54.55 (6) Mdn = 2(1.5) *(NE = 12)*	63.63 (7) Mdn = 3(1) *(NE = 12)*		
- Assessment Living with Aphasia (ALA) (Kagan et al., 2011)	66.7 (4) Mdn = 3.5 (1.75) *(NE = 17)*	33.3 (2) Mdn = 2(1.5) *(NE = 17)*		
- Behaviours Of Anxiety (BOA) (Linley-Adams, et al 2013)	75 (3) Mdn = 3(0.5) *(NE = 19)*	60 (3) Mdn = 2.5(2) *(NE = 18)*		-
- Behaviours Of Anxiety – Carer (BOA – C) (Eccles et al., 2017)	75 (6) Mdn = 3(1.5) *(NE = 15)*	80 (4) Mdn = 3(0) *(NE = 18)*		-
- Signs of Depression Scale (SODS) (Hammond et al., 2007)	60 (3) Mdn – 3 (2) *(NE = 18)*	40 (2) Mdn = 2(1) *(NE = 18)*		-

*Note: NE = Number of respondents with no experience using the measure. * Denotes that >75% consensus reached agreeing methods are useful, ** denotes >75% consensus researched disagreeing methods are useful*

Table 5 indicates strong support for multiple detection strategies. In Round Three, there was 100% agreement on the usefulness of Reviewing Medical History, Discussing Cases with other HCP's, Joint Working with other HCP's, using Supported Interviewing techniques, and engaging in Discussions with Family, Next of Kin, or Carers. Only two approaches failed to achieve strong professional consensus for use with people with receptive aphasia. Use of Standard Clinical Interview achieved consensus for expressive aphasia (80% agreement in Round Three), but was rated largely unsuitable for receptive aphasia, receiving only 35% agreement in Round Three. Similarly, Asking Direct Risk Questions had 100% agreement for expressive aphasia; the consensus was notably lower for receptive aphasia, reaching only 70% agreement in Round Three.

Table 5

Professional Consensus on Suicide Risk Detection Methods for People with Post-Stroke Aphasia

Suicide Risk Detection Methods	Delphi Round Two (N = 23) Percentage Agreement (n) Median Rating / (IQR)		Delphi Round Three (N = 20) Percentage Agreement (n)	
	Expressive	Receptive	Expressive	Receptive
Discussion with Next of Kin, Family or Carers, e.g. to understand mood changes or anything noticed regarding wellbeing	100 (23)* Mdn = 4(1)	100 (23)* Mdn = 3(1)	100 (20)*	100(20)*
Discussion with other HCP's e.g. MDT, ward reviews, or individual discussion.	100 (23)* Mdn = 4(0.75)	100 (23)* Mdn = 4(1)	100 (20)*	100 (20)*
Supported Interview, e.g. with Supported Conversation, Total Communication, visual, written and verbal aids to discuss mood and treatment planning	100 (23)* Mdn = 4(0)	95.7 (22)* Mdn = 4(0)	100 (20)*	100 (20)*
Asking Direct Risk Questions, e.g., "Have you had any thoughts of ending your own life?"	100 (23)* Mdn = 3(1)	52.17 (12) Mdn = 3(1)	100 (20)*	70 (14)

Reviewing Medical History, e.g. to identify historical risk factors such as previous suicidal ideation	95.7 (22) * Mdn = 4(1)	100 (23)* Mdn = 4(1)	100 (20)*	100 (20)*
Joint working with other HCP's, e.g., inviting other health professionals to join sessions or support delivery of communication adaptations or mood measures.	95.7 (22)* Mdn = 4(1)	100 (23)* Mdn = 4(1)	100 (20)*	100 (20)*
Observations, e.g., of behaviour, engagement, and interaction with others	87 (20)* Mdn = 3(1)	95.7 (22)* Mdn = 3(1)	90 (18)*	94.7 (19)*
Informal Conversations, e.g. unstructured conversations to develop the relationship and provide insights into mood changes	87 (20)* Mdn = 3(1)	73.9 (17) Mdn = 3(0.75)	100 (20) *	90 (18)*
Standard Clinical interview, using structured/semi structured verbal interview to discuss mood and treatment planning.	52.17 (12) Mdn = 3(1)	47.8 (11) Mdn = 2(2)	80 (16)*	35 (7)

*Note: * denotes that >75% consensus reached agreeing methods are useful, ** denotes >75% consensus researched disagreeing methods are useful*

Table 6 presents professional consensus ratings on the usefulness of methods for the assessment of suicide risk in people with expressive or receptive aphasia. The results indicate a high level of agreement for most items, particularly within Round Three. Methods achieving 100% consensus for both aphasia types in the final round included Discussion with Next of Kin, Reviewing Medical History, Discussing the case with other HCP's, and Joint working with other HCP's. Most techniques involving adaptation or support for communication, such as using standardised mood measures or observations, reached high consensus levels (85% to 95%). The only method that failed to achieve strong consensus for

patients with receptive aphasia was Standard Clinical Interview (40% agreement in Round Three).

Table 6

Professional Consensus on Suicide Risk Assessment Methods for People with Post-Stroke Aphasia

Suicide Risk Assessment Methods	Delphi Round Two (N = 23) Percentage Agreement (n) Median Rating / (IQR)		Delphi Round Three (N = 20) Percentage Agreement (n)	
	Expressive	Receptive	Expressive	Receptive
Discussion with other HCP's e.g. MDT, ward reviews, or individual discussion	100 (23)* Mdn = 4(1)	100 (23)* Mdn = 4(1)	100 (20)*	100 (20)*
Joint working with other HCP's, e.g., inviting other health professionals to join sessions or support delivery of communication adaptations or mood measures.	100 (23)* Mdn = 4(1)	100 (23)* Mdn = 4(0)	100 (20)*	100 (20)*
Discussion with Next of Kin, Family or Carers, e.g. to understand mood changes or anything noticed regarding wellbeing	100 (23)* Mdn = 4(1)	95.7 (22)* Mdn = 4(1)	100 (20)*	100 (20)*
Asking Direct Risk Questions, e.g., "Have you had any thoughts of ending your own life?"	95.7 (22)* Mdn = 3(1)	69.6 (16) Mdn = 3(1)	100 (20)*	75 (15)*
Reviewing Medical History, e.g. to identify historical risk factors such as previous suicidal ideation	95.7 (22)* Mdn = 3(1)	95.7 (22)* Mdn = 4(1)	100 (20)*	100 (20)*
Observations, e.g., of behaviour, engagement, and	87 (20)* Mdn = 3(1)	91.4 (21)* Mdn = 3(1)	95 (19)*	95 (19)*

interaction with others				
Using Standardised Mood Measures, e.g., visual or verbal self-reported (PHQ-9, VASES etc.) or observer reported (SADQ)	82.6 (19)* Mdn = 3(0)	73.9 (17) Mdn = 3(0.75)	85 (17)*	85 (17)*
Standard Clinical interview, using structured/semi structured verbal interview to discuss mood and treatment planning.	78.3 (18)* Mdn = 3(1)	47.8 (11) Mdn = 2(1)	95 (19)*	40 (8)

*Note: * denotes that >75% consensus reached agreeing methods are useful, ** denotes >75% consensus researched disagreeing methods are useful*

Table 6 presents professional consensus ratings regarding the perceived usefulness of different communication approaches for facilitating suicide risk assessment in people with aphasia. The results indicate strong support for a wide array of non-verbal and modified verbal communication strategies. In the final round, several approaches achieved unanimous (100%) agreement for receptive and expressive aphasia: using images or symbols, relying on body language, and incorporating gestures. Additional highly rated techniques included supporting communication via writing, reading and speaking, drawing, digital apps, and simplified verbal statements, all of which achieved consensus ratings of 90% or higher by Round Three.

Table 7

Professional Consensus on Communication Approaches for Suicide Risk Assessment with People with Post-Stroke Aphasia

Communication Approaches for Suicide Risk Assessment	Delphi Round Two (N = 23) Percentage Agreement (n) Median Rating / (IQR)		Delphi Round Three (N = 20) Percentage Agreement (n)	
	Expressive	Receptive	Expressive	Receptive
Body language, e.g. use of facial expressions to support assessment	100 (23)* Mdn = 4(0)	100 (23)* Mdn = 4(0)	100 (20)*	100 (20)*
Gestures, e.g. thumbs up/ down	100 (23)* Mdn = 4(1)	95.7 (22)* Mdn = 4(1)	100 (20)*	100 (20)*

Images or symbols, provided by the assessor to support conceptual meaning of suicidality	87 (20)* Mdn = 4(0)	100 (23)* Mdn = 4(1)	100 (20)*	100 (20)*
Drawing, e.g., supporting the person to communicate via drawing, or drawing oneself	100 (23)* Mdn = 4(1)	91.4 (21)* Mdn = 4(1)	100 (20)*	95 (19)*
Verbal, e.g., shortened, simplified statements using key words, and open and closed questions	95.7 (22)* Mdn = 4(1)	87 (20)* Mdn = 4(1)	100 (20)*	95 (19)*
Reading and speaking, supporting the person to read and respond to questions in addition to verbal communication	95.7 (22)* Mdn = 4(1)	82.7 (19)* Mdn = 3(1)	100 (20)*	95 (19)*
Digital, Apps such as "Talking Mats", using text to speech, or supporting communication via text	91.4 (21)* Mdn = 3(1)	91.4 (21)* Mdn = 3(1)	100 (20)*	95 (19)*
Writing, supporting the person to write their responses	95.7 (22)* Mdn = 4(1)	78.3 (18)* Mdn = 3(1)	95 (19)*	90 (18)*

*Note: * >75% consensus reached agreeing methods are useful, ** >75% consensus researched disagreeing methods are useful*

Frequency and Risk Formulation

There was a strong consensus on the most useful frequency of delivering suicide risk detection and assessment. Across Rounds two and three, panellists agreed with 85% consensus that risk detection frequency should be completed flexibly according to the needs of the individual. In contrast, panellists agreed with 90% consensus that suicide risk assessment should be undertaken on a weekly basis once risk is detected, though acknowledged this may be affected by service location, or amount of contact with the individual stroke survivor.

There was a consensus rating of 100% agreement across Rounds two and three that risk formulation is a useful approach to understanding suicide risk in this group. Only 69%

agreed that they were confident in their ability to complete risk formulation as part of their clinical role.

Accessibility and Confidence Ratings – Round Two

Verbal/Visual and Observer-Rated Mood Measures

There were differences of professional opinion regarding the accessibility of specific mood measures. The PHQ-9 was the tool most widely agreed to be accessible, with 73% of participants either slightly or strongly agreeing. However, this score still fell short of the established consensus threshold, an outcome that was seen across all other mood measures. Other tools agreed to be accessible by a slight majority included the DISCS at 56.5% agreement, followed by ABC charts and the SAD-Q/H at 52.2% each.

Several mood measures were considered inaccessible by the panel. The ALA faced the highest level of disagreement regarding accessibility (69.5% disagreed it was accessible), followed closely by the BOA, Carer and Survivor versions (65.2% disagreed). The VASES, VAMS, BASDEC, and the SODS were also predominantly viewed as inaccessible, with disagreement ratings for accessibility ranging from 56.5% to 73.9%.

Detection Methods

There was a strong consensus regarding the accessibility of different methods used to detect suicide risk. For accessibility of detection methods, 100% of respondents agreed that engaging with the Next of Kin is an accessible approach. High levels of agreement (over 90%) were also reported for risk questions, supported interviews, standard clinical interviews, informal conversation, discussions with healthcare professionals, and joint working. Observations (82.6%) and reviewing medical history (87%) were also considered broadly accessible.

When considering confidence in detection methods, informal conversation and input from the Next of Kin received universal agreement (100%). Most panellists expressed high confidence (>91%) in the use of risk questions, observations, reviewing medical history, holding discussions with HCPs, joint working, and supported interviews. Standard clinical interviews were also widely regarded as a method panellists felt confident in using, with 82.7% of respondents in agreement. Participants attributed their confidence to a range of

factors including years of experience, specialist training, role speciality, MDT support and education level in additional comments. They attributed lower confidence to less experience, or not enough training in specific tools.

Assessment Approaches and Delivery Methods

The accessibility and delivery of suicide assessment methods revealed strong consensus on several key approaches. All respondents agreed that guidance for risk assessment questions and discussion with the Next of Kin are accessible methods for gathering information. Over 91% of panellists found the following methods highly accessible: observations, reviewing medical history, discussing with HCPs, joint working, and structured clinical interviews. Most respondents (78.3%) also considered mood measures to be accessible.

Regarding confidence in delivery methods, there was universal agreement that images or symbols, writing, reading and speaking, and verbal communication methods are effective for conducting assessments. Most panellists expressed high confidence in using drawing (95.7%), body language (95.7%), gestures (95.7%), and digital methods (92.3%) to facilitate communication. Similarly to detection methods, participants commented that their high confidence was related to experience, training and education levels. Less confidence was related to less experience using the type of method, and some concerns that they would not know how to appropriately use some approaches, such as images.

The final summary of methods that reached professional consensus can be found in Appendix P.

Discussion

The consensus on detection and assessment methods for stroke survivors with aphasia addresses a documented gap in clinical practice. The preference for communication adaptations and multimodal approaches over structured questioning indicates a move toward person-centred care. This alignment with NHS England (2025a) guidance suggests that even for specialist populations, the clinical standard is shifting away from rigid protocols toward detection methods tailored to individual needs.

This practical consensus aligns with existing Delphi studies concerning the management of psychological wellbeing of stroke survivors. Prior research has identified a consensus on clinical competencies to guide stroke clinicians in the implementation of psychological care in aphasia rehabilitation (Baker et al, 2024) and evaluated the utility of non-pharmacological interventions for emotional changes following stroke (Ottaway, 2023). Our findings add to a growing base of stroke research using the Delphi methodology to utilise expert professional experience to inform future strategies to support stroke survivors experiencing psychological distress and suicidality. This method has also been applied in Europe to develop guidelines for assessing and managing risk of suicide in the general population, finding a similar consensus on the importance of family involvement, the use of validated tools, and the reviewing medical history to support comprehensive assessment of suicidality (Lengvenyte et al., 2023). This suggests that our findings may possess a degree of generalisability beyond this specific clinical group, particularly as they constitute the first consensus-based guidance for detecting and assessing suicide risk in those with any communication disorder.

The finding that participants perceived the PHQ-9 as not useful as suicide risk detection tool in receptive aphasia, alongside the DISCS failure to reach consensus, highlights a mismatch between standardised mood measures and the needs of diverse populations. While the PHQ-9 is a standard measure for ideation (Kroenke et al., 2001), its reliance on complex language may create a barrier for this cohort. This supports the observation that risk detection methods can unintentionally exclude those with communication impairments (Hackett et al., 2010; Shiggins et al., 2024). Furthermore, the lack of participant consensus on the DISCS suggests that research validation for low mood does not necessarily mean that it has clinical utility for assessing suicide risk. While the DISCS is validated for use with people with aphasia, this validation predominantly applies to expressive aphasia, leaving a gap in clinical tools for receptive impairments. This aligns with the observation by Schlesinger (2021) that there are few validated measures accessible for this population.

Mood measures were perceived as broadly inaccessible across the sample and achieved the lowest consensus percentage for confidence. Similar barriers regarding accessibility and confidence have been observed in research analysing the use of quality-of-

life measures for stroke survivors with aphasia (Cruice & Ten Kate, 2019). Furthermore, none of the outcome measures identified by participants as both useful and accessible across both types of aphasia include items specific to suicidality. Notably, only the PHQ-9, which offers a single suicide specific question, was rated as useful in those with expressive aphasia. The included instruments screen for low mood and depression in stroke survivors, providing supporting evidence for risk formulation. Sole reliance on these tools, however, yields limited specific information about suicidality due suicide specific items. Participants also reported a heavy reliance on informal assessment which, while individualised, had limited validation and could be influenced by clinician bias or lack of knowledge, sometimes missing key predictors of the construct such as emotional health. In qualitative feedback from this study, some HCP's similarly referenced to the use informal, service specific adaptation to mood measures, such as the PHQ-9. These findings further suggest that it would be useful to move beyond adapting current tools and develop robust, validated suicide detection and assessment frameworks specifically designed for stroke survivors with aphasia (Barrows & Thomas, 2018).

It is hoped that the strong level of consensus among expert panellists can inform development of a protocol to support practitioners in delivering suicide risk prevention for stroke survivors with aphasia. Panellist comments on self-rated confidence reflected the value of experience, training and service support in fostering confidence in approaching suicide risk detection and assessment. The importance of these areas was echoed in Carroll's (2024) work, where SLTs reported that increased training provision, and clear role expectations would support them to feel more comfortable completing suicide screening in people with aphasia.

Despite the extensive experience of the recruited sample, some panellists reported low confidence in specific methods, noting that risk formulation, mood measures and communication approaches are limited by restricted access to specialist professionals. Olsson and Schalling (2025) reported similar findings that specialised stroke professionals felt less competent in delivering aphasia-friendly, adapted communication strategies to support suicide risk assessment. Themes of low confidence are mirrored in healthcare professionals' experiences of delivering suicide risk assessments in general health populations, where a perceived lack of appropriate training, resources, and guidance has

been reported (Dillon et al., 2020; Fedorowicz et al., 2023). These reviews also found that low confidence was linked to practitioner reports of feeling tentative, and ultimately avoidant of suicide risk assessment. Suicide risk detection and assessment are core role expectations for healthcare professionals in stroke (NICE, 2023), and it is important that access to suicide risk prevention is streamlined across all clinical environments. This is particularly crucial for stroke survivors with communication difficulties, as improved access and training may support professionals to attempt assessments they might otherwise avoid (Carroll., 2024).

Although recent clinical guidance has supported moving away from reliance on rigid risk stratification tools, the initial Delphi round found that panellists frequently cited the use of mood measures as part of their detection process. This suggests that clinical services may still place high reliance on such measures to support suicide risk detection as supported by findings by Fedorowicz et al. (2023). Panellists clarified that when mood measures were considered useful, it was primarily in combination with other detection methods, such as direct observation or consultation with family members. This finding is supported by research identifying combined approaches to suicide risk assessment as effective for appraising patients with additional complexities in other healthcare settings (Dillon et al., 2020). Studies have previously highlighted this in the context of communication barriers caused by substance intoxication (Roy et al., 2016) or emotional blunting due to severe depression (Waern et al., 2016), suggesting that evaluating the whole person by synthesising medical records and family communication can support accurate detection of individual risk.

Strengths and Limitations

The study encountered several limitations that are common in Delphi methodology, primarily concerning participant retention and potential biases. Cumulative panellist retention fell below 70% by the third round, representing an overall attrition rate of 35% from the initial panel. This may have introduced attrition bias, as participants with dissenting or less conventional opinions are often more likely to drop out (Boel et al., 2021: Humphrey-Murto & de Wit, 2019). Furthermore, demographic data revealed a reduction in multidisciplinary representation in later rounds compared to the first, which limits the breadth of expertise gathered and the generalisability of the findings to some extent (Shang,

2023). A review of multiple Delphi study methodologies confirms that published retention rates vary widely, from 11% to 100% (Barrington et al., 2021).

However, it is a strength that the study maintained high retention (over 86%) during the critical consensus-making rounds (N = 23 in Round Two vs. N = 20 in Round Three), which enhanced the consistency, validity, and reliability of the final ratings. The length of the second-round questionnaire (>40 items) was identified as a potential contributing factor to the attrition, as existent literature suggests fewer than 20 items is optimal to prevent survey fatigue (Gargon et al., 2019). This feedback informed the design of the third round, which focussed predominantly on usefulness. Strategic decisions were made to exclude ratings on confidence and accessibility to keep the questionnaire concise, as these factors were less likely to change significantly between rounds and including them would have extended survey length. It is recognised that there were similarities and overlap between the methods identified for both detection and assessment methods in Round One; although descriptions of the differences between these constructs was provided on the questionnaire for each participant, this overlap in results may indicate a lack of clarity in these distinctions for participants. Future research evaluating the methods recommended by this consensus could benefit from further defining these constructs to identify more clearly which specific methods may be more effective for each of the tasks.

Though the sample included representation from the UK, Europe, and Pacific Regions, it lacks wider global representation. It is recognised that this limits the generalisability of the consensus across international populations. This limitation may be prominent in non-Western countries that approach suicide prevention strategies differently, such as areas of the world where suicide is still considered an offence or where stigma may limit resource prioritisation (Ochuku et al., 2022). Future research could benefit from evaluating whether suicide risk detection and assessment tools can be culturally adapted to meet the specific needs of these varied communities. The sample of panellists was also predominantly white and female, a common participant demographic in research on healthcare professionals, also found in the work of Schlesinger et al. (2024) and Carroll (2024). This may be representative of structural inequalities in diverse representation within the stroke professional workforce. Professionals from ethnically diverse backgrounds often face disadvantages in attaining senior roles within the NHS (British and Irish Association of

Stroke Physicians [BIASP], 2024; NHS England, 2025b), with certain groups remaining underrepresented within professional associations (e.g., Black and Mixed individuals comprising only 7.6% of BIASP membership). Consequently, future studies could benefit from purposive recruitment strategies to ensure that the professional perspectives informing clinical guidelines reflect true diversity of healthcare populations.

Recommendations

The findings of this study support several recommendations for future research and clinical practice regarding suicide assessment in stroke survivors with aphasia. Firstly, it is recommended that comprehensive training on suicide detection and assessment is provided to all healthcare professionals working in stroke care, with a specific focus on adapting these processes for individuals with aphasia. To support this, future research should focus on the development of a centralised resource, such as a suicide detection/assessment toolkit, to provide practitioners with streamlined access to appropriate measures, communication aids, and clinical guidance. Increasing access to such resources is likely to enhance professional confidence and the perceived accessibility of these tools. Furthermore, a subsequent step is to conduct qualitative research on first-hand experiences of suicide risk detection and assessment processes in stroke survivors. Finally, there is a clear need for the continued development of aphasia friendly mood measures that specifically target symptoms associated with increased suicidality. This should include the creation of a standardised, adapted equivalent to item nine of the PHQ-9 to ensure that the risk of suicidal behaviour can be assessed directly and consistently.

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Chapter 5 – Discussion and Critical Evaluation

Word Count: 3775

Extended Discussion and Critical Evaluation

The overall aim of the thesis portfolio was to understand the experiences of healthcare professionals completing suicide risk assessment across various health settings, and to develop a professional consensus on the most useful methods of suicide detection and assessment for stroke survivors with aphasia. This chapter provides an overview of the findings of the systematic review in Chapter 2 and the Delphi study in Chapter 4. The respective strengths and limitations of each paper are considered. The results are discussed in relation to previous research, and their implications for future research and clinical practise.

Overview of Results

The systematic review and meta-synthesis explored the subjective experiences of healthcare professionals conducting risk assessments across varied health settings. In contrast, the empirical paper focussed on the practical steps required for suicide risk assessment in the context of communication disorder, using a three-round Delphi study with stroke professionals to develop the first consensus on effective methods for detecting and assessing risk in stroke survivors with aphasia.

Systematic Review and Meta-Synthesis

The systematic review and meta-synthesis aimed to improve the understanding of healthcare professionals' experiences of delivering suicide risk assessments, as well as the perceived barriers to completing this task. Completing suicide risk assessment and screening procedures is an increasingly important part of professionals' roles in healthcare. Global and local policies have increased awareness of this duty (World Health Organization [WHO], 2013, 2014; National Health Service [NHS] England, 2025). However, research has found inconsistency in assessment approaches, poor access to specialist training, and limited resources to adequately support professionals in this work (Fedorowicz et al., 2023). A meta-synthesis of existing qualitative research was completed to understand the subjective perspectives of professionals completing suicide risk assessments. Four main themes were identified: 'Assessing Suicide Risk is a Challenging Experience', 'Relying on Experience and Intuition to Guide Assessment', 'Navigating the Gaps Between Guidance and Practice', and 'Systemic Factors Influence Approaches to Assessment'.

Throughout the studies, there was a shared sense of uncertainty, anxiety, and loneliness in the assessment process, this was present across settings and could influence professionals' approaches to, or avoidance of, completing assessments. Participants described the ways they navigated perceived barriers, such as lack of training, by relying on what they had learnt from experience and a felt sense of intuition. While intuition was perceived as important, the dangers of relying solely upon it were explored by participants. Support from other professionals was highlighted as an important part of sharing the perceived responsibility of assessments, with limited support linked to poorer experiences of assessment and increased professional anxiety. Finally, participants discussed their experiences of barriers to assessment, sharing their belief that enhanced training provision, more time, and greater resources would support them to complete suicide risk assessments more effectively. Taken together, these findings suggest that the perceived challenge of risk assessment can influence professionals to become avoidant of engaging with suicidal patients. However, those with greater experience adapt strategies to navigate gaps in training. This is often based on intuition, which participants recognised did not always provide the most reliable outcome when used as the primary indicator for suicide risk. Professionals are aware of the barriers within services and demonstrate a desire to improve their knowledge and training to feel more confident when supporting suicidal patients.

Empirical Paper

The empirical paper aimed to establish the first professional consensus on the most useful approaches to suicide risk detection and assessment in stroke survivors with aphasia. The panellists comprised a diverse range of stroke professionals from clinical services and research, representing a significant depth of professional expertise and experience. In the initial qualitative round, 31 participants provided answers to open-ended questions about their approaches to suicide risk assessment in stroke survivors with aphasia. The most frequently cited methods were identified using manifest content analysis. The primary themes from the first-round analysis included the use of self-reported and observer-rated mood measures, alongside varied approaches to suicide risk detection, delivery methods, and practical assessment strategies. Methods identified as useful to detect the presence of suicide risk in the context of communication disorder were asking direct risk questions, observing behaviour, consulting/joint working with colleagues, reviewing medical history,

adapted or structured interviews, informal conversations and liaising with the next of kin. Methods identified as useful to assess the nature of the suicide risk in the context of communication disorder were the use of digital, visual, and written communication aids. The findings from this first round informed the development of the second and third rounds.

The subsequent Delphi rounds were used to establish an expert consensus. Panellists were asked to consider the usefulness of methods in the context of moderate to severe symptoms of receptive or expressive aphasia. Most methods and approaches identified as useful for the detection and assessment of suicidality in these contexts reached the consensus threshold. Items that did not reach the consensus for receptive aphasia (impaired comprehension of language) were structured clinical interview and direct risk questioning (only as a detection method), as well as the standardised mood measure of the Patient Health Questionairre-9 (PHQ-9; Kroenke et al., 2001) and Depression Intensity Scales (DISCS; Turner-Stokes et al., 2005). For expressive aphasia (impairments in expressed language), only the DISCS did not meet the consensus threshold by Round Three. The items that reached consensus provided an initial protocol of recommended methods to use when approaching suicide risk detection and assessment in stroke survivors with aphasia. As there have been significant gaps in training and guidance on suicidality highlighted throughout a growing body of stroke literature (Schlesinger et al., 2021; Carrol et al., 2024; Olsson & Schilling, 2025), it is hoped that this first professional consensus can be used to support the development of practical tools and training to support practitioners to work with this vulnerable group.

Strengths and Limitations of the Systematic Review and Meta-Synthesis

The systematic review has several strengths, particularly that it is an important and robust addition to suicide assessment research in healthcare settings. To demonstrate its robustness, a broad and inclusive search was undertaken, across multiple databases which represented global literature. The search string was developed following an initial scoping review of available literature, and consultation was undertaken with a specialist librarian to refine the search strategy further. Another strength was the adoption of multiple levels of rigour, including the transparent use of ENTREQ checklist (Tong et al., 2012) to evidence the quality of the systematic review methodology, as well as adopting principles from Lincoln

and Gruba's (1985) framework to ensure credibility, dependability, transferability and confirmability of the report. This multi-level approach was also adopted in appraising the quality of articles included; both the Critical Appraisal Skills Programme (CASP) checklist (CASP, 2024) and Whiffin et al (2021) appraisal system were used to consider the relevance, resonance and rigour of included papers. Finally, PRISMA guidelines were followed (Moher et al., 2009), with a separate second rater independently checking 20% of a random sample of included studies to check they met inclusion criteria and another rater co-rated all articles included using the CASP form (2024), Butler et al (2016) scoring and Whiffin et al (2023) framework to evaluate quality appraisal.

This is the first meta-synthesis on the subjective experience of healthcare professionals completing suicide risk assessments. It synthesizes the qualitative evidence on how healthcare professionals perceive their responsibilities and the process of undertaking a risk assessment, as well as providing insights into the associated emotions and dilemmas that patient encounters and healthcare settings can evoke. The current, limited research on professional delivery of suicide risk assessment draws its main focus on the 'how' and 'how well' of the process, frequently overlooking the professional's subjective perspective about why certain methods are adopted and the subsequent impact on the practitioner (Boukouvalas et al., 2020; Saab et al., 2022; Fedorowicz et al., 2023; Thangada et al., 2024). The findings presented in this thesis offer a nuanced understanding of subjective experiences of healthcare professionals, complementing previous literature. This ultimately supports bridging the gap between what is taught and how it is delivered, by providing specific recommendations for training and supervision.

The review has several limitations. Firstly, it is recommended that a second reviewer screens every stage of a systematic review (Noyes et al., 2024). Limited resources meant this was not feasible within the time scale. However, care was taken to ensure that a second reviewer completed independent screening and quality assessment, thus significantly reducing risk of bias across multiple areas. Furthermore, when completing coding and allocating themes the lead researcher kept a reflective diary, attended supervision to discuss results and provided examples of the coding process to ensure transparency of the process (Thomas & Harnden, 2008). Secondly, there was a saturation of Western based papers, which were predominantly represented by studies from Sweden (*n* = 6). This may limit

the generalisability of the identified themes of experience. Furthermore, it was noted that non-Western studies were categorised as making a 'peripheral' contribution to the synthesis (Whiffin et al., 2021), as some of their findings were less aligned with the specific aims of the review question. Given that the lead researcher is a White woman based in the United Kingdom, this may have introduced bias during the interpretation of findings, potentially resulting in missed cultural nuances. Although a second, independent reviewer agreed with the peripheral categorisation of these papers, future research would benefit from involving Patient and Public Involvement (PPI) to provide more diverse perspectives during the coding processes of global studies (Park et al., 2020)

Strengths and Limitations of the Empirical Paper

The empirical study has several strengths. It represents the first application of the Delphi method to establish a professional consensus on suicide risk detection and assessment for stroke survivors with aphasia. The research followed a three round Delphi structure, including an initial qualitative stage to compensate for the limited existing literature on the topic (Nasa et al., 2021). Retention was maintained at over 70% between individual rounds, though the cumulative retention rate was 64.5%. A 70% retention rate is typically considered a benchmark for reliability (Kilroy & Driscoll, 2006). These retention results suggest that the communication strategy and incentives used were effective in maintaining engagement over the eight-month period of data collection. Data were analysed using manifest content analysis to identify the iterative themes used to inform subsequent rounds, following a recommended approach in the Delphi literature (Hsu & Sandford, 2007; Nasa et al., 2021). To enhance the trustworthiness of the findings, a second reviewer independently verified the coding process. Transparency was maintained by reporting the pre-determined threshold for consensus, panel composition and selection, as well as sharing the iterative feedback process, this was consistent with established Delphi reporting standards (Jünger et al., 2017).

However, the study is subject to several limitations. The sample was predominantly comprised of speech and language therapists (SLTs), psychologists, and neuropsychologists (n = 27 of 31 in the first round). Whilst a practising nurse, occupational therapist and a few professional researchers participated in the earlier rounds, they were

not all retained for the final stage. This may reflect current perceptions of professional remit within stroke services, where psychologists and SLTs are often tasked with managing the intersection of mood disorders and communication barriers (Northcott et al., 2023). However, the resulting sample composition may limit some of the generalisability of the consensus across stroke settings. As noted by Gargon et al. (2019), the loss of specific professional groups during later rounds can introduce attrition bias, potentially resulting in a protocol that reflects discipline-specific perspectives rather than universal clinical utility (Diamond et al., 2014).

Another limitation was the restricted diversity of global representation in the sample, which was mainly comprised of white-identifying, female practitioners. A similar trend was also found in another recent stroke Delphi study (Ottaway et al., 2023). Although recruitment was open to global practitioners, it is considered that this may reflect western centric bias in stroke medicine and research. As socio-cultural factors can have a significant impact on the ways in which individual approached suicide risk assessment, it would have been useful to have recruited greater global representation to support further generalisability of this research.

Implications and Recommendations for Further Research

This combined work offers a considerable contribution to the literature on stroke and suicidology. Suicide in general healthcare settings remains chronically under-researched compared to psychiatric environments (Ballard et al., 2008; Inoue et al., 2017; Burns & Sher, 2025). By exploring the experiences of diverse healthcare professionals completing risk assessments and developing a consensus protocol for stroke survivors with aphasia, the findings provide important insights and overdue representation. People with aphasia are often excluded from research due to communication complexities, and a similar exclusion pattern exists across medical literature for individuals with complex presentations, including learning disability and sensory impairments (blindness/deafness) (DeCormier Plosky, 2022; Pennacchia et al., 2025; Shiggins et al., 2024). The systematic review helped to develop a deeper understanding of why professionals find might find suicide risk assessment challenging when working with people with additional needs, and it is hoped that the

professional consensus can support the development of further specialised guidance to support often overlooked individuals.

Building on the findings within the empirical paper, it will be useful to test the protocol developed by the Delphi study. Future research should explore the impact of such guidance on stroke professionals' self-reported confidence in using such methods, as well as review regularly to see if any further tools and adaptions can be added to support detection and risk assessment processes. It will also be important to include stroke survivors with aphasia and their carers in future reviews of the effectiveness of these approaches to suicide detection and assessment. Several recent articles have provided detailed guidance on how to support those with aphasia to engage in qualitative literature (Herbert et al., 2019; Shiggins et al., 2025). Such guidance will be useful in ensuring that contributions move away from tokenistic representation, and closer to co-production between the individual and researcher (Hersch et al., 2021). There is a recent, growing body of evidence exploring the lived experiences of stroke survivors with mood changes, mood assessment and aphasia (Baker et al., 2024; Siegle et al., 2025), however there is no current research focussed upon exploration of their experiences with suicide specific interventions. It is recommended that research is conducted on the subjective experiences of stroke survivors with aphasia of suicidal ideation, as well as the interventions that were experienced, or not experienced, in their post stroke care. This may be important for highlighting future priorities for stroke research, particularly linked to expanding on the call for greater focus to be drawn to mood changes following stroke (Stroke Association, 2021).

Previous research has indicated that increased normative belief that depression screening is an expected professional duty predicts increased intent to perform the task (Schlesinger et al., 2023). According to the Theory of Planned Behaviour (Ajzen, 1991), normative beliefs involve the perceived social pressure to engage in a behaviour, while control beliefs refer to an individual's perceived ease or difficulty in performing that behaviour. In research by Schlesinger et al (2023), control beliefs were not found to be a significant predictor of intent to screen people with post-stroke aphasia for depression in stroke clinicians. These theoretical considerations may provide a framework for understanding the high representation of Psychologists and Speech and Language Therapists in the empirical paper, as they are often perceived as leaders in their roles as

mental health and communication experts, creating stronger normative beliefs that they should carry out suicide detection. Carroll's (2024) UK and Australia based study expanded the TPB theory to intent to screen for suicidality in stroke survivors with aphasia, finding that the expectation to complete screening predicted a significant increase in UK SLT's intent to screen for suicide risk in those with aphasia. Though the Australian sample also showed an increased intent to screen, this difference did not reach significance. Unclear role expectations were highlighted in qualitative comments by participants as barriers to suicide screening, suggesting the need for clear delineation of role responsibility within services to increase the likelihood of suicide risk detection and assessment completion across roles and services. Future research could focus on piloting the implementation of these clear, refined role descriptions that draw specific focus to the professional responsibility of suicide risk assessment.

Finally, the systematic review found themes about the perceived challenge, and subsequent reliance on intuition for many HCP's working with individuals at risk of suicide. The difficulties encountered by professionals detecting and assessing risk of suicide are well reported throughout literature (Fedorowicz et al., 2023; Boukouvalas et al., 2020). However, with the understanding of the role of increased normative beliefs in facilitating intent to screen for suicide, future research may benefit from exploring the role of intuition or "gut feelings" and how they may interact with the development of control beliefs about suicide risk procedures. For example, control beliefs are typically informed by several factors, including self-efficacy, confidence, knowledge and holding the relevant skills (Ajzen, 1991). The application of Dual Process Theory in healthcare research suggests that reliance on intuitive, or system one, thoughts may distort control beliefs (Croskerry et al., 2009). While this type of processing allows for rapid decision-making in pressurised clinical environments, it is highly susceptible to cognitive bias and can foster an unfounded sense of overconfidence (Sequeira et al., 2019). Within a clinical context, this overconfidence may lead to poorer clinical appraisal. This is of particular concern if a practitioner's repeated reliance on gut feelings has created a false sense of perceived behavioural control and they may report feeling increasingly competent in their role, yet this very confidence could reduce the likelihood of them engaging in the effortful, system two analytical processes required for the complex clinical decision-making required when completing suicide risk

assessment (Croskerry, 2009; Sequeira et al., 2019). The meta-synthesis found a normalisation of the use of intuition or experience in lieu of appropriate training. Though intuition was perceived to be helpful, implementation of high-quality suicide risk management training and strong guidance could support the development of a more grounded approach to managing suicide in HCP's. Research could benefit from further analysis of the factors and experiences that support practitioners to engage both this intuitive sense, as well as the reflective reasoning that informs suicide risk assessment decisions.

Implications and Recommendation for Clinical Practise

The empirical paper provides the first professional consensus on detecting and assessing the risk of suicide in stroke survivors with aphasia. This has significant clinical implications and can support the development of future training and tools to increase accessibility for stroke practitioners. Moving forward, it is recommended that a practical toolkit for suicide detection and assessment is developed based on this professional consensus. While the 'Staying Safe from Suicide' (NHS England, 2025) document provided practical guidance for professionals assessing suicide risk in the UK, it lacked specific guidance on supporting individuals with communication difficulties, demonstrating an over-reliance on verbal risk-questioning. Although further research is needed regarding the implementation and effectiveness of this consensus protocol, current findings of the thesis portfolio support the call for greater access to suicide-specific training, joint working networks, and integrated approaches to detection and risk procedures within stroke services.

The results of the meta-synthesis identified gaps in training as a barrier to completing suicide risk assessments, a finding supported throughout the wider literature (Boukouvalas et al., 2020; Fedorowicz et al., 2023). While recent UK guidance has moved away from inaccurate risk stratification, towards risk formulation approaches (NHS England, 2025), the empirical paper found that one-third of panellists lacked confidence in formulation despite extensive experience. This portfolio, therefore, highlights the need for training that supports HCPs in approaching detection, assessment, and formulation from a more specialised perspective (Hawton et al., 2022). Research indicates that stigma, myths, and

negative attitudes can lead to the avoidance of in-depth assessments (Richard-O et al., 2023); however, interventions such as increased social contact and knowledge-based programmes may mitigate these stigmatising views (Zhamaliyeva et al., 2025). Evidence suggests that incorporating role-play and interactive scenarios into training can bolster risk assessment skills and control beliefs (Richard-O et al., 2023; Gryglewicz et al., 2020), while involving individuals with lived experience in training facilitation could improve positive representation for staff. Finally, formulation training would benefit from the universal integration of suicidal behaviour models, such as the Integrated Motivational-Volitional (IMV) model (O'Connor, 2011), alongside frameworks for understanding suicide within the context of communication difficulties (Costanza et al., 2021)

Research suggests that both joint working and interprofessional consultation are effective methods for detecting and assessing risk (Grant & Lusk, 2015). Furthermore, the systematic review in this thesis highlighted that collegial support is important when managing the complexities of suicide risk assessment. Providing greater access to clinical supervision may support professionals in navigating the challenges of this process. Notably, NICE (2022) guidance stipulates that all practitioners working with individuals who self-harm should have access to regular formal supervision from experienced senior staff; however, there is less specific guidance for those routinely conducting suicide assessments.

Research on healthcare professionals' experiences of supervision in this context is limited. Existing studies involving counsellors suggest that flexible, systemic approaches which shift the focus away from individual onus are more effective in developing clinical responses (White et al., 2024). Currently, there is a lack of quantitative research evaluating the outcomes of increased supervision for these professionals. Increased supervision is not, however, a substitute for formal training. Practitioners may still report feeling undertrained and uncertain if they perceive a gap in their clinical education (Ramberg and Wasserman, 2003). It is recommended that supervision hours be reviewed for staff regularly managing suicide risk, particularly when navigating communication barriers such as those encountered in stroke rehabilitation settings.

Conclusion

In conclusion, this thesis portfolio indicates that healthcare professionals encounter challenges when completing suicide risk assessment in healthcare settings. Participants described relying on a combination of intuition, professional support and experience to navigate gaps in training provision and resources. Additionally, this portfolio identified a professional consensus regarding the approaches experienced stroke clinicians find useful when detecting and assessing suicide risk in survivors with aphasia.

Taken together, this work highlights the necessity of establishing clear role responsibility and providing specialised training and clinical guidance to support healthcare professionals in suicide risk detection and assessment interventions. This is relevant when professionals support individuals with an increased risk of suicide, such as survivors with aphasia. The strengths and limitations of the methods have been considered alongside findings in relation to theories such as the TPB and Dual Processing Theory, as well as clinical frameworks including adapting the “Staying Safe from Suicide” guidance and the IMV, leading to several recommendations informed by existing literature

Appendices

Appendix A - Formatting guidelines for Journal of Clinical Psychology & Psychotherapy

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7. Data Availability Statement
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Book

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Appendix B - Search Strategy

Suicide assessment terms	Healthcare professional terms	Methodological terms
(suicid*) AND (assessment* OR screening OR "risk assessment" OR "SRA")	AND ("health* professional*" OR clinician* OR "health* worker*" OR nurse* OR psychologist* OR physician* OR doctor* OR "mental health staff")	AND (experience* OR perspective* OR view* OR opinion* OR attitude* OR perception*) AND (qualitative OR phenomenolog* OR "grounded theory" OR "thematic analysis" OR "ethnograph*" OR "lived experience")

Note: Boolean operators 'and' and 'or' were used to combine search terms and truncation operators such as '' were used to encapsulate variations of terms*

Appendix C – Example of Theme Generation for Thematic Synthesis

Theme	Codes	Key phrases	Quotes (Excerpt)
2: Relying on Experience and Intuition, in Lieu of Training	Intuition prompts risk assessment	Intuition can't be relied on all the time	"However, when the topic of gut feeling arose, the informants were careful to emphasise that it is not a standalone assessment that can be made solely based on a feeling. One nurse shared that she tried to avoid relying solely on her gut feeling." (Wardig et al, 2024), Concern was expressed that relying on the gut feeling might be unprofessional "(Wolf et al, 2016), "Also, there were different views on the subject of trusting intuition – while some nurses questioned its relevance, others described it as the tool they felt most secure in using." (Jansson & Graneheim, 2018)
		Explaining "Gut feeling"	"…if we feel uncomfortable during that triage process, there's a red flag" (Wolf et al, 2016), "'gut feelings' (an ineffable sense that something is not right, a lump in the stomach, an undefined feeling of unease or unpleasant 'butterflies') to contribute to their overall image of the patient during assessments." (Derblom et al, 2021), "Intuition was described as a vague feeling of discomfort that made them proceed further and assess the risk of suicide." (Jansson & Graneheim, 2018), "Nonverbal cues from patients or uneasy "gut feelings" arising during the patient encounter helped them

	recognize risk for self-directed violence.” (Roy et al, 2016)
“Gut feeling” builds with experience	“I think I have developed a better gut feeling, or perhaps maybe not a better gut feeling, but you trust yourself or your feelings more. It was harder in the beginning, then you immediately ordered constant observation or called the physician… Now it is easier to take it easy or trust your intuition.” (Derblom et al, 2021)
Intuition and gut feelings are valuable	"…Absolutely, if I have a gut feeling that something is wrong and there is a potential risk for suicide, it is crucial to follow that instinct. In such cases, it is important to assess the situation as potentially risky, and signal this concern to colleagues or other appropriate healthcare professionals" (Wardig et al, 2024), "Several nurses referred to this intuition as a “gut feeling”; a feeling that something is not right or that a situation needs to be handled in a special way. They stated the importance of taking their “gut feeling” seriously, as it was usually correct." (Wardig et al, 2022b)
Gut feelings not taught	" A conflict could arise when there was a lack of congruence between the two. “It feels unprofessional […] it is not what I learned in school, where you use risk factors and diverse criteria to make an overall judgment. I do that too, but sometimes there is a conflict between the two and then I have to

		find out what this feeling stands for and choose which part to act on" (Wolf et al, 2016)
Interpreting the whole presentation	Reading between the lines	“The nurses said that they needed to be sensitive to what was said between the lines as the assessment is the basis for whether the patient needs direct care or is referred further in the care system.” (Wardig et al, 2022b)
	Not just verbal communication	"They talk less, withdraw more, you can see that they become more … they start isolating themselves.", " The nurses also tried to observe how patients interacted with each other and paid attention to the emotional content in their meetings with patient." (Derblom et al, 2021) "Everything is stored somewhere in the brain and in the body and one observes a person’s eye contact, affect, everything, yes, everything merges into a global impression.” (Waern, et al 2016)
	Body language	"You are drawn to some room simply to check on the situation, and then depends on whether you perceive something in someone’s body language or tone of voice or otherwise, I don’t know" (Petrik et al, 2015) "whether it’s eye contact or kind of a flat affect or just not really seeming like they’re giving you the whole story, we have further questions we can ask, which are similar, that will build up that score,

	that kind of lead us down that path and justify our working that angle." (Wolf et al, 2018) ""…eighty percent is in the body language, I don't know if this is true, but there are subtle ways of saying things, ways of being, ways of looking at one another." "……. in the end, the gut feeling……. (the patient's) facial expression, ….. anxiety shining in his eyes, the way of speaking or avoiding a question, those are the things that create security or insecurity (in clinical assessment)…" (Waern et al, 2016)
Subtle cues to look out for	Physicians considered relevant components of the history and physical examination as vital for risk assessment. They described clues in their patients' appearance and behavior and mental status examinations prompting their further assessment. A patient comes in with a non-psychiatric complaint, but their behavior seems atypical for what their actual complaint is … not looking me in the eyes, being evasive with answers, [acting] upset over something that seems miniscule." (Du et al, 2025), "nurses having adequate experience and training to detect a patient's subtle cues, and the ability to find a safe place for patients to be more fully assessed within the department." (Wolf et al, 2018)

Experience supporting assessment	Lack of experience = poorer assessment	"I find one of the other challenges is new-to-triage nurses don't have the expertise to know what cues and what questions to ask or what about body language or how the patients are withdrawn or eye contact, you know, very quiet voice, soft spoken, evasive" (Wolf et al, 2016), "The importance of having experience to perform these assessments permeated the interviews. As a junior nurse, suicide risk assessment in TC can lead to feelings of inadequacy and a feeling of lack of competence for the task." "Nurses with less working experience expressed more uncertainty about suicide prevention and making suicide risk assessments than those with several years of experience." (Wardig et al, 2022a)
	Comfort with asking questions = more disclosure	"Having experience in psychiatric care provided a sense of confidence in knowing what to ask, how to ask the questions and what common signs to look for in assessing suicide risk." (Wardig et al, 2024), "Others, however, over time, felt more confident, more self-reliant and more courageous about asking difficult questions and making quicker assessments" (Derblom et al, 2021), "Our participants report the process of understanding and interpreting these patient behaviors as dependent on a nurse's level of nursing experience" (Wolf et al, 2016)

Feelings of security	"As the nurses' experiences increased, they found a sense of security in their own capabilities and learned to speak openly about suicide." (Jansson & Graneheim, 2018)
Experience as a teacher	"Evaluation of emotional contact was something that the psychiatrist learned over time. Although central to the assessment, it was not something that could be taught during a lecture. "Emotional contact is not particularly easy to lecture on or to describe for younger colleagues." "It's all about years of practice, practice and more practice." (Waern et al, 2016)
More effective assessments	"Participants described knowledge from their professional experience in ED and other settings as major assets, enabling quick and adaptive responses to different clinical problems rather than just following lengthy protocols." (Roy et al, 2016)
Effects of previous experiences	" In these meetings, a challenge emerged in not putting in too many personal values based on previous experiences of people with mental illness." (Wardig et al, 2022a), "The nurses reported that sometimes the knowledge about a patient made it more difficult to make a reliable suicide risk assessment." (Wolf et al, 2016), "One nurse said: "My experience is that those who have decided to end their lives, they don't

		talk about it" (I:4)." (Jansson & Graneheim, 2018)
Knowing Patients supports assessment	Developing trust	"The nurses described how trustful patient–nurse relationships could help patients to speak more openly about their situation and nurses to make more reliable assessments." (Derblom et al, 2021), "At the individual staff level, the staff needs to build a close relationship with the clients to get them to open up, but this can be achieved when they have been trained to handle people with suicidal tendencies." (Rukundo et al, 2022), "The interaction could impart a sense of acknowledgement, and sometimes even instill hope. "A consultation that validates the relationship and increases trust is absolutely most important." (Wolf et al, 2016)
	Accessing History	"Knowledge of patients' history and background was considered an essential part of the assessment." (Derblom et al, 2021) "During triage, nurses would check the medical records or chief complaints of patients to confirm their medical history (schizophrenia, depression, anxiety, etc.), and whether they had recently experienced negative life events such as family member death, job loss, divorce, etc. N6: "We were sensitive to patients' medical history of mental illness when checking their medical records". (Du et al, 2015)

Appendix D - ENTREQ Checklist

Enhancing transparency in reporting the synthesis of qualitative research

No.	Item	Descriptor	Manuscript Page No.
1	**Aim**	State the research question or the aim of the synthesis.	27
2	**Appropriateness**	Provide a rationale for why qualitative synthesis is appropriate.	28
3	**Methodology**	Identify the qualitative synthesis methodology (e.g., meta-ethnography).	28
4	**Search strategy**	Describe the search strategy (e.g., electronic databases, hand searching).	28
5	**Selection criteria**	State the inclusion/exclusion criteria used to select primary studies.	29
6	**Electronic Search**	Provide electronic search strategies (e.g., keywords, filters used).	138
7	**Context**	Describe the context of the included studies (e.g., setting, population).	37-43
8	**Study screening**	Describe the process of screening studies for inclusion.	30

9	**Search results**	Report the number of studies identified and screened.	34
10	**Rationale for appraisal**	Describe the rationale for appraising (or not appraising) studies.	29-31
11	**Appraisal tools**	State the specific tools or frameworks used for quality appraisal.	29-31
12	**Appraisal process**	Describe the process of quality appraisal (e.g., number of reviewers).	29-31
13	**Appraisal results**	Present results of the quality assessment of included studies.	37-43 & 149-152
14	**Data extraction**	Describe what data were extracted from the primary studies.	32
15	**Software**	Identify any software used for the synthesis (e.g., NVivo).	29-32
16	**Coding**	Describe the process for coding the data (e.g., line-by-line).	32-33
17	**Study comparison**	Describe how comparisons were made within and across studies.	32-33
18	**Derivation of themes**	Explain whether themes were derived inductively or deductively.	32-33
19	**Quotations**	State whether the findings include participant quotations.	32

20	**Synthesis output**	Describe the synthesis findings (e.g., new theory, conceptual model).	46-55
21	**Research team**	Describe the research team and their role in the synthesis.	28, 29 and 30

Appendix E – CASP Critical Appraisal of Qualitative Studies

CASP Checklist Criteria	Petrik et al, (2015)	Waern et al (2016)	Roy et al (2017)	Jansson & Granehe im (2018)	Munoz-Sanchez et al (2018)	Wolf et al (2018)	Derblom et al (2021)	Rukundo (et al, 2022)
1. Clear statement of research aims	1	1	1	1	1	1	1	1
2. Methodology appropriate	1	1	1	1	1	1	1	1
3. Research design appropriate	1	1	1	1	1	1	1	1
4. Recruitment strategy appropriate	1	0.5	0.5	1	1	1	1	1
5. Data collection appropriate	1	1	1	1	1	1	1	1

6. Reflexivity (Researcher/Participant relationship)	0	1	0	0.5	0.5	0	0.5	0
7. Ethical issues considered	0	0.5	0	1	0.5	0	0.5	0.5
8. Data analysis sufficiently rigorous	0.5	1	1	1	0.5	1	1	1
9. Clear statement of findings	1	1	1	1	0.5	1	1	1
10. Research value/contribution	1	1	1	1	1	1	1	1
Total CASP Score	**7.5**	**9**	**7.5**	**9.5**	**8**	**8**	**9**	**8.5**
Relevance to Synthesis	**Peripheral**	**Core**	**Central**	**Core**	**Peripheral**	**Peripheral**	**Central**	**Central**

CASP Checklist Criteria	Wärdig et al (2022)a	Wärdig et al (2022)b	Wärdig et al (2024)	Du et al (2025)	Xanthopoulou et al (2025)
1. Clear statement of research aims	1	1	1	1	1
2. Methodology appropriate	1	1	1	1	1
3. Research design appropriate	1	1	1	0.5	1
4. Recruitment strategy appropriate	1	1	1	1	0.5
5. Data collection appropriate	1	1	1	1	1

6. Reflexivity (Researcher/Participant relationship)	0	0	0	0	0
7. Ethical issues considered	0.5	0.5	0.5	0.5	0.5
8. Data analysis sufficiently rigorous	1	1	1	0.5	1
9. Clear statement of findings	1	1	1	1	1
10. Research value/contribution	1	1	1	0.5	0.5
Total CASP Score	**8.5**	**8.5**	**8.5**	**7**	**7.5**
Relevance to Synthesis	**Central**	**Central**	**Core**	**Peripheral**	**Central**

Appendix F - Formatting guidelines for Aphasiology

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**Usage in 2021-2023 for articles published in 2019-2023.

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- There are no strict formatting requirements, but all manuscripts must contain the essential elements needed to evaluate a manuscript: abstract, author affiliation, figures, tables, funder information, references. Further details may be requested upon acceptance.
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Greater detail will be required for single case studies than for large group studies. For single case studies detailed and clear assessment details including raw scores on assessments are usually required. Robey et al. (1999) recommend that for single case treatment studies, sufficient detail (e.g., raw scores, descriptive statistics) is required so that standard deviations can be calculated from data presented to allow meta-analysis of series of published single case treatment studies.

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- Methods & Procedures: To include outline of the methodology and design of the study using accepted terms; materials employed and participant numbers with comprehensive relevant demographic information; the nature of the analyses performed.
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Appendix G - Ethical Approval for Empirical Study

University of East Anglia
Norwich Research Park
Norwich. NR4 7TJ

Email: ethicsmonitor@uea.ac.uk
Web: www.uea.ac.uk

Study title: Suicidality Assessment in Aphasia - a Delphi Study (SAADS)

Application ID: ETH2526-0698 (significant amendments)

Dear Kellsey,

Your application was considered on 1st November 2025 by the FMH S-REC (Faculty of Medicine and Health Sciences Research Ethics Subcommittee).

The decision is: **approved**.

You are therefore able to start your project subject to any other necessary approvals being given.

If your study involves NHS staff and facilities, you will require Health Research Authority (HRA) governance approval before you can start this project (even though you did not require NHS-REC ethics approval). Please consult the HRA webpage about the application required, which is submitted through the IRAS system.

This approval will expire on **5th January 2026**.

Please note that your project is granted ethics approval only for the length of time identified above. Any extension to a project must obtain ethics approval by the FMH S-REC (Faculty of Medicine and Health Sciences Research Ethics Subcommittee) before continuing.

It is a requirement of this ethics approval that you should report any adverse events which occur during your project to the FMH S-REC (Faculty of Medicine and Health Sciences Research Ethics Subcommittee) as soon as possible. An adverse event is one which was not anticipated in the research design, and which could potentially cause risk or harm to the participants or the researcher, or which reveals potential risks in the treatment under evaluation. For research involving animals, it may be the unintended death of an animal after trapping or carrying out a procedure.

Any amendments to your submitted project in terms of design, sample, data collection, focus etc. should be notified to the FMH S-REC (Faculty of Medicine and Health Sciences Research Ethics Subcommittee) in advance to ensure ethical compliance. If the amendments are substantial a new application may be required.

Approval by the FMH S-REC (Faculty of Medicine and Health Sciences Research Ethics Subcommittee) should not be taken as evidence that your study is compliant with the UK General Data Protection Regulation (UK GDPR) and the Data Protection Act 2018. If you need guidance on how to make your study UK GDPR compliant, please contact the UEA Data Protection Officer (dataprotection@uea.ac.uk).

Please can you send your report once your project is completed to the FMH S-REC (fmh.ethics@uea.ac.uk).

I would like to wish you every success with your project.

On behalf of the FMH S-REC (Faculty of Medicine and Health Sciences Research Ethics Subcommittee)

Yours sincerely,

Stanley Musgrave, Deputy Chair, FMH-sREC

Appendix H - Participant Information Sheet

Participant Information Sheet

Suicidality Assessment in Aphasia: a Delphi Study (SAADS)

We would like to invite you to take part in our new research study. This research is being undertaken as part of PhD project, and the Chief Investigator is Kellsey McCann. Participating in the research study is completely voluntary. If you are interested in taking part in the study, then please continue reading the participant information sheet which will explain details about the research. Please be aware that this information sheet refers to suicide throughout, please find links/references to supporting charities and services at the end of this document.

Purpose of the Study

Research suggests that rates of suicidality are increased following stroke. It is reported that 10-15% of survivors have experienced suicidal ideation and estimated that stroke survivors are twice as likely to attempt suicide. It is thought that those who have post-stroke complications such as aphasia, may have even greater vulnerability due to factors such as isolation, frustration etc. Currently there are limited outcome measures that can be used to detect and assess the presence of suicidal ideation within stroke survivors, particularly in those with aphasia. Studies have also identified a lack of consistency and confidence in assessing this complex area of need. This study aims to develop a professional consensus on the most suitable methods for detecting and assessing suicidality in people with post-stroke aphasia.

What does taking part involve?

After reading this information sheet and confirming you want to opt in to the study, you will be invited to up to three rounds of an online questionnaire. We will retain your professional email address on a mailing list that is stored on a password protected spreadsheet on our secure drive. These email addresses will be deleted following completion of the study. Each round is expected to last about 20 minutes. The rounds will be sent at four or six-week intervals to support completion across participants. Two weeks after receiving each round, you will receive a reminder email to complete the study, this will be sent to all participants.

You will be asked to assign yourself a unique identifier of numbers, special characters and letters, confirm the email address you wish to use to receive the rounds and consent to the study on the first page of the questionnaire. You also will be asked a set of demographic

questions, including your age bracket, ethnicity, education level, field etc. Upon agreeing to take part in the study information will be anonymously stored using your unique identifier. You will then be asked some questions regarding your opinions about detecting and assessing suicidal ideation in stroke survivors with aphasia. Following the first round the results will be fed back to participants via email. The second round of questions will ask you to reconsider your original ratings to gain a consensus on expert opinions regarding approaches to detection of suicidality and risk assessment. Once these rounds are completed, a general overview of results will be shared again and then data analysis will begin. You will be provided with a debrief sheet at the end of the final round. To thank you for your time, you will be asked to provide an email address for a gift voucher to be sent to.

What are the potential benefits/risks of participation?

You will be contributing to research on post-stroke suicidality. We hope this project will help inform research and practice regarding suicide risk assessment with people with post-stroke aphasia. We recognise that the subject of suicide can be very sensitive and encourage anyone effected by reading about or engaging in this study to seek support if they feel effected by its contents. At the bottom of this information sheet, we include resources to support those affected by suicide. As you are dedicating valuable time to this project, a £10 (or £10 equivalent in other currency) Amazon voucher will be gifted upon the completion of all the rounds of this study (two or three).

What will happen if I do not want to carry on with the study?

If during the rounds of questionnaires, you decide that you no longer want to continue participating in this project, you will be able to withdraw your participation via email to the research team. As part of the consent process, following your withdrawal from the study, we will retain the data provided as it is likely it has informed the next round of questionnaires. If you wish to withdraw your data from the study, you must do so within two weeks of completing each individual round of the questionnaire. You can make this request by contacting the lead researcher (Kellsey McCann) and stating your unique identity number – which you will generate at the start of the study.

How will we use information about you?

We will need to use information from you for this research project.

This information will include your demographic information, such as your age, qualification level, clinical role, and ethnicity. People will use this information to do the research or to check your records to make sure that the research is being done properly.

People who do not need to know who you are will not be able to see your name or contact details. Your data will have a code number instead.

We will keep all information about you safe and secure by:

- The use of anonymised identifiers
- Data will be stored on a secure password protected University provided cloud storage location
- Only the Lead researcher will have access to personalised data
- Only the research team and University auditors will have access to the anonymised data.
- The process of securing your data is in accordance with UK GDPR and the Data Protection Act.

Personal data will be destroyed following completion of the study, anonymised data will be maintained by an administrator in the Universities research database team for 10 years following completion of the research and then will be destroyed in line with local policy.

International transfers

Your data will not be shared outside the UK.

How have patients and the public been involved in this study?

The researcher consulted with stroke clinicians to ascertain the appropriateness of information/consent document when recruiting for a study of this sensitive nature, those consulted had specialised interest in the subjects of suicidality and increasing participation from diverse backgrounds within research and teaching at UEA, both of which were identified as key factors for consideration in this study. Furthermore, a specialist communication therapist in aphasia was consulted in the completion of the outcome measures, this was to better inform the researchers of the methods and adaptation of risk assessment within this group.

Who to contact with questions or concerns?

This study is supervised by Dr. Catherine Ford and Professor Niall Broomfield. If at any point in the study, you have any concerns or questions then you can contact the lead researcher Kellsey McCann via email: k.mccann@uea.ac.uk. For complaints, you can contact Professor Sian Coker (Programme Director of the UEA Doctoral Programme in Clinical Psychology) via email: s.coker@uea.ac.uk

Who has reviewed this study?

This research study has ethical approval from the UEA Faculty of Medicine and Health Sciences Research Ethics Committee.

Resources UK

*If you are distressed by the contents of this study, it is suggested that you contact your supervisor / service lead / or lead researcher (**k.mccann@uea.ac.uk**) via email for further support.*

Survivors of Bereavement by Suicide (SOBS) - https://uksobs.com/

MIND - Losing someone to suicide

First Hand (support for those who have witnessed suicide) - https://first-hand.org.uk/

Cruse - Coping when someone dies by suicide

Resources International

113 - Homepage | 113 Zelfmoordpreventie (Netherlands)

Suicide Prevention Australia - Home - Suicide Prevention Australia

International Association for the Prevention of Suicide - International Association for Suicide Prevention - IASP (Int)"

Appendix I - Debrief for Participants

Thank you for completing the third round of this study. Once all responses have been collected, you will receive an email with an overview of the scores present in these responses. From this data, we will send you an email with the provisional results. It is expected that this will be sent 4-6 weeks after the initial email containing this round of questions.

If you are distressed by the contents of this study, it is suggested that you contact your supervisor / service lead / or lead researcher via email for further support. The email addresses of the lead researcher is included below:

Resources UK Survivors of Bereavement by Suicide (SOBS) - https://uksobs.com/ MIND - Losing someone to suicide First Hand (support for those who have witnessed suicide) - https://first-hand.org.uk/ Cruise - https://www.cruse.org.uk/understanding-grief/grief-experiences/traumatic-loss/coping-when-someone-dies-by-suicide

Resources International 113 - https://www.113.nl (Netherlands), Suicide Prevention Australia - https://www.suicidepreventionaust.org (Australia) International Association for the Prevention of Suicide - https://www.iasp.info (Int)

Kellsey McCann (Lead Researcher): k.mccann@uea.ac.uk

Appendix J– Example Question from First Round Questionnaire

17. Please detail the methods that you would use/suggest to detect risk of suicidality when working with a stroke survivor with aphasia?
Please fill in the text box below *

Enter your answer

Appendix K - Example Question from Second Round Questionnaire

6. Please consider the extent to which you agree that the following observer/informant scales (completed by family or medical staff) are useful in detecting the suicide risk in people with **receptive aphasia?** *

	Strongly Disagree	Slightly Disagree	Slightly Agree	Strongly Agree	No experience in using this scale
Stroke Aphasic Depression Questionnaire and Hospital version (SADQ/-H)	◯	◯	◯	◯	◯
Antecedent, Behaviour, and Consequence (ABC) charts	◯	◯	◯	◯	◯
Behaviours of Anxiety scale - Carer (BOA)	◯	◯	◯	◯	◯

Appendix L – Email Inviting Participants to Second Round Questionnaire

"Dear [*Unique Identifier]*

Thank you again for contributing to the first round of the SAADS, we received a lot of interesting responses relating to detection and assessment of suicidality. The context of the responses was analysed, and the following themes were highlighted across text submitted:

Question 1 – Detection methods	**Question 2 – Assessment methods**
Self-reported Visual Mood Measures	Self-reported Visual Mood Measures
Self-reported Verbal Mood Measures	Self-reported Verbal Mood Measures
Observer Mood/Behaviour Measures	Observer Mood/Behaviour Measures
Risk Assessment Questions – Suicidality	Risk Assessment Questions - Suicidality
Observations	Observations
Review Medical History	Review Medical History
Discussion with healthcare staff/MDT/professionals	Discussion with healthcare staff/MDT/professionals
Joint working with other healthcare staff to interview	Joint working with other healthcare staff to interview
Supported conversation or supported interview (total communication, visual aids, communication aids)	Adapted approaches to Risk Assessment Questions (total communication, visual aids, communication aids)
Clinical Interview (structured, semi-structured, verbal questions)	Clinical Interview (structured, semi-structured, verbal questions)
Unstructured informal conversation with individual	Discussion with Family or Next of Kin or Carer
Discussion with Family or Next of Kin or Carer or peer groups	Risk Formulation

Though themes are similar across both questions, there were difference observed in the frequency of each method. For Q1 (Detection) **Self-reported mood measures (visual & verbal), Supported conversation/interview, Observation** and **Discussion with Family/NOK or carers** were the most frequently described methods. For Q2 (Assessment) **Adapted approaches to risk assessment** and **Risk assessment questions** and **Discussion with healthcare staff/MDT/professionals** were most frequently described.

A follow up questions also asked your thoughts on the key factors to consider when detecting and assessing risk of suicide in people with post-stroke aphasia. Responses suggested that the type and severity of aphasia informed your choice of methods, as well as the reliability of responses due to the person's level of understanding ("yes" or "no" answers) and checking that meaning is shared to avoid making assumptions. Appropriate adaptations of assessment methods o were again reinforced in these responses, and answers to this question further highlights the complexity of completing assessment of suicide risk within this population.

These data have been analysed and used to inform the next round of the questionnaire. This round has been broken down into detection and assessment methods again and asks you to rate the extent to which you agree each method is useful or accessible, and your confidence in using each method.

Please find the link to the next round of the questionnaire: …

You will be asked to cite your personal identifier which is included in this email. This questionnaire could take around 20 – 30 minutes to complete.

We will send a reminder email in 2 weeks.

Any questions, please contact me on this email.

Kind regards,

Kellsey McCann

Trainee Clinical Psychologist (UEA and CPFT)"

Appendix M – Email Inviting Participants to Third Round Questionnaire

"Dear Participant,

ID - [*Unique Identifier]*

Thank you for completing the previous round of the SAADS. I apologise for the slight delay in sending this questionnaire. This email contains a link to the final round of the study.

In this round, you will be asked to reconsider your previous ratings about the usefulness of certain methods of suicide detection and assessment. This time, your ratings are framed with the context of your fellow participant's responses.

Please consider these before rating again. I have included a graph of your responses to the previous round, and the current percentage of agreement amongst participants is displayed on the third-round questionnaire.

We have reached the consensus threshold for some items, and not for others. You have been asked to re-rate all questions again (even those with 100% agreement/disagreement) for the stability of results across rounds.

Link: …

At the end of this questionnaire, there is an opportunity to submit your email and preferred currency to receive an Amazon voucher as a token of our appreciation for completing all three rounds of this study.

If you have any questions, please feel free to contact me.

Kind regards,

Kellsey McCann

Trainee Clinical Psychologist (UEA and CPFT)"

Appendix N – Email Closing Study and Thanking Participants

Dear Participants,

We are delighted to confirm that the Suicidality Assessment in Aphasia: a Delphi Study (SAADS) is now complete. We want to express our sincere gratitude for your continued commitment and valuable participation over the last six months. This research would not have been possible without your dedicated support.

Next Steps and Findings

The data collection phase is finished, and the next stages involve data analysis and writing up the final findings. We aim to submit these findings for publication next year and hope to disseminate the results across 2026. Following analysis, we will send a further email including the levels of consensus established across the three rounds of the study.

We are optimistic that the findings of the SAADS study will significantly help to inform the future development and refinement of suicide detection and risk assessment approaches for stroke survivors with aphasia.

For those who provided an email address to receive an Amazon voucher, we will be processing these over the next few weeks. The voucher will be sent to the email address you provided at the end of the third-round questionnaire. Please keep an eye on your inbox.

If you have any further questions in the meantime, please do not hesitate to contact me.

Once again, thank you for making this important research possible.

Yours sincerely,

Kellsey McCann

Trainee Clinical Psychologist (UEA and CPFT)

Appendix O – An Example of the Codebook for Question One of Round One

Name of Code	Code Description	Examples of Code (Quotes)
Standardized Self- reported Visual Mood Measures	Mood measure using visual scales that are validated within stroke survivors	Visual Analogue Self Esteem Scale (VASES), Depression Intensity Scale Circles (DISCS), Visual Analogue Mood Scales (VAMS), Brief Assessment Schedule Depression Cards (BADSEC)
Standardized Self-reported Verbal Mood Measures	Mood measure using verbal scales that are validated within stroke survivors	Patient Health Questionaire-9 (PHQ-9), Signs of Depression Scale (SODS)
Observer Mood/Behaviour Measures	Mood measure using family/carer/HC professional observer scales that are validated within stroke survivors	Stroke Aphasic Depression Questionnaire (SADQ), Stroke Aphasic Depression Questionnaire (SADQ-H). ABC charts
Direct Risk Assessment Questions - Suicidality	Asking direct closed, or open questions about the stroke survivors risk of suicide	"How bad have things got, Did it ever get to the point where you wanted to end it all?, Have you seriously considered taking your own life?" "Have they expressed thoughts of harming themselves. this would involve asking direct questions around thoughts and actions to end your life."

		"Are you thinking about suicide" or "are you having thoughts about taking your own life" I would ask patients about suicidality in routine risk assessment I would use a risk assessment if there were causes for concern, for example the patient has expressed thoughts of harming themselves. this would involve asking direct questions around thoughts and actions to end your life. Gauge: Ideation, Intent, Plan, & Reasons for living
Observations	Using different strategies to observe stroke survivors engagement, behaviour, interaction with others.	I would also be watching for behavioural observations that may suggest they are at elevated risk of suicidality or mood issues, such as disengagement with care, expressions of hopelessness, possible self-harming behaviours.

		I would look out for warning behaviours, withdrawing from friends, family or society, anxiety, agitation, unable to sleep or sleeping all the time, dramatic changes in mood, rage, anger, seeking revenge, acting recklessly or engaging in risky activities, seemingly without thinking increasing alcohol or drug abuse. A combination, firstly overall impression, demeanour and then questioning.
Review Medical History	Look at medical records of the stroke survivors, identifying any risk factors for suicidality in their history	History of depression and suicide Historic indicators, social care info History of mental health difficulties Review medical notes to obtain any information about pre-existing mental health concerns. mental health conditions (current or previous),

		involvement of psychological services. Post-stroke changes in mood. consider mental health history and if there is any history of depression, suicide attempts, etc that may place them at higher risk.
Discussion with healthcare staff/MDT/professionals	Having conversations with other medical practitioners about the stroke survivors well-being. Can be part of an MDT meeting, ward review or 1 to 1discussion.	Seek a 'handover' or speak with recent treating clinicians liaise with the nursing team about any concerning behaviours Liaison with MDT Discussions with wider MDT MDT discussion
Joint working with other healthcare staff to interview	Inviting other health professionals to join sessions, to support the delivery of communication adaptations, mood measures etc.	Consider joint session with SLT. adapted DISCs with support from SLT Discussion with Neuropsychology/Psychiatry if indicated would be helpful to know how they screen, and joint session to facilitate communication if needed.

		Clinical Interview - jointly with SLT colleagues if needed.
Supported conversation or supported interview (total communication, visual aids, communication aids)	A structured approach to conversation or interview which includes various methods of supporting communication, including Supported Conversation for adults with aphasia, Total communication, Visual aids, communication aids etc.	Qualitative interview with aphasia supports e.g. yes/no boards, visual representations of emotions or visual representations of qualifiers on measures using personalised communication adaptions e.g. closed questions, key words written down or pictorial support. Supported conversation around mood, depending on the level of the patient's comprehension and expressive language ability use total communication approach to explore Supported conversations with patients
Standardised Clinical Interview (structured, semi-structured, verbal questions)	A clinical interview using structured or semi-structured conversation between a mental health	Clinical interview Motivational interview

	professional and a patient or client, designed to gather information for assessment, diagnosis, and planning	
Unstructured informal conversation with individual	Having a conversation around mood and state of wellbeing without formal structural approach	I don't use anything formal. I speak to the person 1:1 open/general questions Informal assessment, Conversation
Discussion with Family or Next of Kin or Carer	Having a conversation with the people around the stroke survivors, to understand mood changes or anything that they have noticed regarding the stroke survivors wellbeing	I speak to the person and their significant others Ask the persons family or carers if the person has expressed suicidal thoughts. clinical interview with patient and family, Check with/speak with care staff (speaking with family and friends may 'veer into' assessment, but even early in approaches to 'screening' I would strongly prefer to establish consent for open dialogue /

		involving family & friends) asking family and friends if they have any concerns with the consent of the patient With consent - discussions with family / carers liaison with family/carers. conversations with NOK/family, I would liaise with family/NOK/patient and review medical notes to obtain any information about pre-existing mental health concerns. conversation with patient and family Liaison with family and MDT Discussions with wider … family, carers or staff caring for the person. Information from staff and family where relevant 3rd party reports from relatives

Appendix P - Professional Consensus

A Professional Consensus on Useful Methods and Approaches to Suicide Risk Assessment and Detection in Stroke Survivors with Aphasia

Mood Measures that reached consensus as useful for detecting suicide risk in people with Expressive Aphasia (>75% agreed)
- Brief Assessment Schedule Depression Cards (BASDEC) - Stroke Aphasic Depression Questionnaire/Hospital (SADQ/H) - Visual Analogue Mood Scales (VAMS) - Visual Analogue Self-Esteem Scale (VASES) - Patient Health Questionairre-9 (PHQ-9)

Mood Measures that reached consensus as useful for detecting suicide risk in people with Receptive Aphasia (>75% agreed)
- Brief Assessment Schedule Depression Cards (BASDEC) - Stroke Aphasic Depression Questionnaire-Hospital Version (SADQ-H) - Visual Analogue Mood Scales (VAMS) - Visual Analogue Self-Esteem Scale (VASES) - Patient Health Questionairre-9 (PHQ-9) (<75% consensus disagreeing with its usefulness)

Risk Detection Methods that reached consensus as useful for detecting suicide risk in people with Expressive Aphasia (>75% agreed)
- Discussion with Family/ Next of Kin/ Carer - Discussing the case with other Healthcare Professionals - Supported Interview - Asking Direct Risk Questions - Reviewing Medical History - Joint working with other Healthcare Professionals - Observations - Informal Conversations - Standard Clinical Interview

Risk Detection methods that reached consensus as useful for detecting suicide risk in people with Receptive Aphasia (>75% agreed)
- Discussion with Family/ Next of Kin/ Carer - Discussing the case with other Healthcare Professionals - Supported Interview - Reviewing Medical History - Joint working with other Healthcare Professionals - Observations - Informal Conversations
Risk Assessment methods that reached consensus as useful for assessing suicide risk in people with Expressive Aphasia (>75% agreed)
- Discussing the case with other Healthcare Professionals - Joint working with other Healthcare Professionals - Discussion with Family/ Next of Kin/ Carers - Asking Direct Risk Questions - Reviewing Medical History - Observations - Using Standardised Mood Measures - Standard Clinical Interview
Risk Assessment methods that reached consensus as useful for assessing suicide risk in people with Receptive Aphasia (>75% agreed)
- Discussing the case with other Healthcare Professionals - Joint working with other Healthcare Professionals - Discussion with Family/ Next of Kin/ Carers - Asking Direct Risk Questions - Reviewing Medical History - Observations - Using Standardised Mood Measures
Communication approaches that reached consensus as useful for facilitating suicide risk assessment in people with Receptive or Expressive Aphasia (>75% agreed)

- Body language
- Gestures
- Drawing
- Speech
- Reading and speaking
- Writing
- Digital
- Images or symbols

Note: All approaches listed above reached the consensus threshold of agreement across both rounds of the study, in supporting individuals with expressive or receptive symptoms.

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